# Demystifying laryngology in the era of examination and collaboration

BY ALBERT MERATI

In the field of laryngology, perhaps more than in any other area of ENT, there has been a philosophical shift (as well as a technological one) in the approach of clinicians caring for patients. **Albert Merati** explains.

Progress in laryngology and care of the performing voice over the past 20 years has included the advent of conspicuous technologies such as fibre-based lasers and improvement of high-fidelity 'chip-tip' scopes; these improvements are important but are only half the story. The contemporary professional voice care community was not built on the technology – the community was built on a decades-long conversation and commitment to demystify vocal fold pathology. And now our trainees are being exposed to this culture as well.

In the past, the cartoonish talisman of a laryngologist may very well have been an atomizer for various 'voice treatments'; our battle shield could now feature a channelled flexible laryngoscope or perhaps even the ubiquitous smartphone and the community connectivity fostered by that device. What has energised this change? The hallmark of our modern professional voice community is to drive and demand thoughtful and reproducible physical descriptions of the pathophysiology that we see during examination. It has been too easy for too long to casually blame our performers (or any patient for that matter) for their technique or 'abuse' being the source of hoarseness we cannot otherwise explain. These elements of performing voice assessment may occasionally be valid but today's otolaryngologists caring for this population are determined to ***explain*** rather than to ***mystify*** vocal fold pathology. Our understanding of vocal fold paresis as a significant clinical entity is an excellent example of this evolution; the field is credibly connecting even subtle findings of vocal fold paresis with physiology and patient complaints. We are imperfect, but this determination among contemporary otolaryngologists continues.

Another more common example of the importance of careful laryngeal examination is in the realm of understanding reflux and its impact on the larynx. I recall one particularly jarring conversation I overheard at a national otolaryngology meeting in which an experienced otolaryngologist described their approach to laryngeal complaints as "PPI then bye-bye" – i.e. if the examining otolaryngologist did not notice anything abnormal on their exam, the patient was given a trial of reflux medication and sent on their way. This attitude leads to several very real issues, not the least of which is the possible over prescription of PPI by otolaryngologists. This approach also serves to undermine the identification and treatment of the very real impact of reflux on laryngeal pathology. The problem occurs when diagnosticians fail to fully pursue the pathophysiological causes of hoarseness, with other studies in laryngeal videostroboscopy and in treating empirically with PPI delaying more focused or complete treatment.

When a patient is hoarse and standard examination (with mirror or with flexible laryngoscopy) fails to yield a positive diagnosis, we may conclude they do not have a large tumour or vocal fold paralysis – but there are many subtler and treatable findings that only further evaluation can unearth. As the breadth and depth of our collective expertise in otolaryngology continues to increase, trainees are exposed to increasingly complex and nuanced aspects of our vibrant field. While trainees may not be receiving all they need in this area, dedicated training in laryngology continues to grow as an integral part of our core otolaryngology programmes.

This growth has also accelerated progress in voice care; when I started laryngology practice 20 years ago, it was all I could do to copy a VHS tape, have it mailed with a letter requesting (and occasionally begging) one of any number of willing but busy senior colleagues to take a few minutes to review the story and the video. Now this consultation happens in seconds via secure

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online technologies – and not just to one colleague, but many. The men and women in these sorts of messaging groups provide insight, experience and perspective that is often needed during clinical care, no matter how well trained and experienced we as individuals may be.

Future directions in laryngology include inevitable changes such as better (and hopefully cheaper) technology with higher quality images, the introduction of appropriately scaled robotic instruments for intracordal surgery and even the introduction of artificial intelligence for the acoustic diagnosis of voice disorders. And then we may all be obsolete...

For now, the rise of the professional voice care community continues to enrich our career-long conversations. I believe that we thrive on the thoughtful description of laryngeal pathology and, as importantly, on communicating about what we see and what we believe it means.

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Prof Merati currently serves as the President-Elect of the American Academy of Otolaryngology – Head and Neck Surgery/ Foundation. He also serves on the Council of the Triological Society as well as that of the American Broncho-Esophagological Association.