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# BRIDGING THE GAP BETWEEN PARENTAL PERCEPTION AND EVIDENCE-BASED SURGICAL DECISION-MAKING IN PAEDIATRIC OTORHINOLARYNGOLOGY

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## ABSTRACT

**Background:** Paediatric ear, nose and throat (ENT) disorders constitute a major proportion of outpatient and surgical workload in tertiary care centres. Parental perceptions and expectations often influence treatment decisions, particularly when surgical intervention is advised. Understanding the concordance between parental expectations and surgeon-recommended management is essential for improving counselling and outcomes. The objective is to determine the prevalence of common ENT disorders in children and to compare parental treatment expectations with ENT surgeon–recommended medical or surgical management in a tertiary care teaching hospital of Andhra Pradesh.

**Materials and Methods:** This prospective descriptive study included 342 children (0–14 years) attending the ENT department over a 12-month period. Demographic variables (age, gender, residence, socioeconomic status), clinical diagnosis, parental treatment preference (medical vs surgical), surgeon-advised management, type of surgery performed, duration of hospital stay, loss of school days, and final clinical outcomes were recorded. Malignant ENT diseases were also included. Data were analyzed using descriptive statistics and concordance proportions.

**Results:** Of the 342 children, 198 (57.9%) were males and 144 (42.1%) females; the majority (61%) belonged to rural areas. The most common disorders were chronic tonsillitis/adenoid hypertrophy (28%), otitis media with effusion and chronic suppurative otitis media (24%), deviated nasal septum and allergic rhinitis (18%), sinonasal infections (15%), and congenital ear anomalies (5%). Malignant conditions (including nasopharyngeal carcinoma and rhabdomyosarcoma) accounted for 2.6% of cases. Surgical management was advised in 164 (48%) cases, most commonly adenotonsillectomy (34%), tympanoplasty (22%), myringotomy with grommet insertion (18%), septoplasty (12%), and endoscopic sinus surgery (8%). Parental preference favoured medical management in 58% of cases where surgery was recommended, showing partial discordance (32%). Mean hospital stay was 3.2 ± 1.4 days for routine surgeries and 7.6 ± 3.1 days for malignant cases. Average school absenteeism was 6.4 days for surgical cases and 2.1 days for medically managed cases. Favourable clinical outcomes were observed in 91% of benign conditions and 70% of malignant cases at follow-up.

**Conclusion:** Common paediatric ENT disorders contribute significantly to morbidity and school absenteeism. A notable gap exists between parental expectations and surgeon-recommended management, particularly regarding surgical interventions. Structured counselling and improved communication strategies may enhance treatment acceptance and outcomes.

**Keywords:** Paediatric Otorhinolaryngology; Adeno-tonsillar Disease; Otitis Media; Parental Perspectives; Surgeon Decision-Making; Shared Decision-Making; Adenotonsillectomy; Tympanoplasty; School Absenteeism; Paediatric Head and Neck Malignancy; Tertiary Care Hospital; Prospective Descriptive Study.

## INTRODUCTION

Paediatric ear, nose, and throat (ENT) disorders are among the most common health problems affecting children worldwide and account for a significant proportion of outpatient visits and hospital admissions. These disorders include a wide range of conditions involving the ear, nose, throat, and related structures such as otitis media, adeno-tonsillar hypertrophy, allergic rhinitis, chronic tonsillitis, rhinosinusitis, hearing impairment, and upper airway obstruction. Although many pediatric ENT diseases are not life-threatening, they can considerably affect the physical, psychological, educational, and social development of children. Persistent ENT disorders may interfere with hearing, speech development, sleep quality, feeding, communication skills, and academic performance, thereby reducing the overall quality of life of affected children.[1,3]

Globally, pediatric ENT diseases continue to pose a major public health challenge, particularly in low- and middle-income countries where healthcare resources and specialist services are limited. According to the World Health Organization (WHO), ear and hearing disorders are among the leading causes of disability in childhood, with many cases being preventable or treatable if diagnosed early.[3] Delayed diagnosis and inadequate treatment can result in long-term complications such as hearing loss, speech delay, learning difficulties, and recurrent infections. The WHO Global Ear Disease Report emphasized the importance of early screening, timely intervention, and improved access to specialized ENT care to reduce the burden of childhood hearing impairment and associated disabilities.[3]

Among pediatric ENT disorders, otitis media remains one of the most prevalent conditions and a major cause of hearing impairment in children. Acute otitis media, otitis media with effusion (OME), and chronic suppurative otitis media are frequently encountered in pediatric practice. Monasta et al. highlighted the substantial global burden of otitis media and its association with hearing deficits and developmental difficulties in children.[5] Recurrent ear infections may adversely affect language acquisition, communication abilities, and school performance during crucial developmental years. OME is particularly important because it often remains asymptomatic while causing conductive hearing loss. Updated management guidelines by Rosenfeld et al. recommended careful monitoring, hearing evaluation, and timely intervention in affected children to prevent long-term complications.[10]

Adeno-tonsillar diseases are another major contributor to pediatric ENT morbidity. Adenoid hypertrophy and recurrent tonsillitis are common causes of outpatient consultations and surgical interventions in children. Enlargement of adenoids and tonsils can lead to nasal obstruction, mouth breathing, snoring, sleep-disordered breathing, recurrent throat infections, feeding problems, and impaired growth. Ahmed et al. reported increasing trends in adeno-tonsillar hypertrophy among children and emphasized its impact on recurrent infections and airway obstruction.[2] Chronic tonsillitis also contributes to repeated antibiotic usage, school absenteeism, and reduced quality of life. Tonsillectomy and adenotonsillectomy remain among the most commonly performed pediatric ENT surgeries worldwide. Updated clinical practice guidelines by Baugh et al. outlined evidence-based indications for tonsillectomy in children with recurrent throat infections and obstructive symptoms.8 Mitchell et al. further demonstrated significant improvement in sleep quality, behavior, and overall quality of life following adenotonsillectomy in pediatric patients.[9]

Nasal and sinus disorders are also highly prevalent among children and frequently coexist with other ENT conditions. Allergic rhinitis, rhinosinusitis, and nasal obstruction contribute to recurrent respiratory symptoms, breathing difficulties, and sleep disturbances. Environmental pollution, allergen exposure, overcrowding, and poor sanitation increase the risk of these disorders, especially in developing regions. Untreated nasal diseases may predispose children to recurrent ear infections and chronic mouth breathing, thereby affecting growth and development. Recurrent upper respiratory tract infections commonly seen during childhood further increase the susceptibility to multiple ENT disorders.

The burden of pediatric ENT diseases is strongly influenced by socioeconomic and environmental factors. Poverty, malnutrition, overcrowding, poor hygiene, recurrent respiratory infections, and limited healthcare access contribute significantly to disease prevalence and severity in developing countries. Rural populations often face delays in diagnosis and limited access to specialized ENT services, resulting in chronic disease and preventable complications. Kumar et al. studied ENT morbidity among rural children in India and reported a high prevalence of ear infections, tonsillar diseases, and hearing impairment associated with poor socioeconomic conditions.4 Similar observations have been made in tertiary care studies evaluating pediatric ENT disease patterns. Sharma et al. documented the changing clinical profile of pediatric ENT disorders and highlighted the increasing burden of chronic inflammatory and infectious conditions among children attending tertiary care hospitals.6 Patel et al. also emphasized the importance of tertiary healthcare centers in diagnosing and managing pediatric ENT diseases effectively.[7]

Pediatric ENT disorders also have important psychosocial implications for both children and their caregivers. Chronic hearing impairment and recurrent infections can affect communication skills, social interaction, emotional well-being, and educational achievement. Sleep-disordered breathing due to adeno-tonsillar hypertrophy may result in behavioral problems, poor concentration, and reduced academic performance. Parents frequently

experience anxiety regarding surgical procedures, anesthesia, and postoperative outcomes in children. Lee et al. reported that parental anxiety is common in pediatric ENT surgical cases and can influence treatment decisions and postoperative care.[12] Effective counseling and communication with caregivers are therefore essential components of pediatric ENT management. Verma et al. further emphasized the importance of shared decision-making between healthcare providers and parents in pediatric surgical practice.[13]

Recent advances in pediatric ENT surgery and perioperative care have improved treatment outcomes considerably. Procedures such as adenotonsillectomy, tympanoplasty, myringotomy with ventilation tube insertion, and endoscopic interventions are now routinely performed with good success rates and low complication rates. Tympanoplasty has shown favorable hearing outcomes in children with chronic tympanic membrane perforation and hearing loss. Browning et al. demonstrated successful graft uptake and hearing improvement following pediatric tympanoplasty.[11] Similarly, adenotonsillectomy has been associated with significant improvement in airway symptoms, recurrent infections, and quality of life.9 Despite these advances, challenges remain in ensuring early diagnosis, timely referral, postoperative follow-up, and equitable access to ENT services, especially in underserved populations.

The epidemiological profile of pediatric ENT diseases varies according to geographic location, socioeconomic conditions, environmental exposure, and healthcare accessibility. Therefore, region-specific studies are essential for understanding local disease patterns and planning appropriate healthcare strategies. Hospital-based studies provide valuable information regarding disease prevalence, clinical presentation, treatment patterns, and surgical indications among pediatric patients. Such data are important for improving healthcare planning, strengthening preventive programs, and optimizing pediatric ENT services.

Considering the significant burden and impact of pediatric ENT disorders, comprehensive evaluation of their clinical profile and management patterns is essential. Understanding the spectrum of pediatric ENT diseases in tertiary care settings may help identify common disorders, treatment trends, and existing healthcare gaps. Therefore, the present study was undertaken to evaluate the clinical profile, disease spectrum, and management patterns of pediatric ENT disorders in a tertiary care setting.

## MATERIALS AND METHODS

This prospective descriptive study was conducted in the Department of Otorhinolaryngology of a tertiary care teaching hospital in Andhra Pradesh from January to December 2024. A total of 342 children (0–14 years) attending the outpatient and inpatient services were included. Children with incomplete records or those lost to follow-up were excluded.

**Study Variables**

**Demographic variables:** Age, gender, residence (rural/urban), socioeconomic status. Clinical variables: Diagnosis (ear, nose, throat, head-neck including malignancy), advised treatment (medical/surgical), type of surgery, duration of hospital stay, school absenteeism, and final outcomes at 3-month follow-up.

**Parental perspective:** Recorded using a structured questionnaire assessing preference for medical vs surgical management before and after counselling.

Descriptive statistics were applied. Concordance between parental expectations and surgeon-recommended treatment was expressed in percentages.

## RESULTS

**[Table 1:] Demographic Profile**

The study included 342 children aged 0–14 years. The majority of participants belonged to the 6–10 years age group (43.3%), followed by 0–5 years (29.8%) and 11–14 years (26.9%). This indicates that middle childhood represents the peak age for ENT consultations, likely due to high exposure to infections, adeno-tonsillar hypertrophy, and school-related transmission of upper respiratory illnesses.

There was a male predominance (57.9%), which is consistent with several paediatric ENT studies reporting higher healthcare-seeking behaviour for male children or slightly higher prevalence of certain ENT disorders in boys.

A significant proportion of children were from rural areas (61.1%), suggesting either higher disease burden, referral trends, or limited access to primary ENT services in rural settings leading to tertiary care utilization. Urban children accounted for 38.9% of cases.

Overall, the demographic profile reflects the typical paediatric ENT population in a tertiary care setting in Andhra Pradesh, with rural predominance and peak presentation in school-going age.

**Table 1: Demographic Profile (n=342)**

| Variable | Frequency (%) |
|---|---|
| Age 0–5 yrs | 102 (29.8) |
| Age 6–10 yrs | 148 (43.3) |
| Age 11–14 yrs | 92 (26.9) |
| Male | 198 (57.9) |
| Female | 144 (42.1) |
| Rural | 209 (61.1) |
| Urban | 133 (38.9) |

**Table 2: Spectrum of ENT Disorders**

Adeno-tonsillar disease was the most common disorder (28.1%), highlighting its major contribution to paediatric ENT morbidity. Chronic tonsillitis and adenoid hypertrophy are known to significantly affect breathing, sleep quality, and school attendance. Otitis media (OME/CSOM) accounted for 24% of cases, making it the second most frequent condition. This underscores the continued burden of middle ear disease in children, particularly in developing regions.

Allergic rhinitis and deviated nasal septum (17.8%) and acute/chronic sinusitis (15.2%) together represent a significant share of nasal pathologies, reflecting the increasing trend of allergic and inflammatory nasal disorders.

Congenital ear anomalies (5.3%) and foreign bodies (4.4%) constituted smaller but clinically important groups, requiring timely intervention to prevent complications.

Malignancies were observed in 2.6% of cases. These included nasopharyngeal carcinoma (3 cases), rhabdomyosarcoma (2 cases), lymphoma (2 cases), and thyroid carcinoma (2 cases). Although uncommon, their presence highlights the need for high clinical suspicion and early referral in paediatric head and neck swellings.

The distribution demonstrates that inflammatory and infective conditions dominate paediatric ENT practice, while malignancies, though rare, represent critical cases requiring specialized management.

**Table 2: Spectrum of ENT Disorders**

| Disorder Category | Frequency (%) |
|---|---|
| Adeno-tonsillar disease | 96 (28.1) |
| Otitis media (OME/CSOM) | 82 (24.0) |
| Allergic rhinitis/DNS | 61 (17.8) |
| Acute/chronic sinusitis | a52 (15.2) |
| Congenital ear anomalies | 18 (5.3) |
| Foreign bodies | 15 (4.4) |
| Malignancies | 9 (2.6) |
| Others | 9 (2.6) |

Malignancies included nasopharyngeal carcinoma (3), rhabdomyosarcoma (2), lymphoma (2), and thyroid carcinoma (2).

[Table 3] Surgeon-Advised Management vs Parental Preference

Surgeons recommended medical management in 52% of cases and surgical management in 48%. However, parental preference before counselling favoured medical treatment in 71.3% of cases, while only 28.7% initially preferred surgical intervention.

This discrepancy resulted in 32% discordance in cases where surgery was recommended. The reluctance toward surgery likely reflects parental anxiety regarding anaesthesia risks, postoperative pain, financial concerns, and cultural perceptions about surgery in children.

Importantly, after structured counselling and detailed explanation of indications, benefits, and risks, acceptance of surgery increased significantly to 84%, demonstrating the critical role of effective communication and shared decision-making in paediatric ENT practice.

This table clearly illustrates the gap between clinical judgment and parental expectations, and the positive impact of counselling in bridging that gap.

**Table 3: Surgeon-Advised Management vs Parental Preference**

| Management | Surgeon Recommended n (%) | Parental Preference Before Counselling n (%) |
|---|---|---|
| Medical | 178 (52.0) | 244 (71.3) |
| Surgical | 164 (48.0) | 98 (28.7) |

Discordance was observed in 32% of surgical cases initially. After structured counselling, acceptance of surgery increased to 84%.

[Table 4] Common Surgeries Performed

Among the 164 children who underwent surgical intervention, adenotonsillectomy was the most common procedure (34.1%). This aligns with adeno-tonsillar disease being the leading diagnosis.

Tympanoplasty (21.9%) and myringotomy with grommet insertion (18.3%) together constituted approximately 40% of surgical procedures, reflecting the substantial burden of middle ear disease requiring operative management.

Septoplasty (12.2%) and endoscopic sinus surgery (7.9%) were performed for structural and chronic sinonasal conditions.

Malignancy-related surgeries accounted for 5.6% of procedures, involving tumour excision and biopsy-based interventions as part of multidisciplinary care.

The surgical profile reflects the spectrum of paediatric ENT surgical practice in a tertiary care hospital, predominantly focused on adeno-tonsillar and middle ear pathologies.

**Table 4: Common Surgeries Performed (n=164)**

| Procedure | Frequency (%) |
|---|---|
| Adenotonsillectomy | 56 (34.1) |
| Tympanoplasty | 36 (21.9) |
| Myringotomy with grommet | 30 (18.3) |
| Septoplasty | 20 (12.2) |
| Endoscopic sinus surgery | 13 (7.9) |
| Malignancy-related surgery | 9 (5.6) |

[Table 5] Hospital Stay, School Absenteeism, and Outcomes

Children with benign conditions had a mean hospital stay of 3.2 ± 1.4 days, reflecting short-duration admissions for routine surgeries such as adenotonsillectomy and tympanoplasty.

In contrast, malignant cases required significantly longer hospitalization (7.6 ± 3.1 days), due to the complexity of surgical procedures, need for additional investigations, and multidisciplinary planning.

Mean school absenteeism was 6.4 days for benign conditions and markedly higher (14.2 days) for malignant diseases. This indicates a substantial educational and psychosocial impact of paediatric ENT disorders, particularly in oncological cases.

At 3-month follow-up, favourable outcomes were observed in 91% of benign cases, demonstrating high effectiveness of medical and surgical management. In malignant conditions, favourable outcomes were noted in 70% of cases, reflecting the comparatively guarded prognosis despite early intervention.

These findings highlight that while most paediatric ENT conditions are treatable with good outcomes, malignancies and delayed acceptance of surgery can prolong morbidity and recovery time.

**Table 5: Hospital Stay and School Absenteeism**

| Variable | Benign Conditions | Malignant Conditions |
|---|---|---|
| Mean hospital stay (days) | 3.2 ± 1.4 | 7.6 ± 3.1 |
| Mean school days lost | 6.4 | 14.2 |
| Favourable outcome at 3 months | 91% | 70% |

## DISCUSSION

The present study reaffirms that adeno-tonsillar disease and otitis media remain the leading causes of paediatric ENT consultations, consistent with contemporary global epidemiological data.[1–4] Adeno-tonsillar hypertrophy continues to represent a major indication for paediatric surgical referral due to recurrent infections, sleep-disordered breathing, and its impact on cognitive development and school performance. Likewise, chronic otitis media remains highly prevalent in low- and middle-income countries, with reported prevalence ranging between 5–8%.[5] The rural predominance (61.1%) observed in our cohort mirrors findings from Indian tertiary centres, where delayed primary care access and recurrent infections contribute to higher disease burden.[6,7]

Nearly half (48%) of the children required surgical intervention. Adenotonsillectomy was the most frequently performed procedure, aligning with contemporary surgical trends in paediatric otorhinolaryngology.[8,9] Tympanoplasty and myringotomy with ventilation tube insertion were commonly undertaken for persistent otitis media with effusion, in accordance with evidence-based recommendations.[10,11] These decisions reflect surgeon adherence to established clinical guidelines, where indications for surgery are based on symptom severity, failure of medical therapy, risk of complications, and quality-of-life impairment.

However, a major strength of this study lies in its examination of the divergence between clinical judgment and parental expectations. We observed a 32% discordance rate in cases where surgery was advised. While surgeons recommended operative management in 48% of cases, only 28.7% of parents initially preferred surgical intervention. This gap illustrates a recurring challenge in paediatric ENT practice: the interface between scientific evidence and caregiver perception.

Parental reluctance toward surgery has been well documented in recent literature.[12-14] Anxiety regarding anaesthesia safety, fear of postoperative pain, concerns about complications such as bleeding or hearing loss, and financial constraints often influence decision-making. In resource-limited settings, indirect costs such as travel, wage loss, and postoperative care further contribute to hesitation. Cultural beliefs may also favour prolonged medical therapy or alternative remedies before accepting surgery. Thus, parental resistance does not necessarily reflect disagreement with medical science but often represents protective instincts shaped by emotional and socioeconomic factors.

From the surgeon's perspective, decision-making is guided by objective clinical findings, diagnostic investigations, and long-term risk-benefit analysis. For example, in recurrent adeno-tonsillitis or obstructive sleep apnoea, delayed surgery may predispose to growth retardation, behavioural issues, or cardiopulmonary complications. Similarly, prolonged otitis media with effusion can impair speech development and academic performance. The surgeon's recommendation for early surgical intervention is therefore often preventive rather than reactive.

This divergence between preventive surgical reasoning and parental preference for conservative therapy creates an ethical and communicative challenge. Surgeons must balance beneficence (acting in the child's best interest) with respect for parental autonomy. Excessively assertive recommendations may undermine trust, whereas overly passive acceptance of parental refusal may compromise long-term outcomes. The 32% discordance observed in this study exemplifies this delicate equilibrium.

Encouragingly, structured counselling significantly improved acceptance of surgery from 68% to 84%. This finding reinforces the importance of shared decision-making frameworks.[15] When surgeons provided clear explanations regarding disease pathology, risks of delayed treatment, expected recovery, and anaesthesia safety, parental confidence increased. Visual aids, audiometric charts, endoscopic images, and simplified risk comparisons were particularly effective in bridging understanding. The data underscore that discordance is often rooted in informational asymmetry rather than true disagreement.

Hospital stay and school absenteeism further contextualize this issue. Although surgical management resulted in short-term absence (mean 6.4 days for benign conditions), it prevented repeated episodes of illness and recurrent absenteeism. Studies have shown that timely adenotonsillectomy significantly reduces missed school days and improves quality-of-life indices.[16,17] Parents initially focused on immediate hospitalization duration may underestimate long-term academic and psychosocial benefits. Thus, surgeon counselling must incorporate discussions about long-term functional outcomes rather than merely procedural details.

The presence of malignancies (2.6%) introduces another dimension of conflict. While rare, paediatric head and neck cancers such as nasopharyngeal carcinoma and rhabdomyosarcoma require prompt surgical and oncologic intervention. Parental denial, fear, and emotional distress may delay acceptance of invasive diagnostic or therapeutic procedures. In such cases, surgeon communication must extend beyond technical explanation to empathetic counselling and multidisciplinary support. Our favourable 70% short-term outcome rate aligns with regional registry data,[18–20] highlighting that early intervention improves survival and functional preservation.

Another noteworthy observation is the influence of rural background on treatment perspectives. Families from rural areas were more likely to initially prefer medical management, possibly due to limited awareness of surgical safety standards or logistical constraints. This emphasizes the need for targeted health education programs and strengthened primary care referral pathways.

Importantly, this study illustrates that conflict between parental expectations and surgeon recommendations is dynamic rather than static. Perspectives evolve through dialogue. Surgeons who adopt a patient-centred communication style, acknowledge parental concerns, and provide evidence-based reassurance can significantly reduce resistance. Conversely, inadequate counselling may perpetuate mistrust and delay treatment.

From a broader systems perspective, the findings underscore the necessity of institutional protocols supporting informed consent discussions, pre-anaesthesia counselling sessions, and educational materials tailored to local literacy levels. Training ENT residents in communication skills is equally essential, as technical expertise alone does not guarantee treatment acceptance.

In conclusion, the conflict between parental perspectives and surgeon decisions in paediatric ENT practice reflects a complex interplay of medical evidence, emotional factors, socioeconomic realities, and cultural beliefs. This study demonstrates that while discordance is common, it is modifiable through structured counselling and shared decision-making. Effective communication transforms potential conflict into collaborative care, ultimately improving clinical outcomes and parental satisfaction.

## CONCLUSION

Adeno-tonsillar disease and otitis media are the most prevalent paediatric ENT disorders, and nearly half of these cases require surgical management, with adenotonsillectomy being the most common procedure. There is often significant initial discordance between parental expectations and surgeon recommendations, particularly regarding the need for surgery, but structured counselling has been shown to substantially improve parental acceptance of evidence-based management. Early surgical intervention in appropriately indicated cases helps reduce school absenteeism and improves clinical outcomes. Although malignant ENT diseases are rare in children, they necessitate timely identification and multidisciplinary management. Effective communication and shared decision-making remain crucial in paediatric ENT practice.

**Limitations:** This was a single-centre study, which limits the generalizability of the findings, and it had a short follow-up duration of only three months. Parental perception was assessed using a self-reported questionnaire, making it subject to potential bias, and no long-term quality-of-life assessment was conducted. Additionally, economic factors were not quantitatively analyzed.

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