Delphi Round 4

Dear Colleagues,

Thank you for your contribution to this NOE Delphi process. We apologise for the major delay in the process, which was somewhat unavoidable. We are now entering Round 4, having had two electronic rounds of questions and one face to face meeting.

In this current round there is only one section, with a total of 5 questions with opportunity for comment. There may appear to be repetition from previous rounds. This is to ensure that we have consensus. Should consensus be reached on all definitions the next step will be that the agreed definitions will be circulated to a wider group including all the organisation stakeholders including BSO, ENT UK, BIA and BSAC for consideration and comment. If there are other organisations who you think should be involved please let us know. If we do not reach consensus we will need to engage in another round of questions.

We have used a number of terms in the definitions that themselves need defining. As was discussed at the Oxford meeting knowing how we are using certain words is critical to agreeing or disagreeing with the proposed definitions. *Please be aware of these definitions as you reply to the questionnaire. They can be viewed here or by following the link at the top of each page.*

Thank you again for your contribution.

Kind regards,

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DEFINITIONS

It was clear from Round 3 that having a clear understanding of terms used in definition is important. Please find below the key definitions used in this document.

Otorrhoea – discharge from the EAC. This may be a symptom or a sign.

Otalgia – pain originating in the ear.
Note a patient may not always complain of pain (eg. in severe dementia) but there are signs suggestive of severe pain (eg. irritability, groaning, holding ear and others). It is acknowledged that in very rare cases eg. in diabetics with severe neuropathy this symptom may be absent.

Granulation tissue - specialised tissue that is formed during the process of healing. It comprises a proliferation of fibroblasts and vascular endothelial cells (angiogenesis), which impart a soft, granular, reddish appearance to the wound and hence the term "granulation". Histologically, it is seen as a proliferation of small capillaries set in oedematous, loose fibroblastic stroma that contains a variable number of acute and/or chronic inflammatory cells.

Inflammation in EAC – presence of erythema and oedema in the EAC.

CT – Non-contrast enhanced, high-resolution acquisition with 1 or less mm slice thickness bone and soft tissue algorithm reconstructions. If intracranial complications are suspected and MRI not availible, contrast enhanced CT can be performed.

MRI- High resolution axial and coronal T1 weighted images as well as T2 and/or STIR images + DWI. This is can be performed without gadolinium but a gadolinium enhanced scan with fat-saturated post-gadolinium T1-weighted images should be considered in patients with an eGFR > 30 , particularly if intracranial complications are suspected or if the differential diagnosis includes malignancy.

Possible NOE – this is a diagnosis made on presenting clinical features and is an indication to proceed to imaging to enable a definite diagnosis of NOE. This definition answers the question; 'who should progress to intial imaging?'

Severe NOE – the reason for defining this as a separate entity is because it may impact duration of therapy and there may be indication for deep sampling or operative intervention. Unless it is defined we will not know how to manage it or whether it needs to be managed differently to NOE which is not considered severe.

Histology – sampling of the external ear canal, showing features of inflammation. The key outcome of investigation is to exclude malignancy and other differential diagnoses eg. cholesteatoma, keratosis obturans, langerhans cell histiocytosis.

Immunocompromise – this refers to any state which may compromise an individal's immune system. It may be the result of frailty/HIV/malignancy/ diabetes/biological drug therapy/others.

Frailty – a condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic clinical failure. As a consequence the frail person is at increased risk of disability and death from minor external stresses[1]

Optimisation of immune state – where possible interventions should be put in place to improve immune function eg. improving diabetic control, reducing/stopping immunosuppression, improving compliance with ARVs.

[1] https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdf