Low priority procedures – a uniquely British concept?

Many of you, I hope, will be unfamiliar with the concept of 'low priority procedures' which are the present preoccupation of the Department of Health in England and Wales. This is an idea which has been bouncing about for some years but in the deepening financial gloom has percolated to the surface and is of particular concern to otorhinolaryngologists. The exact interpretation and implementation of this policy is still uncertain particularly as it coincides with yet another seismic re-organisation of the NHS, in which most of the budget is to be controlled by primary care practitioners (whether they want it or not!) . However, in essence the policy of 'low priority procedures' targets a number of operations which includes adenotonsillectomy, grommet insertion, surgery for snoring, rhinoplasty and functional endoscopic sinus surgery, imposing strict criteria on whether patients referred by general practitioners may be offered these operations or even referred for their consideration. I am sure we would all agree that it is extremely important in any healthcare system to utilise resources responsibly and optimally and the history of surgery and particularly ENT contains many examples of procedures that came and went out of fashion. You may be wondering what this has to do with you and the journal but as I look down this issue's list of contents, I am pleased to see how many of the papers contribute to the evidence of benefit that is becoming increasingly needed to justify what we do. Only by providing this objective evidence will we be able to offer our patients a validated range of treatments.

We may have problems providing randomised controlled trials of surgery for chronic rhinosinusitis or sinonasal tumours [1,2] but we can critically examine the evidence and encourage the prospective collection of data, including functional outcome measures. Furthermore, we can demonstrate that the massive expenditure on some medications such as antibiotics and anti-reflux therapy is equally lacking in rigorous and conclusive proof. Gastro-oesophageal reflux is now held responsible for a wide variety of laryngeal, nasopharyngeal and sinonasal conditions[3-5] but the jury is still out on whether proton pump inhibitors, antacids or other medications have any significant effect.

In this issue authors consider the objective assessment of airflow, from practical guides to rhinomanometry and 3-D modelling of the nose to normal and abnormal values in nasal peak flow and the niceties of septoplasty and inferior tubinectomy. Interestingly, the NHS has yet to alight upon septal and turbinate surgery as a 'low priority' but it is only a matter of time so these objective considerations are timely. Whilst the fine detail of objective airway measurement can evolve[6,7], the selection of patients for nasal surgery is significantly improved by the use of pre-operative objective evaluation[8-10].

An increasing interest in olfaction and its measurement is to be commended. Although we know that maintaining improvement in the sense of smell in the long-term after treatment of nasal polyps can be difficult[11,12], it is an excellent measure of success in the shorter term and a major contributor to quality of life[13]. This applies to both medical and surgical therapy so by focussing on surgical operations, the politicians fail to grasp the bigger picture of medicine in which patients require investigation, diagnosis and treatment, whatever that may be. It falls to us to prove that what we do works and will not only be the UK that demands this information in the future.

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