

SURGICAL PRIORITISATION IN OTOLOGY.

1ST JULY 2020 UPDATE.

As of July 1st 2020, limited surgical services for non-emergency and non-cancer cases are returning to most UK hospitals. However available theatre time remains dramatically below levels prior to the COVID-19 pandemic, and our discussions with colleagues suggest the availability of theatre time varies significantly between hospitals. Most otological surgery was classified as category 4 during the peak of the COVID pandemic, when the original otology guidelines were drafted. Exceptions to this were set out in our initial guidance document. Three months have now passed since the initial recommendations were made. Both the clinical environment we work in, and the needs of those patients already waiting significant times for their surgery, have changed. These revised recommendations have been made in conjunction with the Federation of Surgical Specialty Associations and compliment advice provided by them. We are enormously grateful for the feedback from colleagues around the UK who have highlighted areas where change will help our patients. Please use these as guidelines. Our own clinical assessment should always take priority over the guidelines. However, it is clear there will be times we will not be able to meet the suggested standards set out below as more urgent cases from our own or other specialities take priority in a health service with such greatly reduced elective capacity, resulting from the unavoidable changes in priority the COVID-19 pandemic has created.

- We recommend that all otological cases are re-triaged on a case by case basis if they reach the end of their allocated priority time frame, for example at 3 months for priority 4 patients. The indications for surgery, co-morbidities, patient preference, and the time patients have already been waiting for surgery should be reviewed. It is anticipated that some patients will be upgraded to a higher priority level following their review. For example, some cholesteatoma patients who were prioritised as category 4 at the outset of the pandemic may now be upgraded to category 3. Given that it was not uncommon for mastoid procedures to wait up to 12 months prior to lockdown, realistic targets for surgical waits will be required.
- Where appropriate, patients should be contacted to explain why their operation date is still pending. If required, face to face appointments should be arranged to facilitate risk assessment and to update pure tone audiometry. A small number of patients may require re-imaging to assess disease progression, particularly those with cholesteatomas.
- We continue to recommend the sub-categorisation of category 4 in to those patients that could wait longer than 3 months but not indefinitely (4a) and those patients that can safely wait indefinitely (4b). Patients in category 4a should have a target date for surgery, determined locally and based on local clinical and patient circumstances. However, it is recognised such targets may often be unachievable due to a lack of elective capacity.

- The following should be regarded as the ideal standard for each type of surgery when comparing urgency to cases in other specialities, but recognising that services may not be able to meet this elective capacity at times:

Priority 1-4

Vestibular schwannoma surgery.

- It is not possible to group all VS surgery in to a single category. Very large tumours with impending or actual complications may be category 1b or 2. Small, slowly growing tumours may be regarded as category 4.

Priority 2-4

Cholesteatoma surgery

- It is not possible to group all patients with cholesteatoma in to the same category as individual circumstances differ. Those with impending complications should be category 2. Actively discharging disease with evidence of extensive cholesteatoma should be regarded as category 3. It may be reasonable to consider early cholesteatoma priority 3 before erosion develops. Dry low activity cholesteatomas may still be regarded as category 4.

Priority 1a

Emergency procedures to be performed in <24 hours.

- Ear button battery removal
- Life threatening middle ear conditions

Priority 1b

Urgent procedures to be performed in <72 hours.

- Acute mastoiditis, or severe complications of cholesteatoma, not responding to conservative therapy:
We recommend minimum drilling, and subsequent curettage to reduce generation of bone dust (see ENT UK guidelines for otology surgery). Drilling should be at low speed with reduced irrigation. Consideration may be given to needle aspiration in place of surgical drainage for acute mastoiditis (*Bakhos et al.*).
- Facial nerve palsy secondary to trauma / cholesteatoma.
- Cochlear implantation:

- Patients with meningitis where medically possible.
- Removal of an infected implant.

Priority 2

Procedures to be performed in <1 month.

- MDT directed otological cancer surgery.
- Baro-traumatic perilymph fistula.
- Organic foreign bodies in the ear.
- Cochlear implantation:
 - Pre-lingually deafened children.
 - Device failure leaving user without hearing.
 - Post-meningitis.
 - Other profoundly deaf children meeting NICE criteria may be placed in this category, based upon the clinical team's assessment, and theatre availability.

Priority 3

Procedures to be performed in <3 months.

- Cochlear implantation in other post-lingually deafened children, and profoundly deaf adults.
- Active chronic suppurative otitis media without cholesteatoma may be priority 3 or 4.

Priority 4

Procedures to be performed in >3 months.

- Cholesteatoma - uncomplicated.
- All Ossicular Surgery / Middle ear implants / BAHA.
- Tympanopasty.

- Grommets (exceptions include where PNS biopsy is required which is priority 2, and where significant speech delay is present which may be priority 3).
- Meatoplasty.
- Vestibular Surgery.
- Most non-organic foreign bodies in ears (except button batteries or where causing pain or infection).