In Response to the Letter to the Editor: "Clinical Consensus Statement: Tracheostomy Care"

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What is This?
Letters to the Editor

Clinical Consensus Statement: Tracheostomy Care
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I congratulate Mitchell et al.1 on the consensus statement on tracheotomy care. However, the rationale behind their decision on terminology is unclear. They defined the terms tracheotomy (a temporary opening) and tracheostomy (a permanent opening, such as performed with a laryngectomy) correctly. They stated further that “it was understood among the panel that tracheotomy is the correct name for the surgical procedure discussed in this document.” Nevertheless, they chose to use the term tracheostomy throughout the consensus statement, perpetuating incorrect usage that unfortunately has occurred frequently in our literature. It seems as if the consensus committee intentionally abandoned an opportunity to improve linguistic precision in our field, despite dissent from at least 1 member of the committee. What were they thinking?

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We thank Dr Sataloff for his letter concerning the rationale behind our decision to use the term tracheostomy vs tracheotomy in the “Clinical Consensus Statement: Tracheostomy Care.”

As Dr Sataloff mentioned, the terms are often used interchangeably in the literature, leading to confusion as to whether they are actually synonymous or have different meanings. The panel recognized this discrepancy and discussed the connotation of both terms on the second conference call. Members of the panel believed that the document applied to the management of both a temporary and a permanent stoma and addressed the full spectrum of care, not limited to the surgical procedure itself. Therefore, all panel members, with the exception of one, agreed the term tracheostomy best defines care of the tube and stoma following its initial insertion. The intent of the panel was not to abandon the term tracheotomy but instead to reserve it for use when referring to the procedure of creating an opening in the trachea rather than care of the tube and stoma.

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Comparison of Intratympanic Methylprednisolone and Gentamicin for Ménière’s Disease May Be Misleading

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It was with great interest that I read the article, “The Effect of Intratympanic Methylprednisolone and Gentamicin Injection on Ménière’s Disease,” which appeared in the April 2013 issue.1 I agree with the authors’ conclusions that intratympanic (IT) gentamicin is an effective treatment for Ménière’s disease. However, the way in which the outcomes were assessed could potentially have led to a misleading conclusion. It is accepted that duration of IT steroids is limited to about 3 months,2-4 while gentamicin is a more permanent therapy. Gabra and Saliba reported the rate of complete vertigo control during the 6 months after therapy and for 6 to 12 months after therapy. During these periods, the rate of complete vertigo control after a distant steroid administration would be predictably poor. However, during the 0- to 6-month period the number of vertigo attacks in those treated with steroids was less than half that during the 6 months prior to therapy. Such an outcome would be expected if the steroids eliminated the attacks for the first 3 months and the patients then returned to their baseline. Do the authors have any data on the frequency of vertigo attacks during the initial 3 months after IT steroids? Furthermore, although the number of attacks was assessed in this study there was no report of vertigo severity or other quality of life measures. It would also be of interest to know if the patients who had poor control of vertigo with IT methylprednisolone were offered any further treatment during the 12-month follow-up, and if not why? As the authors mention, there is a “wide range of results concerning vertigo control” with IT steroids (usually dexamethasone), almost all of which are better than the results they report. Is it possible this variation indicates differences in outcome analysis?

In considering IT gentamicin for management of Ménière’s, potential morbidity must be weighed. It was surprising they found a long-term hearing improvement after IT gentamicin, and I was curious if this might be explained by attrition of worse hearing patients. Another major morbidity of gentamicin that is not discussed in this article is loss of peripheral vestibular function that should be expected to occur in the treated ear. Although the imbalance symptoms caused by this may improve with vestibular rehabilitation, this unilateral vestibular hypofunction does not generally occur with steroid treatment. Did the authors assess these symptoms?

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Response to: Comparison of Intratympanic Methylprednisolone and Gentamicin for Ménière’s Disease May Be Misleading

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We highly appreciate the interest in our study.

In 2010, Herraiz et al1 studied the efficacy of transtympanic injections of 40 mg/mL of methylprednisolone in Ménière’s disease (1 dose per week for 3 weeks). Their follow-up intervals were 6, 12, and 24 months. The percentage of patients with no spells reached 41% after 6 months, 81% after 12 months, and 78% after 24 months. Unfortunately, their results were descriptive without a control group; some of their patients needed an intratympanic gentamicin injection for refractory Ménière’s disease.

The pharmacokinetics of dexamethasone and methylprednisolone largely differ. A double-blinded randomized study