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Scoping Workshop

Guideline: **Otitis media with effusion in under 12s: surgery**

Date: **5th August 2021**

Time: **10:00 – 13:00**

Location: **Virtual via Zoom**

Committee members	
Caroline Jones (CJ)	Chair
Veronica Kennedy (VK)	Topic Advisor
NGA staff	
Maija Kallioinen (MK)	Guideline Lead
Laura O'Shea (LOS)	Senior Systematic Reviewer
Aye Paing (AP)	Systematic Reviewer
Ferruccio Pelone (FP)	Health Economist
Sarah Stockton (SS)	Senior Information Scientist
Stephanie Arnold (SA)	Information Scientist
Offiong Ani (OA)	Senior Project Manager
Stephen Murphy (SM)	Clinical Adviser
NICE staff	
Clifford Middleton (CM)	Guideline Commissioning Manager
Martin Allaby (MA)	Clinical Adviser (Chair of the workshop)
Louise Picton (LP)	Medicines Adviser
Rea Gilmour	Guideline Coordinator
Jill Peacock	Guideline Coordinator
Rachel Kettle (RK)	NICE Technical Adviser

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Stakeholders	
Cherry LeRoy	Cleft Lip and Palate Association
Tamsin Holland Brown	Royal College of Paediatrics and Child Health
Samantha Lear	British Academy of Audiology
Iyngaran Vannaiseagarm	British Association Audio-Vestibular Physicians
Mat Daniel	NIHR Nottingham Biomedical Research Centre
Anne Marsden	British Association of Paediatricians in Audiology

Apologies	
Simon Ellis	Guideline Lead
Simran Chawla	PIP Adviser
Miaquing Yang (MY)	Technical Adviser (Health Economics)

Item	Discussions and decisions
1.	**Welcome and introductions** • MA welcomed all participants to the meeting • All stakeholders (SH) introduced themselves • MA outlined the objective of today's meeting which included discussion of the draft guideline scope, review questions, equalities and committee composition • Apologies were noted as above
2.	**Presentation of the draft guideline scope and discussion** • VK provided some background on the existing OME guideline (CG60 published 2008), which will be replaced by this update, and gave a presentation of the draft guideline scope. • The SHs pointed out that under 12s is a very broad age range of children because clinicians usually see pre-school children with OME. • The review questions under the sections of the scope were discussed as follows: Section 1 – risk factors for OME: • There is evidence that nasal obstruction and allergic rhinitis are pre-disposing factors of OME. • Useful to know about modifiable risk factors useful to be able to tell parents what they can do/avoid. But it would also be helpful for practitioners and service users to know the risks of a child having recurrence, so include modifiable risk factors and risk factors of long-term OME. Section 2 – recognition of OME • It was noted that questions are missing how glue ear is diagnosed. • It was also noted that it might be important to consider how do we recognise OME that is significant or worthy of intervention?

- The SHs raised the importance of considering what the right pathway is, including the child having a hearing assessment done accurately in a child-friendly environment.
- The SHs suggested including something about clinical thresholds for what signs, symptoms or factors will warrant treatment and what will not because diagnosis can sometimes be inaccurate because of the perception of "it will get better".
- The SHs advised that diagnosis should be made on what the child feels and how it affects their quality of life in addition to clinical assessments.
- A question was raised about when should a referral be made e.g. referral made by the GP to ENT or audiology at the initial GP visit. SHs agreed that children do not have to be referred to surgeons immediately, as surgery is usually not necessary at the initial stage – an accurate assessment should be given instead to establish hearing thresholds and plan for appropriate management.
- It was discussed that this section is primarily about when should you have some suspicion that a child might have OME, i.e. largely of relevance to primary care.
- SHs felt that a criteria for referral should be included in the scope and agreed that children should be referred to an audiologist in the first instance to provide initial management and avoid delays in the diagnosis/treatment process.
- SHs noted that otoscopy has variable accuracy particular if done by non-specialist, primary care usually have no access to tympanometry so need to consider importance of access to accurate assessment.
- There was varying views about whether the important question is about who should the child be referred to or what the child needs (hearing assessment) regardless of setting.
- It was also noted that it may be important to differentiate 'subjective' and 'objective' hearing loss in the review protocol (determined through clinical signs, symptoms and history alone or through accurate assessment).

Section 3 – natural history of OME:

- These review questions were originally placed under "Management of OME" section but it was agreed that these are not about management and should be a separate section "bridging the gap" between recognition and management.
- It was discussed if it would be possible to make a diagnosis of OME for a child with no hearing loss. It was noted that hearing loss is often fluctuating. Some children present with balance issues that may be related to OME.
- The current definition of hearing loss is >20, children with an assessment of <20 e.g. 15 would still have poorer hearing than before (sub-clinical hearing loss) but not enough to be defined as hearing loss.
- Important to consider fluctuating hearing loss which is very common.

Section 4 – interventions for children with OME:

- It was agreed that the title of the section should be changed from "Management of OME" to "Interventions for children with OME".
- SM assured the SHs that the technical reviewing process which includes drafting protocols and stratifying populations, age groups and interventions will ensure that searches cover as much available evidence as possible.
- The SHs discussed that if a child presents with glue ear, they can get better first line care in audiology than ENT. A holistic picture should be considered.
- The SHs mentioned that insertion of grommets is based on commissioning, funding and waiting time. Grommets are only commissioned for those who meet the criteria.
- The SHs flagged that the guideline scope will need to consider benefits and harms of hearing aids in children with OME.

- The SHs were asked whether any of the interventions listed in the draft scope are not used in current practice and not be relevant for an evidence review.
- The SHs agreed that proton pump inhibitors and reflux medicine are not used in practice to treat OME and reviewing these is not needed. PPIs and reflux medicines are perhaps more relevant for acute otitis media.
- Many of the other treatments listed in the draft scope are also not commonly used but may be used and could be good to review.

Section 5 – intraoperative and postoperative care

- SHs were generally happy with the draft review questions and agreed about their importance.
- SHs flagged that draft review question about follow-up strategy might be contentious because of the different ways things are done in various geographical regions.
- SHs noted that follow-up strategies for all non-surgical treatment might also be relevant.
- There was discussion about what the follow-up strategy question should cover, whether it is about the setting for the follow-up or rather more about the content, timing and frequency.
- The SHs suggested that the guideline should perhaps develop a pathway for all practices and practitioners to follow to deplete variation in practice. However, there might not be evidence to support this.

Section 6 – information for children, parents and carers

- SHs were generally happy with the draft review question but wondered if it should be about what information they “need”, not just “value”. However, it was discussed that this section covers the perceptions and views of the service users and the information provision required from a clinical perspective will be derived from other review questions.

Areas not covered in the guideline

- One SH was interested in others’ views on dietary modifications and their role in management of OME, dairy intolerance comes up frequently in discussions with families.
- SHs agreed that there may be an association with dairy allergy, however, this should be captured by the review question on modifiable risk factors.
- It was also noted that there is a NICE guideline on food allergy in children and a cross reference may be relevant.

Outcomes

- Generally SHs were content with the list of main outcomes.
- SHs suggested to add educational attainment to the outcomes.
- The outcomes could also capture developmental skills more broadly and balance might be missing although there is uncertainty how these would be measured.
- Anxiety of not hearing can be important to consider, however, it is probably covered by psychosocial development or quality of life.

3.	**Equalities considerations** • SHs wondered if it should capture parents who have religious beliefs that might stop them from taking up surgery. • Perhaps could say “Children with complex needs, including learning disabilities” • It was also noted that children who are in a surgical pathway may be disadvantaged because the waiting times are so long. • There may be geographical variation in access to treatment, particularly due to the covid-19 pandemic increasing waiting times.
4.	**Draft Guideline Committee constituency** • It was discussed if a teacher should be a core member or a co-opted member. • Good to drop ‘consultant’ from the roles so that the pool for applicants will be bigger. • There was discussion whether there is a need to have both paediatrician with interest in audiology and a community paediatrician. It was discussed community paediatrician is important because they may meet these children initially. • There was a discussion whether there needs to be another audiovestibular physician (in addition to the Topic Advisor). Majority of the group agreed that one should be sufficient given that there is various other roles with audiology expertise. • There is value in having two ENT surgeons and two paediatric audiologists to get different perspectives or from different geographical areas to give perspective. • It was noted that it would be good to add ‘audiological scientist’ together with audiologist. • It was noted that it is important to include also other professions than doctors, e.g. nurse (health visitor) and/or teacher. • The SHs agreed that teachers can have very specific expertise that’s useful. However, it may be difficult to recruit a teacher as a core member so a co-opted membership could also work.
5.	**Feedback and next steps** • The SHs were reminded of upcoming committee recruitment and draft scope consultation.
	Workshop close