The Journal of Laryngology & Otology (2015), ***129***, *409*.

doi:10.1017/S0022215115001061

EDITORIAL

Focus on epistaxis

Epistaxis remains a major cause of emergency admissions to hospitals. There has been a significant rise in epistaxis admissions with the increasing use of prophylactic anticoagulation for cardiovascular conditions such as atrial fibrillation.[1] Two articles in this issue address aspects of epistaxis management. Hall and colleagues present the findings of a multi-centre audit of epistaxis.[2] They found that there was considerable variability in epistaxis management between participating departments in respect of examination, surgical intervention and length of hospital stay, with variation from accepted standards. They make the case for a national review of practice in order to improve patient experience and efficiency in delivering emergency care in our most common patient encounter. A second article, by Syed and Sunkaraneni, reviews management of epistaxis in hereditary haemorrhagic telangiectasia; it concludes that there is a lack of evidence for the use of many of the available treatments for this condition.[3] The authors propose a flow chart relating the treatment of hereditary haemorrhagic telangiectasia to its clinical severity and document the evidence base (or lack of it) for individual treatments.

Benign paroxysmal positional vertigo (BPPV) is the commonest cause of vertigo requiring patients to be referred to ENT clinics.[4] The Epley particle repositioning manoeuvre has become the standard treatment for this condition. Hughes and colleagues investigated the number of Epley manoeuvres required for symptom control in BPPV. They found that a single Epley manoeuvre was required in 47 per cent of patients and that 84 per cent of patients experienced symptom relief following three Epley manoeuvres.

Lastly, it is important in modern otolaryngological practice to have adequate equipment for diagnosis available in out-patient clinics. This is particularly relevant given the current reliance on endoscopic diagnosis.[5] The article by Hussain and colleagues, which sets out minimum requirements for otolaryngology clinics in National Health Service hospitals in the UK, is timely given the political arguments over funding of healthcare and maintenance of standards.[6]

ROBIN YOUNGS
EDWARD FISHER
Senior Editors

References

1 Biggs TC, Baruah P, Mainwaring J, Harries PG, Salib RJ. Treatment algorithm for oral anticoagulant and antiplatelet therapy in epistaxis patients. *J Laryngol Otol* 2013;**127**:483–8
2 Hall AC, Blanchford H, Chatrath P, Hopkins C. A multi-centre audit of epistaxis management in England: is there a case for a national review of practice? *J Laryngol Otol* 2015;**129**:454–7
3 Syed I, Sunkaraneni VS. Evidence-based management of epistaxis in hereditary haemorrhagic telangiectasia. *J Laryngol Otol* 2015;**129**:410–15
4 Lüscher M, Theilgaard S, Edholm B. Prevalence and characteristics of diagnostic groups amongst 1034 patients seen in ENT practices for dizziness. *J Laryngol Otol* 2014;**128**:128–33
5 Fleming JC, Al-Radhi Y, Kurian A, Mitchell DB. Comparative study of flexible nasoendoscopic and rigid endoscopic examination for patients with upper aerodigestive tract symptoms. *J Laryngol Otol* 2013;**127**:1012–16
6 Hussain SS, Baring D, Cain AJ, Clement WA, Dempster J, Haddow K *et al*. On the minimum requirements for otolaryngology clinics in National Health Service hospitals. *J Laryngol Otol* 2015;**129**:494–5