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# Does smoking increase the risk of peritonsillar abscess formation?

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## Editorial

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Although previous retrospective studies have identified a link between smoking and peritonsillar abscess formation, this has not been tested in a prospective study. In this month's issue of *The Journal of Laryngology & Otology*, Schwarz *et al.* investigate whether smoking increases the risk of peritonsillar abscess formation.[1] The authors of this study identified a statistically significant association between peritonsillar abscess formation and smoking ($p = 0.025$), in agreement with previous retrospective studies.[2] Of the 325 cases of peritonsillar abscess in the National Prospective Quinsy Audit, 17 per cent of patients had a smoking history, although a smoking history was not independently predictive of a 30-day adverse event.[3] The authors of this latest study postulate that smoking leads to injury of the oropharyngeal mucosa, thereby increasing the likelihood of developing abscess formation. Smoking may also increase the risk of abscess formation by altering the tonsillar bacterial flora and/or the local and systemic immunological milieu.

Waiting lists for elective surgery are a topical issue in many publicly funded healthcare systems. In order to reduce waiting times for surgery, McLaren *et al.* introduced a pathway for audiologists to directly schedule children for grommet insertion meeting National Institute for Health and Care Excellence Clinical Guideline 60 ('CG60').[4] Prior to implementation of the new pathway, mean duration between the first audiology appointment and grommet insertion was 294.5 days. Implementation of the new pathway led to a significant reduction in the time interval between the first audiology appointment and surgery (mean duration of 232 days, a reduction of 62.5 days; $p = 0.024$). The authors stress that the ultimate decision regarding surgery still rests with ENT specialists. In addition, the new pathway places greater responsibility on the audiology team regarding surgery-based treatments. Indeed, this may account for the low number of patients adopting the new pathway. Alternatively, the low numbers being referred directly for grommets by the audiology team may reflect a tighter adherence to National Institute for Health and Care Excellence guidelines by audiologists following a strict protocol. Other ENT departments may choose to adopt such a pathway in order to improve service provision, following consultation with their local audiology departments.

Finally, Noor *et al.* review the indications for panendoscopy in the investigation of patients with newly diagnosed head and neck squamous cell carcinoma.[5] Obtaining a tissue diagnosis was still the most common indication for panendoscopy.[6] However, the authors conclude that panendoscopy remains paramount in the assessment of suitability for transoral robotic surgery and in the investigation of an unknown primary.[7] Interestingly, the authors identified only a 1.1 per cent risk of synchronous second primary tumour, of which all were P16 negative, suggesting that the increase in human papillomavirus related disease is responsible for this reduction.[8,9]

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