

NEW ZEALAND AND AUSTRALIAN SOCIETIES OF OTOLARYNGOLOGY HEAD AND NECK SURGERY: TESTS, TREATMENTS AND PROCEDURES CLINICIANS AND CONSUMERS SHOULD QUESTION

Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) is the representative organisation for Ear Nose and Throat Head and Neck Surgeons in Australia, and dates from 1950. ASOHNS, with the Royal Australasian College of Surgeons, provides a nationwide Training Program for future Otolaryngology Head and Neck Surgeons.

1. Don't order computed tomography (CT) scan of the head/brain for sudden hearing loss

Computed tomography scanning is expensive, exposes the patient to radiation and offers no useful information that would improve initial management. CT scanning may be appropriate in patients with focal neurologic findings, a history of trauma or chronic ear disease.

Sudden hearing loss is distinct from progressive loss and chronic ear disease. Sudden sensorineural hearing loss (SSHL) can be described as at least 30dB sensorineural hearing loss (SNHL) in at least three consecutive frequencies within a three-day period.

Supporting Evidence

- Stachler RJ, Chandrasekhar SS, Archer SM, et al. Clinical practice guideline: Sudden hearing loss. *Otolaryngol Head Neck Surg* 2012;146(1S):S1-35.
- Tarshish Y, Leschinski A, Kenna M. Pediatric sudden sensorineural hearing loss: Diagnosed causes and response to intervention. *International Journal of Pediatric Otorhinolaryngology* 2013;77(4):553–9

2. Don't prescribe oral antibiotics for uncomplicated acute discharge from grommets

Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections.

A discharge is uncomplicated when it is not associated with any other symptom, for example fever, pain or swelling of the ear canal.

Supporting Evidence

- Goldblatt EL, Dohar J, Nozza RJ, et al. Topical ofloxacin versus systemic amoxicillin/clavulanate in purulent otorrhea in children with tympanostomy tubes. *Int J Pediatr Otorhinolaryngol* 1998;46:91-101.
- Rosenfeld RM, Schwartz SR, Pynnonen MA, et al. Clinical Practice Guideline: Tympanostomy tubes in children. *Otolaryngol Head Neck Surg* 2013;149(1S): S1-35.

3. Don't prescribe oral antibiotics for uncomplicated acute otitis externa

Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections.

Supporting Evidence

- Rosenfeld RM, Schwartz SR, Cannon CR, et al. Clinical practice guideline: Acute otitis externa. *Otolaryngol Head Neck Surg* 2014;150(1S):S1-24.
- Wipperman J. Otitis externa. *Primary Care: Clinics in Office Practice* 2014;41:1-9.

4. Don't routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis

Imaging of the paranasal sinuses, including plain film radiography, computed tomography (CT) and magnetic resonance imaging (MRI) is unnecessary in patients who meet the clinical diagnostic criteria for uncomplicated acute rhinosinusitis. Acute rhinosinusitis is defined as up to four weeks of purulent nasal drainage (anterior, posterior or both) accompanied by nasal obstruction, facial pain-pressure-fullness or both. Imaging is costly and exposes patients to radiation. Imaging may be appropriate in patients with a complication of acute rhinosinusitis, patients with comorbidities that predispose them to complications and patients in whom an alternative diagnosis is suspected.

Supporting evidence

- Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. *Otolaryngol Head Neck Surg* 2015;152(2S):S1-39.
- Ebell MH, McKay B, Guilbault R, et al. Diagnosis of acute rhinosinusitis in primary care: a systematic review of test accuracy. *British Journal of General Practice* 2016;66(650):e612-32.

5. Don't obtain computed tomography (CT) or magnetic resonance imaging (MRI) in patients with a primary complaint of hoarseness prior to examining the larynx

Examination of the larynx with mirror or fibre optic scope is the primary method for evaluating patients with hoarseness. Imaging is unnecessary in most patients and is both costly and has potential for radiation exposure. After laryngoscopy, evidence supports the use of imaging to further evaluate 1) vocal fold paralysis, or 2) a mass or lesion of the larynx.

It is essential to have the larynx examined by a specialist if the hoarseness has not resolved within 4 weeks.

Supporting evidence

- Schwartz SR, Cohen SM, Dailey SH, et al. Clinical practice guideline: hoarseness (dysphonia). *Otolaryngol Head Neck Surg* 2009;141:S1-31.
- Mau T. Diagnostic evaluation and management of hoarseness. *Medical Clinics of North America* 2010;94(5):945-60.

How was this list created?

RACS and The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) collaborated on the development of a list for Choosing Wisely Australia. Each organisation worked closely with key members including the Sustainability in Healthcare Committee and Professional Development and Standards Board (RACS), and Board of Directors (ASOHS) to develop a list of tests/treatments/procedures for head and neck surgery.