

Editorial

OHBM—International Open Access Journal of Otorhinolaryngology, Hearing and Balance Medicine

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Received: 5 November 2020; Accepted: 5 November 2020; Published: 15 January 2021



Dear colleagues,

It is a great pleasure to write as the Editor-in-chief of the Journal of Otolaryngology, Hearing and Balance Medicine.

As you may know, I have dedicated my entire academic and clinical career to the fields of otology and lateral skull base surgery. Currently, these fields have reached their zenith. Surgical techniques have been standardized, and the quality of therapies has reached the highest level worldwide.

As with any area of otology, otology has presented new therapeutic tools, such as the use of endoscopes, with the aim of reducing the invasiveness of surgical interventions. Whilst this has led to a greater diffusion and attractiveness to younger surgeons, the apparent “simplification” due to an enlarged view risks limiting the use of the microscope, which is still a cornerstone of otologic surgery. Among those who propose the exclusive use of the endoscope and those who propose combined approaches, the same level of standardization and results that purely microscopic techniques have achieved over the years have not yet been reached. The risk could entail having surgeons unable to deal with pathologic or complicated mastoids.

Regarding lateral skull base surgery, the same type of debate is taking place between those who propose surgery as an exclusive option for the treatment of benign tumors (such as neurinomas, meningiomas and paragangliomas) and those who prefer radiotherapy. Prospective studies have demonstrated the value of simple observation of these slow-growing lesions. “Wait and scan” has radically changed the therapeutic approach to these diseases, reducing morbidity and improving the quality of life in many cases. Therefore, a strong debate remains between those who propose radiotherapy as the first-line therapy and those who opt for a period of simple “follow-up” before any treatment.

Clearly, not all tumors are suitable for a “wait and scan” protocol. The patient age, tumor size, tumor growth, and onset of disabling symptoms may represent factors for which surgery remains the best therapeutic option. Lateral skull base surgery requires adequate training and expertise.

Radiation therapy is only apparently a non-invasive procedure. Complications and post-radiation tumor growth have been reported in the literature. Surgery of these cases can be deceptively difficult even in expert hands. For all of these reasons, it is necessary to carefully evaluate all therapeutic options. For example, recent studies by the Gruppo Otologico on Paragangliomas demonstrated how these tumors are radioresistant. Similarly to the use of endoscopes in middle ear surgery, radiotherapy leads to a lack of standardization in skull base surgery. Partial surgery associated with post-operative radiotherapy is, therefore, considered effective by many surgeons when, in reality, the surgical step could be considered an “enlarged biopsy”.

It would be interesting to evaluate when partial surgery alone, especially in patients over 65 years old, can represent a therapeutic alternative. Could this reduce the morbidity of surgery, particularly on the facial nerve?

Finally, an open debate exists on the education of young otologists. Affordable “hands-on” courses, dissection on cadavers, and fellowships in the most experienced centers are basic requirements for the next surgeons. An international consensus that includes common educational standards could be an idea to work on in the future.

I hope this journal can contribute to a serious debate on these controversial aspects.

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