IN CONVERSATION WITH

Muaaz Tarabichi

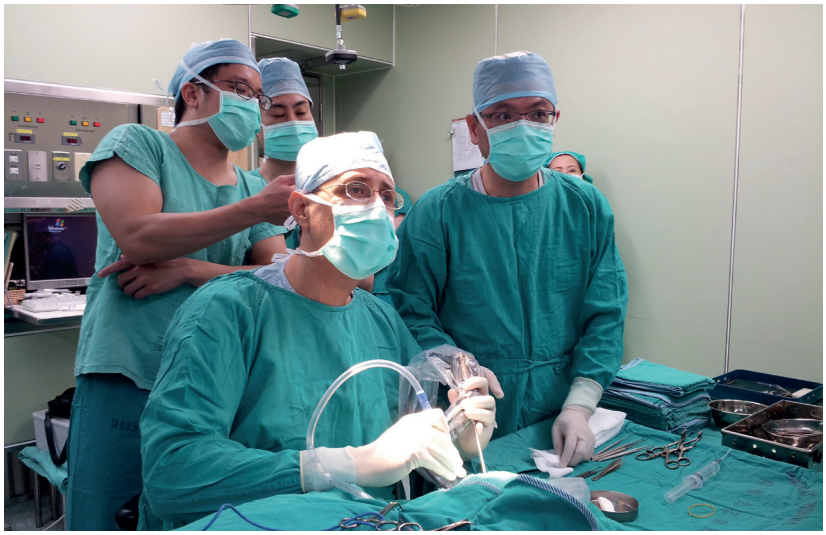
Guest Editor, **Chris Coulson**, speaks to **Dr Muaaz Tarabichi**, a pioneer of endoscopic ear surgery, about how he has seen the technique evolve during his career, what challenges early EES practitioners have faced and his predictions for the future of this procedure.

As the original practitioner of endoscopic ear surgery (EES), we are interested to understand what got you to the position of innovating a new surgical technique. So, to start off, can you tell us a bit about your education and ENT training?

I did my ENT training at McGill University in Montreal Canada. I graduated in 1988, and at that time, endoscopic sinus surgery was being popularised by the Stammberger / Kennedy team. I did not get any endoscopic training during my residency. But I distinctly remember attending a lecture in 1987 by Dr Stammberger (who was a visiting professor in Montreal at that time). I remember having this sceptical conversation with a fellow resident in the back of the lecture hall: "is he really telling us that he can do nasal polyps without using two hands, one for suction and the other for surgery? I do not buy it". I started in endoscopic sinus surgery two years later after the same colleague tried it himself and told me it works. It is amazing to me that the same arguments that deterred me initially from endoscopic sinus surgery were used against me when I advocated EES.

When did you first conceive that EES would be a feasible procedure?

In 1992. I was initially trying to document a "different way" of obtaining the graft for tympanoplasty and I used the scope because you can record nice video with it. But then, I progressed into doing a simple perforation. I was lucky in a way, because my otology mentor, Dr Mendelson, always instructed me to hold the speculum with the left hand when doing stapes and transcanal tympanoplasty, so I was a one handed transcanal surgeon even with the microscope.



Demonstrating endoscopic technique through live surgery in Taiwan during the Annual Meeting of the Taiwanese Society of Otolaryngology in 2012.

How did you put that concept into action? Were there any hurdles outside the clinical side, such as legislation, ethics, colleagues?

I have to admit that my colleagues who have worked closely with me through the years did not object to me doing this and they were all very supportive. I think they knew me personally and know that I am not a "cowboy" who dashes out there without thinking things through. They were also consistently impressed with the images that I was obtaining. But the established otology community who did not know me personally were nothing but vicious and condescending in their approach: they basically thought, why are you fooling around with this? We figured this one out long time ago. But every practitioner of chronic ear surgery knows that this is not the case. Chronic ear surgery as it stands, is not a very successful intervention. Much needs to change to allow for better outcomes.

At what stage did you decide that EES was a 'goer'?

Actually from the get go. Any reasonable person with an endoscope in his hand will immediately recognise the increased ability to visualise the anatomy and disease. But the power of indoctrination and the herd mentality keeps us from doing what's obviously right. I have to admit that when I moved from Wisconsin to Dubai, I hit a period of time when my practice slowed down significantly and I did not have many cases to do; at that time the crowds got to me and I started to question the wisdom of this technique. But then, my practice went up again and every time I got out of the operating room from one of these cases I remember

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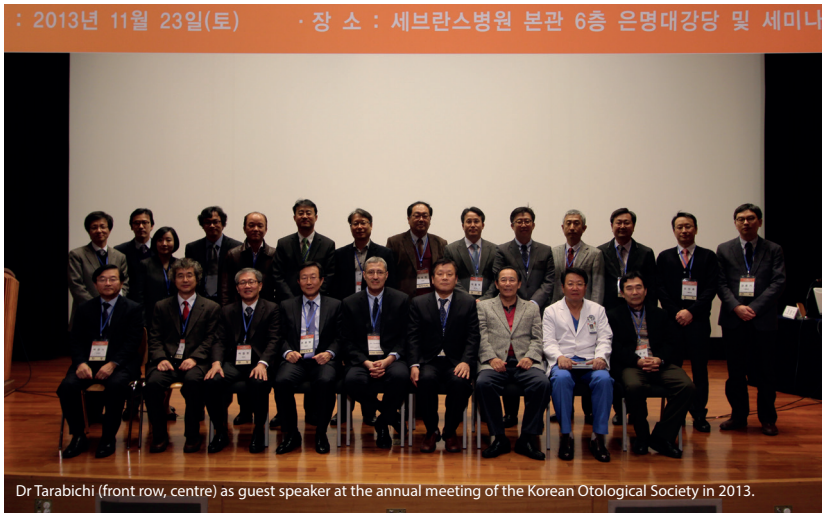

Dr Tarabichi (front row, centre) as guest speaker at the annual meeting of the Korean Otological Society in 2013.


Faculty Picture of the 2015 3rd Endoscopic Ear Surgery Course in St Louis, Missouri, USA.

thinking: How can anybody be against this? How can they get to the disease in this area with the microscope? I am right and they are wrong!

Camera imaging technology has advanced hugely over the last decade. Do you think the timing of EES was related to the available technology of the time?
I think the single chip camera was very limiting. Once we moved to the three chip camera, things got much better, and lately, the high definition camera makes things very crisp looking. On the endoscope side, nothing really changed much.

Has the production of any specific piece of technology improved your ability to perform EES?
Suction instruments have made the technique much easier and have expanded the reach of EES. Also, smaller angled scopes have allowed us more access.

Where do you see EES in 10 years' time?
I think we have a lot of work to further define the role of the endoscope versus the microscope. We are in the very early stages of this technique and much needs to be done to define its roles and outcomes, and I expect it will take us a few years to do that. Beyond that I think we have two frontiers: access to the proximal eustachian tube and access to the lateral base of skull.

What advice would you give to a young surgeon starting out?
Understand the level of indoctrination that we go through in our training. Much of our practice is really a product of years of accumulated wisdom rather than specific data. So, of course, a bit of indoctrination is important to keep us and our patients out of harm's way. But with the introduction of new technology, we need to continuously question the logic of doing things a certain way. Remember, people (and more so surgeons) do not change their mind; they grow older, retire and pass away. So it is left for the young to find a new path.

What lessons have you learned that others could apply?
When you have a new technology that has an application in almost every surgical discipline (like the endoscope), chances are it also applies to the discipline that you are practising no matter what your elders tell you.

As a busy clinician, how do you take 'time-out' and relax?
I have taken to daily kayaking for the last 20 years since I came to Dubai. I take my morning coffee on my kayak about two miles from shore around 5.00 am summertime and 6.30 am wintertime. That gives me a chance to reflect and unwind. I find that I cannot function if I do not do that. I find that if I do not do that, the endoscope smudges more often during surgery. I have not figured out the relationship yet!


Guest faculty and attendees group picture for the 2nd Australian Course in EES in Sydney in 2015.

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