

Health Care Costs Rise as a Result of Delayed Otolaryngology Referral for Voice Disorders

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Abstract

Despite the fact that laryngoscopy is widely used to evaluate individuals with laryngeal/voice abnormalities, when it should be performed is still up for debate. The goal of this study was to ascertain how the length of time between the patient's initial primary care visit and their initial otolaryngology outpatient appointment affected their health care costs for laryngeal/voice issues. Confounding impact is a serious problem in clinical otolaryngology research since it might skew the findings. In this review, we define the term "confounding impact" and discuss how to test and manage it. Confounding effects can be minimised by data analysis and averted through research design. Clinicians would be aware of confounding effects in their studies and cautious about them. They would be able to set up a research design that uses the proper techniques to counteract this effect. To examine the variables involved in the transition from a peer-reviewed journal publication to an original scientific presentation at the American Society of Pediatric Otolaryngology (ASPO) Annual Meeting. To enable potential follow-up to compare initial perceptions of publication success with longer-term publication outcomes, a dataset of presenters was constructed.

About 1/8500 infants are affected by the Pierre-Robin Sequence (PRS), which is characterised by the triad of micrognathia, glossoptosis, and cleft palate. Infants with PRS frequently experience airway blockage due to glossoptosis, which causes pharyngeal obstruction. Any operation, such as lingual frenulectomy, that makes glossoptosis worse may raise the chance of obstruction or worsen an already present obstruction. In this study, two examples of substantial airway decompensation following lingual frenulectomy in infants with PRS that required surgical intervention are covered. We advise against performing lingual frenulectomy on infants who have or are suspected of having PRS due to the potential increased risk of airway obstruction.

Keywords: Otolaryngology; Clinical study; Confounding impact; Dysphonia; hoarseness; Laryngoscopy; Laryngostroboscopy; Laryngeal imaging; Laryngeal electromyography; Evidence-based otolaryngology

Introduction

The phrase "voice disorder" encompasses a wide range of ailments with symptoms that may appear alone or in combination. The complicated interaction of numerous physiological, biochemical, and psychological systems required for voice production makes the disorder's aetiology frequently multifaceted. Beyond recognising apparent or organic laryngeal pathology, diagnosing the aetiology of voice decline is a complicated task that necessitates the expertise of numerous clinicians. Otolaryngologists (Ear, Nose, and Throat, ENT), Speech-Language Pathologists (SLP), voice scientists, psychologists, singing instructors, and vocal coaches make up the multidisciplinary team that helps diagnose voice disorders. To categorise the vocal complaint, each professional will concentrate on a distinct level of vocal symptoms [1]. SLPs may describe voice abnormalities using subjective auditory perceptual judgments, whereas ENTs may describe a vocal issue based on the presence or absence of visually visible pathology. As a result, different medical terms may be used by different professionals to describe the same voice symptoms or presentations. Clinicians sometimes use general classification terminology to describe homogenous groupings of vocal disorders when there are no clear criteria to determine them, such as nonspecific dysphonia, persistent laryngitis, functional dysphonia, or non-organic dysphonia a specific diagnosis [2].

Primary headache syndromes and chronic rhinosinusitis (CRS) are both frequent disease entities, and referrals to otolaryngology clinics frequently involve headache and facial pain. Most of these patients are referred in order to rule out a sinogenic cause for their symptoms. Making the distinction between patients with primary

headache syndromes and those with true sinogenic disease, however, poses one of the biggest challenges in managing such patients. These are the categories of primary headaches we shall discuss in this article: migraine, tension-type headache (TTH), and cluster headache (CH). The fourth category of "other primary headaches" in the IHS-2004 categorization of headaches comprises primary cough headache, primary headache related to sexual activity, exertional headache, hemicrania continua, and hypnic headache. Historically, sinus headache has most commonly been mistaken as one of the more prevalent primary headache types, such as migraine, CCH, and TTH. A sinus headache is generally characterised by pain in the maxillary sinus or the periorbital region of the face and is linked with nasal symptoms. While sinus headache pain is normally mild to moderate in intensity, it can also present as a severe sort of pain that can be pulsatile in nature. In some situations, the clinical history may resemble a migraine attack. Additionally, primary headache syndromes may also be accompanied with rhizogenic symptoms, leading the patient and even the family doctor to believe incorrectly that the underlying cause is sinogenic [3].

It is impossible to propose a specific course of treatment without first

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identifying the dysphonia's root cause. The evaluation of patients with dysphonia must include a laryngeal examination. Mirror laryngoscopy, rigid indirect telescopic endoscopy, flexible fiberoptic endoscopy, and flexible distal chip endoscopy are a few of the techniques used to visualise the larynx. Image quality varies by technique in addition to variations in light and image transmission, and various examiners may have a greater familiarity with one approach than another [4]. The assessment of patients with dysphonia has advanced with the inclusion of stroboscopy to still-light endoscopy. For patients with dysphonia, determining the vocal folds' vibratory characteristics during a stroboscopy procedure assists diagnosis and treatment planning. Different ailments or complaints could necessitate using particular evaluation methods. Clear comprehension of the characteristics of each technique and the capacity to interpret the examination are necessary in order to give the patients with the best care possible [5].

With a lifetime frequency of 28.8% in the general population and a higher prevalence among people who use their voices professionally, voice disorders are a prevalent health problem. 1 Muscle tension dysphonia (MTD), vocal polyps, and vocal nodules are all often observed, and their causes are intimately connected to improper phonation behaviours. 2,3 For instance, vocal nodules typically originate from abuse or overuse, which in turn causes thickening or fibrosis of the vocal fold epithelium [6].

Material and methods

Between April 30, 2020, and October 1, 2020, all patient records who received otolaryngology consultations at a busy tertiary care institution were reviewed. The patient's demographic information, length of stay, COVID-19 status, cause of consultation, and otolaryngology interventions were all recorded. The statistical analysis was completed using R programme. A cross-sectional examination of 116 residency programmes in otolaryngology was conducted. All US otolaryngology residency programmes for the academic year 2019–2020 were located using the Fellowship and Residency Electronic Interactive Database on the internet. The 123 programmes included in the Fellowship and Residency Electronic Interactive Database was reduced to 116 programmes by removing six military programmes and one programme in Puerto Rico [7].

Between January 1, 2014, and December 31, 2018, we did a retrospective review of new paediatric (under 18 years old) outpatient otolaryngology visits at a children's hospital clinic and satellite clinics. For both the PGOMPS Total Score and Provider Sub-Score, factors connected with patient satisfaction were identified using univariate and multivariate binary logistic regression analysis. From September 2014 to July 2016, a tertiary referral hospital provided voice therapy to a continuous group of individuals with voice abnormalities. During video laryngostroboscopy, the vocal folds appearance and vibration were used to make a clinical diagnosis of vocal disorders. A diagnosis of vocal nodules, polyps, or MTD6 getting voice therapy as the initial form of treatment qualified as one of the following inclusion criteria. Following were the exclusion criteria articulation or language difficulties hearing impairment prior surgical treatment for laryngeal issues mental or neurological conditions and pre-treatment VHI-10) scores of less than 10 points (i.e., within the normal limit of healthy subjects) [8].

Discussion

Dysphonia has numerous etiologies, so a precise diagnosis is necessary for therapy planning. For the dysphonic patient to receive the best care, a thorough laryngeal examination, knowledge of and

familiarity with the differential diagnosis, are all required. Despite this, it is still unclear how the general otolaryngology community utilises the numerous laryngeal examination procedures that are currently accessible and how comfortable they are in making diagnoses of particular disorders [9].

Over 60,000 VNS implants for children with refractory epilepsy have taken place since the FDA gave its permission. With children under the age of 18 reporting a 60% drop in seizures 1 year after implantation, VNS therapy has shown to be particularly successful for lowering seizures in the paediatric population. VNS installation is effective but not without risks in the treatment of refractory epilepsy [10].

Conclusion

Mirror laryngoscopy and flexible fibrotic laryngoscopy were the two most frequently used techniques for laryngeal evaluation. Stroboscope is performed or referred for by 84.1 percent of otolaryngologists, however one-third might not be aware of the differences between the two procedures. About 50% of respondents were concerned about overdiagnosing LPR, and otolaryngologists felt more at ease diagnosing voice problems in the presence of apparent laryngeal anatomical abnormalities. Paediatric otolaryngologists frequently treat patients who have a variety of health issues, including epilepsy. The impact of VNS implantation on a patient's respiration and sleep must be taken into account as it becomes increasingly widespread. Breathing issues can be significantly improved by modifying the VNS settings by lowering the current, shortening the stimulation period, or lengthening the off interval.

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Conflict of interest

None

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