Response to "Re: Need for Bronchoscopy in Adenotonsillectomy," from Rahul K. Shah and Diego A. Preciado
Jeffrey C. Rastatter, James W. Schroeder, Jr, Lauren D. Holinger and Adam French
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What is This?
Response to “Re: Need for Bronchoscopy in Adenotonsillectomy,” from Rahul K. Shah and Diego A. Preciado

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The intent of our study was simply to report our findings on a unique subset of patients. Full airway evaluation in these children is based on the concern that young children (<3 years old) who present with sleep-disordered breathing (SDB) might have a synchronous airway lesion (SAL) contributing to the obstruction and early presentation. Direct laryngoscopy and bronchoscopy (DLB) was performed at the time of the adenoidectomy ± tonsillectomy (A±T). Similar studies have addressed this topic in children even younger (<18 months old).1

The patients included in this study did not have a known SAL or signs of other airway pathology such as stridor. All of the patients presented with signs of SDB (snoring, mouth breathing, pausing, etc). This makes the discovery of the SAL even more interesting. As stated in the article, the contribution of these SALs is unclear. Only 4 required independent surgical intervention. It is unclear when and if these lesions would have been discovered if a DLB was not performed. Perhaps obstructive symptoms would have persisted after A±T or new symptoms would have appeared.

We agree with the contributors’ comments about health care cost containment. That is why we merely presented our findings and suggested considering airway evaluation in these young children. We do not absolutely recommend DLB on all children younger than 3 years who have an A±T. We did not do a cost benefit analysis. However, one might consider the additional cost, both financial and quality of life (QOL) related, of not diagnosing and treating SALs that we discovered at the time of surgery. At least 4 may have received additional workup along with further surgery. Others were medically treated for gastroesophageal reflux disease, and this may have improved QOL and possibly limited the need for further testing and symptom workup.

Thus, regardless of whether one considers laryngeal edema or tracheal cobbblestoning significant SALs, or whether the rate of SALs is 59% or 73%, we still consider airway evaluation in children less than 3 years of age who require A±T for SDB.

Jeffrey C. Rastatter, MD
James W. Schroeder Jr, MD
Lauren D. Holinger, MD
Department of Otolaryngology, Northwestern University
Feinberg School of Medicine, Chicago, Illinois, USA
Division of Pediatric Otolaryngology, Children’s Memorial Hospital, Chicago, Illinois, USA
Email: jrastatter@childrensmemorial.org

Adam French, MD
Department of Otolaryngology, University of Illinois School of Medicine, Chicago, Illinois, USA

Reference

Emerging Trends in the Management of Laryngeal Rhabdomyosarcoma*

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We were interested in the clinical photograph section detailing “Childhood Laryngeal Rhabdomyosarcoma Causing Acute Airway Obstruction.”1 In the discussion, the authors state, “Life-threatening childhood laryngeal RMS [rhabdomyosarcoma] causing upper airway obstruction has not yet been reported in the literature.” We recently had an adult case of laryngeal spindle cell rhabdomyosarcoma that we treated with a partial laryngectomy (Figure 1) and adjuvant chemoradiation. In our review of the literature to assist us with the management of this rare entity, we did find a case report of a 13-year-old girl admitted to the intensive care unit with respiratory failure due to a subglottic mass occupying 80% of the laryngeal lumen.2 It is encouraging to us to read about the effectiveness and increasing use of less invasive and organ-preserving modalities to treat this unusual neoplasm, as described in Lujber and Revesz’s article and from our experience.3,4 Our patient case reported here has been approved by our hospital institutional review board.

Chau Nguyen, MD
Division of Otolaryngology–Head and Neck Surgery, Ventura County Medical Center, Ventura, California, USA

* A poster presentation of the case report and review was presented at the Triological Society’s Combined Sections Meeting, January 27 to 29, 2011, Scottsdale, Arizona.