

Highlights from ENT Conference 2018

- Mr. J. Marquis Dowell F.R.C.S.(Ed)

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President, BAO HNS

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Disclosures

No Disclosures to make



Tribute to late Dr. Vincent S. Clarke

Highlights from ENT Conference 2018 - 84th UWI/BAMP CME Conference, LESC 17th Nov. 2018



Highlights from ENT Conference 2018 - 84th UWI/BAMP CME Conference, LESC 17th Nov. 2018

Caribbean Association of Otolaryngology (CAO)

- Had its birth in Barbados in 1992
- First academic conference was held in Jamaica 1993
- 12th Conference was held in Barbados at Savannah Hotel - 2004
- 26th Conference was held at Radisson Aquatica Resort, Carlisle Bay - 30th April - 3rd May 2018

26th Annual CAO Scientific Conference

Held in association with:

- American Academy of Otolaryngology - Head and Neck Surgeons (AAO-HNS)
- University of the West Indies (UWI)
- Barbados Association of Otolaryngologists Head & Neck Surgeons (BAO HNS)



AMERICAN ACADEMY OF
OTOLARYNGOLOGY-
HEAD AND NECK SURGERY



BARBADOS ASSOCIATION OF
OTOLARYNGOLOGISTS
HEAD AND NECK SURGEONS



**26th Annual
Caribbean Association of
Otolaryngology Scientific Conference**

**BARBADOS
2018**

30th April - 3rd May 2018

Radisson Aquatica Resort, Carlisle Bay, St. Michael

Highlights from ENT Conference 2018 - 84th UWI/BAMP CME Conference, LESC 17th Nov. 2018

"Otolaryngology in the Caribbean – Current Trends and Future Concepts"

About the CAO Conference 2018

- Scientific program consisted of 38 lectures in 10 sessions
- 7 Specially Invited Guests Speakers:

Prof. Eugene Myers (Pittsburgh, USA)

Prof. Ignazio Tasca (Imola, Italy)

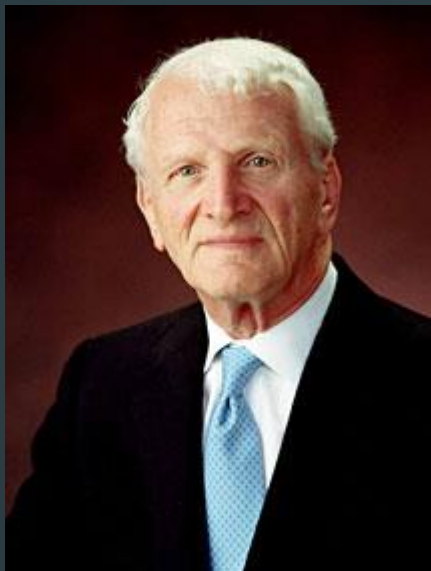
Prof. Joseph Chen (Sunnybrook, Toronto)

Prof. Emeritus Sir Errol R. Walrond (Barbados)

Dr. Daniel Coelho (Virginia, USA)

Dr. Jonothan Russell (Baltimore, USA)

Dr. Sumei Wang (Guangdong, Rep. of China)



About the CAO Conference 2018

- Over 100 participants, including >70 delegates
- 17 different countries :including English-speaking Caribbean, Curacao, Suriname, USA, Canada, Netherlands, Italy, United Kingdom, Republic of China.
- Social program included Evening Welcome Reception, Harrison's Cave, Oistins Town Fish Fry Party, an historic Bridgetown walk, Catamaran Cruise, Formal Banquet & Ball



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“Now She Can Hear” - Cochlear Implantation - A Mother’s Perspective



Indications

Age

One or both ears

Investigations

Preparation

Support services

Device

Surgical Considerations

Post Op care & Switching on of Implant

Rehabilitation & integration



Head and Neck Manifestations of Child Maltreatment

JK Fortson MD, R Su MD, VG Patel MD.

Head and Neck Manifestations of Child Maltreatment

Introduction

- 3.5 million reports are made involving 2.7 million children annually
- 2,000-3,000 Children die from child abuse annually.
- Five children are murdered by a parent or caretaker daily.
- 1,000,000 children are emotionally neglected yearly.

Head and Neck Manifestations of Child Maltreatment

Introduction

- 80% of fatalities are under 5 years old.
- Child abuse is #1 leading cause of child death.
- Soft tissue injuries most common in head, face and total injuries.
- Trauma to head, neck and associated areas >70%.

Head and Neck Manifestations of Child Maltreatment

Risk Factors

- Spouse abuse – 5x increased risk
- Abused often becomes abuser
- Adolescent mothers
- Presence of a step father – 7x more likely than a father.

Head and Neck Manifestations of Child Maltreatment

Risk Factors (cont'd)

- Divorced families
- Handicapped children
- Children under 3 y/o
- Female gender
- Found not to be related to socioeconomic status

Head and Neck Manifestations of Child Maltreatment

Types of abuse

- Physical abuse
- Sexual abuse
- Nutritional neglect
- Drugging or poisoning

Head and Neck Manifestations of Child Maltreatment

Types of abuse (cont'd)

- Medical neglect
- Dental care neglect
- Emotional abuse
- Physical neglect

Head and Neck Manifestations of Child Maltreatment

Indicators of physical abuse

- Significant skin injury.
- Multiple injuries of various ages.
- No history offered, or a changing or contradictory history, for the injuries.
- Injuries inconsistent with the history.

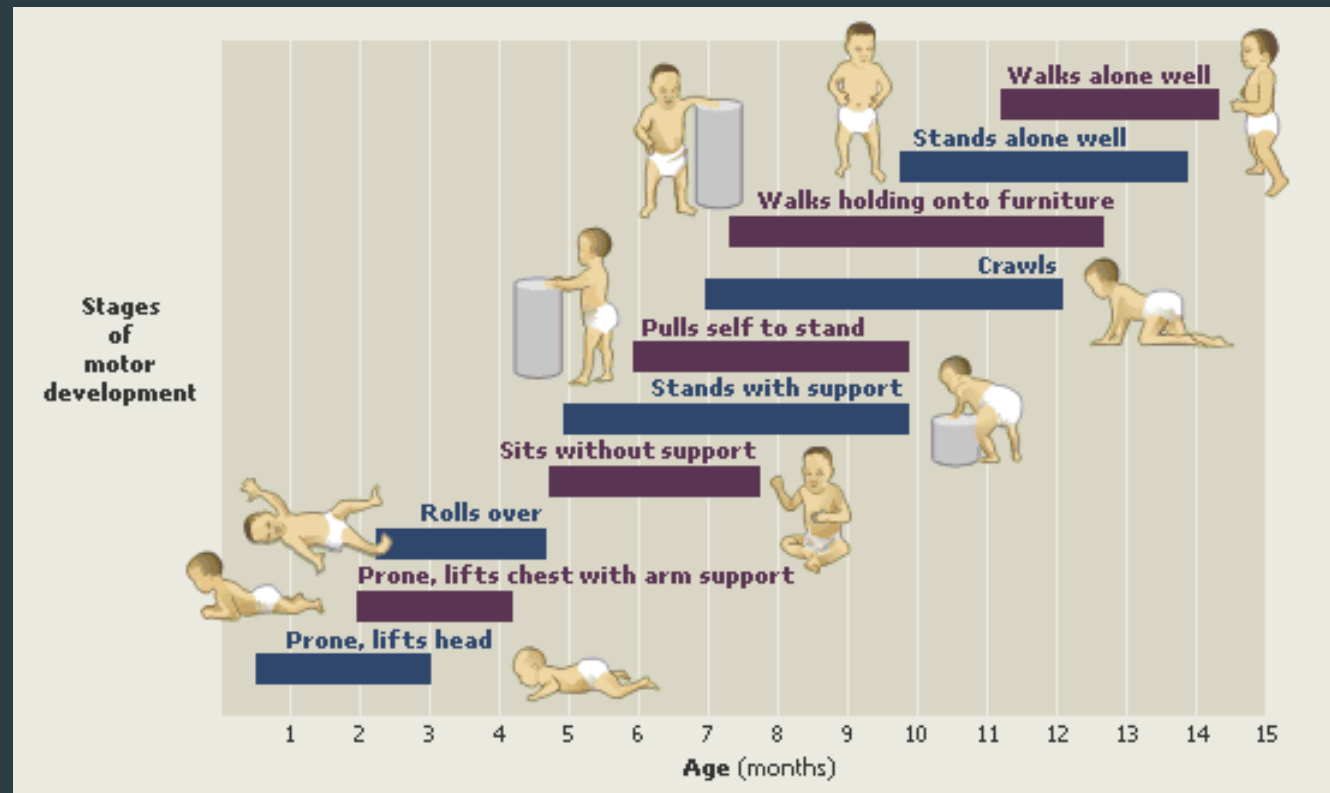
Head and Neck Manifestations of Child Maltreatment

Indicators of physical abuse

- Suspicious attitude in the parents and/or child.
- Injuries in different systems.
- History of unexplained trauma.
- Injuries inconsistent with stage of development.

Head and Neck Manifestations of Child Maltreatment

Stages of Development



Head and Neck Manifestations of Child Maltreatment

Observations in attitude seen in children

- Aggressive
- Passive
- Hypervigilant
- Avoidance of eye contact w/ the caregiver

Head and Neck Manifestations of Child Maltreatment

Observations in attitudes seen in parents

- Unaware of the seriousness of the child's injury.
- Indifferent or unsupportive.
- May belittle the child.
- Try to control the child's communication.

Head and Neck Manifestations of Child Maltreatment

Patterns in child abuse

- Most frequently less than 2 years old.(Radiology)
- On presentation
 - Skeletal injury in 50-80%
 - Head trauma – 13-25%
 - Viscera – 3% (second leading cause of death)

Head and Neck Manifestations of Child Maltreatment

Patterns in child abuse

- Most common cause death/disability is head injury
- One study
 - **31.2% head injuries missed by M.D.**
 - **27.8% reinjured after missed diagnosis**

Head and Neck Manifestations of Child Maltreatment

- ▶ Craniofacial, head, face and neck injuries are seen in over 50% of child abuse cases.

Head and Neck Manifestations of Child Maltreatment

Facial Soft Tissue Injuries

Aging of Bruises

- <24 hrs - red/purple
- 12-48 hrs - purple blue
- 48-72 hrs - brown
- >72 hrs - yellow

Contusions consistent w/
an open hand slap



Head and Neck Manifestations of Child Maltreatment

Facial Soft Tissue Injuries



Human bite mark

Head and Neck Manifestations of Child Maltreatment

Differential Diagnosis in Cranio-cerebral Trauma

- Seizure disorder
- Viral illness
- Colic
- Feeding disorder
- Meningitis



Head and Neck Manifestations of Child Maltreatment

Symptoms of Cranio-cerebral Trauma

- Lethargy
- Irritable
- Vomiting
- Anorexia
- Rigidity
- Seizures
- Difficulty breathing
- Developmental delay
- Unable to track.

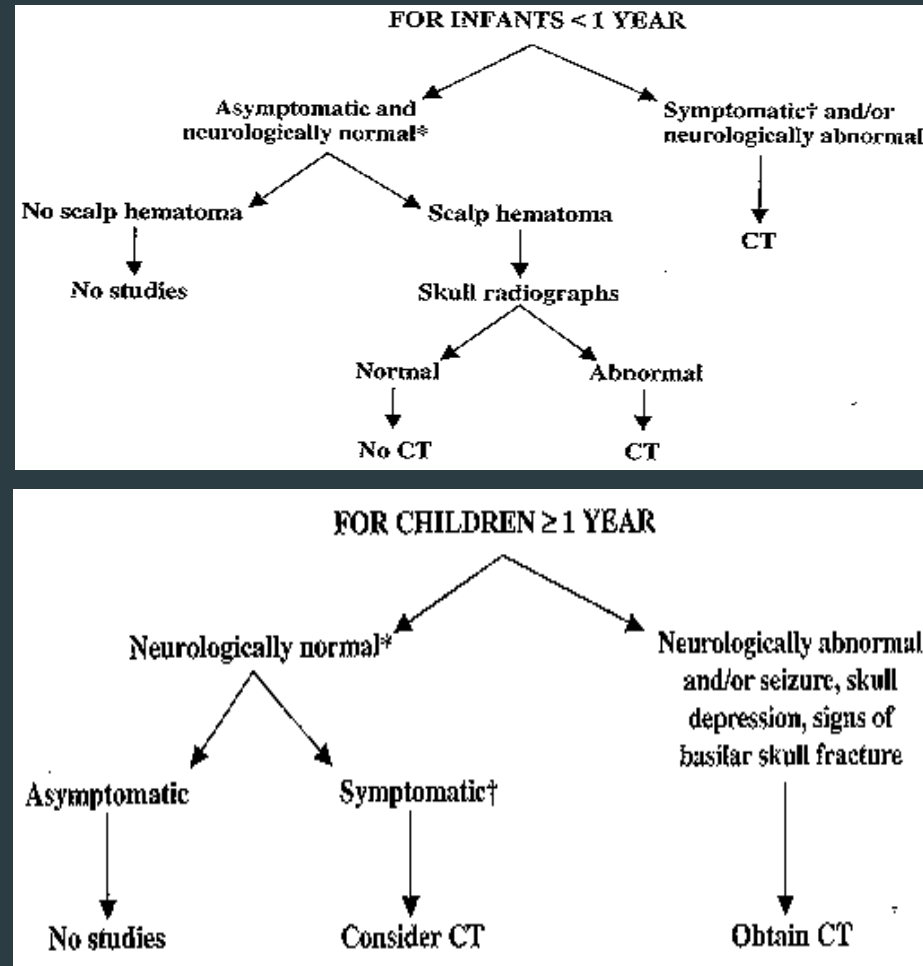
Head and Neck Manifestations of Child Maltreatment

Signs of Cranio-cerebral Trauma

- Retinal hemorrhage
- Skull fracture
- Brain edema
- Subdural hematoma
- Bruises to head, neck, or chest.
- Fractures elsewhere
- Absence of external injuries in the presence of severe brain injury.



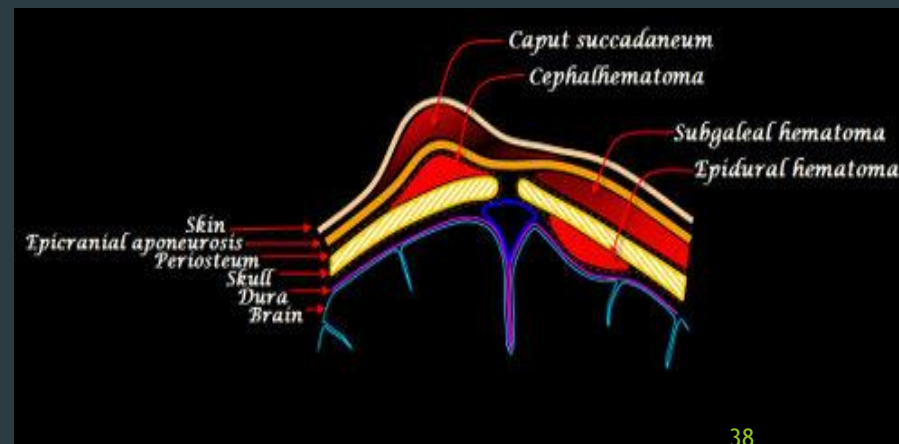
Head and Neck Manifestations of Child Maltreatment



Head and Neck Manifestations of Child Maltreatment

Soft tissue injuries to scalp

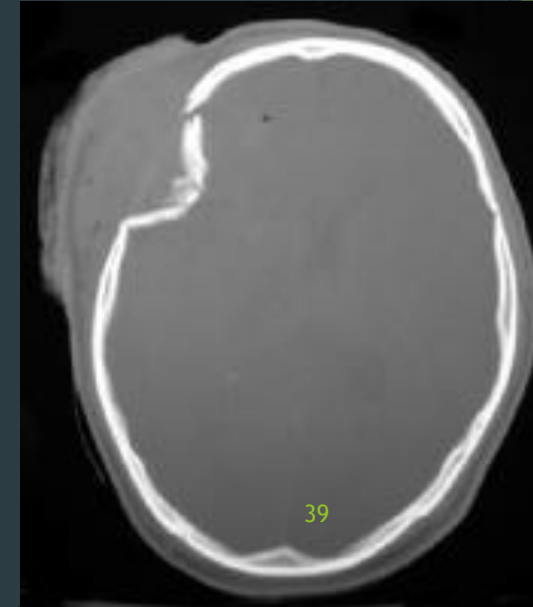
- Subgaleal hematoma due to hair pulling.
- Soft tissue injuries
 - Abrasions
 - Lacerations
 - Contusions



Head and Neck Manifestations of Child Maltreatment

Skull Fractures

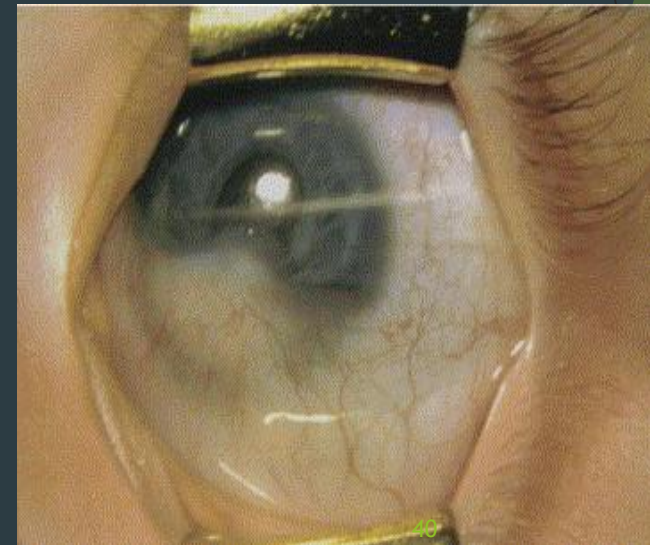
- Multiple fractures
- Bilateral fractures
- Basilar skull fracture: Battle's sign
- Fractures crossing sutures occur more often in abuse than in accidental injury



Head and Neck Manifestations of Child Maltreatment

Ocular Trauma

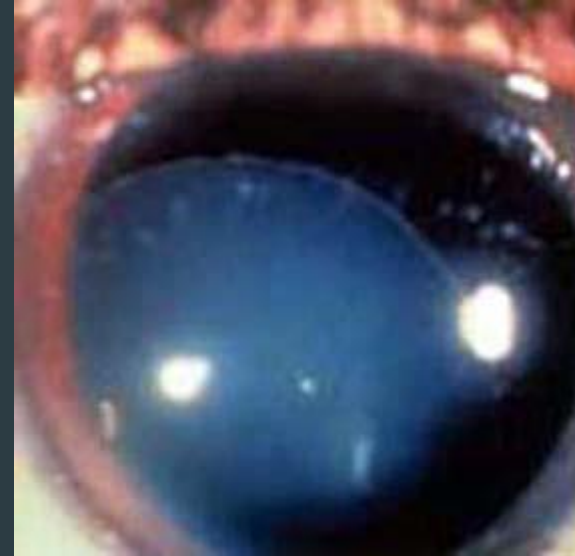
- Periorbital ecchymosis
- Unexplained keratoconjunctivitis
- Intraocular hemorrhages



Head and Neck Manifestations of Child Maltreatment

Ocular Trauma

- Cataracts
- Subluxated lens
- Leukocoria
- Chorioretinal and macular scarring



Head and Neck Manifestations of Child Maltreatment

Nasal Trauma



- Nasal fractures
- Soft tissue injuries
- Septal perforations



- Nasal septal hematoma
 - Presents w/ nasal congestion
 - Discharge and swelling
 - Nasal septal tenderness

Head and Neck Manifestations of Child Maltreatment

Auricular Trauma

- Pinna hematoma
- Loss of external ear substance
- Cauliflower ear
- Bruising to earlobes



Head and Neck Manifestations of Child Maltreatment

Auricular Trauma

- Ruptured eardrum
- Bilateral ear injury
- Children < 1 y/o



Head and Neck Manifestations of Child Maltreatment

Oral Trauma

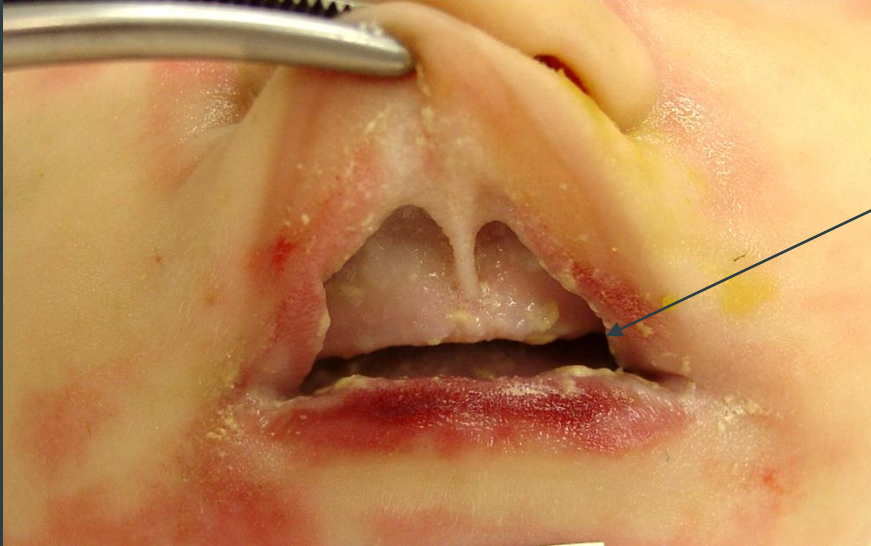
- Central focus of communication and nutrition
- Lacerations and contusions
 - Tongue
 - Buccal mucosa
 - Palate
 - Gingival
 - Alveolar mucosa
 - Frenulum

Head and Neck Manifestations of Child Maltreatment

Oral Trauma

- Fractured, displaced, or avulsed teeth
- Facial bone and jaw fractures
- Burns – caustic substances, scalding liquids

Head and Neck Manifestations of Child Maltreatment



Scarring at the angles of the mouth may be indicative of repetitive injury

Signs of smothering, suffocation and forceful bottle feeding may manifest w/ perioral and mucosal bruising



Head and Neck Manifestations of Child Maltreatment



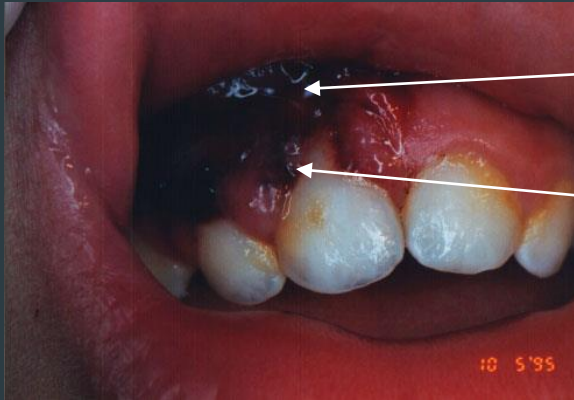
Trauma to frenulum

Head and Neck Manifestations of Child Maltreatment

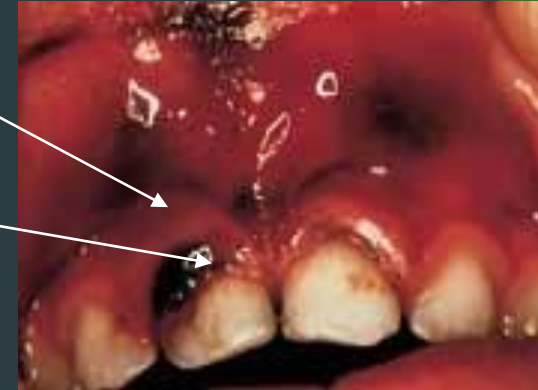
Tongue Lacerations



Head and Neck Manifestations of Child Maltreatment



Alveolar &
Gingival
Trauma



Fractured teeth

Dental avulsion



Head and Neck Manifestations of Child Maltreatment

Mandibular fractures



Head and Neck Manifestations of Child Maltreatment

Chemical burn



Electrical burn



Thermal burn



Head and Neck Manifestations of Child Maltreatment

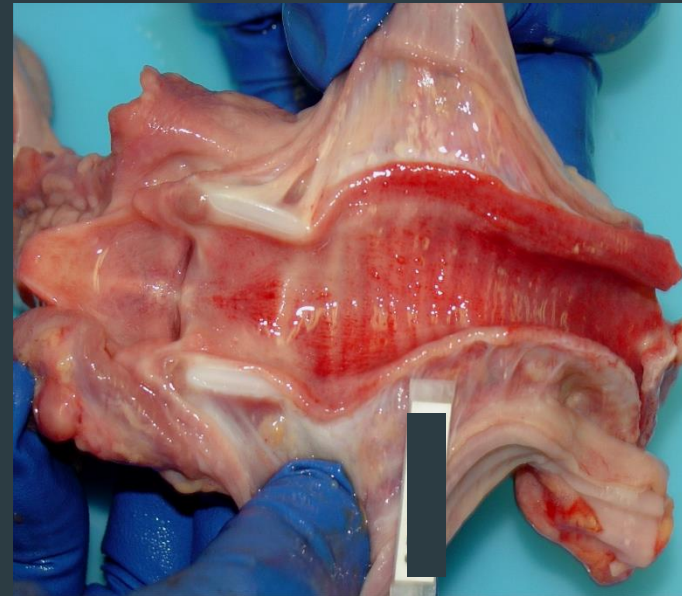
Neck Trauma

- ▶ Soft tissue injuries
 - Gripping of the neck
 - Choking
 - Shaking (as in SBS)
- ▶ Perforations
 - Esophageal
 - Hypopharynx
 - Pharynx



Head and Neck Manifestations of Child Maltreatment

Evidence of Strangulation/Choking



Head and Neck Manifestations of Child Maltreatment

Conclusions

- Complete evaluation of pediatric patients is essential in the identification of children who may be abused.
- Methodical and thorough examination of the head and neck can greatly assist in diagnosing abuse.
- Healthcare personnel should perform brain scans to screen for occult head injuries in children with suspected abuse injuries.
- A low threshold for suspicion of abuse is imperative.
- Appropriate documentation and communication with state agencies is imperative in prevention.



“Scarless Thyroidectomy”

Transoral Central Neck Surgery

“Leave No Trace”

Jon Russell, MD

Assistant Professor - Head and Neck Endocrine Surgery

Director of Endoscopic and Robotic Thyroid and Parathyroid Surgery

Johns Hopkins Medicine

Objectives

- ▶ Define the problem of thyroid nodules/cancer
 - ▶ Increasing incidence, essentially stable mortality
 - ▶ Should we be talking about morbidity instead?
 - ▶ Imperfect identification of high-risk patients
- ▶ Why scarless thyroid and parathyroid surgery?
 - ▶ Impact of a scar
 - ▶ History of previous attempts
 - ▶ Johns Hopkins Experience

“Scarless Thyroidectomy”

Problem

- ▶ Palpable thyroid nodules in 5% of women, 1% of men
 - ▶ Palpable & same-size non-palpable lesions pose the same risk of malignancy
- ▶ 7-15% of these will be cancer
- ▶ 63,000 cases/year in the US
- ▶ Predicted to become the 3rd most common cancer in women by 2019

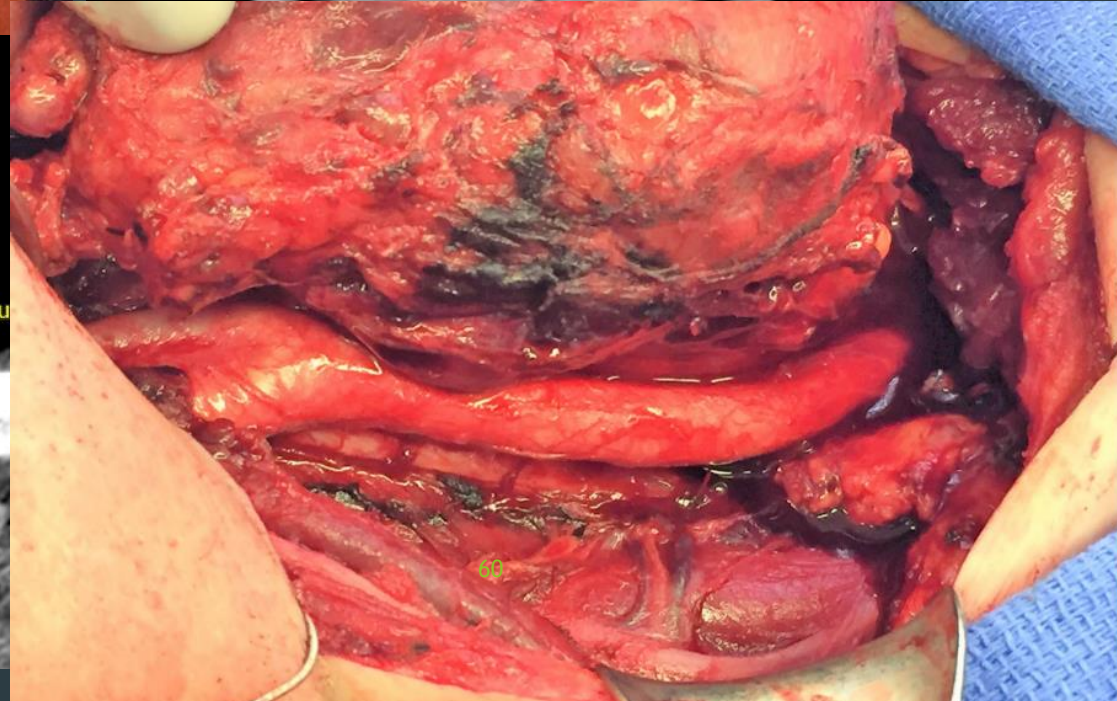
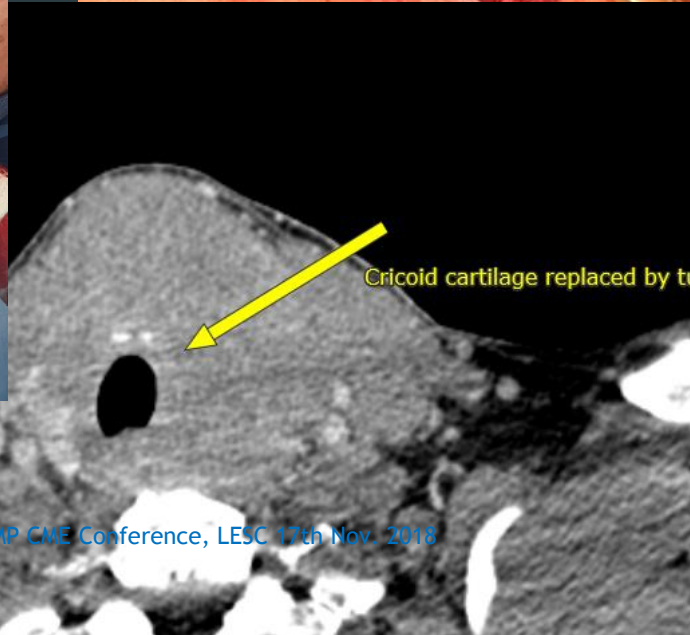
2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer

The American Thyroid Association Guidelines Task Force
on Thyroid Nodules and Differentiated Thyroid Cancer

59

Bryan R. Haugen,^{1,*} Erik K. Alexander,² Keith C. Bible,³ Gerard M. Doherty,⁴ Susan J. Mandel,⁵ Yuri E. Nikiforov,⁶ Furio Pacini,⁷ Gregory W. Randolph,⁸ Anna M. Sawka,⁹ Martin Schlumberger,¹⁰ Kathryn G. Schuff,¹¹ Steven I. Sherman,¹² Julie Ann Sosa,¹³ David L. Steward,¹⁴ R. Michael Tuttle,¹⁵ and Leonard Wartofsky¹⁶

What we see....



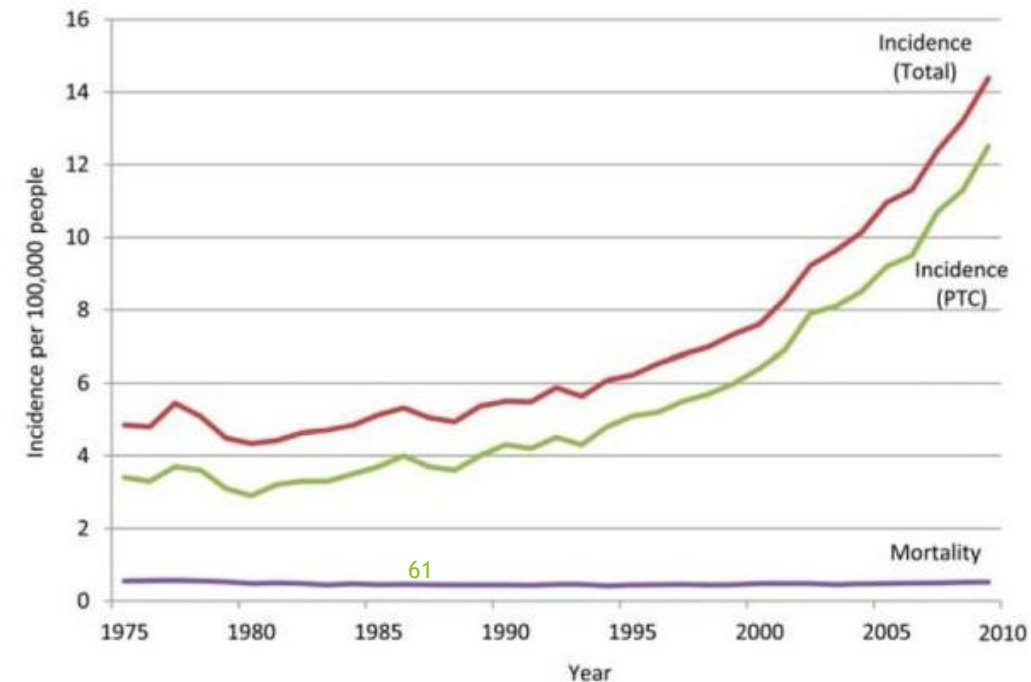
“Scarless Thyroidectomy”

- ▶ “Cancers demonstrate a diversity of behavior, encompassing a spectrum of risk that ranges from indolent tumors that cause no harm during a patient’s lifetime to more aggressive subtypes that inflict considerable morbidity and death.^{1,2} Papillary thyroid cancer (PTC) is generally an indolent cancer type, and has experienced a disproportionate escalation in incidence corresponding to the wider use of advanced medical imaging.”³⁻⁵

Increasing Diagnosis of Subclinical Thyroid Cancers Leads to Spurious Improvements in Survival Rates

[Allen S. Ho, MD,¹](#) [Louise Davies, MD,^{2,3}](#) [Iain J. Nixon, MD,¹](#) [Frank L. Palmer, MD,¹](#) [Laura Y. Wang, MD,¹](#) [Snehal G. Patel, MD,¹](#) [Ian Ganly, MD,¹](#) [Richard J. Wong, MD,¹](#) [R. Michael Tuttle, MD,⁴](#) and [Luc G. T. Morris, MD, MSc¹](#)

Figure 1



Highlights from ENT Conference 2018 - 84th UWI/BAMP CME Conference, LESC 17th Nov. 2018

Observation trials

Miyauchi experience (Japan)

After 22 years of follow up and observation in ~1200 patients (low risk papillary microcarcinomas)

- 8% size increase >3mm
- 4% regional metastasis
- Absolute risk of nerve paralysis and hypocalcemia decreased
- Uncommon in US

Assumptions

- ▶ First do no harm
- ▶ To help a patient with a thyroid nodule requires a near absence of iatrogenic morbidity
 - ▶ Most nodules benign, most malignancies indolent
- ▶ Leaving a scar is one kind of harm
- ▶ If we can SAFELY eliminate a scar, we should

“Scarless Thyroidectomy”



“Scarless Thyroidectomy”

Impact of Postthyroidectomy Scar on the Quality of Life of Thyroid Cancer Patients

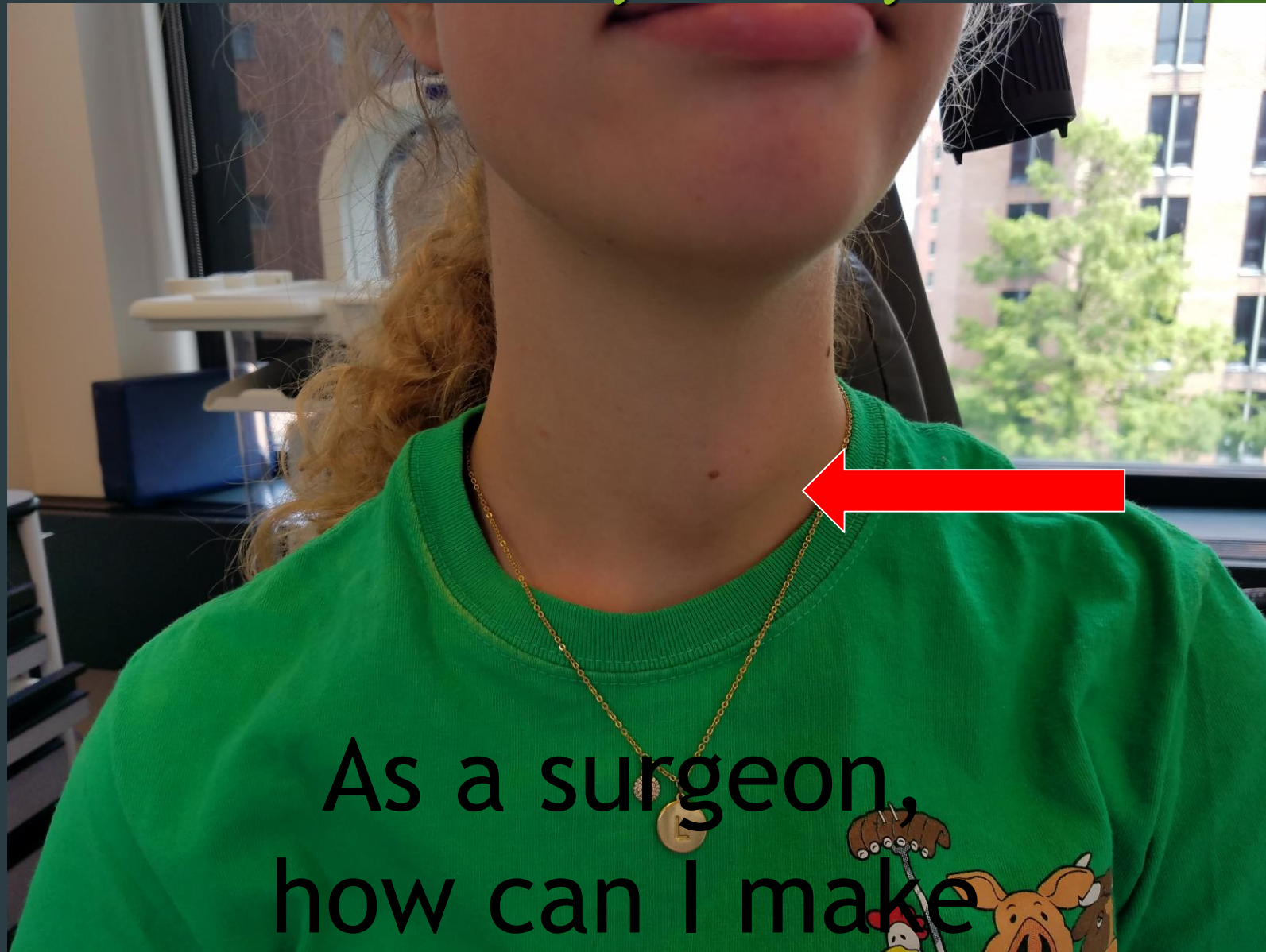
Yuri Choi, Ji Hye Lee, Yeon Hee Kim¹, Yong Sang Lee², Hang-Seok Chang², Cheong Soo Park²,
Mi Ryung Roh

“The QoL does not seem to be associated with the severity or type of the scar, but rather with the presence of the scar itself....

Thus, all patients with post-thyroidectomy scars may be affected by decreased QoL regardless of the characteristics of the scar or their own status....

Our finding suggest that the QoL of patients with post-thyroidectomy scars is impaired after traditional thyroidectomy as much as that of patients with other chronic skin diseases, such as psoriasis, vitiligo, and severe atopic dermatitis.”

“Scarless Thyroidectomy”



As a surgeon,
how can I make
her life BETTER?

NOT by giving her a scar

- ▶ JH research (to be presented at COSM 4/2018)
- ▶ 7 patients with a scar vs 5 without, photos presented to 193 casual observers
 - ▶ Significant penalty for overall attractiveness, perceived quality of life, and appearance of the neck
 - ▶ Average casual observer willing to pay >\$10,000 to avoid a neck scar

“Scarless Thyroidectomy”

Ideal surgery would be safe, cost effective, and have no cosmetic impact

- ▶ Bilateral Axillo Breast Approach (BABA)
- ▶ Retroauricular/Facelift
- ▶ Axillary
- ▶ Robot vs Endoscopic
- ▶ Transoral

“Scarless Thyroidectomy”

Eren Berber,¹ Victor Bernet,² Thomas J. Fahey III,³ Electron Kebebew,⁴ Ashok Shaha,⁵
Brendan C. Stack, Jr.,⁶ Michael Stang,⁷ David L. Steward,⁸ and David J. Terris⁹
for the American Thyroid Association Surgical Affairs Committee

American Thyroid Association Statement on Remote-Access Thyroid Surgery

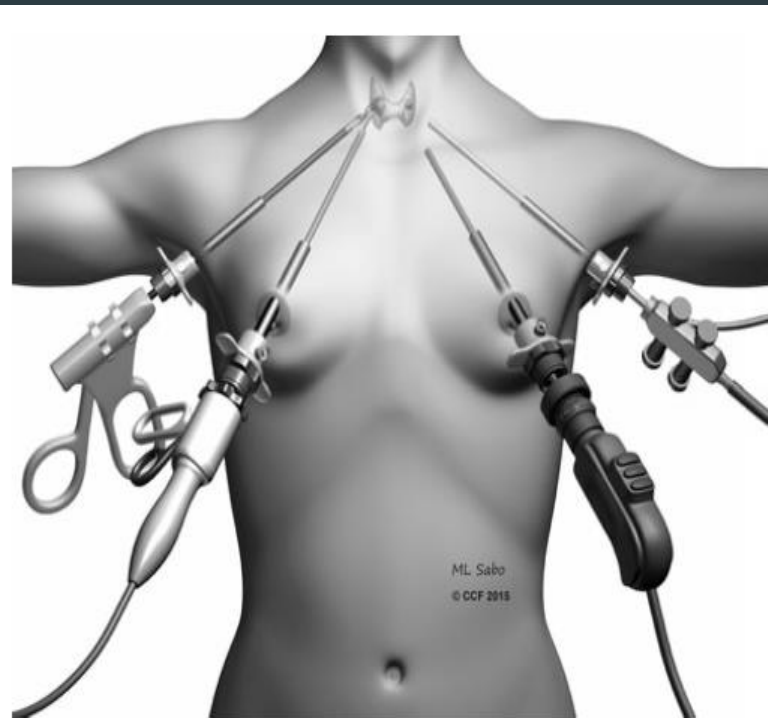


FIG. 1. Illustration showing the bilateral axillary breast approach.

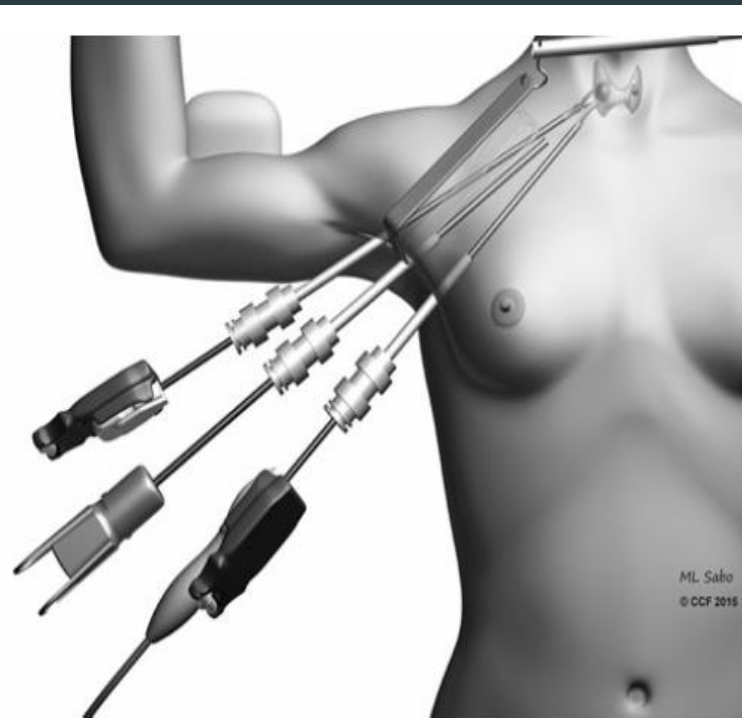


FIG. 2. Illustration showing the setup and instrumentation for a transaxillary thyroidectomy.

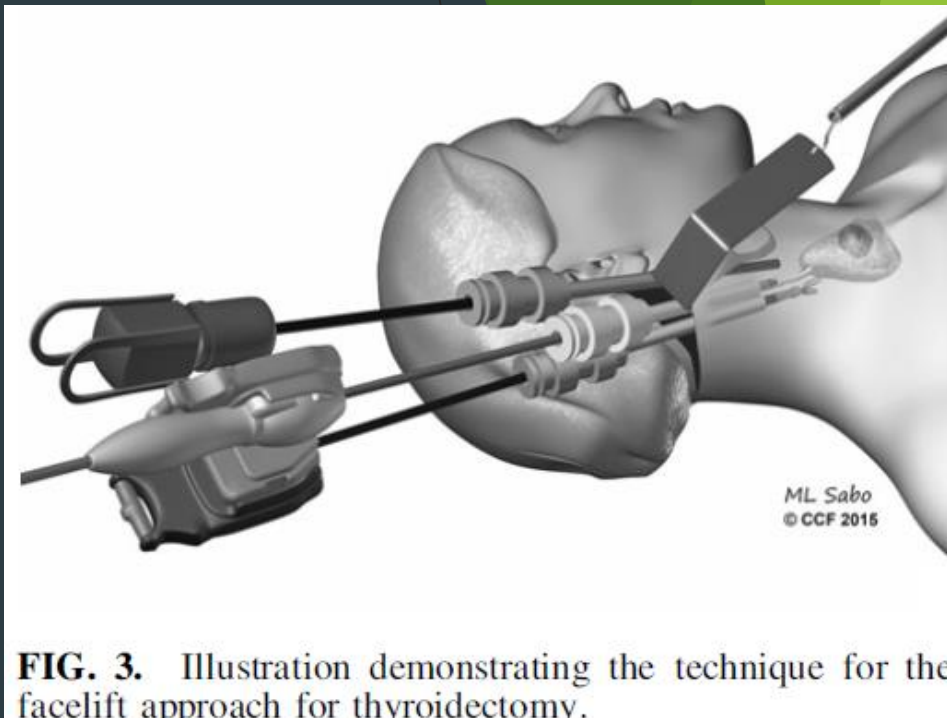


FIG. 3. Illustration demonstrating the technique for the facelift approach for thyroidectomy.

“Scarless Thyroidectomy”

TABLE 1. A SUMMARY OF RESULTS FROM MAJOR U.S. REMOTE-ACCESS THYROIDECTOMY STUDIES

<i>Author (year)</i>	<i>Number of procedures</i>	<i>Approach</i>	<i>Pathology (n)</i>	<i>Tumor size (cm), M (range)</i>	<i>Operative time (minutes), M ± SD or range</i>	<i>Complications, n (%)</i>	<i>Conversion to open, n (%)</i>	<i>Hospital stay (days), median</i>
Kandil <i>et al.</i> (2012) (16)	100	TAA	—	—	108.1 ± 60.5	1 (1)	2 (2)	1
Kuppersmith and Holsinger (2011) (15)	31	TAA	PTC (3), benign (28)	2.7 (1.0–4.6)	132–328	4 (13)	0 (0)	1
Aliyev <i>et al.</i> (2012) (17)	16	TAA	PTC (10), FTC (1), benign (5)	1.8	183 ± 11	3 (19)	0 (0)	1
Landry <i>et al.</i> (2011) (10)	12	TAA	PTC (1), FTC (1), benign (9)	2.1 (0.8–2.8)	142 ^a	4 (30)	0 (0)	1
Terris <i>et al.</i> (2011) (18)	18	Facelift	PTC (2), FTC (1), benign (15)	—	154.9 ± 23.8	2 (11)	0 (0)	0
Kandil <i>et al.</i> (2014) (19)	12	Facelift	PTC (1), FTC (2), benign (9)	1.2	156 ± 15.8	0 (0)	0 (0)	1

“Scarless Thyroidectomy”

World J Surg
DOI 10.1007/s00268-015-3320-1

World Journal
of Surgery

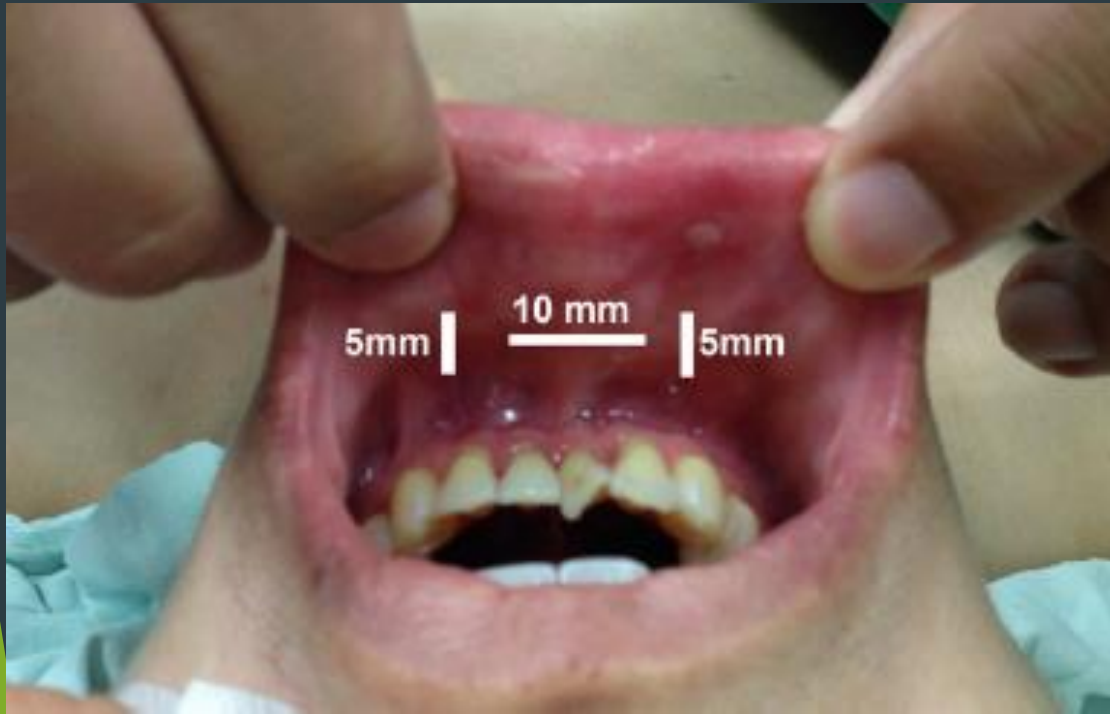


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ORIGINAL SCIENTIFIC REPORT

Transoral Endoscopic Thyroidectomy Vestibular Approach: A Series of the First 60 Human Cases

Angkoon Anuwong¹



“Scarless Thyroidectomy”

Complications	Number (rate)
Hypoparathyroidism	
Temporary	3 (5 %)
Permanent	0
Recurrent laryngeal injury	
Temporary	2 (3.33 %)
Permanent	0
Mental nerve injury	0
Hematoma	1 (1.67 %)
Infection	0
Subcutaneous emphysema	0
Pneumomediastinum	0
Tracheal injury	0
Esophageal injury	0

Table 2 Operative details

Details	Value
Operation (<i>n</i> = 60)	
Hemithyroidectomy	34 (56.67 %)
Bilateral thyroidectomy	26 (43.33 %)
Operative time (median, mins)	115.5 (75–300)
Hemithyroidectomy	90 (75–180)
Bilateral thyroidectomy	135.5 (105–300)
Blood loss (median, mL)	30 (8–130)
Drainage volume (average, mL)	74.76 (33–250)
Drainage removal (average, days)	3 (2–4)
Hospital stay after surgery (mean, days)	3.6 (2–7)

“Scarless Thyroidectomy”

Johns Hopkins 1/2018

Operative Details		
Procedures N=81, on 78 patients*		
	Lobectomy	50
	Total Thyroidectomy	20
	Sistrunk	2
	Parathyroidectomy	10
	Robotic	7 ⁺
	Endoscopic	73 ⁺⁺
BMI (median, range, kg/m ²)		
	Total	27.3 (18.4-48.2)
	Robotic	32.0 (23.0-44.0)
	Endoscopic	27.0 (18.4-48.2)
Operative Time (median, range, mins)		
	Total	160 (63-480)
	Robotic	322 (287-377)
	Endoscopic	156 (63-480)

*One patient underwent parathyroidectomy with lobectomy, one lobectomy with sistrunk, one patient had a lobectomy followed by a completion thyroidectomy.

+One robotic case was converted to open and one to endoscopic (448 mins)

++One endoscopic case was converted to open (123 mins)

Transoral Parathyroidectomy

30 year old female with a history of left otalgia
Neurotology workup demonstrates normal MES
Left neck mass noted on imaging following MVA
Referral to Head and Neck Endocrine Surgery



JOHNS HOPKINS
MEDICINE

“Scarless Thyroidectomy”

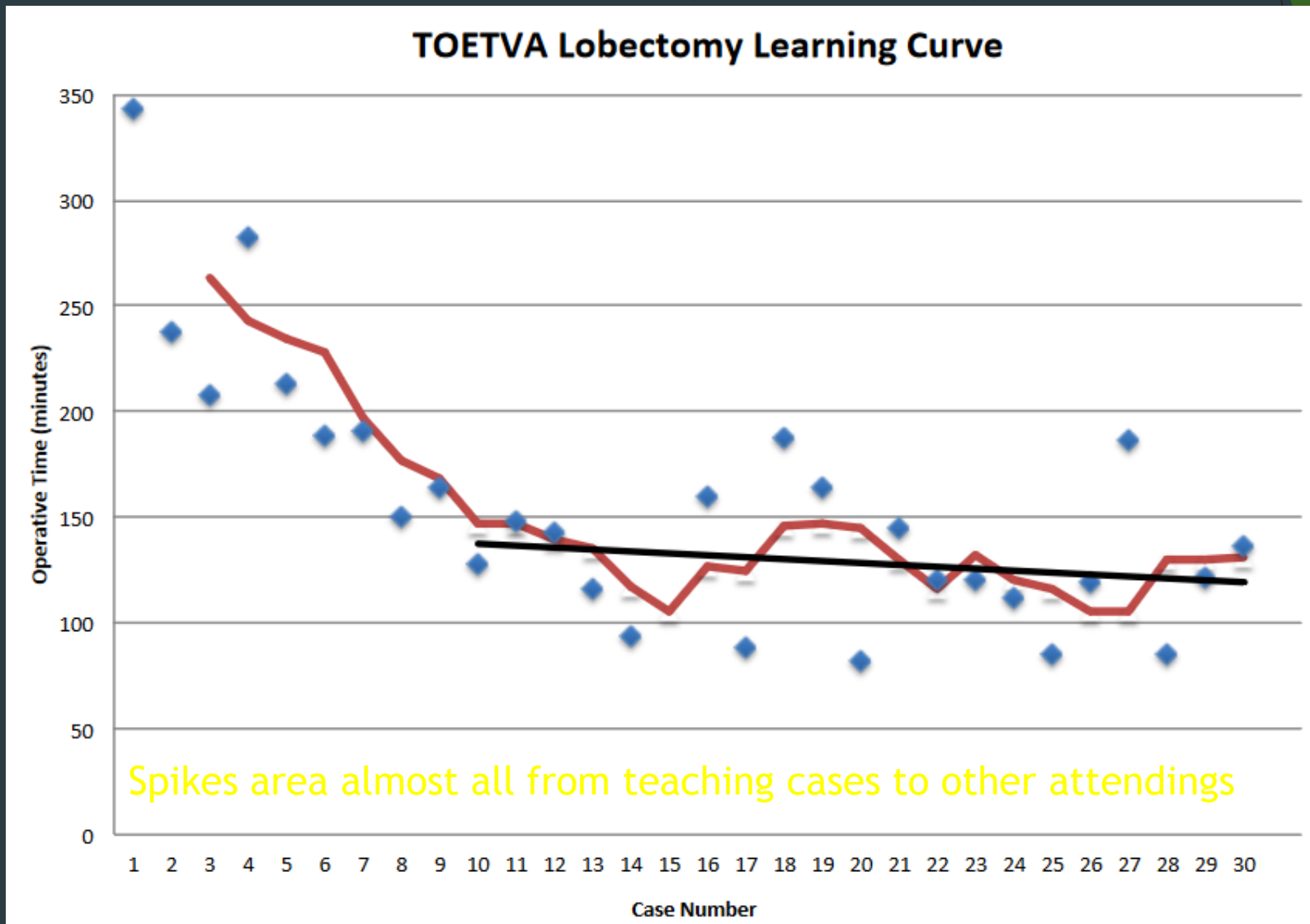
Complications	N(%)
Hypoparathyroidism	
Temporary	0
Permanent	0
Recurrent Laryngeal Nerve Palsy	
Temporary	2 (3.2%)
Permanent	0
Mental Nerve Injury	0
Skin Burn	2(3.2%)
Syncope	2(3.2%)
Hematoma	0
Infection	0
Esophageal Injury	0

“Scarless Thyroidectomy”



Worst complication to date- small skin pigmentation change due to scope thinning

“Scarless Thyroidectomy”



“Scarless Thyroidectomy”



“Scarless Thyroidectomy”

Right lobectomy with nerve Dissection



“Scarless Thyroidectomy”



“Scarless Thyroidectomy”



“Scarless Thyroidectomy”

Table III. Surgical Outcomes

Approach	RFT	TOETVA	P value
N	20	20	
Operative Time* (median, range, minutes)	201 (124-293)	188 (89-343)	0.36
Permanent RLN injury (%)	0	0	NA
Permanent MN injury (%)	0	0	NA
Extrathyroidal parathyroids within specimen (%)†	10	0	0.49
Placement of drain (%)	70	10	0.0002
Completion of intended approach (%)	100	95	0.999
Postoperative day of discharge (median, range)	1.0 (1-2)	0.5 (0-1)	0.002
Ultimate avoidance of cervical incision (%)	85	95	0.60
Hematoma/seroma (%)	10	0	0.49
Hypertrophic scarring (%)	15	0	0.23

*Converted cases were not included in median operative time for any cohort. †Excluding planned parathyroidectomy. RLN; recurrent laryngeal nerve, MN; mental nerve

“Scarless Thyroidectomy”

Endoscope vs Robot

Approach N	Robotic 7	Endoscopic 7	Endoscopic 20	P value*
Operative Time + (median, range, minutes)	322 (287-377)	213 (189-343)	188 (89-343)	0.01//0.001
Permanent RLN injury (%)	0	0	0	NA
Permanent MN injury (%)	0	0	0	NA
Permanent <u>hypoparathyroidism</u> (%)	0	0	0	NA
<u>Extrathyroidal parathyroids</u> within specimen ⁺⁺ (%)	0	0	0	NA
Placement of drain (%)	43 (3/7)	14 (1/7)	10 (2/20)	0.19//0.03

Transoral central neck surgery is...

- Safe
- Efficient
- Valuable to patients and some members of society
- Equivalent to endoscopic sinus surgery in the 1980s?

Who is a candidate?

- ▶ Any patient with a benign nodule
 - ▶ Nodule <6cm? ~10cm lobe?
- ▶ Localized parathyroid adenomas
- ▶ Indeterminate nodules
 - ▶ Location/size more important in these cases
- ▶ T1 PTC in favorable location
- ▶ About half of Dr. Russel’s patients

Future Directions

- ▶ Long term results
- ▶ Train residents/fellows
- ▶ Train qualified colleagues
- ▶ Define indications and also those patients who may benefit from less invasive management



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Thank You