TWJ Short Fellowship - Observership at the Causse Clinic and 19th International Course in Middle Ear Surgery and Hearing Restoration

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The Causse Clinic has a well-established reputation for excellence in middle ear surgery. It is not for nothing that the TWJ Foundation fund short fellowships to observe surgery there and attend the course on middle ear surgery. As I enter the final three months of my training, it appears to be the perfect time to attend the course. I have established competency in surgery in this area, and this course affords me the opportunity to assess the expert and experienced perspectives of otologic surgeons other than those who have trained me.

Some differences between French and UK practice were immediately apparent. In France, the surgeons were the unquestioned prime asset of the organisation. Their time was sufficiently valuable for patients to be anaesthetised, strapped to the table, cleaned and draped prior to their arrival. It was not uncommon for patients to be prepared in such a fashion for some time prior to the arrival of the surgeon. Operations would be electronically video-recorded and copies given to the patient. Laser safety measures were not a priority. All patients had a CT, even though the operating surgeon felt it was not necessary, because it was imposed on them by legal precedent. Anaesthetists entered and departed the operating theatre, monitoring a number of patients at once and responding to requests to change the blood pressure. All surgery was under general anaesthesia. Patients would be kept in hospital for some days after surgery for what we would consider a routine Day Case procedure. The differences in administration between privately-owned and publicly-owned facilities was also clear – with the clinic being more responsive to the requests of clinicians. Lastly, the supplies of entrecôte and wine at lunch lent the whole establishment a much more civilised feel than the chips and beans many of us are used to!

There were some practical differences. The use of speculum holders to facilitate permeatal surgery (only possible with general anaesthesia); vein grafts in stapes surgery; a diode laser instead of KTP (yet not used to cut stapedius); rifampicin placed on Merocel to pack the ear canal after surgery. Fluoride was used as a frequent long-term treatment for otosclerosis. Much of the chronic otitis media surgery was performed with a post-auricular approach. Their technique of fashioning cartilage was elegant.

But despite these minor differences, the similarities shone through. The range of pathology was similar to that which we encounter in the UK. Many of the implants used were also similar. Even more atypical cases, such as otosclerosis with a narrow air-bone gap was approached in the same way as it is in the UK – by highly experienced surgeons. Indeed, the panel discussions at the subsequent Course highlighted the fact that there may well be more variation between centres in the UK than between the RNTNEH and the Causse Clinic. However, RNTNEH practice is probably more similar to that of Prof. Briggs from Melbourne.

The course gave a fantastic insight into otology. Sujana Chandrasekarar gave a superb talk outlining a cause of vestibulopathy that is under-recognised and treatable – visual vestibular imbalance. Difficulties in our understanding of retraction pockets were discussed at length. Even seeing the variation between clinicians in the management of unilateral glue ear was educational.

I would highly recommend this combination of Observership and Course for those senior trainees who have sufficient experience in otology to not necessarily need supervised observed cadaveric dissection, but rather to hear the perspective of experienced otologic surgeons from France, Germany, the USA, Brazil, Australia, South Africa, India and of course the UK!