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Safety standards for invasive procedures in out-patient departments, managing subglottic stenosis in pregnancy, a critical review on follow up of head and neck cancer patients, and a new classification for cochleovestibular malformations

Musheer Hussain, Jonathan Fishman and Edward Fisher, Senior Editors

Editorial

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The inception of the World Health Organization checklist has transformed the way surgeons operate around the world. The emphasis has hitherto been on in-patient procedures, with an increase in out-patient based operative procedures in British Isles checklists to avoid errors. Coates and Carrie[1] have produced a useful safety standard for endoscopic procedures performed under local anaesthetic in the out-patient setting. The authors draw attention to the shift toward ambulatory care in the health service, directed by patient choice, technological advances and the opportunity for cost savings.

The presence of subglottic stenosis in pregnant women is significant and rare, and may lead to a life-threatening delivery;[2] management therefore requires expertise. Damrose and colleagues[3] describe their use of balloon dilatation with non-invasive ventilation techniques in the treatment of pregnant patients with idiopathic subglottic stenosis. There is limited experience in the management of this condition, so this paper is an excellent addition to our knowledge.

Kytö *et al.*[4] have challenged the current follow-up duration of head and neck cancer patients. *The Journal of Laryngology and Otology* published the UK consensus documents on head and neck cancer, including various aspects of follow up,[5–7] that has informed British practice. Kytö *et al.* report on 456 patients with new malignancies of the head and neck, seen over nine years, who were followed up for five years in keeping with current guidelines. The authors found that 22 per cent of patients ($n = 94$) relapsed during the study period; 90 per cent of these relapses occurred in the first three years of follow up. Interestingly, all patients with a late recurrence had symptoms of the disease; however, cases of a recurrent tumour in patients with no symptoms were all found within 34 months of the original therapy.

Various classifications for cochleovestibular malformations exist. Grover *et al.*[8] have added to this in their well thought out paper that considers three features of cochlear anatomy. Their multicentre study, comprising 436 patients, is an important contribution to the earlier works of Jackler *et al.*,[9] and Sennaroglu and Bajin.[10]

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