

Reza Rahbar

Reza Rahbar is professor of otolaryngology at Harvard Medical School and associate otolaryngologist-in-chief at Boston Children's Hospital. He initiated and leads IPOG, the International Pediatric Otolaryngology Group. I met up with him to ask more about it.



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How was the International Pediatric Otolaryngology Group first conceived?

The first conversation happened when we were having a discussion between colleagues about the difficulties with some of the clinical scenarios we come across and how to manage some of the things that are really hard to study.

One of the first questions that came up in our conversation was 'how long would you keep a patient with a new tracheostomy in your ICU before you do your first tube change?'. Some people said 10 days, some said seven. If I recall correctly, John Russell said, "three days because we have limited ICU beds" and I thought that was amazing because it took us seven days in Boston to do this. If I could change that in my hospital and save four days in intensive care per tracheostomy doing, say, 50 tracheostomies a year, that's 200 days of ICU bed.

So, that's what initiated our thinking. Then we decided to all get together to look at these issues where there is no specific information or even retrospective data of what is safest. We created the group in 2015 and started with a multicentre questionnaire and consensus evaluation, which became the first guideline. It was

mostly based around airway management. We did the tracheostomy one, we did laryngeal cleft – the first publications were mainly around difficult, complex airway management, though some of them are based on simple, straightforward questions.

How were the guidelines received?

As we were publishing these first consensus papers, I noticed that the frequency with which they were being referenced kept going up. We also realised that the information is important, not just for larger institutions but also for smaller units where there may be only one or two paediatric otolaryngology clinicians, and in countries where they don't have access to a lot of paediatric care so may have less experience in how to manage these conditions.

How did things change after that first phase?

The second phase of IPOG came about when we were approached by Richard Smith, Professor of Otolaryngology, University of Iowa. He said, "I love these consensus papers and I would like to do one on children's hearing loss – a consensus on how to manage it, including when to get a CT, when to get an MRI, and when to do genetic x, y, z tests".

So, Richard Smith did the first non-airway consensus paper, which was the hearing loss paper, and it was extremely well received by everyone. Since then, colleagues have reached out and we have published 18 papers on various topics, with five or six more on the way.

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IN CONVERSATION WITH

How do you envisage otolaryngologists around the world will use the guidelines?

That's the biggest message that I want to get to the individuals who are reading this. The purpose of these papers is not to tell people what to do; the purpose is to put out information based on peer review articles, clinical research and clinical expert teams' knowledge to provide a paradigm of how to manage each entity, but also the critical part is to show the variation of care that exists globally.

We started to include tables which illustrate, for each step of the consensus paper, the proportion of contributors who feel that each test is necessary. For example, 80% of the authors would arrange an MRI and 40% a CT. This is based on peer review articles and clinical expertise as most of the authors would have access to the tests that they wish to perform.

This is important because when the people who are in an institution that may not have so much clinical expertise look at the guideline, they know what is recommended and, if they deviate from this paradigm, where they fall in comparison.

What is the strength of these guidelines compared to others that have been produced?

If you look at all the clinical practice guidelines and consensus papers that have been published, they are all very good and informative, but the vast majority are either intercountry or at best, intercontinental. There are very few that are truly international, and they tend to have relatively few authors, with maybe four to six hospitals included.

Thus, my second goal with this venture was to have 20-30 people from different institutions as contributing authors, so we really get a sense of what's happening globally. We want to be sure we have included institutes from South America, Africa, India, the US – from all over.

I was aware that you moved direction during Covid. Can you tell me how that came about?

Phase three was initiated during Covid when, in early 2020, I received many emails from colleagues around the world asking, 'What are you guys doing? What is happening in Boston? What kind of protective equipment are you using? Are you seeing patients? Are you doing endoscopies?'. These were all questions we didn't know how to answer. One Monday I was in the OR and said to my fellow, Dr Erica Mercier, "we really need to address these questions because people are reaching out".



So, we sent out a questionnaire with all the Covid-related questions that people had. We had 306 institutions in 60 countries around the world who responded within three to four days – unheard of! That explains the desperation people felt.

So, we put out the first 'IPOG COVID Report'. Then, when we sent out the report, we had so much positive feedback and requests for another report because the situation was evolving so quickly. So, we were also able to provide a second.

That period really changed IPOG from being a group publishing educational articles on single clinical questions to a group that people could reach out to and ask, 'what's happening here? Can you help us?'. This also led to the creation of the IPOG website, which gave access to the reports by everyone. The website lists all of the consensus guideline publications and the editorial board members. It also has a section where you can contact the board with ideas for further topics for articles. The credit of putting the website and all the work on the background goes to Dr Erika Mercier.

You already mentioned Richard Smith. Have you had other people come to you keen to lead a particular guideline?

Often colleagues reach out, keen to initiate a guideline. One thing that we as the editorial board want to do is be sure that the papers we put out are written by true colleagues that have clinical and / or research expertise on the specific subject. I would not want to lead the project on congenital cholesteatoma when people don't consider me an expert in that field – that will diminish the value of our paper and it will diminish IPOG. So, one of my hardest jobs is to be respectful to people when they reach out to us and say 'I want to do this project', as we need to be sure that the individual is considered an expert in the field by other colleagues. Then when they involve the 20 to 30 other authors from around the world, we also need to be confident that they are

experts – which we define as a clinical expert, research expert, or having significant publications in the field, often a combination of all these. This is definitely something we have paid more attention to over time as the group's work has grown.

What are your thoughts regarding future directions for the group?

I don't know what the next phase is, to be truthful. We want to expand it, but the expansion so far wasn't by design. If Richard had not called me, we may still be publishing only airway stuff. From phase one to three was serendipity; it all happened because of Covid. Otherwise, we wouldn't probably have the website and be where we are right now.

What I would say as of right now, the future is for IPOG to be firstly a platform that provides a consensus, peer review / expert opinion on complex and simple paediatric otolaryngological disorders. The second is to provide a platform for all paediatric otolaryngologists to share ideas, collaborate, and to have a way to access each other if they need to find a specialist in another country. Finally, we are thinking that in the next year we are going to start to provide webinars with expert discussion of relevant paediatric topics.

That sounds exciting, I'll keep an eye on the IPOG website or more information. Thank you for talking to me.

To learn more about IPOG, visit: www.ipog.info

INTERVIEW BY



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