

Editorial

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The twentieth century saw great advances in the diagnosis and treatment of head and neck cancer. Green and colleagues¹ from London and Leeds (UK) remind us in their article in this issue that ‘... despite relatively high cure rates and survival, treatment with surgical excision, chemotherapy or radiotherapy results in tissue loss and fibrosis within the upper aerodigestive tract. Severe long-term disability may ensue ...’. One strategy to help patients is regenerative medicine. This includes cell transplantation, the injection of bioactive factors, scaffolds and bioengineering of laryngeal structures. We published a paper on this topic in 2015,² which is updated by more recent studies cited in this month’s article. The authors advise that research and development should focus on pathologies in which there is a high disease burden in the patient population. They conclude: ‘Regenerative techniques may decrease operating time, eliminate the need of a donor site, improve healing and improve quality of life outcomes’.

Training and skill acquisition in temporal bone surgery is close to the heart of all otolaryngologists. There have been numerous challenges facing teachers and students in recent years, such as a lack of organs donated for teaching, and the UK organ-retention scandal and its legal repercussions. One such challenge has been the difficulties in supply and use of human temporal bones, which has been the topic of previous papers in *The Journal of Laryngology & Otolology*,^{3–6} and ideas such as plastic bones or three-dimensional (3D) printed bones have been considered.⁷ Having acquired a means of practising temporal bone dissection, how do we determine that the trainee has enough skill to safely move from the temporal bone laboratory to the real patient? This issue includes a paper by Stavrakos and colleagues from Thessaloniki, Greece,⁸ which uses 3D-printed bones and applies the principles of objective structured assessment of technical skill (‘OSATS’). This involved two assessors evaluating videos of the dissection, and answering seven questions and one overall question on the performance. The results suggested that the method was reliable and valid. This type of assessment seems labour-intensive for an ENT department, which will involve staff time that requires funding, but it seems to be a fair way of determining when a trainee is fit to transfer safely from the laboratory to the patient and so satisfy the demands of regulators and the public.

The ever-popular topic of nasal irrigation has two contributions in this month’s issue of *The Journal*. Turfe and colleagues from various US centres⁹ describe how fluid dynamics modelling can show the efficacy of douching on reaching the maxillary sinus in standard antrostomy versus more extensive endoscopic medial maxillectomy in recalcitrant maxillary sinus disease. The latter allowed faster and more forceful coverage of the sinus, although both methods produced complete coverage, which is perhaps unsurprising. Ocak and colleagues from Ankara, Turkey, compare a douche with surfactant versus one with sodium hyaluronate, and compared mucociliary clearance in both.¹⁰ They found that both methods were superior to saline, and similar to one another. The general topic of nasal douching was covered in recent years in an article in *The Journal* from Guangzhou, China.¹¹

This month sees the retirement of our long-serving Managing Editor, Rosamund Greensted, and the arrival of our new Managing Editor, Catherine Hyland. Both have had distinguished careers before joining *The Journal*. We thank Rosamund for her enormous contribution to *The Journal* since 2004. Rosamund’s efforts have encompassed tasks and guidance that go well beyond the requirement of her formal role, and we all will miss her both personally and professionally. We wish Rosamund every happiness in her retirement and welcome Catherine warmly to *The Journal* family.

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