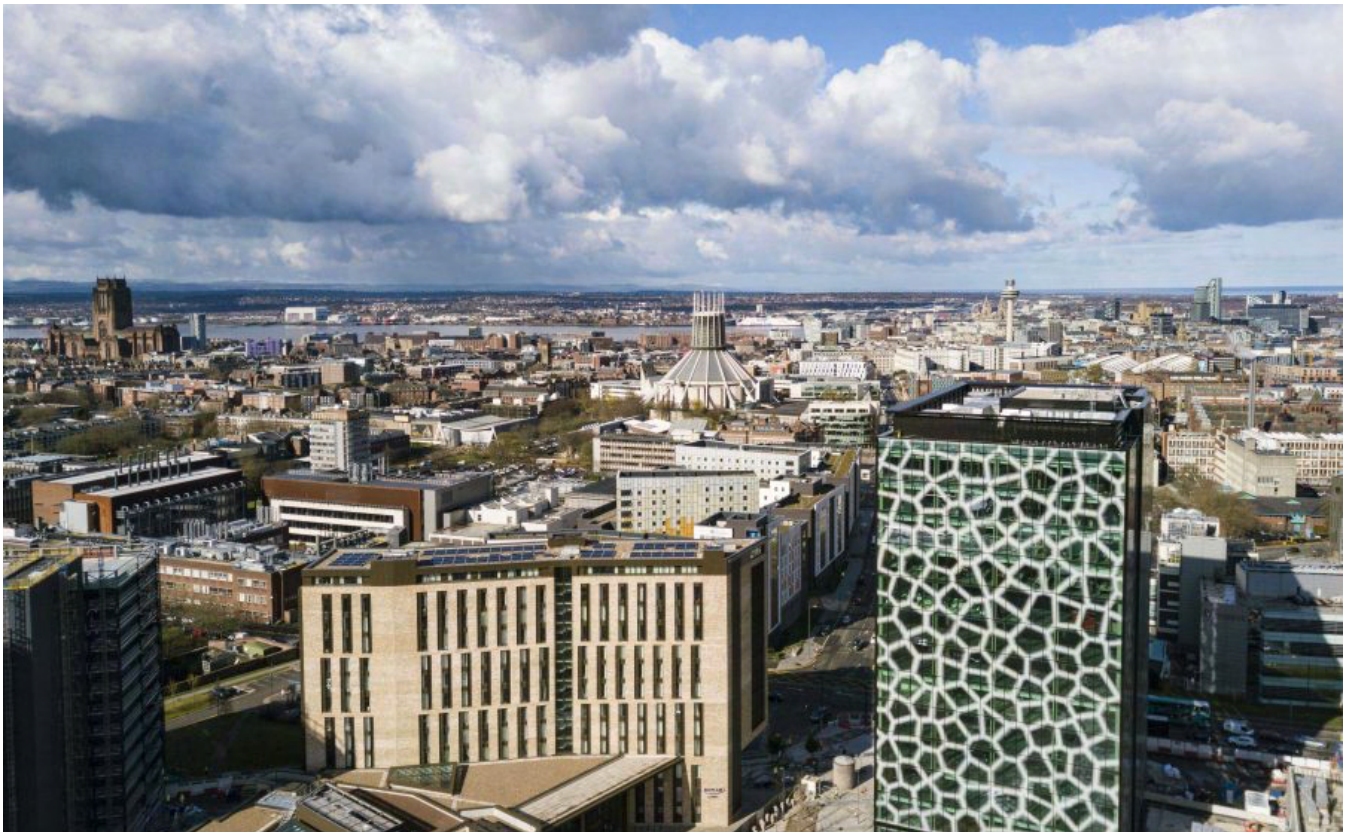


british. association for paediatric otorhinolaryngology

**2026 Annual Meeting
Liverpool**



BAPO 2026 ANNUAL MEETING

24–25 September 2026

Spaces at the Spine, 2 Paddington Village, Liverpool

A two-day programme of paediatric ENT clinical practice, research, innovation and collaboration

BAPOJ Revision Course

23 September 2026

Institute in the Park, Alder Hey Children's Hospital, Liverpool

A one-day programme of didactic lectures covering the breadth of paediatric ENT

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Wishes from Past Presidents

'I am writing to wish the BAPO meeting every success. It is a great disappointment to me not to be there but I shall be thinking of you. It is a matter of great pride that the organisation we set up about 30 years ago has prospered so well and continues to thrive.' - Peter Bull, BAPO President 1993-1996

'So pleased to hear my old fog horn from my boat is around! Please give my regards to all who might remember me from many moons ago'. Andrew Freeland, BAPO President 1999-2002

'I hope you have a very successful meeting!' - Martin Bailey, BAPO President 2002-2004

'Hope the meeting goes well' - Ken Pearman, BAPO President 2004-2006

'Good luck with the meeting. Liverpool is a great venue' - Dave Albert, BAPO President 2008-2010

'I'm sure it will be a brilliant meeting- congrats and best wishes' - Gavin Morrison, BAPO President 2012-14



Mr Bailey and Mr Albert, 2026

Welcome to BAPO 2026

A very warm welcome to you all joining us in Liverpool. The annual meeting in Liverpool is the largest BAPO meeting to date and is only made possible through the hard work and dedication of the people who contribute their time and energy into making it a 3-day event of learning, networking and above all, fun.

We have world class speakers from the UK and Eire, and across the world including Marlene Soma, Suzanne Crowe, Sharon Cushing and Juliana Bonilla-Veles. I'm particularly delighted that this year's John Evans Lecture will be delivered by my friend and mentor, Ray Clarke. He will, I'm sure, be as entertaining as ever and will no doubt inspire us to pursue interests other than our day job! The talks will be interspersed with our BAPOJ Research Prize Pitches, panel discussions as well as pop-up oral presentations by our very talented trainees. There will be posters on display on electronic poster boards throughout the meeting. And we have the wonderful Knotty Ash Children's signing choir performing for us and of course a networking evening of fun and healthy competition at the Flight Club.

It isn't possible for me to thank everyone individually, but Hannah Emerson, our co-opted trainee rep has been amazing; organising and liaising with venues and sponsors. Heather's Media Hub has been great with sending communications and reminders. The BAPO Council and past council members have been fantastic with offers of support and of help. Mira de Kruijf, our Honorary Associate Secretary has been invaluable, keeping the ticketing system and website under control. My colleagues at Alder Hey have been, as always, totally incredible with advice on the programme and invited speakers- the one piece of advice I give to all my trainees is 'choose your colleagues wisely' - I have hit the jackpot with mine! I am grateful to all the BAPO members that came forward and agreed to be Chairs, Speakers, Moderators, Panellists and Judges. Also, thanks to our non-ENT colleagues, nurses, AHPs, overseas speakers and attendees from across the globe. Sharing ideas only enriches our practice and I'm indebted to them for travelling to Liverpool to enhance our programme. Our industry partners have been incredibly generous this year and we hope to continue our close partnership with old and new sponsors for years to come. I'd particularly like to thank BAPO member and non-member attendees - without your support, the meeting and indeed the organisation wouldn't thrive as it does. BAPOJ enables trainees to engage with the organisation without charge, and I do hope that when you become consultants, you will choose to become full BAPO members.

It has been an absolute honour to serve as your president for the past year. BAPO helped me to develop as a paediatric ENT surgeon, and I really hope that I have been able to payback in some small way. Steven Powell will take over this year and will host the next BAPO Annual meeting in Newcastle on 9-10 September 2027.

But in the meantime, there is plenty that BAPO offers- please check our website for more information on courses that you can attend to enhance your paediatric ENT knowledge and skills. You can also get involved with BAPO; get in touch with us at info@bapo.co.uk



Bapo planning meeting March 2025

Su De BAPO President 2025-26

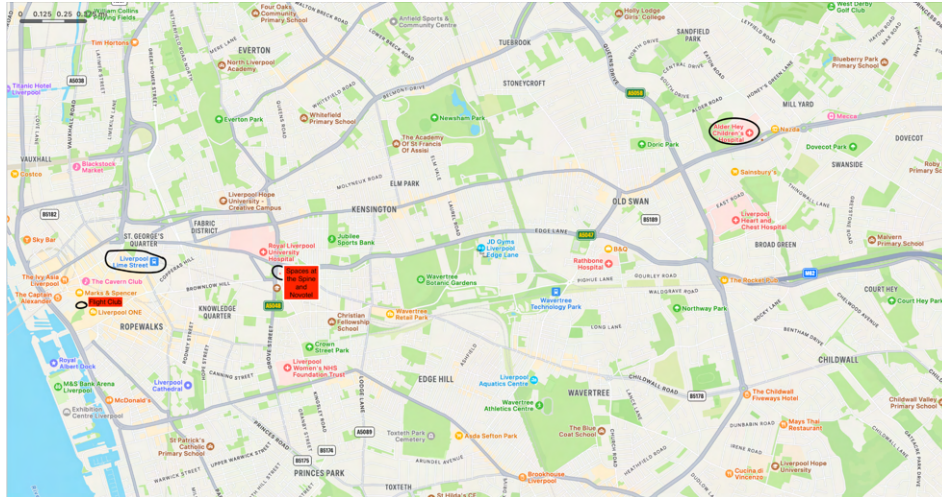
Hannah Emerson Co-opted BAPO Trainee Council Member 2025-26

BAPO 2026 Annual meeting Venue

Spaces at the Spine • 2 Paddington Village, Liverpool

Getting there

- Train: Liverpool Lime Street — approximately a 19-minute walk or £5–6 taxi.
- Car: access from the M6 via the M57, M62 or M58.
- Parking: Paddington Village Multi-Storey, Elm Grove, Grove St, Smithdown Lane, Liverpool L7 3FA. Standard day tariff: £12.
- <https://www.spacesatthespine.co.uk/how-to-find-us>



BAPO 2026 Annual meeting Virtual Delegates

- A zoom link will be emailed to you prior to the meeting.

BAPOJ Revision Course Venue

Institute in the Park • Alder Hey Children's Hospital, Liverpool

Getting there

- Train: Liverpool Lime Street then a taxi or bus to Alderhey Childrens Hospital
- Car: access from the end of the M62 Sat nav: **L14 5AB**
- Parking: Visitors to the Institute in the Park should park in the hospital multi-storey car park unless instructed otherwise. Once you have parked and made your way down to the hospital entrance on the ground level, you should find yourself in the hospital atrium. Make your way towards the WH Smith entrance and walk past our Emergency Department on your left and across the small road. The Institute in the Park is the brown wooden building straight ahead of you. Car Park tariff: £8

Networking evening

Flight Club, Liverpool One • Thursday 24 September • 19:00–late.

Getting there

- A 30 minute walk from Spaces at the Spine or hop into a taxi to Liverpool One. the Flight club is located by Chavasse Park on the upper floor

Before you arrive

- Download the meeting pack to your phone, so that you have handy access to the programme, abstracts and general information. Alternatively, there will be a QR code on your badge that takes you to the programme on the website.

Presenters

- All presenters are requested to send presentations to **bapo.presentations2026@gmail.com** at the latest **by 17 September**.
- **Oral pop up presenters and BAPOJ research prize presenters and poster presenters:** Please **name the file as per instructions** sent out by email.
- **Invited speakers and moderators:** Please name your presentation slides '**SurnameBAPO2026**' or '**Title of PanelBAPO2026**'

On arrival at Spaces at the Spine

- A cloakroom is available to leave coats/small baggage and will be manned until 6.30 pm on Thursday and 4.30 pm on Friday.
- You will be required to collect your badge from the reception desk and will be directed by staff to the lifts to take you to the top floor.
- Don't forget to bring your badge on Friday!

During the Event

- There will be catering stations for tea and coffee on the top floor and down the spiral staircase on the 12th floor. Poster boards and sponsors will be located on both floors. Please visit them during the breaks. Let a volunteer or member of staff if you have any food allergies.
- There will be a photographer present at the meeting. If you do not wish to be photographed or for your photos to not be used for BAPO publicity (website, social media, presentations), then please let the photographer know.
- Please help keep the programme to time by returning to the lecture theatre promptly following breaks. Volunteers will announce a 5-minute warning.

Sponsors Passport

- Please do endeavour to visit and engage with our sponsors, who have been very supportive of our conference
- There is a £100 Amazon voucher up for grabs - please collect stickers from each sponsor stand to complete your sponsor passport, and drop it into our allocated box by **1pm on Friday**. There is a prize for whoever visits the most and hands in a completed passport! If there is a tie, they will be drawn at random, the winner will be announced during the prize giving.

Prizes

- There are prizes for best oral and poster presentations and for the BAPOJ Research Award winner
- Winners of these prizes and other BAPO prizes will be announced during the prize giving at the end of the meeting

After the Event

- Please hand your badge into the box so it can be recycled (unless you wish to keep it)
- Your feedback will be gratefully appreciated- please use the QR code on your ticket to provide feedback after the event
- Your certificate of attendance will be sent to you once feedback is received.

Quirky Facts about Spaces at the Spine

The Spine building was designed around the concept of the human body. The name derives from the striking geometric staircase to the north of the building, inspired by the form of the human vertebrae.

The Spine is one of the healthiest buildings in the UK.

There are 23 million polygon shapes that are printed on the outside of the building that form a Voronoi pattern. Every single one of these shapes are unique and no two are the same. This pattern represents the microscopic derma layer of the human skin.

The architect referred to a study done by Naso in the 1980's where they had to research which plants to take with them on the space station which produced more oxygen in the air to improve the air quality for the astronauts.

Another study that the architect referred to is that in Japan, doctors often prescribe forest bathing as a way to improve your mental wellbeing in a natural way. This term is referred to in Japan as 'shinrin yoku'. It's a method of being calm and quiet amongst the trees, observing nature around you whilst breathing deeply which helps you de-stress. When you are inside The Spine, on a sunny day, the sun shines through the Voronoi pattern in the glass which mimics the dappled light that would come through the trees in the forest.

The Spine was designed with a philosophy that people will feel healthier when they walk out of the building than what they did when they walked in.

Inside the building, rather than an atrium found in a typical commercial building, The Spine's series of double-height sky gardens act as a 'vertical village', representing the 'lungs' of the building.

On the ground floor of the building supporting 'The Steps', there are large concrete columns with a distinct pattern on them. The pattern embossed are moulded to reflect the trabecular system within human bones, which is the strongest part of a bone for reflecting mechanical stress

The building is accredited to a WELL Platinum Standard which measures attributes of the building that impact people coming to the building. These ten concepts are Air, Water, Nourishment, Light, Movement, Thermal Comfort, Sound, Materials, Mind and Community

All of the surfaces and furniture within the building have had to be carefully thought out to achieve the WELL Platinum Standard. Everything down to the type of paint, plaster, woods, furniture, fabrics and flooring. These have been carefully selected to ensure that they help promote the air quality by removing toxins, ensuring that there are no solvents used, and to ensure that sustainable materials were used.

For example:

Some of the flooring and wall paper in the events space is made out of 95% recycled plastic bottles.

All of the wood used is real, oak and timber are used throughout which get better with age.

There is a copper handrail used at The Steps; copper is a substance that doesn't pass on any pathogens to others.

BAPO Council 2025-26

Sujata De	President
Haytham Kubba	Past-President
Steven Powell	President-Elect
James Ramsden	President-Elect Designate
Hasnaa Ismail-Koch	Hon Secretary
Kate Blackmore	Treasurer and BAPOJ Liaison
Mira de Kruijf	Associate secretary
Jess Bewick	
Sunil Sharma	
Sanj Gupta	
Rania Mehanna	
Andy Hall	
Hannah Emerson	Co-opted Trainee representative
Ayla Tabaksert	BAPOJ Representative

With thanks to our sponsors

This meeting is made possible by the generous support of our industry partners

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We would like to thank the sponsors for the support provided for this scientific conference. The sponsors take part as exhibitors only and have had no involvement in the agenda, content of the presentations, selection of speakers or the pre-conference activities.

Programme BAPOJ Revision Day

Wednesday 23 September

Institute in the Park, Alder Hey Children's Hospital, Eaton Rd, Liverpool L12 2AP

(for those who have registered for BAPOJ revision course)

08.45 - 9.15			Arrival Registration Coffee
0915-1045	Otology	Chair Sunil Sharma	
0915-0930	Congenital abnormalities/Microtia	Sunil Sharma	
0930-0945	Assessment of hearing	Sharon Cushing	
0945-1000	Congenital Hearing loss	Andy Hall	
1000-1015	Implants	Sharon Cushing	
1015-1030	OME/AOM/Complications	Sunil Sharma	
1030-1045			Questions Coffee
11.10-12.30	Head & Neck	Chair TBC	
11.10-11.25	Cervical Lymphadenopathy	Mira de Kruijf	
11.25-11.35	Trisomy 21	Kate Blackmore	
11.35-11.50	Branchial Abnormalities	James Ramsden	
11.50-12.10	Lympho-vascular anomalies	Juliana Bonilla-Velez	
12.10-12.25	Nasal Dermoids	Grace Khong	
12.25-12.45			Questions + Discussion Lunch
1330-1500	Airway	Chair Mira de Kruijf	
1330-1345	Laryngomalacia	Marlene Soma	
1345-1405	Subglottic Stenosis, haemangiomas and cysts)	Juliana Bonilla-Velez	
1405-1420	Vocal cord Immobility	Hasnaa Ismail-Koch	
1420-1445	Open and Endoscopic Airway procedures	Liam Sutton	
1445-1500			Questions + Discussion Coffee
15.15-17.00	Rhinology/General/ Emergency	Chair Kate Blackmore	
15.15-15.35	Securing the Emergent Airway	Ravi Thevasagayam	
15.35-15.50	Nasal Obstruction /Polyposis/ PCD /Rhinitis	Andy Hall	
15.50-16.05	Rhinosinusitis; orbital & intracranial complications	Grace Khong	
16.05-16.20	ENT-related syndromes/ Craniofacial Syndromes	Michelle Wyatt	
16.20-16.35	Paediatric Tracheostomy	Rania Mehanna	
16.35-16.55	OSA/Obstructed Sleep Disordered Breathing	Stephen Powell	
16.55-17.15			Final Questions and Close

Programme BAPO 2026 Annual meeting

Thursday 24 September 2026 Spaces at the Spine, Paddington Village, Liverpool

830–930	Registration	
930–940	President's welcome and housekeeping	Su De
	Session 1:	Chair: Kate Blackmore
940–1020	BAPOJ Research Prize 2026	Panel: Andy Hall Haytham Kubba Jess Bewick
	BAPOJ1: Developing novel materials for paediatric tracheostomy tube design	Josh Law; Jennifer Olsen; Jason Powell
	BAPOJ2: Are sterile drapes and gowns necessary for all paediatric ENT operations? Assessing the exposure of bodily fluids during adenotonsillectomy procedures	Chee Yen Soon; Henry Dunne; Chong Yi Kang
	BAPOJ3: Who Progresses? Phenotyping Long-Term Audiological Trajectories Following Newborn Hearing Screening	Chloe Swords; Mohammad Ghunaim; Chong Kang; Nico Jonas; Jessica Bewick
1020–1050	PANEL: Emergency debates Moderator: Mike Saunders	Panellists: Kate Stephenson Moe al Salem Sheneen Mehgi Andrew Hoey
1050–1120	Coffee and browse posters	
1100–1120	Present your poster (judging session)	
	Session 2:	Chair: Mira de Kruijf
1120–1140	Key note: Building a Paediatric ENT surgery Service Down Under	Marlene Soma
1140–1200	Nurse/ AHP presentations- Specialist ENT Nursing: Making a difference in Paediatric ENT	Anita Lee/ Louise Ross/ Alison Flynn
1200–1220	Who needs sleep anyway?	Chris Grime
1220–1240	What after an adenotonsillectomy for children with Down syndrome and OSA	Liam Sutton
1240–1340	Lunch and meet the sponsors	
1240–1340	Nurse breakout session	Breakout room
	Session 3:	Chair: Su De
1340–1410	John Evans Lecture: 'A Wilde Knight' Ray Clarke	
1410–1440	Pop-up presentations 1:	Moderators: Mat Daniel Andrea Burgess
	O3.1 Preliminary Safety and Efficacy of AK-OTOF Gene Therapy for Otoferlin Gene (OTOF)-mediated Hearing Loss <i>Eli Lilly and Company</i>	Brian Lin, on behalf of the AK-OTOF-101 trial
	O3.2 Paediatric Eustachian Tube Balloon Dilatation: The First UK Experience Alder Hey Children's Hospital, Liverpool, United Kingdom	Emma Hogg; Grace Khong; Sunil Sharma
	O3.3 Patterns and Predictors of Hearing Aid Rejection in Paediatric Patients: A Single-Centre Experience Alder Hey Children's Hospital, Liverpool, United Kingdom	Dickson Dewantoro; Yeshaa Mirani; Timothy Davies; Oliver Little; Sunil Sharma
	O3.4 Beyond Drainage: Tympanic Membrane Perforation upon Presentation as a Major Risk Factor for Complications in Pediatric Mastoiditis Shamir medical center, Zerifin, Israel	Ofer Israel; Itai Asher; Jacob Pitaro; Rona Bourla; Yael Garti; Haim Gavriel; Yuval Mizrakly
	O3.5 Paediatric SENTIO™ Transcutaneous Bone Conduction Hearing Implant: Our Tertiary ENT Paediatric Experience Alder Hey Children's, Liverpool, United Kingdom;	Emma Hogg; Dickson Dewantoro; Kristin Bryce; Timothy Davies; Oliver Little; Sujata De; Sunil Sharma
1440–1500	Managing allergic rhinitis in children	Vibha Sharma
1500–1530	Coffee and browse posters	
1510–1530	Present your Poster (judging session)	
	Session 4:	Chair: Sarah O'Donnell
1530–1535	Update on Greener Future Sustainability prize	Jonny Abbas
1535–1605	Pop-up presentations 2:	Moderators: Adam Donne Lesley Cochrane
	O4.1 Higher Revision Adenoidectomy Rates in Afro-Caribbean Children Compared with the General Paediatric Population: A Five-Year Tertiary Centre Review Oxford University Hospitals NHS Trust, Oxford, United Kingdom	Amna Qamar; Ilan Elango; Harrypal Panesar; Ciba Paul
	O4.2 Should day-case adenotonsillectomy criteria be expanded to allow for the growing childhood obesity epidemic? A retrospective review of 99 children undergoing adenotonsillectomy with weight over 98th centile. Royal Belfast Hospital for Sick Children, Belfast, United Kingdom	Aisling Clarke; Gavin Donaldson; Conor Jackson; Keith Trimble
	O4.3 Paediatric ENT litigation in England: a retrospective analysis of NHS Resolution claims notified 2018–2023 University College London Hospital, London, United Kingdom	Foteini Stefania Koumpa; Talisa Ross; Annakan Navaratnam; Su De
	O4.4 Does Clot Size Matter? Rethinking Anticoagulation Duration in Paediatric Orogenic Sinus Thrombosis Alder Hey Children's Hospital, Liverpool, United Kingdom	Sara Mahmood; Randa Ghazal-Asswad; Kristin Bryce; Sunil Sharma
	O4.5 Do patients require ongoing medication for drooling despite salivary gland surgery? Addenbrookes Hospital, Cambridge, United Kingdom	Mohammad Ghunaim; Chloe Swords; Chong Kang; Nico Jonas; Jessica Bewick
1605–1625	The importance of aetiological assessment on access to early hearing intervention	Sharon Cushing
1625–1645	National Button Battery Guidance	Nara Orban
1645–1715	PANEL- Craniofacial Moderator: Sunil Sharma	Panellists: Anusha Henedige Rob Nash Juliana Bonilla-Velez Sharon Cushing
1715–1830	Reception	
1900–late	Flight club networking evening	

Friday 25 September 2026

	Session 5:	Chair: Ayla Tabaksert
900-930	PANEL: Trainee matters: research, innovation and life in paediatric ENT Moderator: Hannah Emerson	Panellists: Tom Hampton Jonny Abbas Lizzie Maughans Michael Mather
930-935	The SALT Paediatric Laryngology Working Group	Marion Alston
935-940	Update from last years Research prize winner	Ben Talks
940-1000	From Patient to Patient voice	Thomas Pearce
1000-1030	Pop-up presentations 3: 5x5 mins each	Moderators: Malin Wendt Marianne Elloy
	O5.1 Dynamic Four-Dimensional CT in the Evaluation of Paediatric Tracheobronchomalacia: A Ten-Year Single-Centre Retrospective Review Great Ormond Street Hospital, London, United Kingdom	Sophie Bondje; Elizabeth Maughan; Colin Butler
	O5.2 Microlaryngobronchoscopy in Children with Recurrent Croup: Are We Performing Too Many? Cambridge University Hospital, Cambridge, United Kingdom; The University of Jordan, Amman, Jordan	Mohammad Ghunaim; Imogen Seago; Chloe Swords
	O5.3 Cumulative corticosteroid exposure in paediatric subglottic stenosis Addenbrookes Hospital, Cambridge, United Kingdom	Chloe Swords; Mohammad Ghunaim; Chong Kang; Nico Jonas; Jessica Bewick
	O5.4 Transitioning adolescent tracheostomy patients to adult care: A national survey of current practice Cardiff University, Cardiff, United Kingdom; University Hospital Wales, Cardiff, United Kingdom	Bay Hill; Yasmine Kamhieh; Julie Bickel; Andrew Hall
	O5.5 Multidisciplinary Paediatric Airway Guide and Simulation Training University Hospitals Sussex, Brighton, United Kingdom	Sarah Humphries; Isabella Atherley; Thomas Geyton
1030-1100	Coffee and browse posters	
	Session 6:	Chair: Hasnaa Ismail-Koch
1100-1115	Presidential address	Su De
1115-1150	PANEL: Otology & Implants incl RABBIT launch Moderator: James Ramsden	Panel: Sunil Sharma Sharon Cushing Andy Hall Jaya Nichani
1150-1220	Pop-up presentations 4:	Moderators: Samantha Goh Keith Trimble
	O6.1 Endoscopic vs External Paediatric DCR: A Systematic Review and Meta-analysis Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom; Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom	Rohan Pinto; Grace Khong
	O6.2 Paediatric one stop neck lump clinic: A pilot service evaluation Sheffield Children's Hospital, Sheffield, United Kingdom	Gyanesh Sethi; Nicola Stobbs; Christopher NG
	O6.3 Predictors of Recurrence Following Nasal Dermoid Sinus Cysts Excision: A 13-Year Retrospective Cohort Study Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom; Bolton NHS Foundation Trust, Bolton, United Kingdom	Arshad Zubair; Dillan Shetty; Ravi Sharma; Grace Khong
	O6.4 DigiBel: A Pilot Evaluation of a Web-Based, Child-Friendly Audiometry App for Detecting Conductive Hearing Loss. Norfolk and Norwich University Hospital, Norwich, United Kingdom; Cambridge University Hospital, Cambridge, United Kingdom	Rachael Collins; Tamsin Holland-Brown
	O6.5 BapoGPT: Artificial Intelligence Versus ENT UK for Patient and Parent Information Sheffield Teaching Hospitals, Sheffield, United Kingdom	Dalton Barham; William Greenough
1220-1240	Launch of BAPO/ BRS nasal airway surgery guidance Update on Choanal atresia Surgery (20 mins)	Grace Khong
1240-1340	Lunch and meet the sponsors	
1310-1340	BAPO Annual General Meeting	BAPO members only
	Session 7	Chair: Su De
1340-1400	Working with sick children- looking after yourself	Suzanne Crowe
1400-1420	Toward Precision Medicine for Head and Neck Lymphatic Malformations	Juliana Bonilla-Velez
1420-1455	PANEL: Paediatric Airway Moderator: Michelle Wyatt	Panel: Marlene Soma Steven Powell Rania Mehanna Ian Lilly
1455-1525	Coffee and browse posters	
1525-1545	Prize giving	Hasnaa Ismail-Koch Mira de Kruif Kate Blackmore
1545-1600	Thanks, Presidential handover and invitation to BAPO 2027	Steven Powell

AGM Agenda

Apologies for absence

Minutes of the 2025 AGM

Matters Arising

Hon Secretary report incl Charity application update

Finance report incl proposed membership fee increase and updating of membership database

Demitting Council members

Nominations and elections to Council

- **President-elect designate, Member and BAPOJ member**
- **Vote for new council member(s): (nominees are Eishaan Bhargava, Claire McLarnon, Jaya Nichani, Amit Parmar, Ciba Paul, Chris Thompson)**

Amendments to Constitution: Proposed amendments to reflect inclusion of full members from Northern Ireland and Eire, amended term for some executive council positions and introduction of subcommittees/ groups

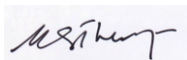
Any other business

Date and venue of BAPO 2027 Annual meeting- Newcastle 10 September 2027

Minutes of AGM 2025

BAPO AGM
University of Glasgow
12 Sept 2025
Minutes

- Apologies
- Matters arising
- Vote for new member
6 candidates for 3 places. *Sunil Sharma, Jess Dewick and Sanj Gupta duly elected to 4 year terms*
- Charity Status update
We have applied to become a CIO. This application was approved at the last AGM.
- Approve the Trustees
4 Trustees voted for by membership
Nicola Hughes For Unanimous Non Against No Abstentions
Peter Bull For Unanimous Non Against No Abstentions
Mike Kuo For Unanimous Non Against No Abstentions
Su De (ex -officio) For Unanimous Non Against No Abstentions
- Finance report
Financial report available on website and approved by members.
- Presidential Election
2 Candidates – James Ramsden elected to President by council 27-28 and starts 4 year term
- Changes to constitution/ BAPO rules
“The production of the annual report shall be the responsibility of the Hon Sec”
“The Submission of the accounts shall be the responsibility of the Treasurer”
- Council Demitting
MW,AB,ME,RT,NJ,DT
- Council positions voted by council
Hon Sec won by Hasnaa unopposed
Ass Sec vote Mira de Kruijf
Treasurer Kate Blackmore unopposed
BAPOJ Liaison Kate Blackmore



MS Thevasagayam
Hon Sec

Constitution

British Association for Paediatric Otorhinology

Rules of the Association (revised 2025)

1. TITLE

- 1.1. The Association shall be known as the British Association for Paediatric Otorhinology.

2. AIMS

- 2.1. To promote all aspects of paediatric otorhinology.
- 2.2. To hold meetings at which those interested in paediatric otorhinology may meet, discuss clinical practice and present clinical and research papers.
- 2.3. To take an overall interest in the development of paediatric otorhinology in Great Britain, with special reference to the needs of those in training.
- 2.4. To provide advice on paediatric otorhinology to ENT-UK and other organisations and bodies.
- 2.5. To liaise with similar organisations in Europe and worldwide.

3. MEMBERSHIP

- 3.1. Full membership is open to medically qualified professionals in Great Britain with an interest in paediatric otorhinology.
- 3.2. Associate membership is open to health care professionals in Great Britain with nonmedical qualifications who have a similar interest in paediatric otorhinology.
- 3.3. Overseas membership is open to those with an interest in paediatric otorhinology, who reside abroad.
- 3.4. Applicants for membership should email the Honorary Secretary or Associate Secretary as per the website. No sponsorship is required. Membership is subject to approval by Council. Applicants for membership should set up a direct debit.
- 3.5. The subscription will be fixed at the AGM and will be the same for full, associate and overseas members. The subscriptions are payable before March 1st annually, and may be changed by a two-thirds majority of full members attending an Annual General or Extraordinary Meeting of the Association.

4. COUNCIL

- 4.1. Membership of Council shall consist of the following Full Members holding specialist accreditation:
 - 4.1.1. The Chairman: the Chairman of the Council is also the President of the Association.
 - 4.1.2. The Past President, President Elect and President Elect Designate.
 - 4.1.3. The Honorary Secretary.
 - 4.1.4. The Treasurer.
 - 4.1.5. The Associate Secretary.
 - 4.1.6. Other Members: no less than four and no more than eight full members.
 - 4.1.7. Members can be co-opted to serve on Council as required.
 - 4.1.8. Two trainee representatives (not holding specialist accreditation) who will liaise with the Association of Otolaryngologists in Training and represent trainee matters.
 - 4.1.9. A quorum of four members, including one executive officer, shall be required for Council meetings.
 - 4.1.10. The President and Secretary are the executive officers of the Association.

- 4.1.11. The production of the annual report shall be the responsibility of the Honorary Secretary.
- 4.1.12. The Submission of the accounts shall be the responsibility of the Treasurer.

4.2. Election of Council

- 4.2.1. The Council shall be elected by Full members at the Annual General Meeting.
- 4.2.2. Nominations from a full member, a date specified in the call for nominations. If more than one nomination per vacancy is received an election will take place at the AGM. Information on candidates will be made available and each full member will have a vote. Nominations for President/ Honorary Secretary/ Associate Secretary/ Treasurer can be made by a full member and seconded by full member. Candidates should be current or past council members. If more than 1 nomination is received then vote of elected council members will take place at the council meeting. The trainee representative candidates can self-nominate. If there are 10 or more trainee members, the vote will be of trainee members only. If there are less than 10 trainee members then the full membership will vote. The local trainee representative is nominated by the local organizer of the forthcoming BAPO meeting one year in advance and will be co-opted for the Spring and Autumn council meetings.

4.3. Terms of Office

- 4.3.1. The Chairman / President shall normally serve for one year. This will be preceded by one year on council as President Elect designate, one year as President Elect and followed by one year as Past President. The current and President elect designate will also assume positions as Council members for the European Society of Paediatric Otolaryngology.
- 4.3.2. The Honorary Secretary shall normally serve for four years, and be eligible for re-election for a further two two-year terms. The Treasurer shall normally serve for four years, and be eligible for re-election for a further two two-year terms. The Associate Secretary shall normally serve for four years, and be eligible for reelection for a further two two-year terms.
- 4.3.3. Council Members shall normally serve for four years.
- 4.3.4. The Chairman and Council Members shall not be re-elected within two years.
- 4.3.5. The elected trainee representative shall serve for a period of two years. They are not eligible for re-election as trainee representative but will be eligible to stand for Council election within two years, if specialist accreditation has been achieved. The co-opted local representative shall serve for a period of one year prior to the BAPO meeting. They will be eligible for election as trainee representative following this.

5. MEETINGS

- 5.1. The annual meeting shall consist of a concise Annual General Meeting and a scientific programme.
- 5.2. The Annual General Meeting shall present the Associations accounts, elect new officers to the Council and report on the business of the Association.
- 5.3. The content of the scientific programme shall be the responsibility of the Council.
- 5.4. The Susanna Leighton Fellowship Prize will be awarded to the presenter of the most outstanding oral presentation. The prize is 1000EUR to attend the next meeting of the European Society of Paediatric Otolaryngology. The prize is awarded to the presenter and non-transferable.
- 5.5. The venue and date of the Annual General Meeting will be agreed by Council and approved at the AGM.
- 5.6. Other meetings may be convened by Council at times other than the Annual General Meeting. Council may also arrange academic meetings at other times than the Annual General Meeting.

6. CONSTITUTION

- 6.1. The constitution may be changed by a two-thirds majority of Full Members attending an Annual or Extraordinary General Meeting.
- 6.2. Proposed changes to the Constitution will be notified to Full Members by email.

Speakers, Chairs, Moderators, Panellists & Judges

Jonathan Abbas • Manchester

Panellist / Speaker



Senior ENT trainee in North West, with a subspecialty interest in Paediatric Otolaryngology. Honorary Senior Lecturer at The University of Manchester. Research interests include technology-enhanced learning, digital transformation in healthcare, and Net Zero change.

Moe Alsalem • Portsmouth

Panellist



Mr Mohammad Alsalem is a Consultant Paediatric ENT Surgeon at Portsmouth Hospitals University NHS Trust. He completed advanced paediatric ENT fellowships at Evelina London and St George's Hospitals. His interests include complex paediatric airway surgery, medical education, and academic research.

Marion Alston • London

Speaker



Marion is a specialist in ENT / voice (paediatrics and adults) for 30+ years, leading the outpatient voice service for children and young people and running the paediatric voice clinic alongside a consultant laryngologist at the Royal National ENT & Eastman Dental Hospitals; UCLH NHS Foundation Trust. She founded the national paediatric laryngology working party, striving to prioritise paediatric laryngology, improve pathways, national guidance and services.

Jessica Bewick • Cambridge

Judge/ Dragon



Jessica Bewick is a paediatric ENT surgeon practicing at Cambridge University Hospital NHS Trust, specialising in treating children with complex airway diseases, obstructive sleep apnoea, hearing difficulties, and head and neck conditions. Additionally she is Clinical Director for surgery in paediatrics and critical care and member of BAPO council.

Kate Blackmore • Middlesbrough

Chair



Kate Blackmore is an ENT Consultant at The James Cook University Hospital in Middlesbrough subspecialising in paediatric ENT and an Honorary Clinical Senior Lecturer at the University of Newcastle. She undertook a paediatric fellowship at the Royal Hospital for Sick Children, Glasgow. She has an interest in undergraduate and postgraduate education and has a Masters degree in Medical Education. She is currently treasurer for BAPO and council lead for BAPO juniors.

Juliana Bonilla-Velez • Seattle

Panellist / Speaker



Dr. Juliana Bonilla-Velez, MD, MS is an Associate Professor and Pediatric Otolaryngologist, Head & Neck Surgeon at Seattle Children's Hospital and the University of Washington School of Medicine in Seattle, WA, USA. She is the Surgical Director of the Seattle Children's Vascular Anomalies Program, and Co-Director of the Vascular Anomalies Task Force, a national group of pediatric otolaryngologists focused on the management of vascular anomalies.

Andrea Burgess • Southampton

Moderator



Mrs Burgess has been a consultant ear, nose and throat (ENT) surgeon with an interest in paediatrics and otology since 2006. Mrs Burgess is also involved in the development of paediatric ENT at a local and national level and supporting trainees. She has been a BAPO council member.

Ray Clarke • Liverpool

Speaker



Prof Clarke recently retired as a consultant at Alder Hey Children's Hospital. He was one of the first whole-time children's ENT doctors in the NHS and has a particular interest in education and training. He was awarded the Silver Scalpel as best surgical trainer in the NHS in 2004 and has contributed to, authored and edited numerous textbooks. He was President of BAPO from 2014-16 and President of ESPO from 2023-25.

Lesley Cochrane • London

Moderator



Miss Cochrane is a Consultant Paediatric ENT Surgeon at Great Ormond Street Hospital. She is lead surgeon for the Paediatric Voice and the Learning academy. She is the training program director for the North London Otolaryngology Training program and committee member for the Training Interface Group fellowship in cleft lip and palate surgery. She is Vice Chair of Specialist Advisory Committee for Otolaryngology at the Royal College of Surgeons and National lead for Otolaryngology ST3 recruitment.

Suzanne Crowe • Dublin

Speaker



Suzanne Crowe is a Paediatric Anaesthetist and ICU Consultant at Crumlin Hospital, Dublin and is President of the Irish Medical Council. She has written a memoir titled 'Intensive Care: True Stories of Healing, Heartache and Hope from Inside Irish Children's Medicine' that details the enormous challenges faced by health staff who are dealing with incredibly vulnerable patients as well as the wonderful moments that can happen between doctors, patients and their families.

Sharon Cushing • Toronto

Panellist / Speaker



Sharon Cushing is a full time paediatric otolaryngologist and the Director of the Cochlear Implant Program at The Hospital for Sick Children and a Full Professor at the University of Toronto. Dr. Cushing has a clinical and surgical interest in disorders of the external, middle and inner ear, including hearing loss and vestibular dysfunction. Her research interest include vestibular and balance function and dysfunction in children, and its association with hearing loss and cochlear implantation.

Mat Daniel • Nottingham

Moderator



Mat is a Paediatric ENT consultant at Nottingham University Hospital. He holds a PhD and has extensive research experience. He has Master's degrees in Coaching & Mentoring and in Medical Education, is Nottingham University's lead for undergraduate ENT, and has significant experience in career-related coaching for doctors.

Sujata De • Liverpool

Chair / Speaker



Su is a consultant paediatric ENT surgeon at Alder Hey Children's Hospital and an Honorary Senior Lecturer for the University of Liverpool. She is the Children's ENT Lead for getting it Right the First Time (GIRFT), and the National Clinical Lead for Specialised Surgery in Children. She is a Board member of ESPO and the current President of BAPO.

Adam Donne

Moderator



Adam Donne trained in Manchester and did a Paediatric otolaryngology fellowship at Evelina Children's Hospital, London. He was awarded a PhD on Molecular Biology of Respiratory Papillomatosis. He has been a consultant at Alder Hey since 2009. He was lead of the National Respiratory Papillomatosis Airway Interventional Registry.

Aikaterini Dritsoula • Leeds

Judge



Ms. Aikaterini Dritsoula is a Consultant ENT Surgeon based in Leeds Teaching Hospitals NHS Trust, United Kingdom, with particular interests in Complex Paediatric Airway & Paediatric Obstructive Sleep Apnoea Surgery and research. She is Honorary Senior Lecturer in Leeds Institute of Medical Research, School of Medicine.

Marianne Elloy • Leicester

Moderator



Marianne Elloy is a Consultant Paediatric Surgeon in Leicester.

Hannah Emerson • Liverpool

Moderator



Hannah is an ENT ST8 Specialist Registrar in the North West Deanery with a strong interest in paediatric ENT. She is the Co-opted Trainee Rep on BAPO Council and is organising BAPO 2026. She has a strong interest in education and leadership.

Alison Flynn • Liverpool

Chair



Lead ENT Nurse Practitioner RGN RSCN MSc BA(Hons) Alison Flynn is a motivated experienced nurse with 46 years of experience as an adult and paediatric health care setting. Within her present role she cares for and is lead nursing professional for children and their families with tracheostomies and complex healthcare needs. Alison provides training, expert advice and liaison in this field and is also the lead nurse for the tongue tie service; providing nurse led clinics in this area of health care. Alison is a Doctor of Philosophy and her thesis was on: A Narrative inquiry into the stories parents tell of having a child with a tracheostomy.

Steve Frampton • Southampton

Judge



Steve Frampton is a Consultant ENT Surgeon and Clinical Director for Head & Neck Services at University Hospital Dorset, with time also at University Hospitals Southampton. He undertook his fellowship in Paediatric ENT at Starship Children's Hospital in Auckland and is currently Chair of the Regional Operational Delivery Network for Paediatric ENT.

Julian Gaskin • Bristol

Judge



Julian Gaskin qualified as a doctor in Leicester and completed his ENT registrar training in the East Midlands. He undertook a specialist 12 month fellowship in paediatric ENT at the Royal Manchester Children's Hospital, one of the largest children's hospitals in Europe, undertaking in particular advanced paediatric airway procedures. Mr Gaskin was appointed as a paediatric and adult ENT consultant in 2015 before moving to Bristol in 2016. He has a specialist interest in paediatric airway conditions. Roles he has undertaken include Honorary Senior Lecturer for the University of Bristol, Treasurer and Membership Secretary for the South Western Laryngological Association, Regional Representative for ENT-UK and Regional Specialty Professional Advisor for the Royal College of Surgeons of England.

Samantha Goh • Liverpool

Moderator



Sam Goh is a consultant in Alder Hey Children's Hospital. Her sub-specialty interests are head and neck disorders, complex airway and sialendoscopy. She currently leads the thyroid and parathyroid surgery service in Alder Hey. She was a trainee in London and West Midlands and completed a 2-year fellowship in SickKids, Toronto.

Emma Gosnell • Manchester

Judge



Emma Gosnell is a Consultant ENT Surgeon at Manchester Children's Hospital

Chris Grime • Liverpool

Speaker



Chris Grime is a respiratory Consultant at Alder Hey Children's Hospital. He completed his training at Royal Brompton Hospital, Evelina London Children's Hospital, Kings College Hospital and Great Ormond Street Hospital. He has completed a MRes with Imperial College London studying sleep disordered breathing and its association with asthma in children. He has an interest in Sleep disordered breathing, Sleep medicine and the use of technology in healthcare.

Andrew Hall • Cardiff

Judge/ Dragon



Andy Hall is a Consultant Paediatric ENT Surgeon in Cardiff and is a current BAPO Council member.

Tom Hampton • Liverpool

Panellist



Tom Hampton is an ST8 and the NIHR Clinical Lecturer in Hearing Health at the University of Liverpool. His interest is transdisciplinary research into quality of life, inequalities, environment and public health, particularly for children. He conducts Global Health research with collaborators in Africa and Asia on anything related to sound, noise, communication, ethics (and ENT surgery!)

Andrew Hoey

Panellist



Andrew Hoey is a Locum Paediatric ENT Consultant at The Royal London Hospital, specialising in paediatric head and neck and complex airways. He completed paediatric ENT fellowships at both Evelina London and Great Ormond Street. In his spare time, he enjoys travelling and trying his hand at DIY.

Lily Jablenska • London

Judge



Lily Jablenska is a Consultant Paediatric ENT surgeon at the Evelina Childrens Hospital, London.

Yasmine Kamhieh • Cardiff

Judge



Yasmine Kamhieh is a Paediatric ENT Consultant in Cardiff.

Anusha Hennedige • Liverpool

Panellist



Anusha Hennedige is a Consultant Maxillofacial and Craniofacial Surgeon in Liverpool, trained at University of Edinburgh and University of Aberdeen Dental Institute. Specialising in craniofacial surgery, ear reconstruction, and facial deformity, she leads collaborative research, teaches at University of Liverpool, and drives innovation in craniofacial surgery internationally.

Hasnaa Ismail-Koch • Southampton

Chair



Hasnaa Ismail-Koch is a paediatric ENT Consultant in Southampton and is the current Honorary Secretary of BAPO.

Conor Jackson • Belfast

Judge



Consultant for the past 10 years in the Sick Children's Hospital in Belfast. Past fellow at Starship Children's hospital, Auckland. TPD for ENT in N Ireland 2019 - 2025

Chong Kang • Cambridge

Judge



Chong Kang is a Paediatric ENT Consultant at Addenbrookes Hospital, Cambridge

Grace Khong • Liverpool

Speaker



Grace Khong is a dual fellowship trained Consultant Paediatric ENT Surgeon at Alder Hey Children's Hospital, Liverpool, where her work includes advanced rhinology and skull base surgery. She serves as faculty on international courses, has numerous book chapters and peer-reviewed publications, and is a member of the ESPO Standing Scientific Committee.

Mira de Kruijf • Manchester

Chair



Mira de Kruijf is a Consultant Paediatric ENT Surgeon at the Royal Manchester Children's Hospital (RMCH). Her areas of interest include general paediatric ENT, drooling and progressive airway obstruction in children and MPS. She has an active research interest and completed a PhD in cancer immunology. She is a council member of BAPO and sits on the Education Committee for the European Society of Paediatric Otolaryngology (ESPO) and is the National Online Training Programme Director for ENT in England.

Haytham Kubba • Glasgow

Judge/ Dragon



Consultant in children's ENT in Glasgow since 2003; Honorary Associate Professor in Child Health at Glasgow University; President of ENT Scotland; Past-president of BAPO. Clinical interests are neurodisability, head and neck malformations and airway surgery. Published over 170 research papers. Co-author of "Browning's Audiology for Clinicians (3rd ed)"

Rachael Lawrence • Bradford

Judge



Rachael Lawrence is a Consultant at Bradford Royal Infirmary, specialising in Paediatric ENT, Otology and Auditory Implantation. After completing her ENT training in the East Midlands, she undertook fellowships in Royal Manchester Children's Hospital and Addenbrooke's, Cambridge. In her spare time, she enjoys learning British Sign Language.

Anita Lee • Liverpool

Speaker



Anita Lee is an ENT Specialist Nurse. She delivers nurse led ear care, for patients with wax, foreign bodies, hearing issues and infections. She sees patients following adeno tonsillectomy and grommet surgery and is the lead nurse for BAHA's. She also delivers the nurse-led telephone and epistaxis clinics.

Ian Lilly • London

Panellist



Ian Lilly is a Consultant in Paediatric ENT at the Evelina Children's Hospital, London

Michael Mather • Newcastle

Panellist



Michael Mather is a Clinical Lecturer with an interest in otology based in the North East of England. His PhD focussed on using high throughput genomics to understand the evolution of adaptive immunity in adenoid tissue and glue ear.

Lizzie Maughan • London

Panellist



Lizzie Maughan is an NIHR Academic Clinical Lecturer in Paediatric ENT Surgery in the North Thames (London) Deanery

Sheneen Meghji • Nottingham

Panellist



Sheneen Meghji is a Consultant in Paediatric ENT at Nottingham University Hospital

Rania Mehanna • Dublin

Panellist



Rania Mehanna is a Paediatric Otolaryngologist with a special interest in Airway/ Head & Neck Surgery at the CHI at Crumlin Hospital, Dublin. She is Ass. Clinical Professor at the University College Dublin. She also serves on the council for BAPO and ESPO Training & Education Committee.

Rob Nash • London

Panellist



Robert Nash is an otologist and auditory implant surgeon at Great Ormond Street Hospital. His research interests are in genetic hearing loss, congenital ear anomalies and auditory implants.

Jaya Nichani • Manchester

Panellist



Jaya Nichani is a paediatric ENT surgeon at the Royal Manchester Children's Hospital with an interest in implant surgery and otology.

Sarah O'Donnell

Chair



Sarah O'Donnell is a paediatric ENT surgeon in Leeds with an interest in system based healthcare.

Nara Orban • London

Speaker



Nara Orban is an ENT Surgeon in London with an interest in paediatrics. She is a passionate experienced healthcare leader and innovator. She has particular interest in bringing novel therapies and digital healthcare applications to market, as well as affecting positive organisation change in complex healthcare systems.

Lakhbinder Pabla • Newcastle

Judge



Lakh Pabla is a Consultant Paediatric ENT Surgeon at the Great North Children's Hospital with a specialist interest in paediatric airways and ENT lead for the Northern Cleft service. She is passionate about medical education, contributing to Newcastle Hospitals' undergraduate leadership team and partnerships with Newcastle Medical School

Ciba Paul • Oxford

Judge



Ciba Paul is a Consultant ENT Surgeon at John Radcliffe Hospital, Oxford. She is currently the Thames Valley ENT training Programme Director.

Thomas Eliot Pearce • Cardiff

Speaker



My name is Thomas Eliot Pearce. I am 19 years old and am currently studying medicine at Cardiff University. I have the craniofacial condition Pfeiffer syndrome type 2. I have undergone numerous surgeries and hope I can share insight into that experience as well as the impact on my life. I have represented patients at the charity Headlines and at NHS England.

Steven Powell • Newcastle

Panellist



Steven Powell graduated from Newcastle University and undertook higher surgical training in otolaryngology in the North East followed by a one-year fellowship at the Royal Children's Hospital in Melbourne, Australia. His main specialist interest is the management of children with airway disorders. He is President Elect of the BAPO.

James Ramsden • Oxford

Moderator



James Ramsden (FRCS PhD) is a paediatric ENT consultant at the John Radcliffe Hospital in Oxford. He completed fellowships in Sydney and Toronto prior to his appointment in Oxford in 2008. He has a particular interest in paediatric otology, cochlear implantation, and inherited deafness.

Louise Ross • Liverpool

Speaker



Louise Ross is a nurse specialist at Alder Hey Children's Hospital with an interest in expanding the nursing role in paediatric ENT outpatients.

Mike Saunders • Bristol

Moderator



Mike Saunders is a past president of BAPO, and a paediatric ENT Surgeon in Bristol.

Alok Sharma • Edinburgh

Judge



Alok Sharma is a paediatric ENT surgeon in Edinburgh with an interest in otology.

Ravi Sharma • Liverpool

Judge



My practice involves specialised airway assessment and treatment of children with complex breathing disorders. My interests lie in diagnosing, investigating and treatment of children with blocked noses, hearing problems and sleep disorders arising from enlarged tonsil and adenoids. I have a special interest in surgical treatment of drooling in children.

Sunil Sharma • Liverpool

Moderator / Panellist



Sunil is a Consultant at Alder Hey Children's Hospital, having trained in London and Toronto. His interests include endoscopic ear and implantation surgery, microtia and craniofacial surgery. He is TPD, SAC LM, and Regional ENT Lead, Chief Investigator for RABBIT, NICE committee member and section editor for Scott Brown's.

Vibha Sharma • Manchester

Speaker



Vibha Sharma is a Consultant Paediatric Allergist at the Royal Manchester Children's Hospital. She is also an Honorary Senior Lecturer in the Lydia Becker Institute of Immunology and Inflammation at the University of Manchester. She has extensive expertise in the assessment and management of allergic conditions in childhood. She is an advisor for the National Institute for Clinical Excellence (NICE) on immunotherapy products. She also serves as the custodian of the United Kingdom Fatal Anaphylaxis Registry, supporting ongoing understanding and prevention of fatal anaphylactic reactions in the UK.

Marlene Soma • Sydney

Panellist / Speaker



Marlene Soma is a Consultant Paediatric ENT Surgeon with a particular interest in paediatric airway surgery at Sydney Children's Hospital, Sydney. She trained at both Great Ormond St Hospital for Children and at Cincinnati Children's Hospital Medical Center. She is actively involved in teaching and research, runs courses for registrars, nurses and other ENT Surgeons. She is an executive member of the Australian New Zealand Society Paediatric Otorhinolaryngology (ANZSPO). She is skilled in the management of complex airway disorders and champions a multidisciplinary approach.

Kate Stephenson

Panellist



Kate Stephenson is a Consultant Paediatric Otolaryngologist at Birmingham Children's Hospital. She has trained and worked as a specialist in both the UK and South Africa, completing a fellowship at Great Ormond Street Hospital. Her interests include laryngology, airway and head & neck alongside global surgery.

Liam Sutton • London

Speaker



Liam Sutton is a Paediatric Otolaryngologist, Head and Neck and Tracheal Consultant at Great Ormond Street Hospital for Children. He established the first paediatric hypoglossal nerve implant service in Europe. In addition to his interest in complex sleep, he specialises in paediatric airway surgery and rhinology.

Ayla Tabaksert • NE Deanery

Chair



Ayla Tabaksert is an ENT registrar in the Northern Deanery and is the current Trainee rep on BAPO Council

Ben Talks • Newcastle

Speaker



Ben is an ENT registrar in the Northern Deanery and Wellcome 4Ward North Clinical PhD Fellow at Newcastle University. He will be presenting work supported by the 2025 BAPO Juniors Research Grant on a novel system examining the effect of e-cigarette exposure on middle ear epithelium.

Christopher Thompson • Edinburgh

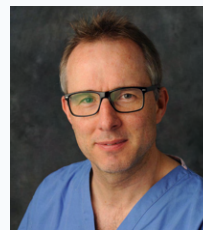
Judge



Chris Thompson is a consultant at RHCYP in Edinburgh, having completed his training in the East of Scotland and the Senior Paediatric ENT Fellowship at Alder Hey. He has an interest in Paediatric Airway and Head and Neck Surgery, medical education and holds an honorary position at the University of Edinburgh.

Keith Trimble • Belfast

Judge / Moderator



Keith Trimble is a Consultant Paediatric Otolaryngologist with 18 years' NHS consultant experience and specialist training in paediatric ENT at SickKids Hospital, Toronto. Clinical Lead for Paediatric ENT in Belfast Trust and current President of the Irish Otolaryngology Society.

Malin Wendt • Stockholm

Moderator



Malin Wendt, MD, PhD, is a Senior Consultant in Pediatric ENT at Karolinska University Hospital, Stockholm, Sweden, specializing in airway, aerodigestive challenges, and vascular anomalies. She is co-head of the Karolinska Pediatric Aerodigestive Team, Karolinska-representative in ERN-CRANIO, and serves on the board of the Nordic Society of Pediatric Otorhinolaryngology (NSPO).

Lina Woods • Dublin

Judge



Lina Woods is a consultant ENT paediatric ENT Surgeon in Dublin.

Michelle Wyatt • London

Moderator / Judge



Michelle Wyatt is a paediatric ENT Surgeon at Great Ormond Street Hospital with an interest in paediatric Airway and a past President of BAPO.

APPENDIX- ABSTRACTS

BAPOJ Research Prize Presentations

Session 1 • 09:40–10:20, Thursday 24 September. BAPOJ1

Developing novel materials for paediatric tracheostomy tube design

Josh Law, Jennifer Olsen, Jason Powell

Newcastle University, Newcastle upon Tyne, United Kingdom. Great North Children's Hospital, Newcastle upon Tyne, United Kingdom

Abstract

Background. Paediatric tracheostomy is performed as an adjunct to long-term ventilation or to relieve airway obstruction, particularly in infants. Respiratory complications are common, resulting in morbidity, mortality, and excess healthcare costs. Contributing mechanisms likely include biofilms on PVC, silicone or polyurethane tube surfaces, which are often scaled-down versions of adult designs posing unique challenges due to smaller airway calibres and ongoing growth. Recent advances in biomaterial additives manufacturing provide an opportunity to design a paediatric-specific tracheostomy tube with increased cytocompatibility and biofilm-resistance.

Methods. We have a systematic review paper in preparation, identifying 3-5 biomaterial additives with promising mechanical and immunological properties to function optimally as a tracheostomy tube coating. Prototypes will be designed and 3D-printed using biomedical CAD/CAM and stress tested to ensure durability when exposed to the warm and humid conditions of the trachea, led by Jenny Olsen (School of Engineering, Newcastle University) who brings expertise in medical devices. Further immunological testing supervised by Jason Powell (MRC Clinician Scientist and Consultant Paediatric ENT Surgeon) will assess biofilm resistance after bacterial culture exposure and cytocompatibility using an air-liquid interface (ALI) culture taken from primary paediatric epithelial cells (biobanked within the Powell research group), to build performance profiles compared to current products. The 1-2 best designs for an optimised, next-generation paediatric tracheostomy tube will be taken forward for onward research.

Intended use. £500 would be used for 3D-printing costs, £500 for plasticware and media associated with the ALI airway epithelial culture, and £500 for in vitro assays and other consumables.

BAPOJ2

Are sterile drapes and gowns necessary for all paediatric ENT operations? Assessing the exposure of bodily fluids during adenotonsillectomy procedures

Chee Yen Soon, Henry Dunne, Chong Yi Kang

Cambridge University Hospitals NHS Foundation Trust, Cambridge, United Kingdom

Abstract

BACKGROUND

Tonsillectomies account for 17% of the UK's elective workload, costing the NHS £68 million and generating 41kg CO₂e per operation, equivalent to the monthly electricity consumption for a three-bedroom house.^{1,2} At Cambridge University Hospitals, usage of sterile personal protective equipment (PPE) in selected ENT operations cost £6,176 annually. The rationale for gowning requires interrogation. Sterile consumables significantly drive this financial and environmental burden. The surgery is clean-contaminated with no part of the surgeon touching the operation site. The surgical site is rapidly contaminated by the patient's oro-pharyngeal flora during and immediately after surgery, hence theoretical risk of surgeon to patient contamination is very low. What is less clear is the degree of contamination risk from patient to surgeon. There variability with gowning in tonsillectomy with 25% of surveyed surgeons not using sterile gowns for tonsillectomy.³

METHODOLOGY

This prospective, observational study aims to quantify the extent and distribution of bodily fluid splashback during elective adenotonsillectomies. The £1,500 grant will fund essential resources – primarily water-sensitive paper sheets (as used in agriculture) to assess volume and degree of splashback during the operation, which will be analysed using image processing software to quantify and map fluid distribution.

ANTICIPATED IMPACT

The findings will provide objective data to understand risk exposure and provide an evidence base to optimise surgical drape and gown use from both a safety and sustainability perspective. If, as anticipated, splashback is negligible, our findings will support surgeons to safely minimise PPE waste, reduce financial costs and carbon emissions across the NHS.

References

1. Cannon, Joseph et al. "Carbon footprint of tonsillectomy." *The surgeon : journal of the Royal Colleges of Surgeons of Edinburgh and Ireland* vol. 22,4 (2024): 242-247. doi:10.1016/j.surge.2024.06.001
2. Rizan, Chantelle et al. "The carbon footprint of products used in five common surgical operations: identifying contributing products and processes." *Journal of the Royal Society of Medicine* vol. 116,6 (2023): 199-213. doi:10.1177/01410768231166135
3. Thakrar, Jai et al. "UK national survey on surgical gowning for tonsillectomy." *The Journal of laryngology and otology* vol. 138,8 (2024): 845-848. doi:10.1017/S0022215124000331

BAPOJ3

Who Progresses? Phenotyping Long-Term Audiological Trajectories Following Newborn Hearing Screening

Chloe Swords, Mohammad Ghunaim, Chong Kang, Nico Jonas, Jessica Bewick

Addenbrookes Hospital, Cambridge, United Kingdom

Abstract

Children identified through the NHS Newborn Hearing Screening Programme (NNHSP) who do not initially meet cochlear implant (CI) criteria represent a heterogeneous cohort with poorly defined long-term outcomes. The natural history and longitudinal audiological phenotypes of hearing loss progression in this population remain uncertain across biological and socio-environmental factors.

This regional retrospective cohort study will assess serial audiograms to phenotype longitudinal hearing trajectories over a 10-year period in children identified via NNHSP who were not initial CI candidates. Using serial audiograms, we will map individual hearing trajectories alongside data linkage across regional electronic healthcare records, socio-economic parameters, congenital cytomegalovirus status and R67 genetic results, allowing stratification into infectious, genetic and idiopathic aetiological groups.

The primary outcome will be progression to CI candidacy. Secondary analyses will evaluate age at and time to referral following attainment of eligibility, delayed or absent referral despite eligibility, and predictors of progression, including baseline audiometric severity, area-level deprivation (indices of multiple deprivation), safeguarding, ethnicity, and markers of healthcare engagement.

Funding will support secure database development to ensure confidential data handling and statistical analysis of longitudinal outcomes, given the multicentre nature of this study (estimated 12 sites).

This study will generate clinically relevant evidence to improve risk stratification and follow-up pathways for children identified through national hearing screening programmes. The lessons learnt will be identified for transferability to other parts of the countries to evaluate similarities and differences in the patient pathway.

Oral Pop-up Presentations

Session 3

03.1 Preliminary Safety and Efficacy of AK-OTOF Gene Therapy for Otoferlin Gene (OTOF)-mediated Hearing Loss

Brian Lin, on behalf of the AK-OTOF-101 trial and site teams and Eli Lilly and Company
Eli Lilly and Company, Boston, United States; Eli Lilly and Company, London, United Kingdom

03.2 Paediatric Eustachian Tube Balloon Dilatation: The First UK Experience

Emma Hogg; Grace Khong; Sunil Sharma
Alder Hey Children's Hospital, Liverpool, United Kingdom

03.3 Patterns and Predictors of Hearing Aid Rejection in Paediatric Patients: A Single-Centre Experience

Dickson Dewantoro; Yeshaa Mirani; Timothy Davies; Oliver Little; Sunil Sharma
ENT Department, Alder Hey Children's Hospital, Liverpool, United Kingdom; Audiology Department, Alder Hey Children's Hospital, Liverpool, United Kingdom

03.4 Beyond Drainage: Tympanic Membrane Perforation upon Presentation as a Major Risk Factor for Complications in Pediatric Mastoiditis

Ofer Israel; Itai Asher; Jacob Pitaro; Rona Bourla; Yael Garti; Haim Gavriel; Yuval Mizrakly
Shamir medical center, Zerifin, Israel

03.5 Paediatric SENTIO™ Transcutaneous Bone Conduction Hearing Implant: Our Tertiary ENT Paediatric Experience

Emma Hogg; Dickson Dewantoro; Kristin Bryce; Timothy Davies; Oliver Little; Sujata De; Sunil Sharma
Alder Hey Children's, Liverpool, United Kingdom; Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom

Session 4

04.1 Higher Revision Adenoidectomy Rates in Afro-Caribbean Children Compared with the General Paediatric Population: A Five-Year Tertiary Centre Review

Amna Qamar; Ilan Elango; Harrypal Panesar; Ciba Paul
Oxford University Hospitals NHS Trust, Oxford, United Kingdom

04.2 Should day-case adenotonsillectomy criteria be expanded to allow for the growing childhood obesity epidemic? A retrospective review of 99 children undergoing adenotonsillectomy with weight over 98th centile.

Aisling Clarke; Gavin Donaldson; Conor Jackson; Keith Trimble
Royal Belfast Hospital for Sick Children, Belfast, United Kingdom

04.3 Paediatric ENT litigation in England: a retrospective analysis of NHS Resolution claims notified 2018–2023

Foteini Stefania Koumpa; Talisa Ross; Annakan Navaratnam; Su De
University College London Hospital, London, United Kingdom; University College Hospital London, United Kingdom; Alder Hey Hospital, Liverpool, United Kingdom

04.4 Does Clot Size Matter? Rethinking Anticoagulation Duration in Paediatric Otogenic Sinus Thrombosis

Sara Mahmood; Randa Ghazal-Asswad; Kristin Bryce; Sunil Sharma
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04.5 Do patients require ongoing medication for drooling despite salivary gland surgery?

Mohammad Ghunaim; Chloe Swords; Chong Kang; Nico Jonas; Jessica Bewick
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Sophie Bondje; Elizabeth Maughan; Colin Butler
Great Ormond Street Hospital, London, United Kingdom

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Mohammad Ghunaim; Imogen Seago; Chloe Swords
Cambridge University Hospital, Cambridge, United Kingdom; The University of Jordan, Amman, Jordan

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Addenbrookes Hospital, Cambridge, United Kingdom

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Cardiff University, Cardiff, United Kingdom; University Hospital Wales, Cardiff, United Kingdom

05.5 Multidisciplinary Paediatric Airway Guide and Simulation Training

Sarah Humphries; Isabella Atherley; Thomas Geyton
University Hospitals Sussex, Brighton, United Kingdom

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06.1 Endoscopic vs External Paediatric DCR: A Systematic Review and Meta-analysis

Rohan Pinto; Grace Khong
Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom; Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom

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Gyanesh Sethi; Nicola Stobbs; Christopher NG
Sheffield Children's Hospital, Sheffield, United Kingdom

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Arshad Zubair; Dillan Shetty; Ravi Sharma; Grace Khong
Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom; Bolton NHS Foundation Trust, Bolton, United Kingdom

06.4 DigiBel: A Pilot Evaluation of a Web-Based, Child-Friendly Audiometry App for Detecting Conductive Hearing Loss.

Rachael Collins; Tamsin Holland-Brown
Norfolk and Norwich University Hospital, Norwich, United Kingdom; Cambridge University Hospital, Cambridge, United Kingdom

06.5 BapoGPT: Artificial Intelligence Versus ENT UK for Patient and Parent Information

Dalton Barham; William Greenough
Sheffield Teaching Hospitals, Sheffield, United Kingdom

Oral presentation Abstracts

ORAL PRESENTATIONS Session 3

03.1

Preliminary Safety and Efficacy of AK-OTOF Gene Therapy for Otoferlin Gene (OTOF)-mediated Hearing Loss

Brian Lin, On behalf of the AK-OTOF-101 trial and site teams and Eli Lilly and Company

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Abstract

Main Theme: Otology

Introduction: The otoferlin gene (*OTOF*) encodes otoferlin, a protein critical for signaling at the inner hair cell synapse. Individuals with *OTOF*-mediated hearing loss typically present with congenital, severe to profound sensorineural hearing loss, with preserved otoacoustic emissions early in life. Recent advances in gene therapy and intracochlear delivery support the potential to restore physiologic hearing in individuals with *OTOF*-mediated hearing loss using a one-time, local administration of AK-OTOF (AAVAnc80-hOTOF). The objective of this gene therapy trial for *OTOF*-mediated hearing loss is to assess the safety, tolerability, and preliminary efficacy of escalating doses of AK-OTOF.

Methods: Clinical trial participants have profound hearing loss, as assessed by auditory brainstem response (ABR), at baseline and receive a one-time intracochlear administration of AK-OTOF using a minimally invasive transcanal approach and the Akouos Delivery Device. Safety assessments and auditory function tests, including ABR and behavioral audiometry, are performed over the trial and long-term follow-up period.

Results: The preliminary safety profile is favorable, with no related serious adverse events and no adverse events related to AK-OTOF gene therapy or the Akouos Delivery Device. Initial clinical evidence shows that AK-OTOF gene therapy has the potential to restore physiologic hearing in individuals with *OTOF*-mediated hearing loss. Safety and efficacy data from participants will be presented.

Conclusion: Available data suggest that AK-OTOF may be safely administered to participants, with onset of restoration of physiologic hearing as early as one month following administration.

03.2

Paediatric Eustachian Tube Balloon Dilatation: The First UK Experience

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Abstract

Theme: Paediatric Otology

Introduction

Eustachian tube balloon dilatation is a minimally invasive procedure for the treatment of eustachian tube dysfunction (ETD). Although widely adopted in adults, its use within paediatric patients remains limited with no UK-based published series. Eustachian tube balloon dilatation may be indicated in children with persistent otological symptoms despite conventional management. This project aimed to evaluate the outcomes of balloon dilatation for ETD in children treated at our tertiary ENT paediatric unit.

Methods

This was a retrospective review of paediatric patients treated with eustachian tube balloon dilatation over a 3-year period. Patient reported-outcomes scores using the Eustachian Tube Dysfunction Questionnaire (ETDQ-7) were recorded pre-operatively and at 6 weeks and 3 months post-operatively.

Results

16 patients underwent balloon dilatation for ETD with a mean age of 13 years. 46% of patients underwent concurrent procedures including turbinate reduction, adenoidectomy and septoplasty. The most frequently reported symptoms were popping of ears and nasal obstruction. The mean ETDQ-7 score pre-operatively was 27.1. All patients experienced an improvement in their ETDQ-7 score at 6-weeks post-operatively, including those with a history of cleft palate repair who had undergone repeated ventilation tube insertion previously. There was a statistically significant improvement ($p < 0.0001$) in ETDQ-7 scores at both 6 weeks (mean 12.4) and 3 months (mean 11.25) post operatively.

Conclusion

This project demonstrated significant improvements in patient reported outcome measures post-operatively following balloon dilatation for ETD. To the authors knowledge, this is the first series of paediatric eustachian tube balloon dilatation presented in a UK cohort.

03.3

Patterns and Predictors of Hearing Aid Rejection in Paediatric Patients: A Single-Centre Experience

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Abstract

Main Theme: Otology

Introduction: Consistent auditory stimulation is essential for speech and language development. Non surgical bone conduction hearing aids (NSBCHAs) are widely used in paediatric patients with conductive or unilateral hearing loss, yet reasons for device rejection in children remain poorly described.

Methods: Retrospective review of paediatric patients referred for NSBCHAs assessment at a tertiary children's hospital. Demographic, audiological, and clinical data were analysed, including hearing loss characteristics, devices trialled, and documented reasons for rejection.

Results: Of 371 referred children, 10 (2.7%) declined amplification. The median age was 9 years (range 3–17). All had conductive hearing loss. The most common diagnosis was microtia with atresia. Rejections were predominantly child led with reasons including discomfort, intolerance of background noise, unnatural sound quality, and physical irritation.

Conclusion: NSBCHAs rejection in paediatric is uncommon. Children with unilateral hearing loss were more likely to reject. Understanding reasons for refusal may improve optimisation of hearing rehabilitation strategies.

03.4

Beyond Drainage: Tympanic Membrane Perforation upon Presentation as a Major Risk Factor for Complications in Pediatric Mastoiditis

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Abstract

Main Theme: Otology.

introduction:

The initial treatment of Acute Mastoiditis (AM) in children is source control, achieved either by myringotomy or ventilation tube (VT) insertion, alongside antibiotics. Patients presenting with tympanic membrane (TM) perforation are typically considered “drained” and therefore do not undergo additional surgical intervention at presentation. The clinical significance of TM perforation in this setting remains unclear. This study aimed to compare the clinical characteristics and outcomes of pediatric mastoiditis patients with and without TM perforation, hypothesizing that perforation may represent a marker of more aggressive disease.

Materials and Methods: A retrospective cohort study analyzed pediatric patients hospitalized with AM. Patients were divided into two groups: intact TM versus TM perforation, (including pre-existing VT) at presentation.

Results: Of 174 patients, 33 (19.0%) presented with TM perforation, including 4 with VT. Compared with those without perforation, these patients exhibited higher peak temperature at home (40.0°C [39.2–40.5] vs. 39.3°C [38.7–40.0], $p=0.019$) and underwent imaging more frequently (10 [30.3%] vs. 17 [12.1%], $p=0.009$). Rates of subperiosteal abscess were comparable between groups (7 [21.2%] vs. 24 [17.0%], $p=0.571$). However, intracranial complications were significantly more common in the perforation group (6 [18.2%] vs. 4 [2.8%], $p=0.004$).

Conclusions: Pediatric mastoiditis with TM perforation is associated with a more severe clinical course and a higher rate of intracranial complications. These findings challenge the traditional treatment paradigm and suggest that such patients may require closer monitoring and potentially earlier and more aggressive management.

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03.5

Paediatric SENTIO™ Transcutaneous Bone Conduction Hearing Implant: Our Tertiary ENT Paediatric Experience

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Abstract

Category: Paediatric Otolaryngology

Introduction

SENTIO™ is a novel transcutaneous implantable conductive hearing device licensed for patients aged 12 years and over with conductive or mixed hearing loss and single-sided deafness. Evidence in the paediatric population, particularly in syndromic children, remains limited. We report our experience of audiological and surgical outcomes at our tertiary ENT paediatric unit.

Methods

A retrospective review of patients undergoing SENTIO™ implant insertion between January 2025 and February 2026 was performed. Data collected included patient demographics, surgical indications and outcomes, and audiological outcomes using the patient-reported Children's Home Inventory for Listening Difficulties (CHILD) questionnaire pre and post-implant insertion, and Bamford-Kowal-Bench (BKB) testing.

Results

Six patients (median age 13.6 years; range 11-15) underwent implantation, including one bilateral. 33% of patients had a history of craniofacial syndromes and 50% of patients demonstrated canal atresia or stenosis. Overall, audiological outcomes improved following implantation, although one patient demonstrated reduced CHILD and BKB scores in some domains. Two children were unable to complete the CHILD questionnaire due to comorbidities. There were no reported surgical complications. Variation in operative technique, allowing for a shallower skull depth to be drilled in paediatric patients was used, which was compensated for by using a longer fixation band; and implant position was considered in children with microtia or previous percutaneous implant insertion.

Conclusion

SENTIO™ insertion demonstrated favourable audiological and surgical outcomes, with no post-operative complications. Our series discussed variations in surgical technique to compensate for a shallower skull thickness in the paediatric cohort.

ORAL PRESENTATIONS Session 4

O4.1

Higher Revision Adenoidectomy Rates in Afro-Caribbean Children Compared with the General Paediatric Population: A Five-Year Tertiary Centre Review

Amna Qamar, Ilan Elango, Harrypal Panesar, Ciba Paul

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Abstract

Introduction: Revision adenoidectomy in children is an uncommon but significant undertaking, particularly in younger patients. Large cohort studies report revision rates of 1–3%, with younger age at initial surgery associated with increased risk. Persistent obstructive sleep apnoea (OSA) and middle-ear disease are the most frequently reported indications for revision. However, revision adenoidectomy outcomes in Afro-Caribbean children are limited.

Methods: A retrospective review was conducted of Afro-Caribbean children undergoing adenoidectomy at a tertiary centre over a five-year period. Data collected included demographics, age at primary and revision surgery, indications, and interval between procedures. Revision rates in the Afro-Caribbean cohort were compared with those of the overall paediatric adenoidectomy population during the same period. Subgroup analysis was performed for children aged under 3 years and those 3 years and older.

Results: A total of 128 Afro-Caribbean children underwent primary adenoidectomy (mean age 5.2 years), of whom nine required revision surgery (6.3%). Children requiring revision were younger at primary surgery (mean age 2.1 years), and most were for persistent OSA (88.9%). Afro-Caribbean children demonstrated a higher revision rate (6.3% vs 2.2%). The greatest disparity was observed in children under 3 years, with revision rates of 17.9% versus 2.0%. Revision rates for children 3 years and older were comparable (3.1% vs 2.3%). The mean interval between primary and revision surgery was 24.2 months.

Conclusion: Revision adenoidectomy occurred more frequently in Afro-Caribbean children under 3 years of age. Further research is needed to explore potential population-specific factors influencing adenoidal regrowth and revision risk.

O4.2

Should day-case adenotonsillectomy criteria be expanded to allow for the growing childhood obesity epidemic? A retrospective review of 99 children undergoing adenotonsillectomy with weight over 98th centile.

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Abstract

Background: Northern Ireland has the highest level of childhood obesity in primary 1 children in the UK. Updated BAPO guidance recommends overnight admission for paediatric patients weighing >98th centile undergoing adenotonsillectomy due to perceived historical respiratory risks. Utilising coblation techniques and bespoke opioid-sparing anaesthesia may safely facilitate day-case selection in conjunction with GIRFT guidelines. This study evaluated the safety, efficacy, and success rates of day-case intracapsular adenotonsillectomy in this unique cohort.

Methods: A retrospective, single-institution review in Belfast analysed data from 99 paediatric patients (>98th weight centile) over a two-year period from August 2024. Monitored parameters included weight, z-scores, co-morbidities, pre-operative sleep studies, and 28-day surgical complications or re-admissions.

Results: The cohort averaged 9 years old and 56.3kg in weight (range: 16.9–108kg; mean z-score: 2.72, range: 1.78–4.86). Minor respiratory complications occurred in 5% of patients (5/99), requiring only brief supplemental oxygen or transient need for an oropharyngeal airway; no major or additional inpatient respiratory complications occurred. The overall day-case rate reached 86%, with 22/36 planned admissions successfully converted to day-cases. Overall saving of 85 bed days. Overnight admission was required for 14 patients, 11 of whom had significant co-morbidities. Secondary haemorrhage occurred in 1%, and unrelated re-admissions occurred in 5%.

Conclusion: A weight >98th centile is not an absolute contraindication for day-case adenotonsillectomy when using a meticulous intracapsular technique and opioid-sparing anaesthesia in high-acuity centres. Risk stratification utilising a z-score <3 and the absence of co-morbidities achieves an optimal day-case rate with exclusively minor, post-operative respiratory complications.

04.3

Paediatric ENT litigation in England: a retrospective analysis of NHS Resolution claims notified 2018–2023

Foteini Stefania Koumpa, Talisa Ross, Annakan Navaratnam, Su De

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Abstract

INTRODUCTION: Paediatric ENT clinical negligence litigation carries significant financial and governance implications, yet remains poorly characterised. This study aimed to characterise the nature, cause, and cost of paediatric ENT claims notified to NHS Resolution and identify themes amenable to risk reduction.

METHODS: Retrospective analysis of NHS Resolution data for paediatric ENT claims (aged 0–17) notified 2018/19–2022/23. Two independent reviewers categorised each claim by subspecialty, diagnosis, age group, operative involvement, and cause code, with complete agreement. Groupings included delay in diagnosis or treatment, consent failure, operative error, and failure to perform investigations.

Results: 72 claims were identified across paediatric ENT, of which the highest proportion related to paediatric otology (54%, n=39). Cholesteatoma was the single most litigated diagnosis (32%, n=23). Delay in diagnosis was identified in 47% of claims (n=34) and delay in treatment in 15% (n=11). Claims were equally distributed between operative (50%) and non-operative (50%) contexts. Consent or information failures were identified in 17% of claims (n=12), all of which remain open. The highest estimated potential value for open claims involved delayed adenotonsillectomy resulting in hypoxic brain injury (£11.6m), and delayed diagnosis of otogenic brain abscess (£5.5m). Eight closed claims resolved without damages, incurring defence costs only (mean £1,265).

Conclusion: Cholesteatoma diagnostic delay and consent failure are the most frequent and preventable contributors to paediatric ENT litigation. These findings support standardised cholesteatoma surveillance pathways and robust consent practices in the post-*Montgomery* era. Half of claims arose without operative involvement, highlighting risk beyond theatre.

O4.4

Does Clot Size Matter? Rethinking Anticoagulation Duration in Paediatric Otogenic Sinus Thrombosis

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Abstract

Background and aims

Otogenic cerebral venous sinus thrombosis (OCVST) is a rare complication of otitis media and mastoiditis, developing in an estimated 0–3% of cases, with a mortality rate of 5–10%. Despite widespread use of anticoagulation, no consensus exists on optimal treatment duration or how interval imaging should guide management. We aimed to determine whether the radiological extent of thrombosis predicts anticoagulation duration, and to define an appropriate timeframe for follow-up MRI.

Methods

We retrospectively reviewed seven years of paediatric OCVST cases presenting to Alder Hey Children's Hospital, UK. Demographic, clinical, radiological and laboratory data were collected. Patients were stratified by thrombosis extent: single sinus involvement, multi-sinus involvement without internal jugular vein (IJV) thrombosis, and multi-sinus involvement with IJV thrombosis. Interval MRI findings were correlated with anticoagulation duration.

Results

Seventeen children were included (mean age 3.7 years; 82% male). All underwent contrast-enhanced CT and MRI/MRV. Complete recanalisation occurred by four months in all single-sinus cases (n=4). Among multi-sinus cases without IJV involvement (n=8), complete recanalisation was uncommon; collateral-dependent or partial recanalisation predominated (62.5%). Outcomes were similar in IJV-involved cases (n=5). All patients received anticoagulation for a median of six months, regardless of thrombosis extent or radiological resolution.

Conclusion

Anticoagulation duration appeared driven more by radiological stability and collateral circulation than by initial thrombosis extent. We propose a standardised, haematology-informed pathway defining anticoagulation duration and optimal timing of follow-up MRI — bringing clarity to a condition where guidance has long been lacking.

O4.5

Do patients require ongoing medication for drooling despite salivary gland surgery?

Mohammad Ghunaim, Chloe Swords, Chong Kang, Nico Jonas, Jessica Bewick

Addenbrookes Hospital, Cambridge, United Kingdom

Abstract

Main theme: General

Introduction: Drooling is a common and distressing problem in children with neurological conditions, significantly impacting quality of life. Surgical interventions targeting the salivary glands are increasingly used when conservative measures fail, however the proportion of patients requiring ongoing medical therapy following surgery is not well characterised.

Aims: To evaluate the rate of post-operative medication use for drooling following surgical intervention in a paediatric cohort over a 10-year period.

Methods: A retrospective audit was conducted at a Tertiary Paediatric ENT unit. All patients under the age of 16 years undergoing surgery for drooling between 2016 and 2026 were identified. Relevant OPCS codes were used to classify procedures. Post-operative medication prescriptions were extracted and cross-referenced with surgical records.

Results: Median age at surgery was 4 years (range 0–16), with an equal sex distribution. 70 patients had a relevant surgical procedure. Following surgery, 61.4% of patients (n=43) required ongoing medical therapy for drooling, generating 1,362 post-operative medication records. 38.6% (n=27) have no further medication records.

Conclusion: Over 60% of children undergoing surgical intervention for drooling at our centre required ongoing medication post-operatively, suggesting that surgery alone may be insufficient. These findings highlight the need for robust multi-modal treatment pathways and structured long-term follow-up in this patient group.

ORAL PRESENTATIONS Session 5

O5.1

Dynamic Four-Dimensional CT in the Evaluation of Paediatric Tracheobronchomalacia: A Ten-Year Single-Centre Retrospective Review

Sophie Bondje, Elizabeth Maughan, Colin Butler

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Abstract

Background: Paediatric tracheobronchomalacia (TBM) is a heterogeneous disorder of dynamic central airway collapse. Flexible bronchoscopy is the reference standard but is invasive, uninformative about extraluminal causes, and cannot be quantified. Dynamic four-dimensional CT (4DCT) is an increasingly used non-invasive adjunct whose role alongside bronchoscopy remains poorly defined.

Objectives: To describe the diagnostic yield, concordance with bronchoscopy, radiation exposure, and MDT contribution of 4DCT in suspected paediatric TBM.

Methods: Single-centre retrospective review of children under 18 years undergoing 4DCT for suspected TBM at Great Ormond Street Hospital (GOSH), 2015–2025. As 4DCT is not routine for TBM at GOSH, this is a selected surgical referral cohort. B&B findings were compared with 4DCT descriptively, given inconsistent respiratory-phase standardisation and lack of paediatric normative data.

Results: Twenty patients underwent 22 4DCT studies (14 male; median age 2.5 years). Oesophageal atresia/TOF was commonest (6/20). 4DCT demonstrated TBM in 14/20 (70%); extrinsic vascular/mediastinal compression was found in 14/20 (70%), most commonly innominate-artery compression. Bronchoscopy was available in 16/20 (80%); where B&B was performed (n=10), the upper trachea was most often worst affected, consistent with innominate-artery compression. Median dose-length product was 10.3 mGy·cm (effective dose ~0.27 mSv). 4DCT contributed to a surgical decision in 13/20 (65%).

Conclusion: 4DCT is feasible, low-dose, and identifies extraluminal causes of collapse often missed at bronchoscopy, informing MDT management. This selected cohort reflects non-routine 4DCT use locally; nonetheless it shows 4DCT is genuinely quantifiable, unlike bronchoscopy, supporting wider use to stratify severity and build prospective evidence.

O5.2

Microlaryngobronchoscopy in Children with Recurrent Croup: Are We Performing Too Many?

Mohammad Ghunaim, Imogen seago, Chloe Swords

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Abstract

Introduction: Recurrent croup is a frequent indication for referral to paediatric ENT, yet the role of routine microlaryngobronchoscopy (MLB) remains uncertain. We evaluated the prevalence of airway abnormalities, associated risk factors, management and clinical outcomes in children undergoing MLB for recurrent croup.

Methods: A retrospective review was performed of children undergoing MLB for recurrent croup at a tertiary paediatric centre between 2016 and April 2026. Patients undergoing MLB for alternative indications or before six months of age were excluded. Demographics, clinical presentation, endoscopic findings, investigations, treatment and outcomes were analysed.

Results: Of 125 children identified, 121 met the inclusion criteria. Median age at symptom onset was 12.4 months and median age at ENT review was 40 months. Children experienced a median of 3.5 croup episodes annually, with 42% requiring hospital admission. Airway abnormalities were identified in 76/121 (62.8%) patients; however, structural airway abnormalities were present in only 35/121 (28.9%). The commonest structural abnormalities were laryngomalacia (13.2%) and subglottic stenosis (7.4%). Reflux-type endoscopic findings were uncommon (9.9%). No statistically significant association was demonstrated between structural airway abnormalities and bottle feeding, parental smoking or positive allergy testing. Despite investigation and treatment, 52.9% of children continued to experience recurrent croup during follow-up.

Conclusion: Although non-specific endoscopic abnormalities were frequently identified, clinically significant structural airway pathology was found in fewer than one-third of children. Careful patient selection using recognised risk factors may improve referral pathways and reduce unnecessary invasive airway endoscopy while maintaining diagnostic yield.

References

The management of recurrent croup in children

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05.3

Cumulative corticosteroid exposure in paediatric subglottic stenosis

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Abstract

Main theme: Airway/General

Introduction: Systemic glucocorticoids are integral to the management of acute exacerbations of subglottic stenosis (SGS), but long-term use carries well-documented adverse effects. Emerging adult evidence links cumulative lifetime doses of 500–1000 mg prednisolone-equivalent to increased systemic risk, while emerging paediatric literature proposes an annualised threshold of 100 mg/year, reflecting the greater relevance of dosing pattern and growth-window timing in children. Neither benchmark has been applied to paediatric SGS. This study aimed to quantify cumulative and annualised corticosteroid exposure and associated systemic adverse effects in this population.

Methods: Patients aged <16 years with a diagnosis of SGS managed at a tertiary paediatric ENT centre over a 10-year period were identified. Corticosteroid prescriptions (dose, route, indication) were extracted from electronic records and converted to prednisolone-equivalent doses using standard conversion factors. Systemic biomarkers, including adrenal suppression and growth/weight parameters, were recorded.

Results: 70 patients met inclusion criteria (mean age 2.7 years, 70% male). A total of 736 corticosteroid doses were prescribed, with a median per-patient cumulative dose of 75 mg prednisolone-equivalent. 12 patients (17%) exceeded the proposed 100 mg/year threshold and 5 (7%) exceeded 500 mg total dose.

Conclusion: Children with SGS accrue substantial, often unmonitored, systemic corticosteroid exposure. As no validated paediatric threshold exists for lifetime cumulative dose, these findings support routine tracking of both cumulative and annualised exposure, multidisciplinary input from paediatric endocrinology, and exploration of steroid-sparing strategies to reduce iatrogenic burden in this population.

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O5.4

Transitioning adolescent tracheostomy patients to adult care: A national survey of current practice

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Abstract

Main theme: General

Introduction

Transitioning adolescents with tracheostomies to adult care presents significant challenges, including variation in service provision, equipment and multidisciplinary support. This is, to our knowledge, the first study to explore tracheostomy transitioning practice.

Methods

We conducted a multi-centre questionnaire-based cross-sectional study. 30 clinicians from 21 centres across Great Britain completed a 13-item survey exploring service provision and challenges. Quantitative data were analysed descriptively. Qualitative data emerged from free text responses via inductive thematic analysis.

Results

The cohort (n=30) comprised paediatric (n=13), adult (n=13) and dual practice (n=4) professionals; predominantly specialist nurses (n=16). Units (n=21) transitioned an average 2.5 patients annually, with most formal handovers occurring between 17-18 (n=9), to long term ventilation teams or no defined service (n=12;each). Twelve units lacked any pathway. Eleven units utilising defined processes lacked unifying frameworks but consistently incorporated early structured meetings and multidisciplinary collaboration. Challenges included absence of single teams, consumable/equipment sourcing, and double lumen tracheostomy transitioning. Thematic analysis identified inadequate service co-ordination with structural mismatches between paediatric and adult care causing negative patient and carer experience. Participants advocated for standardised pathways, targeted training, and enhanced family support, with improved resource allocation assuring “no postcode lottery care.” The survey remains open and expanded qualitative results will be presented.

Conclusion

This study, the first to assess transitioning of tracheostomy dependent adolescents, shows regionally fragmented processes which lack formal structure. It provides an evidence base to support nationally commissioned, standardised pathways, incorporating multidisciplinary co-ordination, formalised cross-service communication and robust family support systems.

05.5

Multidisciplinary Paediatric Airway Guide and Simulation Training

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Abstract

Main Theme: Airway

Introduction

Paediatric airway emergencies are low frequency but high risk. There exists a huge variation in clinician experience and confidence. Aside from optional infrequent courses, clinicians lack exposure to regular rigid bronchoscopy simulation training. Our aim is to create a clear concise video resource and app to improve multidisciplinary competence managing the acute paediatric airway. We propose frequent protected in-person multidisciplinary departmental simulation training using our education model.

Methods

We created an app accessible by QR code containing a 90 second instructional video on assembling the rigid ventilating bronchoscope and foreign body retrieval kit, including links to up-to-date sizing charts and national paediatric airway guidelines. 10 ENT doctors from SHO to consultant were tested assembling the equipment before and after accessing the app. 3 domains were tested: confidence, performance and set up times. Statistical testing was conducted using the Wilcoxon signed-rank test.

Results

Confidence score significantly increased from 62 to 91% ($p < 0.005$). Performance score significantly increased from 70 to 89% ($p < 0.01$). Set up time significantly reduced from 161 to 106 seconds on average ($p < 0.005$). Improvements were seen across all grades, most notably in the SHO group. Qualitative analysis was also conducted.

Conclusion

We present an easy-to-access and quick paediatric airway guide for use by the multidisciplinary team when managing time-sensitive emergency airway cases. We are rolling the model out to all teams involved in caring for these children including anaesthetics, scrub nurses and ODPs with the eventual aim to run a biannual departmental in-person mandatory refresher course.

ORAL PRESENTATIONS Session 6

O6.1

Endoscopic vs External Paediatric DCR: A Systematic Review and Meta-analysis

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Abstract

Introduction The optimal approach for paediatric dacryocystorhinostomy (DCR) remains debated with increasing adoption of endoscopic techniques despite variable outcome reporting. This study compared success, revision and complication rates between endoscopic and external paediatric DCR.

Methods

A PRISMA-guided systematic review identified studies reporting outcomes following primary paediatric (<18 years) endoscopic or external DCR. Random-effects meta-analysis was performed to pool success, revision and complication rates. Subgroup analysis compared outcomes between approaches. Follow-up duration between groups was also assessed.

Results

Twenty studies were included (14 endoscopic; 6 external). External DCR demonstrated significantly higher pooled success rates than endoscopic DCR (94.4% vs 84.6%, $p < 0.001$). Revision surgery was significantly more common following endoscopic DCR (7.2% vs 1.8%, $p = 0.003$). Complication rates were low in both groups and did not differ significantly (5.1% vs 8.7%, $p = 0.229$). Follow-up duration was comparable between techniques (median 14.4 vs 8.8 months, $p = 0.186$).

Conclusion

External paediatric DCR was associated with higher pooled success rates and lower revision burden compared with endoscopic DCR, without a significant difference in complications. These findings suggest external DCR may provide more reliable primary outcomes. However, interpretation is limited by study heterogeneity and the predominantly retrospective evidence base. Prospective comparative studies with standardised outcome reporting are required.

O6.2

Paediatric one stop neck lump clinic: A pilot service evaluation

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Abstract

Introduction:-

Neck lumps are a common paediatric referral causing significant parental anxiety. One-stop clinics integrating same-day assessment and ultrasound reduce appointments and time to diagnosis.¹

Evidence derives predominantly from adult cohorts; paediatric data remain scarce. Biopsy underpins most adult models but is poorly tolerated and often unnecessary given the predominantly benign aetiology of paediatric neck masses. We report outcomes from a paediatric one-stop neck lump clinic at a tertiary centre.

Method:-

This ad hoc service arose from co-availability of a head and neck surgeon and radiologist at a tertiary paediatric centre. We retrospectively reviewed patients across five sessions (March–June 2026) seen with same-day point-of-care ultrasound, classified as the one-stop model. Outcomes included ultrasound diagnosis and management at first attendance.

Results:-

Fifty-seven patients were seen; 17 presented with a neck lump, of whom 10 (59%) underwent same-day ultrasound (6 female, 4 male; age range 1y10m–16y7m). Reactive lymphadenopathy was the most common finding (n=7, 70%); further diagnoses included parotitis, sebaceous cyst, and a U2 thyroid nodule with reactive lymphadenopathy (each n=1). Four (40%) were discharged; one was listed for surgery and one given patient-initiated follow-up. These six avoided a return appointment, saving £477.36 (6 × £79.56). Four required telephone (n=1) or face-to-face follow-up (n=3). No malignancy; FNA was not required.

Conclusion:-

Feasible and safe, this clinic achieved same-day ultrasound in 59% of neck lump attendances, with 40% discharged and cost savings, consistent with evidence this model reduces appointments and time to diagnosis.^{2,3}

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O6.3

Predictors of Recurrence Following Nasal Dermoid Sinus Cysts Excision: A 13-Year Retrospective Cohort Study

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Abstract

Main Theme: Rhinology

Introduction: Nasal dermoid sinus cysts (NDSCs) are rare congenital anomalies requiring surgical excision, with recurrence posing a significant clinical challenge. Outcomes vary significantly based on multiple factors, such as surgical approach, nature of lesion, prior infections and timing of surgery.

Methods: A retrospective review of 55 paediatric patients undergoing primary NDSC excision between 2012 and 2025 at a UK tertiary centre was conducted. Data on demographics, clinical presentation, extension of lesion, surgical approach, and recurrence were collected. Univariate analyses and multivariate logistic regression were employed to identify independent predictors of recurrence and a Kaplan-Meier curve assessed recurrence-free survival.

Results: The cohort comprised 55 patients (29 males, 26 females) with a mean age of 3.6 years (range: 0-15). The overall recurrence rate was 18.2% (10/55). The majority of recurrence events (90.0%) were identified within the first 24 months postoperatively. Multivariate analysis identified deep extension (intraosseous or intracranial) as a significant independent predictor of recurrence (OR: 10.16, $p=0.015$). Open rhinoplasty approach demonstrated a significantly increased risk (OR: 19.73, $p=0.013$). Preoperative infection or clinical presentation (cyst vs. sinus) were not found to be significantly associated with recurrence. Scar revision were required in 2(3.6%). The mean follow-up was 30.3 months (median: 20.1 months).

Conclusion: Deep extension and open rhinoplasty approach are significant independent predictors of recurrence in NDSCs. These findings underscore the importance of meticulous preoperative imaging to delineate lesion depth and careful selection of surgical approach to minimise recurrence risk. We recommend a minimum follow-up of 24 months.

O6.4

DigiBel: A Pilot Evaluation of a Web-Based, Child-Friendly Audiometry App for Detecting Conductive Hearing Loss.

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Abstract

Theme: Otology

Background

App-based audiometry has the potential to transform access to hearing assessment, but there are currently no apps designed specifically for children or capable of differentiating between conductive and sensorineural hearing loss. DigiBel is a novel, web-based audiometry app developed to be child-friendly, portable, and suitable for home use. This pilot study evaluated its usability, child preference, and diagnostic accuracy compared with standard pure tone audiometry (PTA).

Methods

Ten children (ages 4–9) with confirmed conductive pathology completed DigiBel testing alongside standard PTA. Measures included child usability ratings, stated preference, DigiBel air and bone conduction thresholds, and concordance with clinical pass/fail classification. Sensitivity and specificity were calculated using standard audiometry as the reference.

Results

Engagement was high: 8/10 children rated DigiBel positively, and 7 preferred it over standard testing, frequently describing it as “fun”, “less confusing”, or more motivating than conventional audiometry. DigiBel correctly identified 19/20 ears with conductive hearing loss, yielding >99% sensitivity and specificity for pass/fail classification. Bone-conduction screening within the app produced BC-pass in 13/15 tested ears, aligning with masked clinical BC thresholds and demonstrating DigiBel’s ability to distinguish conductive patterns.

Conclusions

This pilot study demonstrates that DigiBel can deliver accurate, engaging behavioural thresholds and reliably identify conductive hearing loss. Its strong usability and diagnostic agreement in this sample support its potential for home monitoring, remote follow-up, and early detection of fluctuating conductive loss. Larger-scale validation will explore longitudinal performance and real-world home-use reliability.

O6.5

BapoGPT: Artificial Intelligence Versus ENT UK for Patient and Parent Information

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Abstract

Main Theme: General / Innovation

Introduction:

AI use in healthcare is increasing, with over 75% of patients willing to use generative AI for health information instead of traditional sources(1,2). Given that over 40% of adults lack sufficient literacy to understand general health information(3), it is crucial to understand both the accessibility and quality of information generated by AI. This study evaluates whether AI meets an acceptable standard for paediatric otolaryngology health information.

Methods:

ChatGPT, Microsoft Copilot, and Google Gemini (default models, no custom prompts) were asked to generate three patient information leaflets on paediatric ENT topics: Otitis media with effusion, Juvenile Nasal Angiofibroma, and post-tonsillectomy care. ENT UK e-Leaflets were used as comparators.

Responses were blindly assessed for readability using Flesch Reading Ease Score (FRES) and Flesch-Kincaid Grade Level. Quality was blindly rated with the EQIP instrument and Global Quality Score (GQS). ANOVA was performed to evaluate differences

Results:

AI responses were significantly less readable than traditional leaflets (FRES 53.6 vs 74.1; $p=0.019$, Reading age 8.0 vs 5.7 $p=0.054$) and significantly lower quality (EQIP 38.2% vs 67.8%; $p=0.006$). AI leaflets were also shorter (616 vs 1123 words). GQS favoured traditional leaflets (3.1 vs 4.7) though this was not statistically significant ($p=0.065$).

Conclusion:

ENT UK leaflets outperformed all tested AI models in both readability and quality. Clinicians and families should exercise caution when using AI-generated health information. With both AI models and patient use evolving at a rapid pace, future work to optimise AI produced healthcare information is needed.

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Poster Presentations- Abstracts

POSTER PRESENTATIONS Group 1

P1.1	Social deprivation and secondary post-tonsillectomy haemorrhage in children: a retrospective cohort study	Matthew Ryan, Nicole Monaghan, Ian Street	University of Liverpool, Liverpool, United Kingdom. Alder Hey Children's Hospital, Liverpool, United Kingdom
P1.2	Long Term Outcomes of Paediatric Epistaxis Management – Follow up from a 4 year prospective cohort study	Charlotte Loh, Thomas J Crotty, Raghad Alshammasi, Stephen Garry, Colleen B Heffernan	Department of Paediatric Otolaryngology, Children's Health Ireland, Dublin, Ireland. Department of Surgery, Royal College of Surgeons, Dublin, Ireland
P1.3	withdrawn		
P1.4	The Paediatric Trojan Horse: Head and neck rhabdomyosarcomas presenting as inconspicuous diagnoses in the paediatric population	Siham Mohamed Shamsudeen, Lisa O'Byrne, Nadia Van Den Berg, Collen Heffernan, Sheehan Patrick, Eimear Phelan	Department of Otolaryngology, Children's Health Ireland at Temple Street, Dublin, Ireland
P1.5	withdrawn		

P1.6	Nurse-led otolaryngology clinics: a systematic review and cross-sectional survey.	Emma Grady, Laura Fay, Colleen Heffernan	University College Dublin, Dublin, Ireland. Department of Paediatric Otolaryngology, Children's Health Ireland at Temple Street, Dublin, Ireland
P1.7	Aortopexy for Innominate artery compression syndrome (IACS): A case series from a Tertiary Paediatric Children's Hospital	Alexandra Nelson, Julian Gaskin	Somerset Foundation Trust, Taunton, United Kingdom. Bristol Royal Hospital for Children, Bristol, United Kingdom
P1.8	Lessons Learned from Organising a National Conference: Why Trainees Should Consider Taking on Leadership Roles	Jessica Chapman, Shayan Shahidi, Callum Findlay	University Hospital Southampton, Southampton, United Kingdom. 2Queen Alexandra Hospital, Portsmouth, United Kingdom. Salisbury District Hospital, Salisbury, United Kingdom
P1.9	Outcomes of paediatric pre-auricular sinus excision – comparison of sinusectomy vs. supra-auricular approaches	Adam Garrard, Roksana Sobiecka, Madhankumar Krishnan, Sujata De	Alderhey, Liverpool, United Kingdom
P1.10	Frenotomy for Tongue-Tie: Biostatistical Analysis Report	Abel Abel, Shayan Shahidi, Eleanor Sproson, Jennifer Hilton	Queen Alexandra Hospital, Portsmouth, United Kingdom

P1.1

Social deprivation and secondary post-tonsillectomy haemorrhage in children: a retrospective cohort study

Matthew Ryan, Nicole Monaghan, Ian Street

University of Liverpool, Liverpool, United Kingdom. Alder Hey Children's Hospital, Liverpool, United Kingdom

Abstract

Introduction:

Post-tonsillectomy haemorrhage is a common cause of unplanned representation. Whether socioeconomic deprivation is associated with bleeding is unclear. This study assessed the association between IMD decile and secondary post-tonsillectomy haemorrhage in the paediatric population.

Methods:

A retrospective cohort study included paediatric patients undergoing tonsillectomy between September 2023 and February 2026. The primary outcome was postoperative-tonsillectomy bleed requiring representation within 14 days. IMD was grouped as more deprived (deciles 1–5) and less deprived (deciles 6–10). Univariable and multivariable logistic regression were used, adjusting for age, sex and surgical technique.

Results:

Of 2469 records, 2354 patients met inclusion criteria with a bleed rate of 1.3%. Bleeding occurred in 24/1733 (1.38%) patients in the more deprived group and 7/621 (1.13%) in the less deprived group. Deprivation was not associated with bleeding on univariable analysis (OR 1.23, 95% CI 0.53–2.87; $p=0.63$) or after adjustment (aOR 1.19, 95% CI 0.50–2.79; $p=0.70$). Increasing age was independently associated with bleeding (aOR 1.24 per year, 95% CI 1.12–1.36; $p<0.001$).

Conclusions:

This appears to be the first paediatric cohort study assessing deprivation and post-tonsillectomy bleeding. Social deprivation was not significantly associated with secondary post-tonsillectomy haemorrhage in this cohort; older age remained the most consistent predictor of bleeding. Although socioeconomic disadvantage has been associated with poorer tonsillectomy outcomes in some previous studies, our findings do not support using deprivation alone to alter discharge pathways or perioperative management. Instead, deprivation may be more relevant to postoperative support and safety-netting than to haemorrhage risk stratification itself.

P1.2

Long Term Outcomes of Paediatric Epistaxis Management – Follow up from a 4 year prospective cohort study

Charlotte Loh, Thomas J Crotty, Raghad Alshammasi, Stephen Garry, Colleen B Heffernan

Department of Paediatric Otolaryngology, Children's Health Ireland, Dublin, Ireland. Department of Surgery, Royal College of Surgeons, Dublin, Ireland

Abstract

Main Theme: General

Introduction: Recurrent paediatric epistaxis is a common condition that is often distressing for children and their caregivers. Although treatments such as Naseptin or silver nitrate cautery are widely used, a recurrence of epistaxis after an initial symptom free period is frequent. Yet, there is a lack of robust, long-term studies comparing treatment modalities and sustained success rates. This study aims to address that gap by evaluating long-term outcomes in a previously established paediatric cohort.

Methods: We performed a follow-up analysis of a 2020 cohort at a tertiary paediatric otolaryngology centre. Anonymised data, including age, sex, healthcare attendances, interventions and epistaxis frequency, were collected using a standardised proforma. Statistical analysis was performed using R Statistical Software (v4.5.1; R Core Team 2025).

Results: 210 patients were scheduled for a telephone appointment and 145 (69.0%) were successfully contacted. Mean age was 13.08 years, with 125 males and 85 females. Median follow-up was 48 months. Among the 75 patients (51.7%) who reported persistent epistaxis, 65.3% (n=49) had not sought any further medical care. Persistent epistaxis was reported in 44.1% (n = 30) of patients treated with Naseptin alone, compared to 57.6% (n = 30) of those who also received silver nitrate cautery. There was no significant difference in the rate of recurrence.

Conclusion: Persistent epistaxis was common, with no significant difference between treatment with Naseptin alone and those who also received silver nitrate cautery. Patient/parent education is essential to explain the aetiology of recurrent paediatric epistaxis and appropriate first aid.

P1.4

The Paediatric Trojan Horse: Head and neck rhabdomyosarcomas presenting as inconspicuous diagnoses in the paediatric population

Siham Mohamed Shamsudeen, Lisa O'Byrne, Nadia Van Den Berg, Collen Heffernan, Sheehan Patrick, Eimear Phelan

Department of Otolaryngology, Children's Health Ireland at Temple Street, Dublin, Ireland

Abstract

Main theme: Head and Neck

Background: Rhabdomyosarcomas (RMS) are the most common sarcoma subtype found in the paediatric population; most commonly occurring within the head and neck region. They account for approximately 5% of paediatric malignancies and are found most often in children under five. Prognosis is dependent on the subtype, with embryonal RMS being the most prevalent.

Methods & Results: We present a case series of three head and neck paediatric rhabdomyosarcoma patients. The first patient, a five-year-old male, presented with a firm swelling over the right lateral nose and an associated erythematous region of the alar crease after a nasal bone injury. Subsequent histology confirmed an alveolar rhabdomyosarcoma. The second patient, a five-year-old male, presented with a facial nerve palsy and otalgia. Subsequent examination showed a mass in the external auditory canal. Further imaging and biopsy confirmed embryonal RMS. The final patient, a fifteen-year-old female, presented with a six-month history of a left pinna lesion, with no history of associated trauma. Initial fine needle aspiration showed evidence of degenerate multinucleate cartilage cells, without evidence of malignancy. An ensuing incisional biopsy confirmed embryonal RMS.

Conclusion: ENT surgeons should remain vigilant for atypical presentations of paediatric rhabdomyosarcomas.

Keywords: rhabdomyosarcoma, facial palsy, nasal bone injury

P1.6

Nurse-led otolaryngology clinics: a systematic review and cross-sectional survey.

Emma Grady¹, Laura Fay², Colleen Heffernan²

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Abstract

Main Theme: General

Background

Within otolaryngology, nurse-led clinics have been well established in several countries; however, they remain poorly characterised in the literature. This study aimed to characterise these clinics and explore clinicians' perceived advantages and disadvantages with this model of care, to inform service development.

Methods

A systematic review of the literature was conducted using PRISMA guidelines. In parallel, a cross-sectional electronic survey was distributed to 350 paediatric otolaryngologists across 46 countries using convenience sampling.

Results

A total of 25 studies were included in the systematic review.

63/350 paediatric otolaryngologists from 8 countries replied to the survey, enabling the profiling of 50 nurse-led clinics. Most respondents perceived that nurse-led clinics reduced waiting times and increased consultant capacity to provide more complex care. At the same time, limitations of this model included scope-of-practice concerns, prescribing restrictions, and variable access to investigations.

Conclusion

Nurse-led clinics improve service efficiency and access to care, though significant barriers to wider implementation remain. Further research is required to evaluate clinical outcomes and cost-effectiveness, as well as to develop formalised training pathways to support the expansion of these services.

P1.7

Aortopexy for Innominate artery compression syndrome (IACS): A case series from a Tertiary Paediatric Children's Hospital

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Abstract

Introduction

IACS is a rare vascular cause of paediatric airway obstruction resulting from anterior compression of the trachea by the innominate artery. Clinical presentation is variable and may include stridor, recurrent respiratory infections and respiratory distress, often making diagnosis challenging. Most cases are managed conservatively, with surgical intervention reserved for severe airway compromise. We present a series of four infants with severe IACS requiring aortopexy within the first year of life.

Methods

A retrospective review was undertaken of four infants diagnosed with IACS at Bristol Royal Hospital for Children. Clinical presentation, laryngotracheobronchoscopy findings, radiological investigations, management and outcomes were reviewed. All patients underwent multidisciplinary airway assessment and were subsequently referred to Great Ormond Street Hospital (GOSH) for surgical management with aortopexy.

Results

Between January 2018 and January 2026, four infants were referred for surgical management of IACS. All patients were male; two of which were twins. All infants had laryngotracheobronchoscopy and 4D CT imaging demonstrating distal tracheal compression. Tracheal stenosis ranged from 58% to 84%, with dynamic calibre change of 39% to 52%. All patients proceeded to aortopexy with postoperative improvement in airway symptoms and no major complications.

Conclusion

IACS is an uncommon but important cause of severe airway obstruction in infancy. This case series highlights the variable presentation of the condition and the value of combined endoscopic and radiological assessment in identifying those requiring surgical intervention. The clustering of cases in siblings may suggest a possible underlying genetic contribution, which could be a potential area for further research.

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P1.8

Lessons Learned from Organising a National Conference: Why Trainees Should Consider Taking on Leadership Roles

Jessica Chapman, Shayan Shahidi, Callum Findlay

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Main theme: General

Introduction:

Clinical training provides limited opportunities to gain practical leadership experience, despite leadership being a core competency for consultants. Organising a national ENT trainee conference offers a unique opportunity to develop these skills. This reflective review explores the lessons learned from leading a national conference and the wider value of leadership roles.

Methods:

Learning points were identified from each stage of the project, from initial planning to post-conference delegate feedback. Key aspects included programme development, sponsorship, venue management, budgeting, and event promotion.

Results:

Delivering a successful conference required more than organisational skills alone. Before taking on this role, I did not consider myself a leader, assuming that good planning would be sufficient. However, our first task was to establish a shared vision for the conference, including its purpose, location, and themes. I soon realised that bringing people together around a common goal is a core element of leadership.

The most rewarding aspect was working within a motivated and supportive committee. Although unexpected challenges required flexibility and collaborative problem-solving, the conference's success relied on the strength of the team rather than any one individual. This experience changed my perspective on leadership: it is not about directing others, but about enabling a team to achieve a shared objective.

Conclusion:

Trainees are well placed to identify gaps and challenges in training and design events that are relevant for their peers. Undertaking this leadership role provided valuable experience with benefits that extend beyond the event and are applicable to consultant practice.

P1.9

Outcomes of paediatric pre-auricular sinus excision – comparison of sinusectomy vs. supra-auricular approaches

Adam Garrard, Roksana Sobiecka, Madhankumar Krishnan, Sujata De

Alderhey, Liverpool, United Kingdom

Background

Preauricular sinuses are common congenital anomalies that can lead to recurrent infections. Various surgical techniques, including simple sinusectomy and the more extensive supra-auricular approach, are used to excise these tracts.

Objectives

This study aimed to compare the outcomes of sinusectomy versus supra-auricular excision in a paediatric population.

Methods

A retrospective cohort study was conducted at a tertiary paediatric referral centre. Cases from 2009–2025 were identified. Clinical records were reviewed. Data were compiled and analysed between sinusectomy and supra-auricular approaches. Statistical tests were used for identifying significance.

Results

A total of 63 patients (71 ears) were included, with mean age 6.9 years at surgery. Of 71 sinuses, 37 (52.1%) were excised via sinusectomy and 34 (47.9%) via the supra-auricular approach. Postoperative complications occurred in 16 cases (22.5%), significantly more often in the sinusectomy group (32.4%) than the supra-auricular group (11.8%, OR 3.6, $p < 0.05$). Recurrences were observed in 11 cases (15.5% overall): 9 (24.3%) after sinusectomy versus 2 (5.9%) after supra-auricular excision (OR 5.14, $p > 0.05$). No patients in either group experienced facial nerve injury. Median follow-up time was significantly longer after sinusectomy (10.7 months) than after supra-auricular excision (4.8 months, $p < 0.05$), reflecting extended surveillance in recurrent cases.

P1.10

Frenotomy for Tongue-Tie: Biostatistical Analysis Report

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Main Theme: Head and Neck

Background: Tongue-tie (ankyloglossia) can significantly impair infant feeding, affecting both breastfeeding and bottle-feeding. Frenotomy is commonly performed to address these difficulties, yet its effectiveness remains debated. This study evaluated feeding outcomes following frenotomy in infants and paediatric patients.

Methods: Consecutive patients undergoing frenotomy between October 2023 and November 2025 at Portsmouth University Hospitals Trust were prospectively assessed. Infants under one year received clinic-based division under local anaesthetic, while children aged one year or older underwent division under general anaesthetic in theatre; the surgical technique was otherwise standardised. Feeding outcomes were measured using the Breastfeeding Self-Efficacy Scale–Short Form (BSES-SF), the Pediatric Eating Assessment Tool (PediEAT-10), and additional symptom-based questions. Pre- and post-operative scores were compared using paired t-tests.

Results: Of 121 patients, 94 had complete paired data. The cohort was predominantly infants, with 12 children (13.2%) aged ≥ 12 months. Mean follow-up was 3.8 months. Significant feeding improvements were observed across feeding modalities. Exclusively breastfed infants demonstrated a 14.6% mean improvement in BSES-SF scores and a 31.6% reduction in breastfeeding symptoms (both $p < 0.001$). Exclusively bottle-fed infants showed a 29.4% reduction in feeding symptoms ($p < 0.001$). Mixed-fed infants under one year showed greater symptom improvement (32.79%) than those aged ≥ 1 year (20.35%).

Conclusions: Frenotomy was associated with meaningful feeding improvement across all age groups. However, children over one year demonstrated smaller percentage improvements, suggesting that earlier intervention may confer greater benefit.

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POSTER PRESENTATIONS Group 2

P2.1	Early discharge after adenotonsillectomy: how successful is it, and what gets in the way?	Fran Naranda, Matija Daniel, Purushothaman Sudarshan	NUH NHS Trust, Nottingham, United Kingdom
P2.2	Surgical intervention in the management of recurrent epistaxis in children: A scoping review	Jessica Hardwick (Joint First Author), Olivia Hunter (Joint First Author) Frazer Lim (Joint First Author), Dickson Dewantoro, Timothy Davies, Grace Khong	University of Liverpool, Liverpool, United Kingdom. Alder Hey Children's Hospital, Liverpool, United Kingdom
P2.3	A Novel Application of Coblation in Blunt Proximal Tracheal Trauma and Ring Disruption: A Case Report	Jameela Abuhafeth, Fareed Ahmed, Sanjeev Gupta	Sheffield Children's Hospital NHS, Sheffield, United Kingdom. University of Sheffield, Sheffield, United Kingdom
P2.4	SPA ligation: a case series in the paediatric population	Foteini Stefania Koumpa, Juliet Laycock, Liam Sutton	University College London Hospital, London, United Kingdom. East Surrey Hospital, Surrey, United Kingdom. Great Ormond Street Hospital, London, United Kingdom
P2.5	Reducing Same-day Cancellations in Paediatric ENT Theatres	Medha Verma, Benjamin Kennard-Wolfe, Andrew Hoey	Queen Mary University of London, London, United Kingdom. Barts Health NHS Trust, London, United Kingdom

P2.6	withdrawn		
P2.7	Long Laryngeal Cleft Repair: A 22-Year Single-Centre Experience	Foteini Stefania Koumpa, James Johnston, Elizabeth Maughan, Liam Sutton, Colin Butler, Richard Hewitt	University College London Hospital, London, United Kingdom. Great Ormond Street Hospital, London, United Kingdom. Starship Children's Hospital, Auckland, New Zealand
P2.8	Reliability and accuracy of artificial intelligence models in supporting primary care referral decisions for paediatric ENT presentations: a blinded comparative study	Ivan Mani, Adam Garrard, Su De, Grace Khong, Samatha Goh, Sunil Sharma, Eriola Mushi	Alder Hey, Liverpool, United Kingdom. Mid Cheshire Trust, Crewe, United Kingdom
P2.9	A systematic review of the impact of material design and reprocessing on biofilm formation on tracheostomy tubes	Josh Law, William Law, Jennifer Olsen, Jason Powell	Newcastle University, Newcastle upon Tyne, United Kingdom. Imperial College London, London, United Kingdom. Great North Children's Hospital, Newcastle upon Tyne, United Kingdom
P2.10	Systemic Corticosteroid Use in Paediatric Orbital Cellulitis: A Two-Cycle Audit	Yin Sebastian Tan, Ying Ki Lee, Haytham Kubba	Royal Hospital for Children, Glasgow, United Kingdom

P2.1

Early discharge after adenotonsillectomy: how successful is it, and what gets in the way?

Fran Naranda, Matija Daniel, Purushothaman Sudarshan

NUH NHS Trust, Nottingham, United Kingdom

Main theme: general

ABSTRACT:

Background: "Getting It Right First Time" recommends a 2-4 hour postoperative stay following a tonsillectomy. We sought to establish whether our unit achieves this and to identify clinical and systemic barriers to early discharge.

Methods: Medical and nursing notes review of all 94 children undergoing day-case tonsillectomy (+/- other procedures) between September and December 2025.

Results: Overall, 28.7% of patients went home at their earliest discharge time, and 46.3% within 3.5 hours. Early discharge was more common at weekends (53.8%) than weekdays (10.9%) and, paradoxically, more common when a 2-hour stay was planned (38.6%) than 3-hours (13.5%). Children aged 2–3 years had the lowest early discharge rates. Overall, 91.1% of delays were deemed avoidable. The most common single factor was pharmacy delay, but in 56.7% more than one factor led to delay. Intracapsular tonsillectomy achieved early discharge more often (47.7%) than extracapsular (33.3%).

Conclusion: Tonsillectomy discharge at 2 hours is achievable, and most delays are at least potentially avoidable. The high success rates for weekend lists suggest that cohorting high-volume surgery improves flow. Early prescribing and dispensing of discharge medication, day-case anaesthesia, intracapsular techniques, and an appropriate staff mindset could all lead to better overall resource utilisation and shorter waiting times.

P2.2

Surgical intervention in the management of recurrent epistaxis in children: A scoping review

Jessica Hardwick (Joint First Author), Olivia Hunter (Joint First Author) Frazer Lim (Joint First Author), Dickson Dewantoro, Timothy Davies, Grace Khong

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Background: Recurrent epistaxis affects approximately 9% of children and is typically managed using topical therapies and silver nitrate cautery. Surgical intervention is reserved for refractory cases; however, there is limited evidence regarding the optimal surgical approach.

Methods: A scoping review was conducted according to a prospectively registered protocol (Open Science Framework registration ID: 9mfxz). MEDLINE, Embase, and the Cochrane Library were searched from inception to December 2025. Studies reporting surgical management of recurrent epistaxis in children (<18 years) were included. The primary outcome was recurrent epistaxis following surgery.

Results: Twelve studies comprising 553 paediatric patients met the inclusion criteria. The weighted mean age was 10.3 years. Prior to surgery, 76 patients had undergone silver nitrate cautery and 46 had received topical antiseptic cream. Coagulopathy status was variably reported, with 24 patients (4.3%) documented to have an underlying coagulopathy. Bipolar or electrical cautery was the most frequently reported intervention (225 exposures) and was associated with a recurrence rate of 19.1%. Radiofrequency coagulation demonstrated the lowest recurrence rate (2.4%; 2/83 patients), followed by microwave ablation (7.4%; 10/135 patients). Laser therapy demonstrated a recurrence rate of 26.8% (11/41 patients), while sphenopalatine artery ligation demonstrated a recurrence rate of 33.3% (4/12 patients). Overall recurrence following surgical intervention was 13.9% (72/517). No mortality was reported.

Conclusions: The literature describing surgical management of recurrent paediatric epistaxis remains limited and heterogeneous. Radiofrequency coagulation and microwave ablation demonstrated the lowest reported recurrence rates. Further prospective comparative studies are required to determine the optimal surgical management strategy.

P2.3

A Novel Application of Coblation in Blunt Proximal Tracheal Trauma and Ring Disruption: A Case Report

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Airway/Head and Neck

Introduction

Equestrian-related trauma poses a significant risk to paediatric and adolescent riders, with head and neck injuries contributing disproportionately to severe morbidity and mortality. Within ENT practice, airway involvement represents a high-risk subset of these injuries. Although uncommon, tracheal trauma is associated with rapid clinical deterioration and requires early recognition and urgent management.

Coblation is a minimally invasive technique widely used in ENT to ablate soft tissues at low temperatures through the use of radiofrequency energy and saline. Indications for its use continue to grow, with its use widely accepted for management of tracheal pathology such as granulation tissue.

Method & Results

We report the case of a 14-year-old female who sustained blunt neck trauma following a horse kick. A CT scan demonstrated disruption of the anterior proximal tracheal wall with associated subcutaneous emphysema, consistent with blunt proximal tracheal injury. Coblation was successfully utilised to manage the disrupted tracheal rings endoscopically, and the patient recovered without complication.

Conclusion

This case highlights the potential role of coblation as a novel therapeutic option in the management of tracheal ring disruption, and adds another indication for which the technology can be successfully utilised.

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P2.4

SPA ligation: a case series in the paediatric population

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Introduction

Epistaxis is a common paediatric presentation, with the majority of cases managed conservatively. In refractory cases, sphenopalatine artery (SPA) ligation offers a minimally invasive surgical option with an established evidence base in adults. However, data in the paediatric population remain limited, and a proportion of affected children have underlying haematological or coagulation disorders. This case series reports our experience with endoscopic SPA ligation at a tertiary paediatric centre.

Methods

A retrospective case series of all paediatric patients undergoing endoscopic SPA ligation at Great Ormond Street Hospital was performed. Fifteen procedures were carried out in 13 patients. Two patients underwent staged bilateral SPA ligation as separate planned procedures, rather than representing recurrence. Patient-reported symptomatic outcomes and complications were recorded.

Results

Thirteen patients underwent 15 SPA ligation procedures in total. Four patients (31%) had pre-existing haematological or coagulation defects. Twelve of 13 patients (92%) reported significant symptomatic improvement following surgery. One patient (8%) reported no improvement. No significant perioperative or postoperative complications were recorded in any patient, including those with underlying coagulopathy.

Conclusion

Endoscopic SPA ligation is an effective and well-tolerated intervention for refractory paediatric epistaxis, with a high rate of symptomatic improvement and a favourable safety profile, including in those with coagulation disorders. This series from a specialist paediatric centre supports its broader application in children and adds to the limited evidence base in this age group. Larger prospective studies are warranted to further define outcomes and refine patient selection

P2.6

Reducing Same-day Cancellations in Paediatric ENT Theatres

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Main Theme: General

Introduction: Same-day cancellations (SDCs) waste theatre capacity and compound elective surgery backlogs¹. In Q4 2025/26, NHS England reported 23,056 last-minute non-clinical elective cancellations². GIRFT recommendations emphasise timely pre-assessment and pathway review to reduce same-day surgery cancellations in ENT³.

Methods: We retrospectively reviewed paediatric ENT theatre cancellations at the Royal London Hospital between October and December 2025. SDCs were confirmed from electronic patient records. Following our intervention, we assessed SDCs between March and May 2026. SDC rates were compared using chi-square/Fisher exact tests, with Wilson 95% confidence intervals.

Intervention: From March 2026, we implemented electronic consent forms that were sent to parents 48 hours prior to surgery. These included reminder messages providing families with contact details of the scheduling team in the event their child was unwell or unable to attend their surgery.

Results: Confirmed SDCs decreased from 30/230 ENT cases (13.0%) to 19/253 (7.5%; risk difference -5.5%; $p=0.044$). Among cancelled ENT cases, SDCs decreased from 30/51 (58.8%) to 19/43 (44.2%; $p=0.157$). Cancellations because surgery was no longer needed, fell from 8/30 to 0/19 ($p=0.016$). However, administrative/capacity causes rose from 1/30 to 7/19 ($p=0.004$).

Conclusion: A 48-hour digital prompt was associated with fewer confirmed SDCs and elimination of SDCs due to resolution of symptoms. Rates were still above the NHS England average of 5%. Residual operational causes, small samples, winter baseline effects, post-cycle unknowns and inconsistent avoidability coding limit inference. Better documentation and earlier clinical review will be the focus in the next cycle.

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P2.7

Long Laryngeal Cleft Repair: A 22-Year Single-Centre Experience

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Airway

Introduction

Long laryngeal clefts (Benjamin-Inglis Grades 3 and 4) are rare congenital anomalies with significant morbidity. At Great Ormond Street Hospital, we repair these using an open approach. We present outcomes of our single-centre series over two decades.

Methods

Retrospective review of patients with Grade 3 or 4 laryngeal clefts repaired 2001–2023. Fisher's exact and Mann-Whitney U tests used as appropriate.

Results

42 patients underwent repair (24 male); 33 Grade 3, 9 Grade 4; median follow-up 47 months (IQR 19–71). Age at operation differed by grade: Grade 3 patients were older (median 204 days), typically presenting with and maintaining a pre-operative tracheostomy, whereas Grade 4 patients presented earlier (median 29 days, $p=0.036$), usually intubated rather than tracheostomised pre-operatively. Comorbidity burden was high: tracheomalacia (67%), GORD (55%), cardiac anomalies (50%). Half required pre-operative fundoplication for reflux control; 72% of Grade 3 patients (13/18) were decannulated at median 31 months (IQR 19–48), compared with none of the 3 tracheostomy-dependent Grade 4 patients. Oral feeding was achieved in 62% overall. Revision surgery was required in 45% (39% Grade 3 vs 67% Grade 4). Mortality was 7%.

Conclusion

Severe laryngeal clefts carry substantial morbidity but are generally survivable with open repair in selected cases with multidisciplinary decision-making. Grade 3 and 4 patients follow distinct airway trajectories, with Grade 4 disease associated with earlier presentation but poorer decannulation outcomes. GORD is near-universal and despite fundoplication in half, aspiration persists in half post-operatively, highlighting ongoing MDT need.

P2.8

Reliability and accuracy of artificial intelligence models in supporting primary care referral decisions for paediatric ENT presentations: a blinded comparative study

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Introduction

AI tools are increasingly accessed by primary care clinicians and parents for clinical guidance. Performance in urgent paediatric ENT referral decision-making remains largely untested, despite safety implications of mis-triage.

Methods

Ten standardised paediatric ENT primary care scenarios were developed across three urgency tiers: cannot-miss emergencies, urgent presentations, and over-triage-prone cases. Five paediatric ENT consultants independently established the consensus reference standard, with concordance to GIRFT guidance. Five AI models were tested: three consumer LLMs (GPT-5, Claude, Gemini) and two medical AI tools (ClinicalKey AI, Glass Health). Each scenario was posed three times per model on separate days, generating 150 anonymised outputs scored by two blinded raters using a pre-specified categorical checklist.

Results

Inter-rater agreement was almost perfect (Cohen's kappa=0.94). Claude achieved the highest accuracy (73.3%), followed by Glass Health (66.7%), GPT-5 and Gemini (both 56.7%). ClinicalKey AI failed structurally, unable to produce forced-choice triage (3.3%). All functional models reliably identified Tier 1 emergencies (epiglottitis, post-tonsillectomy bleed, orbital cellulitis: 100%). All models performed poorly on middle-urgency referrals: recurrent epistaxis (0% — universal under-triage to reassurance), B-symptom neck lump (20% — over-triage), and unilateral nasal symptoms (27%). Only Gemini produced unsafe major undercalls (6.7%). Test-retest consistency was 67–90%. Models did not capitulate to parental pressure.

Conclusion

AI reliably recognises paediatric ENT emergencies but under-uses routine ENT referral for symptoms warranting specialist assessment. Medical AI was not uniformly superior to consumer LLMs.

P2.9

A systematic review of the impact of material design and reprocessing on biofilm formation on tracheostomy tubes

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Theme. Airway.

Introduction. Tracheostomy is a common surgical procedure associated with increased respiratory tract infections, contributing to significant morbidity, mortality, and healthcare utilisation. Biofilm formation on tracheostomy tube surfaces is a likely contributor, as biofilms detach and seed into the airway. There is limited consensus in the literature and clinical guidelines regarding how material design and reprocessing choices influence biofilm burden.

Methods. Following PRISMA systematic review guidelines, a search was conducted across Medline, EMBASE, CINAHL, and CENTRAL databases, yielding 581 unique articles. Inclusion criteria were studies assessing biofilms on adult or paediatric tracheostomy tubes via colony counts, crystal violet assays, electron microscopy, or infrared spectroscopy, in relation to tube material, surface additives, or reprocessing methods. Case reports, animal studies, and review articles were excluded.

Results. 16 studies published between 2002 and 2025, across nine countries, were included (8 in vitro, 8 in vivo). Across five studies, no tube material, including PVC or silicone, consistently demonstrated superior biofilm resistance. Four studies evaluated biomaterial additives: antimicrobial and nanoparticle-based coatings, such as octenidine dihydrochloride, gentamicin nanoparticles, and silver oxide dual-nanostructure coatings, showed promising in vitro efficacy with acceptable cytocompatibility. Nine studies examined reprocessing methods, finding chlorhexidine consistently outperformed saline and sterile water for biofilm removal, although repeated reprocessing cycles may degrade tube surfaces and increase subsequent biofilm susceptibility.

Conclusion. Advanced biomaterial coatings represent a promising avenue for reducing tracheostomy biofilms. Chemical disinfectants can be more decisively recommended for biofilm removal. Larger-scale trials are needed to confirm safety, clinical impact, and optimal reprocessing protocols.

P2.10

Systemic Corticosteroid Use in Paediatric Orbital Cellulitis: A Two-Cycle Audit

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Main Theme: General

Introduction:

Orbital cellulitis is an infection of tissues posterior to the orbital septum, most commonly arising from sinusitis in children. If untreated, it can lead to complications including cavernous sinus thrombosis, visual loss, and death. Although intravenous antibiotics remain the mainstay of treatment, the role of systemic corticosteroids is less well established. This two-cycle audit evaluated corticosteroid use in children with orbital cellulitis.

Methods:

A retrospective audit was conducted from January 2025 to April 2026 at the Royal Hospital for Children Glasgow. Paediatric patients with preseptal or orbital cellulitis were identified from handover lists. Clinical Portal and HEPMA records were reviewed to determine corticosteroid use, including steroid type, dose, route, and frequency.

Results:

The total patient population had a median age of 3.2 years, with a M:F gender ratio of 1.75:1. In cycle 1 (January–August 2025), 31 patients with preseptal or orbital cellulitis were identified. Six (19.4%) received systemic corticosteroids. Median length of stay was 5 days in the steroid group versus 2 days in the non-steroid group. Following protocol revision in November 2025 to consider corticosteroid use, cycle 2 (November 2025–April 2026) identified 24 patients, of whom four (16.7%) received steroids. Median length of stay was 4.5 days in the steroid group and 3 days in the non-steroid group.

Conclusion:

Systemic corticosteroids were used infrequently despite protocol revision. Further dissemination of the updated protocol and a third review are planned to assess uptake and support future evaluation of corticosteroid use in orbital cellulitis.

POSTER PRESENTATIONS Group 3

P3.1	Seasonal variation in paediatric tonsillectomy outcomes: A retrospective analysis of 349,993 tonsillectomies.	Adam Garrard, Timothy Davies, Hollie Davies, Su De	Alder Hey Hospital, Liverpool, United Kingdom. NHS England and NHS Improvement, Leeds, United Kingdom
P3..2	Improving the Management Pathway for Paediatric Nasal Fractures	Yeshaa Mirani, Dickson Dewantoro, Su De	Alder Hey Children's Hospital, Liverpool, United Kingdom
P3.3	3.5 Years of Experience in Endoscopic Laryngeal Cleft Repair in Leeds Children's Hospital. Should Pathophysiology Guide Surgical Management?	Natasha Quraishi, Elizabeth Kershaw, Sarah O'Donnell, Aikaterini Dritsoula	Paediatric ENT Department, Leeds Children's Hospital, Leeds Teaching Hospitals NHS Trust, Leeds, United Kingdom
P3.4	Electrical Vestibular Stimulation in Children: A Tolerability and Feasibility Study	Peter Gaskell, Sophie Prosser, Richard Irving, Raymond Reynolds	University of Birmingham, Birmingham, United Kingdom. University Hospitals Birmingham, Birmingham, United Kingdom. Birmingham Children's Hospital, Birmingham, United Kingdom
P3.5	Intrafamilial Variable Expressivity in Waardenburg Syndrome: Bilateral Hearing Loss in Two Siblings Against a Background of Unilateral Involvement Across Three Generations	Samantha Jia Qi Lee, Bebek Bhattarai, Haytham Kubba, Juan Mora	University of Glasgow, Glasgow, United Kingdom. Royal Hospital for Children, Glasgow, United Kingdom. NHS Scotland, Greater Glasgow and Clyde, United Kingdom

P3.6	Making Noise About Misophonia: Improving staff awareness and action about Misophonia in paediatric settings	Ashlea O'Grady, Thomas Hampton, Sunil Sharma	University of Liverpool, Liverpool, United Kingdom. Alder Hey, Liverpool, United Kingdom
P3.7	Risks and implications of paediatric tracheostomy – beyond the consent form	Vasudha Sethuraman, Keya Bajaj, Shanuga Rubaraj, Nilesh Vakharia	Colchester General Hospital, East Suffolk and North Essex NHS Foundation Trust, Colchester, United Kingdom. St George's University of London, London, United Kingdom. Anglia Ruskin University, Chelmsford, United Kingdom. Victoria Hospital, Kirkcaldy, NHS Fife, Kirkcaldy, United Kingdom
P3.8	Paediatric Button Battery Ingestion – Successful Implementation of a Regional, Standardised, Multi-Specialty, Multi-Centre Emergency Management Protocol in the West Midlands	Thomas Yeung, Neil Giblett	Royal Stoke University Hospital, Stoke-on-Trent, United Kingdom. New Cross Hospital, Wolverhampton, United Kingdom
P3.9	Rare case of papillary thyroid carcinoma developing from a thyroglossal duct cyst complicated by laryngeal compression – diagnostic and therapeutic approach	Matei-Corneliu Deleanu	'Marie Sklodowska Curie' National Children Emergency Hospital, Bucharest, Romania
P3.10	Paediatric Pre-Clival Abscess with Associated Skull Base Osteomyelitis and Lemierre's Syndrome – Diagnostic Challenges and Surgical Management	Adam McClean, Sheneen Meghji	Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom

P3.1

Seasonal variation in paediatric tonsillectomy outcomes: A retrospective analysis of 349,993 tonsillectomies.

Adam Garrard, Timothy Davies, Hollie Davies, Su De

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Main Theme: General

Introduction:

Seasonal changes in infection burden, environmental conditions and healthcare utilisation may influence recovery after paediatric tonsillectomy. This study examined whether postoperative outcomes following paediatric tonsillectomy in England varied by season.

Methods:

A retrospective observational study was performed using national aggregate data derived from Hospital Episode Statistics and Office for National Statistics data. Paediatric tonsillectomies between 1 April 2012 and 31 March 2025 were included. Outcomes were length of stay (LOS) ≥ 2 nights, all-cause 30-day emergency readmission, readmission with bleeding, surgical arrest of post-tonsillectomy bleeding (PTB), readmission with infection, and readmission with pain. Pairwise seasonal comparisons were performed using Pearson chi-squared tests with Holm correction for multiple testing.

Results:

A total of 349,993 paediatric tonsillectomies were analysed. Overall, 3.21% had LOS ≥ 2 nights, 6.73% had 30-day emergency readmission, 4.42% had readmission with PTB, 0.78% underwent surgical arrest of PTB, 0.67% had readmission with infection, 0.70% had readmission with pain. LOS ≥ 2 nights was significantly higher in Winter Vs. Summer (RR 1.081), Winter Vs. Autumn (RR 1.091), Spring Vs. Summer (RR 1.133) and Spring Vs. Autumn (RR 1.143). LOS ≥ 2 nights differences were most prominent in the 0-2 & 3-4 age groups. Bleeding-related outcomes showed no robust overall seasonal variation.

Conclusion:

A clear, albeit modest seasonal effect was demonstrated on LOS ≥ 2 nights, particularly in younger children, whereas bleeding outcomes showed little consistent overall seasonal variation.

P3.2

Improving the Management Pathway for Paediatric Nasal Fractures

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Main Theme: Rhinology

Introduction:

Paediatric nasal fractures are the most common facial fractures in children and require timely assessment to ensure good cosmetic and functional outcomes. ENT UK recommends specialist review within 3–7 days of injury. In children, fracture healing occurs more rapidly than in adults, making earlier intervention essential to maximise the opportunity for successful fracture reduction¹. This audit evaluated compliance with national guidance and identified opportunities to improve the referral pathway to ENT.

Methods:

A retrospective audit was conducted of children referred to the paediatric ENT emergency clinic with suspected nasal fractures between June and September 2025. Data collected included attendance, fracture confirmation, timing of referral and assessment, and subsequent management.

Results:

Forty-three children were referred, of whom 34 attended clinic. Fourteen had confirmed nasal fractures. Nine underwent fracture reduction (seven under local anaesthetic and two under general anaesthetic), one declined treatment, and four were unsuitable for manipulation because they presented outside the optimal treatment window. The mean interval from injury to referral was five days. Only 12 patients were assessed within seven days of injury, while the longest delay was 60 days. 9 represented to the emergency department following their initial attendance.

Conclusion:

This audit identified significant delays within the referral pathway, resulting in poor compliance with national guidance and missed opportunities for fracture manipulation. To address this, a patient initiated follow up pathway with QR linked patient information has been developed to improve awareness, facilitate timely specialist review, reduce delays, and improve service efficiency.

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P3.3

3.5 Years of Experience in Endoscopic Laryngeal Cleft Repair in Leeds Children's Hospital. Should Pathophysiology Guide Surgical Management?

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Main Theme: Airway

Introduction

Laryngeal clefts are rare congenital structural abnormalities creating a gap between the larynx and oesophagus, arising from failure of the tracheoesophageal septum to develop. Symptoms include coughing and choking when feeding and aspiration leading to respiratory infections. Relation with genetic syndromes and neuromuscular disease¹ complicates identifying if the structural gap or the associated functional swallowing issues are at fault, raising the question: should pathophysiology guide surgical management?

Methods

Retrospective review of laryngeal cleft repairs over 3.5 years. Data extracted included demographics, presentation, co-morbidities, operative findings, surgical technique and outcomes.

Results

17 laryngeal cleft repair cases were identified. 82% of children were male. Age distribution was 2-12 years. 82% had choking followed by 76% with unsafe swallow then 65% with recurrent chest infections. 18% had no co-morbidities, the remainder had gastrointestinal, neurological and/or respiratory comorbidities. All had type 1 laryngeal cleft, 41% had additional airway anomalies. 41% of repairs were performed endoscopically and 59% microscopically. Children with lack of overall symptom improvement had a greater prevalence of co-morbidities in comparison to children with overall symptom improvement (100% vs 70%).

Conclusion

Surgical repair of type 1 laryngeal clefts can confer great benefit² and should be considered especially if morbidity is high with recurrent chest infections. Pathophysiology is important for decision-making to proceed to surgery and parents/carers should be consulted accordingly. If symptoms are due to functional swallowing issues rather than the structural gap of the laryngeal cleft then the risk of lack of improvement is higher.

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P3.4

Electrical Vestibular Stimulation in Children: A Tolerability and Feasibility Study

Peter Gaskell, Sophie Prosser, Richard Irving, Raymond Reynolds

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Main Theme: Otology

Introduction

Electrical vestibular stimulation (EVS) evokes a torsional eye movement that can be used to estimate peripheral vestibular function (1,2). Although EVS has been used in adults, its use in children has not been explored (3). The primary aim was to assess tolerability in children and the feasibility of obtaining ocular data suitable for vestibular assessment.

Methods

Twenty-eight healthy children aged 8–16 years (15 boys, 13 girls; mean age 11 ± 2.5 years) received sinusoidal EVS (0.5 Hz, 15 s) while fixating a LED in a darkened booth. Current intensity was increased from 0.5 to 4 mA as tolerated. After each test, participants rated difficulty keeping their eyes open (E), vestibular sensation (V), and skin sensation (S) on a 0–10 scale. Ocular torsion was recorded using Interacoustics VisualEyes goggles (Middlefart, Denmark). Where data quality permitted, responses were quantified using the peak Fast Fourier Transform magnitude at 0.5 Hz.

Results

71% of children (20/28) tolerated 4 mA, while 89% (25/28) tolerated 2 mA. Mean discomfort ratings at 4 mA were $E=1.7$, $V=3.2$, and $S=3.5$; corresponding values at 2 mA were $E=1.7$, $V=2.9$, and $S=2.2$. 50% of children produced usable eye-tracking data at 4mA. Data quality was limited by blinking, distraction, and loss of eye tracking.

Conclusion

EVS is well tolerated in children and shows promise as a rapid assessment of peripheral vestibular function. Further work is needed to optimise testing conditions and improve eye tracking reliability.

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P3.5

Intrafamilial Variable Expressivity in Waardenburg Syndrome: Bilateral Hearing Loss in Two Siblings Against a Background of Unilateral Involvement Across Three Generations

Samantha Jia Qi Lee, Bebek Bhattarai, Haytham Kubba, Juan Mora

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Main Theme: Otology

Introduction: Waardenburg syndrome (WS) is a genetic condition that is commonly inherited in an autosomal dominant manner. Hallmark presentations of WS include congenital hearing loss, heterochromia, hypertelorism and a white forelock. There are four types of Waardenburg syndrome, usually distinguished by their presentation and genetic cause. Sensorineural hearing loss (SNHL) is a prevalent feature of individuals with WS.

Methods: This case reports 2 sisters with Type 1 WS (WS1). Medical records were obtained through online databases. Family tree diagrams were constructed to demonstrate the inheritance pattern.

Results: The older sister, Child A presents with a white forelock, dystopia canthorum, heterochromia irides and a flat nasal bridge. She had a bilateral Universal Newborn Hearing Screen (UNHS) referral result, following which diagnostic testing revealed bilateral SNHL. This differed from prior family history of WS presenting with unilateral hearing loss. The type of WS was concluded to be familial heterozygous PAX3 c.274G>T p/(glu92*) pathogenic variant. The younger sister also had bilateral referral UNHS results and bilateral SNHL on diagnostic testing. The same pathogenic variant was detected— consistent with her mother and older sister.

Conclusion: Child A and B's mother, grandmother and great-grandfather displayed unilateral H. Child A and B, however, both presented with bilateral HL. Hearing loss has appeared in 4 generations of the family. Penetrance of SNHL in WS1 was found to be 69% in a study by Newton and interfamilial variation in penetrance has been showed to be very wide in families with WS1.

P3.6

Making Noise About Misophonia: Improving staff awareness and action about Misophonia in paediatric settings

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Otology

Misophonia is a disorder characterised by intense emotional and physiological responses to specific trigger sounds. Despite increasing recognition in the literature, its awareness and management within paediatric hearing health services remain unclear. This study aimed to evaluate clinicians' awareness, experience and documentation practices relating to misophonia in paediatric ENT and audiology settings.

Methods

A cross-sectional survey was conducted among clinicians working in paediatric ENT and audiology services, including audiologists, ENT doctors and nursing staff. A structured questionnaire explored participants' knowledge of misophonia, confidence in identifying the condition, clinical experience with affected patients, current documentation practices, and interest in further training or resources.

Results

Awareness of misophonia amongst paediatric hearing health professionals was extremely limited. Confidence in identifying the condition was low, and no respondents reported formally recognising misophonia in clinical practice. Although some clinicians had encountered behaviours consistent with sound sensitivity, these presentations were not attributed to misophonia. Documentation practices were informal, with no standardised assessment tools, documentation processes or referral pathways identified. Despite these findings, all participants expressed interest in receiving further education, training and clinical resources to support recognition and management of the condition.

Conclusion

Awareness, recognition and documentation of misophonia within paediatric ENT and audiology services appear limited. The absence of standardised documentation practices and referral pathways may contribute to under-recognition of affected children. Our findings highlight the need for targeted clinician education, development of standardised assessment and documentation approaches, and further research to support earlier identification and appropriate management of paediatric misophonia.

P3.7

Risks and implications of paediatric tracheostomy – beyond the consent form

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Abstract

Introduction

Paediatric tracheostomy is a critical intervention, with approximately 1,200 procedures performed annually in the UK. Whilst immediate operative risks are routinely discussed, the profound long-term social, psychological, and financial impacts on the family unit are frequently overlooked during the consent process.

Methods

A comprehensive literature review was conducted to evaluate not only the operative complications, but also caregiver burden, and the wider biopsychosocial impacts of paediatric tracheostomy. We contrasted adult versus paediatric care demands and examined medico-legal frameworks governing informed consent.

Results

Paediatric tracheostomies carry an approximate 40% complication rate, most notably accidental decannulation and mucous obstruction—exacerbated by narrow tubes lacking inner cannulas. Beyond physiological risks, the necessity of 24-hour airway monitoring imposes severe psychological strain on caregivers, leading to hyper-vigilance, anxiety, sleep deprivation, and strained family dynamics. Caregivers frequently experience "financial toxicity" due to employment reduction and indirect medical costs. Families routinely report feeling overwhelmed and unprepared during transition to life at home, exposing significant limitations in traditional surgical consent models that focus narrowly on operative morbidity.

Conclusion

Consent for paediatric tracheostomy must go beyond procedural risks to reflect a complex biopsychosocial commitment. Integrating staged, multidisciplinary counselling—explicitly addressing psychological distress, financial costs, and 24-hour caregiving burdens—is essential to fulfil ethical obligations and properly equip families for the long-term reality of tracheostomy management.

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P3.8

Paediatric Button Battery Ingestion – Successful Implementation of a Regional, Standardised, Multi-Specialty, Multi-Centre Emergency Management Protocol in the West Midlands

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Main theme: General

Introduction

Button battery (BB) ingestion in children is a rare but time-critical emergency with potentially fatal complications. In oesophageal impaction, emergency removal in theatre is paramount, however at the time of writing there is no gold-standard Ear, Nose and Throat (ENT) nor paediatric consensus on primary interventions and peri-operative management. The use of oral sucralfate, nasogastric tube (NGT) insertion and post-removal imaging differs significantly between centres. To standardise peri-operative care, we have designed and successfully implemented an evidence-based regional management protocol within the West Midlands.

Methods

A survey was distributed to ENT consultants ascertaining regional variation in practice. The survey enquired whether ingested BBs were removed on-site or transferred to a tertiary unit, and peri-operative measures taken. Whether a standardised protocol would be beneficial, was included. Recommendations in a European Paediatric position paper were evaluated. [1]

Results

5.9% of consultants (n = 17) agreed that a regional consensus currently existed. 82.4% strongly agreed a regional protocol would positively impact clinical outcomes. Accordingly, a comprehensive protocol was designed, with a management flowchart incorporating BB location, clinical stability, and logistics for inter-hospital transfer. Sucralfate administration, NGT insertion, acetic acid irrigation, antibiotic prophylaxis and post-removal imaging guidelines were included.

Conclusion

Following promising consultant stakeholder support, a comprehensive, standardised evidence-based emergency management protocol for paediatric BB ingestion has been implemented regionally. Since, real-world application of the protocol has been demonstrated following a case of BB ingestion managed with successful outcome. Review of prospective multi-regional data will guide the path ahead.

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P3.9

Rare case of papillary thyroid carcinoma developing from a thyroglossal duct cyst complicated by laryngeal compression – diagnostic and therapeutic approach

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Thyroglossal duct cyst is one of the most common benign tumors located in the cervical region, with most studies estimating its incidence in the general population at 5–7%. Of all patients undergoing excision of a thyroglossal duct cyst, fewer than 1% show malignant cellular changes, which are generally discovered incidentally on histopathological examination.

Case presentation: A 14-year-old female patient was referred to the emergency department from a private hospital for an anterior cervical mass that had first appeared 4 months earlier and had increased in size over the previous month and a half. The patient also presented with dysphonia, dysphagia, and marked nocturnal stertor. At the private hospital where she initially presented, she had been diagnosed with a thyroglossal duct cyst and surgery was planned. During the attempt to insert the ETT, the anesthesiologist observed a large laryngeal deformity and decided to stop the procedure. At our center, the patient underwent ultrasound, flexible nasopharyngolaryngoscopy (which revealed a large mass in the right hemilarynx), contrast-enhanced cervical CT, and cervical MRI. Despite all these investigations, it was not possible to establish with certainty the origin of the tumor (cervical or laryngeal), and an exploratory cervicotomy with excision of the lesion was therefore performed. The preliminary pathological result established the diagnosis of a thyroglossal duct cyst, but a more detailed evaluation revealed malignant changes in one region of the specimen.

This case represents a diagnostic first for our center and required a collective effort from everyone involved: ENT surgeons, radiologists, and pathologists.

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3.10

Paediatric Pre-Clival Abscess with Associated Skull Base Osteomyelitis and Lemierre's Syndrome – Diagnostic Challenges and Surgical Management

Adam McClean, Sheneen Meghji

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Introduction

Pre-clival abscesses are rare, life-threatening infections, often developing secondary to central skull base osteomyelitis. Sources of infection include otitis media, sinusitis, and dental infections. Clinical presentation is variable, potentially leading to delayed diagnosis and complications including cranial nerve palsies and spinal cord compression. The objective of this case report is to discuss the diagnostic challenges of this condition, and demonstrate a safe, effective surgical technique for its management.

Methods

We report the case of A five-year-old female presenting with headaches, neck stiffness, fever, and sore throat. Initially treated as meningitis. CT scanning demonstrated no intracranial abnormality. Following no improvement with medical management and the development of an abducens nerve palsy, an MRI was performed, revealing extensive skull base osteomyelitis, a large pre-clival abscess, and thromboses in the cavernous sinuses and right internal jugular vein. Surgical drainage was achieved using trans-oral coblation under direct vision with a trans-nasal endoscope. Postoperatively, she was treated with intravenous antibiotics and anticoagulation therapy.

Results

Surgical drainage and subsequent antibiotic and anticoagulant therapy led to full clinical recovery. The chosen surgical technique allowed for a bloodless operative field, minimal surrounding tissue damage, and reduced post-operative pain. Microbiological testing identified *Fusobacterium necrophorum*, confirming Lemierre's syndrome.

Conclusion

This case highlights the diagnostic complexity of paediatric pre-clival abscesses. Early surgical intervention and prolonged antibiotic therapy, along with consideration of anticoagulation in cases of thrombosis, are crucial for optimal recovery. The use of coblation for surgical drainage offers a promising, minimally invasive option for accessing and treating these abscesses.

POSTER PRESENTATIONS Group 4

P4.1	withdrawn		
P4..2	Evaluating a GP-led Rhinology Clinic for Paediatric Patients	Siham Mohamed Shamsudeen, Cristina Warren, Lisa O'Bryne, Nadia Van Den Berg, Colleen Heffernan	Children's Health Ireland at Temple Street, Dublin, Ireland. Grangegorman Family Practice, Dublin, Ireland
P4.3	Family Life Impacts of Paediatric Respiratory Papillomatosis Study (FLIPPer)	Ellen Hardy, Adam Donne, Dan Hawcutt	University of Liverpool, Liverpool, United Kingdom. Alder Hey Children's, Liverpool, United Kingdom
P4.4	A Hidden Airway Threat: Emergency Management of a Congenital Cervical Teratoma in the Neonatal Period	Adam McClean, Sheneen Meghji	Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom
P4.5	withdrawn		

P4.6	Small Airways, Big Distances: Logistics and Outcomes of Paediatric Inhaled Foreign Body Removal across Queensland, Australia	Harry Crook, Christian Inglis, Rahul Thomas, Ajay Kevat, Gareth Lloyd	University of Oxford, Oxford, United Kingdom. Department of Respiratory and Sleep Medicine, Queensland Children's Hospital, Brisbane, Australia. Australian Centre for Health Services Innovation, Queensland University of Technology, Brisbane, Australia. Department of Otolaryngology Head and Neck Surgery, Queensland Children's Hospital, Brisbane, Australia
P4.7	Primary Surgical Repair of Paediatric Unilateral Choanal Atresia: A Systematic Review and Meta-Analysis	Vedika Dhunoo, Arshad Zubair, Grace Khong	Department of Paediatric Otolaryngology, Alder Hey Children's NHS Foundation Trust, Liverpool, UK, Liverpool, United Kingdom
P4.8	Quality Improvement: Improving Paediatric Airway Emergency Skills through Refresher Training in a District General Hospital	Thomas Yeung, Nur Wahid, Deepak Kumar, Raina Lele, Attila Dezso, Sheneen Meghji, Neil Giblett	Royal Stoke University Hospital, Stoke-on-Trent, United Kingdom. Walsall Manor Hospital, Walsall, United Kingdom. Keele University School of Medicine, Newcastle-under-Lyme, United Kingdom. Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom. New Cross Hospital, Wolverhampton, United Kingdom
P4.9	Introducing a new service for awake ventilation tube insertion in children	Catalina Florea, Haytham Kubba	Royal Hospital for Children, Glasgow, United Kingdom
P4.10	A Bloody Induction: Diffuse Alveolar Haemorrhage in a Child with Severe Obstructive Sleep Apnoea	Adam McClean, Rukmini Ghosh, Yash Meghani, Sheneen Meghji	Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom

P4.2

Evaluating a GP-led Rhinology Clinic for Paediatric Patients

Siham Mohamed Shamsudeen, Cristina Warren, Lisa O'Bryne, Nadia Van Den Berg, Colleen Heffernan

Children's Health Ireland at Temple Street, Dublin, Ireland. Grangegorman Family Practice, Dublin, Ireland

Main Theme: Otology

Background:

A GP-led rhinology clinic was introduced in the ENT Department at Children's Health Ireland (CHI), Temple Street, to manage patients aged 9 or older with epistaxis and patients aged 12 or older with nasal obstruction/congestion. This study aimed to evaluate the service, including parental satisfaction.

Methods:

The prospective database of patients directed to this service was analyzed to determine the number of patients seen and their outcomes. An anonymized electronic survey (SurveyMonkey) was sent to all patients who attended the clinic, with approval from the CHI Research Ethics Committee.

Results:

78 patients met the inclusion criteria for the service. 5 patients accepted the appointment but then did not attend. 1 patient declined an appointment because the issue had resolved. 1 patient preferred to remain on the consultant waiting list. 7 patients were referred to the consultant clinic by the GP for further evaluation. 54 patients were successfully discharged following GP-led management. Survey responses indicate that most families reported high levels of satisfaction with the clinic.

Conclusion:

A GP-led rhinology clinic may provide a safe and efficient pathway for managing selected pediatric rhinology referrals while preserving consultant capacity for more complex cases. High levels of patient and family satisfaction support the continued development of this model of care.

P4.3

Family Life Impacts of Paediatric Respiratory Papillomatosis Study (FLIPPer)

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Background

Recurrent Respiratory Papillomatosis (RRP) is a chronic condition characterised by the growth of papillomas in the airway which may cause breathing difficulties and vocal changes. Patients often undergo repeated surgeries and adjuvant therapies to control the effects.

Whilst treatment options are well researched, there is limited understanding of the broader impact, which may be explored through the parental perspective.

Methods

A qualitative study was conducted, using a semi-structured narrative interview with parents of children with RRP. Interviews were recorded, transcribed and thematically analysed. Background characteristics were collected to contextualise findings.

Results

Five parents of four children were interviewed: three individually and two jointly. The children had a mean of 8.75 years since diagnosis, and averaged treatments biannually.

Analysis revealed five overarching themes: Medical Concerns, Parental Experiences, Direct Impact on the Child, Challenges, and Support Systems; with 13 subthemes.

Parents described balancing their emotional responses with remaining strong for their children; educational disruptions due to treatments; and concerns for the future. Experiences commonly focused on vocal changes; the long-term impact on education, and admiration for their child's resilience. Disease severity impacted experiences, with more frequent interventions linked to greater disruption on careers, family life and education.

Conclusion

Though the rarity of RRP limited the participant pool, this study highlights RRP's impact beyond physical symptoms, into educational, emotional and social domains. Overlapping themes reflect the multifaceted effect, underscoring the need for holistic support strategies to mitigate the broader burden.

P4.4

A Hidden Airway Threat: Emergency Management of a Congenital Cervical Teratoma in the Neonatal Period

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Abstract

Introduction

Congenital cervical teratomas are rare neonatal tumours, occurring in approximately 1 in 30,000 live births. They pose significant diagnostic and management challenges due to the risk of life-threatening airway obstruction. Antenatal polyhydramnios may be an early indicator of upper aerodigestive tract compression; however, prenatal diagnosis can be missed. Early recognition and surgical intervention are essential to optimise outcomes.

Methods

A neonate was delivered at a peripheral hospital with an 8x7x7cm lateral neck mass that had not been identified antenatally despite documented polyhydramnios. Within hours of birth, the infant developed acute respiratory distress progressing to periods of apnoea. Following resuscitation and intubation, the patient was transferred to a tertiary paediatric intensive care unit (PICU). MRI demonstrated a large mixed solid-cystic lesion with vascular components, with a broad differential diagnosis.

Results

Following multidisciplinary team discussion, definitive surgical excision was performed on day four of life. Complete macroscopic resection was achieved. Histopathology confirmed a mature cervical teratoma. The infant was extubated post-operatively but required reintubation 48 hours later following seizure activity. Successful extubation was subsequently achieved, and the patient was discharged from PICU six days postoperatively. A vocal cord palsy and feeding difficulties resolved with conservative management, including nasogastric feeding and speech and language therapy.

Conclusion

Congenital cervical teratomas should be suspected in neonates presenting with a lateral neck mass and a history of polyhydramnios. Antenatal diagnosis allows consideration of Ex-utero intrapartum treatment (EXIT) when airway compromise is anticipated. Early multidisciplinary involvement and surgical excision in a specialist centre are critical.

P4.6

Small Airways, Big Distances: Logistics and Outcomes of Paediatric Inhaled Foreign Body Removal across Queensland, Australia

Harry Crook, Christian Inglis, Rahul Thomas, Ajay Kevat, Gareth Lloyd

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Abstract

Main Theme: Airway

Introduction

Inhaled foreign body (IFB) is a serious condition for which bronchoscopy is the diagnostic and therapeutic gold standard. Queensland Children's Hospital (QCH) is the tertiary referral service for paediatric bronchoscopy in Queensland, an area seven times larger than the United Kingdom. We describe the methods of retrieval to QCH and compare patients retrieved with those presenting locally.

Methods

We conducted a retrospective cohort study at QCH. Children with suspected IFB from January 2018- December 2024 were included. Data analysed included mode and timeline of retrieval, clinical features, and complications.

Results

345 children underwent bronchoscopy with median age of 19 months (IQR 13–33); 167 (48.4%) had IFB found. 190 (55%) children were retrieved from other centres. 100 (53%) retrieved patients had IFB, compared to 66 (43%) non-retrieved. Retrieval modes were ambulance (122), private car (21), aeroplane (26) or helicopter (13). Children were retrieved from small rural and remote hospitals; regional and metropolitan non-tertiary centres; 12 (6%) were transferred interstate. Mean time from presentation to arrival at QCH was 12.4 hours. On arrival at QCH, 90% of patients' X-Ray findings had changed from earlier imaging. During follow up, 4 (3%) non-retrieved patients developed Bronchiectasis, compared to 2 (1%) retrieved patients. There were no mortalities in the retrieval group.

Conclusion

Retrieving paediatric patients with IFB to a tertiary centre that covers a large geographical area is complex. Reviewing the retrieval pathway and patients' clinical features gives opportunity to evaluate this process.

P4.7

Primary Surgical Repair of Paediatric Unilateral Choanal Atresia: A Systematic Review and Meta-Analysis

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Introduction

Unilateral choanal atresia (UCA) is a congenital posterior nasal obstruction with an incidence of 1 in 5,000–8,000 live births. Despite being twice as common as bilateral disease, optimal surgical technique and outcomes remain poorly defined. This systematic review and meta-analysis evaluated the effectiveness and safety of surgical repair for UCA.

Methods

A PRISMA-compliant systematic review was registered on PROSPERO (CRD420261336288). Multiple databases were searched for studies published between 2000 and 2026. Eligible studies included paediatric patients (0–18 years) with UCA undergoing primary surgical repair; revision surgeries were excluded. Methodological quality was assessed using the Newcastle-Ottawa Scale (NOS) and meta-analysis of pooled restenosis rates was performed.

Results

Twenty-nine studies encompassing 709 UCA patients from 18 countries were included. Transnasal endoscopic choanoplasty was the predominant approach; stents were used in 18 studies (62.1%) and mitomycin C in 13 (44.8%). The pooled restenosis rate was 18.7% (range 0–72%). Mucosal flaps were employed in 13 studies (44.8%), with a lower mean restenosis rate than non-flap studies (9.9% vs. 26.2%), though not statistically significant ($p = 0.207$). Age at surgery did not correlate with restenosis (Spearman $\rho = -0.26$, $p = 0.254$). NOS assessment rated 14 studies (48.3%) as good quality and 15 (51.7%) as fair; none were poor.

Conclusions

UCA repair carries a restenosis rate of 18.7%. Mucosal flap use was associated with a clinically meaningful reduction in restenosis, and age at surgery did not predict outcome. Prospective comparative studies with standardised outcome reporting are needed to define optimal management.

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P4.8

Quality Improvement: Improving Paediatric Airway Emergency Skills through Refresher Training in a District General Hospital

Thomas Yeung, Nur Wahid, Deepak Kumar, Raina Lele, Attila Dezso, Sheneen Meghji, Neil Giblett

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Main Theme: Airway

Introduction

Paediatric airway emergencies are high-stakes, infrequent events that generate significant anxiety among ENT surgeons across all grades. [1] Limited exposure during training compounds this, particularly in District General Hospitals (DGHs). A regional face-to-face refresher course was developed and delivered to ENT and anaesthetic colleagues at Walsall Manor Hospital to address technical proficiency and confidence in paediatric airway management.

Methods

Three plenaries covered paediatric airway scenarios, managing difficult cases in a DGH, and rigid bronchoscopy and paediatric tracheostomy principles. A practical session involved bronchoscope assembly and simulated foreign body removal. Pre- and post-session surveys used 5-point Likert scales to assess confidence. A separate survey evaluated ENT scrub nurses' familiarity with bronchoscope assembly. Concurrently, the paediatric bronchoscope tray was audited to assess equipment readiness for clinical use.

Results

Audit of the paediatric bronchoscope tray identified missing components, rendering it unfit for emergency use; a new bronchoscope was subsequently procured. Among 17 clinicians, confidence in performing rigid bronchoscopy increased by 58.9% (23.5% pre- to 82.4% post-session). All attendees reported improved understanding of paediatric airway scenarios and bronchoscopy principles; 94.1% reported improved confidence managing difficult DGH cases. None of the scrub nurses (n=6) had previously assembled a bronchoscope; 83.3% reported low confidence, and all felt a course would benefit their practice.

Conclusion

This quality improvement initiative identified critical gaps in both equipment readiness and clinical skills. Bronchoscope tray audit prompted essential procurement; simulation training yielded significant gains in proficiency and confidence. Future follow-up will assess long-term impact on clinical practice.

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P4.9

Introducing a new service for awake ventilation tube insertion in children

Catalina Florea, Haytham Kubba

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Innovation

Introduction

Otitis media with effusion is the commonest disease of childhood. The associated hearing loss can affect language, education and socialisation. Ventilation tubes (VTs) normalise hearing but the waiting list in many hospitals is long. Awake outpatient VTs could be a quicker solution for selected children. We present our experience of setting up this service.

Method

(1) Permission from the clinical governance committee for new interventional procedure, (2) business case for funding of new equipment, (3) compare options for topical anaesthesia (EMLA, co-phenylcaine, phenol) and means of application, (4) trial the rapid VT insertion device (Solo +, Karl Storz Ltd) on suitably-consented children undergoing VT insertion under GA to familiarise with technique, and compare microscope vs endoscope, (5) finalise protocol, (6) Clinics: pre Solo with 7 slots and Solo with 6 slots, (7) disseminate referral criteria

Results

The final protocol comprises: microscope, topical phenol applied with orange top fine bacteriology swab and VT insertion with the Solo+ device. Referral criteria are: neurotypical children aged 10-16 with uni/bilateral OME or recurrent AOM, no ear wax, normal canals and nil significant TM retractions. Attempted VT insertion in 9 children (4 boys, 5 girls, age 10 to 16 years, median 13 years). Successful attempts in 8 cases. One case refused. All children and families very happy with the procedure.

Discussion

We continue to refine our process as we gain experience, and we may reduce our minimum age criterion in due course. For selected children, awake VT insertion is an excellent option.

P4.10

A Bloody Induction: Diffuse Alveolar Haemorrhage in a Child with Severe Obstructive Sleep Apnoea

Adam McClean, Rukmini Ghosh, Yash Meghani, Sheneen Meghji

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Abstract

Introduction:

Diffuse alveolar haemorrhage (DAH) is a rare, life-threatening condition characterised by haemoptysis, hypoxaemia, and respiratory failure. Aetiologies are diverse and include negative-pressure pulmonary oedema secondary to upper airway obstruction. While obstructive sleep apnoea (OSA) is a common cause of intermittent upper airway obstruction in children, DAH associated with OSA is rarely reported. We present a case of DAH occurring during induction of anaesthesia in a child with severe OSA.

Methods:

A 7-year-old boy with obesity, autism spectrum disorder, and severe OSA was admitted for sleep nasendoscopy and revision adenotonsillectomy. Dexmedetomidine was administered preoperatively because of behavioural challenges. Following inhalational induction with sevoflurane, profound oxygen desaturation occurred. Video laryngoscopy revealed brisk haemorrhage arising from the trachea. The patient was intubated but subsequently developed pulseless electrical activity. Cardiopulmonary resuscitation was initiated, with return of spontaneous circulation achieved within one minute following chest compressions and adrenaline administration. Bronchoalveolar lavage confirmed diffuse lower airway haemorrhage. Surgery was abandoned, and the patient underwent CT angiography before transfer to the paediatric intensive care unit.

Results:

The patient was intubated and ventilated for seven days with positive-pressure support, inotropic therapy and tranexamic acid infusion. High-dose methylprednisolone was given to address the differential diagnosis of a sevoflurane-associated reaction. Revision adenoidectomy was successfully completed on day five, and the patient was extubated on day seven.

Conclusion:

DAH should be considered in children with severe OSA who develop acute respiratory compromise during anaesthetic induction. Early recognition, airway control, multidisciplinary management, and cardiorespiratory support are critical to achieving favourable outcomes.

POSTER PRESENTATIONS Group 5

P5.1	Reducing paediatric post-tonsillectomy readmissions: can enhanced analgesia education make a difference?	Naining Xu, Riya Manandhar, Ileana Anderco	Blackpool Victoria Hospital, Blackpool, United Kingdom
P5..2	Paediatric case of Nasopharyngeal granular cell lesion	Sara Ibrahim, Ayla Tabaksert, Claire McLarnon	Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle upon Tyne, United Kingdom
P5.3	Vincristine-Induced Vocal Cord Paralysis in Children: A Large Case Series and Evaluation of Laryngeal Ultrasound for Assessment of Vocal Cord Mobility.	Kitty Thorpe, Jeanette Payne, Ravi Thevasagayam	The University of Sheffield, Sheffield, United Kingdom. Sheffield Children's Hospital, Sheffield, United Kingdom
P5.4	Unilateral Choanal Atresia: Does Age at Surgery and Technique Matter?	Vedika Dhunoo, Arshad Zubair, Grace Khong	Department of Paediatric Otolaryngology, Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom
P5.5	Impact of the Kingdon review on pediatric audiology services in the North East and North Cumbria	Marwa Saad, Aoife Waters	Cumberland Infirmary Carlisle, Carlisle, United Kingdom

P5.6	Hearing Loss Severity, Progression, and Newborn Screening Outcomes in Children with Congenital Cytomegalovirus: A Single-Centre Retrospective Cohort Study	Samantha Jia Qi Lee, Bebek Bhattarai, Haytham Kubba, Juan Mora	University of Glasgow, Glasgow, United Kingdom. Royal Hospital for Children, Glasgow, United Kingdom. NHS Scotland, Greater Glasgow and Clyde, United Kingdom
P5.7	Multidisciplinary Evaluation of the Paediatric Airway: Our Tertiary UK Paediatric Experience	Yeshaa Mirani, Emma Hogg, Sam Goh, Chris Grime	Alder Hey Children's Hospital, Liverpool, United Kingdom
P5.8	Introducing Serial COLDS Scoring in Elective Paediatric ENT Surgery: A Quality Improvement Project	Sufia Laulloo, Alice Halim, Avinash Das, Ali Salamat	Royal Bolton Hospital, Bolton, United Kingdom
P5.9	Paediatric head and neck cancer – a tertiary centre experience	Laura Brennan, Dalton Barham, Nicola Stobbs, Dan Yeomanson	Sheffield Childrens Hospital, Sheffield, United Kingdom

P5.1

Reducing paediatric post-tonsillectomy readmissions: can enhanced analgesia education make a difference?

Naining Xu, Riya Manandhar, Ileana Anderco

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Introduction

Post-tonsillectomy haemorrhage remains the most significant complication following paediatric tonsillectomy and a leading cause of emergency re-attendance and readmission. National benchmarks report post-operative haemorrhage rates of approximately 3.5%. However, a substantial proportion of post-operative complications is also pain-related, contributing to reduced oral intake and dehydration. In addition to surgical factors, post-operative analgesia management may represent a modifiable contributor to avoidable readmissions. This study evaluated local outcomes at Blackpool Victoria Hospital and assessed whether enhanced parental analgesia education could reduce post-tonsillectomy readmissions.

Methods

A retrospective review was undertaken of all paediatric tonsillectomies performed between January 2024 and August 2025. Data were extracted from electronic patient records. Outcomes included primary and secondary haemorrhage, unplanned readmission, A&E attendance, and return to theatre within 28 days. Following cycle one analysis, a structured post-operative telephone follow-up intervention was implemented to reinforce parental adherence to the analgesia regime and discharge instructions in line with the Alder Hey guideline.

Results

Three hundred and fourteen patients were included in cycle one. The haemorrhage-related readmission rate was 8.28% (n=26). Primary haemorrhage occurred in 0.96% (n=3) and secondary haemorrhage in 7.32% (n=23). Additional causes of readmission included pain (1.91%), infection (1.59%), epistaxis (0.96%), fever (0.32%), and morphine intolerance (0.32%).

Conclusion

Haemorrhage-related readmission rates exceeded national benchmarks and were driven predominantly by secondary haemorrhage. Pain-related presentations contributed to post-operative complications, highlighting a potentially modifiable gap in discharge education and analgesia management. A telephone follow-up intervention was introduced to improve analgesia adherence, with a re-audit ongoing to assess its impact.

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P5.2

Paediatric case of Nasopharyngeal granular cell lesion

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Introduction: Granular cell tumours are rare benign soft tissue tumour with neuroectodermal differentiation. They can be located in a wide variety of sites with 20% located in the head and neck with predilection for the tongue. To our knowledge this is the first published paediatric case of Nasopharyngeal granular cell tumour.

Clinical Case: 11 year old male referred to otolaryngology department with symptoms of persistent snoring, recurrent tonsillitis and nasal obstruction failed to manage with nasal sprays. Overnight oxygen saturation results were normal. Clinical examination showed bilateral grade 4 tonsils with turbinate erythema and hypertrophy. He had coblation adenotonsillectomy and examination under anaesthesia of the nose. The intraoperative findings showed grade 2 tonsils with large abnormal polypoid mass seen in the upper nasopharynx which was biopsied. The pathology results showed benign nasopharyngeal granular cell lesion. The patient was followed up after six weeks and he had ongoing nasal obstruction and snoring. He had nasoendoscopy in clinic which showed significant residual lesion occupying his nasopharynx. He had an MRI scan demonstrating benign residual nasopharyngeal tissue. Following discussion at skull base MDT he had completion removal of nasopharynx lesion with combined endonasal and transoral approach using coblation. Intraoperative findings demonstrated exophytic tumour arising from superior right nasopharynx overlying the right eustachian tube cushion. He is awaiting biopsy results and follow up in clinic.

Conclusion: This rare case of Nasopharyngeal granular cell lesion demonstrated the multidisciplinary approach to such lesions and the novel use of coblation technique in the excision of such lesions.

P5.3

Vincristine-Induced Vocal Cord Paralysis in Children: A Large Case Series and Evaluation of Laryngeal Ultrasound for Assessment of Vocal Cord Mobility.

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The University of Sheffield, Sheffield, United Kingdom. Sheffield Children's Hospital, Sheffield, United Kingdom

Abstract

Background: Vincristine is a fundamental component in paediatric Acute Lymphoblastic Leukaemia (ALL) regimens. However, its use is frequently limited by its dose-limiting neurotoxicity. More commonly this results in peripheral and autonomic neuropathy, but occasionally manifests cranially as Vocal Cord Paralysis (VCP). Traditional diagnostics such as flexible nasal endoscopy (FNE) or micro-laryngo-tracheo-bronchoscopy (MLTB) impose significant physical distress and clinical risk in paediatric oncology patients.

Objective: To present the clinical course of a twelve-patient cohort with vincristine-induced VCP and assess non-invasive Laryngeal Ultrasound (LUS) as a diagnostic and surveillance tool.

Methods: A retrospective review of 291 paediatric patients receiving Vincristine (2010-2026) was conducted. Demographics, clinical features, diagnostic methods, management strategies and recovery timelines were analysed.

Results: Twelve patients (all B-cell ALL; 8 female) developed secondary VCP, yielding an institutional incidence of 4.1%. Median age at onset was 3 years; 11/12 had bilateral VCP. 58.3% of patients (7/12) required a tracheostomy due to severe respiratory compromise. All patients demonstrated complete resolution of VCP following modification of chemotherapy. One patient remains tracheostomy-dependent three years post-diagnosis. Previous cases were diagnosed using traditional FNE and/or MLTB; however, a recent case used FNE for initial diagnosis and LUS for surveillance, which was well-tolerated and provided full functional assessment.

Conclusion: Vincristine induced VCP is a severe toxicity associated with significant acute and long-term airway morbidity. While FNE/MLTB confirms diagnosis, LUS is a reliable, patient friendly and non-invasive alternative for assessing vocal cord mobility. Its integration into clinical protocols can minimise procedural trauma in vulnerable oncology cohorts.

P5.4

Unilateral Choanal Atresia: Does Age at Surgery and Technique Matter?

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Main theme: Rhinology

Introduction: Unilateral choanal atresia (UCA) is a rare congenital nasal anomaly presenting with unilateral nasal obstruction and discharge^{1,2}. Unlike bilateral choanal atresia, presentation may be delayed and surgery is usually elective². Re-stenosis and revision surgery remain important challenges³. This study evaluated UCA outcomes at a tertiary paediatric centre, focusing on age at surgery and operative technique.

Methods: Retrospective case-note review identified paediatric patients undergoing surgical management of UCA between January 2015 and March 2026. Data included demographics, co-morbidities, atresia type, surgical approach, number of procedures, inter-procedure intervals, and restenosis rates. Mann-Whitney U, Fisher's exact, and Spearman correlation tests were used, with Poisson regression to assess the independent effect of surgical approach on procedure count controlling for age.

Results: Twenty-eight patients underwent surgery; 60.7% (n=17) were female and median age at first surgery was 11.4 months. Co-morbidities were present in 50.0% (n=14), most commonly cardiac and airway anomalies. Restenosis occurred in 60.0% (n=15). Younger age correlated significantly with more procedures (Spearman $r = -0.51$, $p = 0.006$). Flap techniques were associated with fewer procedures (median 1 vs 3; $p = 0.007$) and lower restenosis (37.5% vs 70.6%). Flap technique remained independently associated with fewer procedures after controlling for age (IRR 0.42, 95% CI 0.20–0.91; $p = 0.027$).

Conclusion: Younger age at first surgery and transoral dilatation were associated with greater procedural burden and higher restenosis rates. Where anatomically feasible, endoscopic repair may improve durability and reduce revision surgery. Prospective multicentre studies are required to validate these findings.

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P5.5

Impact of the Kingdon review on pediatric audiology services in the North East and North Cumbria

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Abstract

Main theme: Otology.

Introduction: Kingdon review was an independent review of the paediatric hearing services in England.¹ This was triggered by concerns raised in NHS Lothian and failures in English services. Paediatric hearing services carry a high risk as undiagnosed hearing loss can have lifelong impact on children. Kingdon review made recommendations to improve the paediatric hearing services. In this regional survey we aimed to identify the impact the Kingdon review had on paediatric audiology services in terms of staffing levels, morale and funding.

Methods: Survey of paediatric audiology leads in five regional centres via semi-structured online interview, and thematic analysis of transcribed interview notes.

Results: 80% of centres are understaffed, there is difficulty with staff recruitment and retention. Staff morale was impacted by findings from Lothian and Kingdon review, which led to staff loss. Some centres had access to funding and study time as a direct result from the local paediatric review, but this was not uniform. 60% of centres had to recall patients for assessment. No centre could confirm concrete plans to implement recommendations of the Kingdon review, and centres anticipate challenges with funding and time required for implementation.

Conclusions: Paediatric audiology services in the northeast and north Cumbria are understaffed. Kingdon review had an impact on staff retention and staff morale. There has been access to funding for education and study leave following the review, but this is not uniform. Staffing and funding improvement is required for implementation of the recommendations of the Kingdon review.

References

1-Kingdon review of children's hearing services: final report

P5.6

Hearing Loss Severity, Progression, and Newborn Screening Outcomes in Children with Congenital Cytomegalovirus: A Single-Centre Retrospective Cohort Study

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Main Theme: Otology

Introduction: Congenital cytomegalovirus (cCMV) is one of the leading non-genetic causes of sensorineural hearing loss (SNHL), demonstrating an unpredictable trajectory. This study aims to identify trends in hearing loss severity, laterality, and progression in children with cCMV to contribute evidence to support screening and management guidelines for cCMV.

Methods: A single-centre retrospective cohort study of 31 children diagnosed with cCMV from 2001 to 2023. Universal Newborn Hearing Screening (UNHS) result, age of HL and cCMV diagnosis were recorded. Audiological evaluations involved diagnostic ABR, pure tone audiometry and VRA. Pure tone average (PTA) was calculated across 500, 1000, 2000 and 4000Hz thresholds.

Results: 30 out of 31 patients had SNHL. 48% passed and 45% were referred on UNHS. 71% were diagnosed with cCMV after 3 weeks of age. 67% of patients with SNHL were diagnosed after 3 months of age. There were 14 patients with unilateral and 16 with bilateral HL at diagnosis. Median poorer ear PTA was 71dB HL (IQR 25) at best audiogram, and 109db HL (IQR 29) at worst. No significant difference in poorer ear PTA was identified between UNHS groups at best audiogram ($U=57.0$, $p=0.416$). However, poorer ear PTA at worst audiogram was significantly higher in the refer group ($U=31.5$, $z=-2.322$, $p=0.019$, $r=0.559$).

Conclusion: cCMV associated SNHL is variable in severity, laterality and onset. UNHS refer patients may be at greater risk of higher severity HL later in life. This highlights the importance of close monitoring of SNHL progression in cCMV patients.

P5.7

Multidisciplinary Evaluation of the Paediatric Airway: Our Tertiary UK Paediatric Experience

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Main theme- Airway

Introduction

Joint paediatric airway assessment involving ENT and Respiratory allows the evaluation of airway structure and function in a single anaesthetic episode. This approach reduces repeat procedures, minimises hospital visits and facilitates real-time multidisciplinary decision making, particularly in complex cases. This project aimed to evaluate the indications and outcomes of combined paediatric ENT and Respiratory airway assessment at our tertiary paediatric centre.

Methods

A service evaluation was conducted of patients undergoing flexible bronchoscopy and an ENT procedure, including microlaryngoscopy and bronchoscopy (MLTB) at our unit between August 2025 and May 2026. Patient demographics, indications and procedure findings were analysed.

Results

Sixteen patients (aged 11 months-14 years) underwent flexible bronchoscopy with an additional ENT procedure in the same anaesthetic. Thirteen patients (81.3%) underwent combined MLTB and flexible bronchoscopy, the remainder underwent flexible bronchoscopy combined with other ENT procedures such as adenotonsillectomy and removal of foreign bodies. The common indication for airway assessment was recurrent chest infections in 7 patients (43.7%). Eight procedures were performed as a day case, the remainder requiring inpatient admission. Among the 13 patients undergoing joint MLTB and flexible bronchoscopy, seven patients (53.8%) had normal findings.

Conclusion

Combined paediatric ENT and Respiratory airway assessment is a useful approach for children with complex airway presentations. It reduces the need for multiple anaesthetics and supports multidisciplinary assessment. This model could be considered in future service planning. However, this was a small service evaluation, and a larger retrospective review is needed to assess its impact on patient outcomes.

P5.8

Introducing Serial COLDS Scoring in Elective Paediatric ENT Surgery: A Quality Improvement Project

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Main Theme: Airway

Introduction: Perioperative respiratory adverse events (PRAEs), including laryngospasm and bronchospasm, are recognised complications of paediatric ENT surgery that may increase morbidity, prolong recovery, and disrupt theatre efficiency. The COLDS score is a validated tool for perioperative respiratory risk stratification in children. This quality improvement project aimed to establish baseline PRAE rates and identify opportunities to standardise respiratory risk assessment prior to introducing serial COLDS scoring.

Methods: A two-cycle Plan–Do–Study–Act quality improvement project was undertaken. Cycle 1 comprised a retrospective review of elective paediatric ENT procedures performed under general anaesthesia between April and May 2026. Data collected included procedure type, postoperative respiratory events, theatre-list cancellations, and documentation of respiratory and autism spectrum disorder (ASD)-related concerns within preoperative anaesthetic assessments.

Results: Forty-eight patients across 13 theatre lists met the inclusion criteria. Three PRAEs occurred (6.3%): one laryngospasm, one bronchospasm, and one clinically significant obstructive sleep apnoea episode, all following adenotonsillectomy. Three theatre lists experienced cancellations; two were associated with respiratory complications, while one involved two patients with ASD. Respiratory risk factors were documented in 44/48 cases (91.7%) and ASD-related concerns in 7/48 cases (14.6%).

Conclusion: Cycle 1 established baseline PRAE rates and quantified their impact on theatre efficiency. These findings identified an opportunity to standardise respiratory risk assessment through serial COLDS scoring at pre-assessment, 72-hour screening, and day-of-surgery review. Cycle 2 will evaluate the impact of this intervention on risk identification, communication, and perioperative planning.

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P5.9

Paediatric head and neck cancer – a tertiary centre experience

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Abstract

Introduction:

Paediatric head and neck malignancies are a rare and heterogeneous group of tumours with diverse clinical presentations, pathological features and treatment pathways. As such, evidence to guide management remains limited, with most research studies focusing on individual tumour types. This study aimed to characterise the presentation, management and outcomes of paediatric head and neck cancers treated at a UK tertiary referral centre.

Methods:

A retrospective review was undertaken of paediatric patients managed through a tertiary head and neck oncology service over a 20-year period. Demographic, radiological, pathological, treatment and outcome data were collected from multidisciplinary databases and electronic records. Haematological malignancies were excluded. Descriptive statistical analysis was performed.

Results:

Thirty-seven patients were identified with a mean age at diagnosis of 8.5 years. Rhabdomyosarcoma was the most common histological diagnosis (22.2%), followed by acinic cell carcinoma (19.4%), mucoepidermoid carcinoma (13.9%) and papillary thyroid carcinoma (13.9%). The parotid gland was the most frequent primary site (n=12), followed by the thyroid (n=7). Surgery alone was the predominant treatment modality (62%), while 35% required multimodal therapy incorporating chemotherapy, radiotherapy or proton therapy. Postoperative complications occurred in 33.3% of surgically treated patients. A mortality rate of 11.1% was seen, all in patients with recurrent sarcoma.

Conclusions:

Paediatric head and neck cancers are uncommon and highly heterogeneous, requiring individualised multidisciplinary management. Salivary and thyroid malignancies demonstrated favourable outcomes following surgery, whereas soft tissue sarcomas were associated with higher recurrence rates and mortality. Collaborative multicentre studies are needed to optimise management strategies and improve long-term outcomes.

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POSTER PRESENTATIONS Group 6

P6.1	withdrawn		
P6..2	withdrawn		
P6.3	The Role of Inhaled Corticosteroids in Preventing Hospital Attendance and Improving Clinical Outcomes in Children with Recurrent Croup: A Systematic Review	Dean Robinson, Agamemnon Pericleous	University College Hospital NHS Trust, London, United Kingdom
P6.4	Paediatric Voice: reflections and insights from a 7-year clinical evaluation of a joint paediatric voice clinic	Marion Alston, Jonathan Fishman, Gemma Wotherspoon	UCLH NHS Foundation Trust, London, United Kingdom
P6.5	Outcomes following mastoid obliteration surgery in 45 paediatric patients: a case series	Adam Garrard, Roksana Stobiecka, Sunil Sharma	Alderhey Hospital, Liverpool, United Kingdom

P6.6	Still Standing: Revisiting The 'One on, One Off' Paediatric ENT Theatre Model 12 Years Later	Karthika Shanthakunalan, Paul Spraggs	Basingstoke Hospital, Hampshire, United Kingdom
P6.7	A retrospective audit of paediatric endoscopies in a tertiary centre	Matthew Holmes, Dema Motter, Mai Abdelaal, Mihiar Atfeh	University Hospitals Plymouth, Plymouth, United Kingdom
P6.8	Paediatric Play Specialists role in Reducing Anxiety Before Procedures	Keya Bajaj	Medical Student, St Georges University, London, United Kingdom
P6.9	A retrospective analysis of post-nasal space radiographs.	Mazin Mohamed, Siobhan Hoare, Colleen Heffernan	University College Dublin, Dublin, Ireland. Department of Paediatric Radiology, Children's Health Ireland at Temple Street, Dublin, Ireland. Department of Paediatric Otolaryngology, Children's Health Ireland at Temple Street, Dublin, Ireland

P6.3

The Role of Inhaled Corticosteroids in Preventing Hospital Attendance and Improving Clinical Outcomes in Children with Recurrent Croup: A Systematic Review

Dean Robinson, Agamemnon Pericleous

University College Hospital NHS Trust, London, United Kingdom

Abstract

Introduction:

Recurrent croup is a common cause of repeated healthcare utilisation in children. Although corticosteroids are widely used in acute croup, their role in reducing hospital attendance and improving outcomes in recurrent croup remains unclear.

Methods:

A systematic literature search was conducted across major medical databases. Studies were selected using predefined PICO-based inclusion and exclusion criteria and a PRISMA-guided screening process. Studies evaluating inhaled or systemic corticosteroids in children with recurrent croup were included. Primary outcomes were hospital admission and re-attendance rates. Secondary outcomes included croup severity scores, symptom improvement, and adverse effects.

Results:

Of 432 records identified, eight studies met the inclusion criteria, comprising six randomised controlled trials and two observational studies. ICS use was associated with reduced hospital admission rates and improved clinical outcomes compared with placebo. Improvements in croup severity scores and symptom burden were observed with both inhaled and systemic corticosteroids. Systemic corticosteroids were associated with lower admission and re-admission rates than placebo and ICS. Among inhaled therapies, nebulised budesonide was associated with lower re-admission rates than nebulised dexamethasone.

Conclusions:

High-quality evidence from randomised controlled trials and systematic reviews supports the use of corticosteroids in acute croup, demonstrating consistent benefits across multiple clinically relevant outcomes. In contrast, evidence for recurrent croup remains limited and is predominantly observational. While ICS appear to reduce admissions and improve symptom severity, their role in preventing recurrent croup remains investigational. Further prospective studies are required to establish the optimal corticosteroid regimen and define the role of early home-based ICS therapy.

P6.4

Paediatric Voice: reflections and insights from a 7-year clinical evaluation of a joint paediatric voice clinic

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Main theme: paediatric laryngology

Introduction

Voice disorders affect an estimated 6–23% of children and young people (CYP) with a lifetime prevalence of 12% (Carding, Roulstone and Northstone, 2006; Fujiki, et al. 2024), and may significantly impact quality of life, educational attainment, social and classroom participation, confidence and emotional wellbeing (Stojanovic et al., 2023). Multidisciplinary paediatric voice services, integrating otolaryngology and speech and language therapy (SLT), are increasingly recognised as gold standard for assessment and management. This study reviews the activity and outcomes of a joint paediatric voice clinic over a seven-year period.

Methods

A retrospective clinical evaluation of medical records was undertaken for all CYP attending a joint paediatric voice clinic (2019 and 2026). Data extracted included demographics, diagnosis, videostroboscopic findings, surgical interventions, voice outcome measures (including GRBAS, pVHI, Children's Voice Questionnaire), and co-morbidities, including neurodiversity. Clinical outcomes and service development were analysed descriptively.

Results

A diverse paediatric population with a range of voice disorders was identified. Joint assessment facilitated comprehensive and targeted multidisciplinary management. Videostroboscopy significantly enhanced diagnostic accuracy, supporting informed treatment planning and surgical decision-making. Access to specialist nurses and play specialists improved patient engagement, procedural tolerance and family-centred care, particularly among younger children and those with additional needs. Integrated SLT input enabled timely rehabilitation and conservative management where appropriate.

Conclusions

Joint paediatric voice clinics provide an effective model of care, supporting accurate diagnosis, streamlined management and improved patient experience. Videostroboscopy and specialist team involvement are valuable components of service delivery contributing to high-quality, child-centred voice care.

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P6.5

Outcomes following mastoid obliteration surgery in 45 paediatric patients: a case series

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Introduction: Mastoid obliteration is used in paediatric chronic ear disease to reduce cavity-related morbidity and improve postoperative quality of life. Paediatric outcome data using validated patient-reported measures remain limited.

Aims: To evaluate disease-specific quality of life and hearing outcomes after mastoid obliteration surgery in a paediatric cohort.

Methods: We report a single-centre case series of 45 paediatric patients undergoing mastoid obliteration surgery. Outcomes were assessed pre-operatively and at 3 months post-operatively. The primary outcome was disease-specific health-related quality of life measured using the Chronic Otitis Media Questionnaire-12 (COMQ-12). Secondary outcomes included pure tone audiometry (PTA). Pre- and post-operative scores were compared using statistical testing.

Results: COMQ-12 scores demonstrated a significant average improvement of -4.96 (95% CI 2.81-7.11) post operatively. Greater improvements in post-op COMQ-12 scores were seen in patients with higher pre-op COMQ-12 scores. Improvements were maintained in patient subgroups who had concurrent co-morbidity and those who did not. There was no significant difference in PTA thresholds pre and post operatively.

Conclusion: In this paediatric case series, mastoid obliteration surgery was associated with a significant short-term improvement in disease-specific quality of life at 3 months, without a significant change in audiometric thresholds over the same period. These findings support mastoid obliteration as a procedure that can improve patient-reported outcomes in children while maintaining hearing in the early postoperative period.

P6.6

Still Standing: Revisiting The 'One on, One Off' Paediatric ENT Theatre Model 12 Years Later

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Main Theme: Innovation

Introduction:

Efficient theatre utilisation is increasingly important in addressing growing paediatric ENT waiting lists. In 2014, our department described a novel 'One on, One off' theatre model, utilising two anaesthetists, two operating department practitioners and an ENT surgeon to maximise theatre efficiency. Twelve years later, we evaluated whether this model continues to deliver efficient, high-volume paediatric day-case surgery within the NHS.

Methods:

A retrospective evaluation was undertaken of morning paediatric ENT theatre sessions between January and July 2026. Data collected included planned and completed procedures, theatre utilisation and cancellations. Procedures included tonsillectomy, adenoidectomy, grommets and other paediatric ENT day-cases.

Results:

Fourteen consecutive theatre lists were analysed. Ninety-three procedures were scheduled, of which 85 (91.4%) were completed, averaging 6.1 procedures per session. Mean theatre utilisation was 80.4%. Most cancellations resulted from patient-related factors, including illness, patient choice and changes in clinical management, rather than limitations of the theatre pathway. Despite these unavoidable cancellations, the alternating anaesthetic model maintained continuous theatre flow, with only one list overrunning, attributable to the addition of non-ENT procedures rather than inefficiencies within the operating pathway.

Conclusions:

Twelve years after its original publication, the 'One on, One off' theatre model remains a sustainable and efficient approach to delivering high-volume paediatric ENT day-case surgery. Despite increasing NHS service pressures, this simple workflow continues to optimise theatre productivity while maintaining flexibility to accommodate unavoidable patient-related cancellations. This reproducible model offers a practical solution for paediatric ENT units seeking to improve theatre efficiency and maximise operative capacity

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P6.7

A retrospective audit of paediatric endoscopies in a tertiary centre

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INTRODUCTION

Paediatric airway endoscopies are a commonly performed diagnostic procedure in tertiary paediatric otolaryngology departments. There is heterogeneity in the literature regarding the indications and findings of these procedures. The aim of this audit was to understand the indications, and outcomes for patients undergoing airway endoscopy, with a particular focus on patients with recurrent croup.

METHODS

The inclusion criteria included all paediatric patients who had undergone an airway endoscopy from November 2018-November 2023. There were no exclusion criteria. Basic demographics, indications, clinical findings and outcomes were recorded. Those patients that had images from the procedure available, underwent further subgroup analysis examining the incidence of reflux and shortened aryepiglottic folds.

RESULTS

115 patients underwent diagnostic endoscopies. The cohort was predominantly male (68.7%). Recurrent croup was the most common referral indication (40.0%), followed by noisy breathing (13.9%) and swallowing/choking concerns (12.2%), with a smaller number listed for other reasons such as voice change, and recurrent respiratory infections. Normal anatomy was the most frequent intraoperative finding (60.0%), followed by reflux changes (56.5%) and shortened aryepiglottic folds (44.3%).

6/46(13%) recurrent croup patients were under 3 years old but those younger patients were more likely to have positive findings. 33/46 (71%) croup patients had abnormal findings.

CONCLUSION

This audit is being used to create a local clinical guideline outlining the criteria for referral to ENT for recurrent croup.

P6.8

Paediatric Play Specialists role in Reducing Anxiety Before Procedures

Keya Bajaj

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Abstract

Main Theme - General

Introduction: Hospitalisation and medical procedures are anxiety-inducing events for children, and this impacts their psychological wellbeing and can worsen the hospital experience. Paediatric play specialists are becoming increasingly recognised in healthcare teams and they use play-based interventions to support children and reduce anxiety.

Methods: This literature review explores the role of play specialists in reducing anxiety in children and analyses the efficacy of interventions like therapeutic toys, storytelling, preparatory play, and audiovisual distractions. Furthermore, it looks at the effectiveness of these interventions based on a child's developmental stage, age, parental involvement, and timing of the intervention.

Results: Although the literature broadly supports the use and effectiveness of play specialists, significant limitations remain in the evidence base. Across studies, there is a large amount of variability between research designs, methods and outcome measures which reduces the strength of the evidence presented while also reducing the generalisability of the information making it difficult to draw conclusions. Furthermore, clearly identifying the role of paediatric play specialists within healthcare teams is a key point that needs to be established. Overall, play specialists have a key role in healthcare teams and facilitate communication between the parents, child and the healthcare professionals involved.

Conclusion: The evidence shows that interventions used by play specialists cause a significant decrease in anxiety levels in children who are hospitalised or have a chronic illness.

P6.9

A retrospective analysis of post-nasal space radiographs.

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Background:

Adenoid hypertrophy is common in the paediatric population. While endoscopy is the gold standard for diagnosis, lateral post-nasal space (PNS) radiography remains widely used. This study evaluated the clinical utility of PNS radiographs over a 5-year period in the management of paediatric adenoid hypertrophy, with particular attention to their impact on referral pathways and surgical decision-making.

Methods:

We conducted a retrospective review of all PNS radiographs performed for suspected adenoid hypertrophy or related symptomatology between June 2020 and May 2025. We collected data on referral source, technical adequacy, and adenoid-nasopharyngeal (AN) ratios. We tracked subsequent otolaryngology referrals and surgical outcomes.

Results:

Over the five-year period, 548 radiographs were performed, with 98% originating from non-surgical specialities. The mean patient age was 6.3 years; the maximum average AN ratio was 0.61 in three-year-olds. Suboptimal positioning was identified in 23% of films. Only 13% of the total cohort ultimately proceeded to adenoidectomy, underscoring the limited direct impact of the radiographs on operative management.

Conclusion:

Lateral PNS radiography remains a frequently utilised first-line investigation despite technical limitations and only moderate diagnostic utility. Because most requests originate from non-surgical specialities, it appears to serve primarily as an accessible triage tool before an ENT specialist referral rather than as a definitive guide to surgical decision-making.