Re: "Decision Making in the Choice of Surgical Management for Preauricular Sinuses with Different Severities"

Dong-Hee Lee

Otolaryngology -- Head and Neck Surgery 2013 149: 650
DOI: 10.1177/0194599813499889

The online version of this article can be found at:
http://oto.sagepub.com/content/149/4/650

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>> Version of Record - Sep 16, 2013

What is This?
I read with great interest the article by Huang et al\textsuperscript{1} and was impressed by their result that the figure 8 incision with extended fistulectomy can achieve adequate wound exposure for radical excision of the inflamed tissue and a satisfactory surgical outcome. Because the preauricular sinus is rare in Western countries, there have been few clinical reports on its clinical presentation or treatment. Most large clinical studies on preauricular sinus have been performed in Asian countries.\textsuperscript{2,4} Although this article gave some tips to otologic, plastic, or pediatric surgeons, I have some comments. The authors chose the surgical procedure according to 2 important factors: (1) the severity and range of the inflamed tissue at the time of surgery and (2) the presence/absence of fistula. I agree that these decision criteria are logical. However, I think that the former is a very important factor to consider in this study while the latter is not. It was already reported that previous incisional drainage of an abscess was not a prognostic factor for recurrence.\textsuperscript{2,3} Most incisional drainage wounds are well healed enough to be ignored during preauricular fistulectomy, and its iatrogenic fistula opening has to be included only within the skin incision. It seems to be unimportant whether the skin incision is linear wide or figure 8.

In my opinion, the more important surgical step to prevent recurrence must be the removal of auricular cartilage. This is because too many short sinocartilaginous distances of preauricular sinus can make it difficult to dissect most sinus tracts from the auricular cartilage, and this is the evidence that routine removal of auricular cartilage along with the sinus tract can help to prevent a recurrence.\textsuperscript{5} However, I did not find out in this article if there might be a difference in the removal of the auricular cartilage between the authors’ 2 methods (wide excision versus figure 8 incision with extended fistulectomy). If the authors did not consider this in their analysis, their study might draw an improper conclusion that just a difference of the skin incision could make the difference in postoperative recurrence.

Of course, a wider surgical view field can help the surgeon perform the operation more easily and remove the tract more completely. However, I think that there may be no difference in the surgical view field between wide excision and figure 8 incision with extended fistulectomy. This can be also be seen in the authors’ figures 2 through 4.

Considering these comments, future studies can provide better results for the readers.

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Disclosures
Competing interests: None.
Sponsorships: None.
Funding source: None.

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Response to “Re: ‘Decision Making in the Choice of Surgical Management for Preauricular Sinuses with Different Severities’”

DOI: 10.1177/0194599813499890

No sponsorships or competing interests have been disclosed for this article.

We thank Dr Lee for his comments on our article. Nevertheless, we would like to respond to a few points raised by Dr Lee.

In the study, one of the factors influencing the choice of surgical approach was the formation of a fistula with 2 openings, both of which may be situated at variable distances, different planes, or both. If the 2 openings are situated at a close distance or if the infected preauricular fistula results in a limited necrotic area, local wide excision may be an adequate surgical procedure because fistula openings may be included within the skin incision, allowing for total removal of the lesion. However, if there are separate openings with a longer distance (despite congenital or iatrogenic holes) or the openings are not at the same plane of the skin surface, a figure 8 incision with extended fistulectomy would be preferred because this technique not only provides wide exposure of the surgical field but also can preserve more intact skin. In contrast, when using a local wide excision, a substantial amount of normal adjacent tissue would be sacrificed between the 2 openings, and extra normal skin sacrifice may also be needed to avoid a dog-ear defect (Figure 1). Therefore, the degree of skin tension would greatly increase during wound closure using traditional local wide excision, leading to poor cosmetic outcomes. It is very important to determine the proper incision approach when dealing with fistulas with 2 openings.

At our institution, removal of auricular cartilage during preauricular sinusectomy or fistulectomy is routinely performed to minimize the recurrence rate. Hence, there were no differences in the percentage of ears that received this procedure between the 3 approaches. On the other hand, a significant difference was observed in the recurrence rate between groups II and III. One of the reasons poorer outcome was observed in group II may be that the group included more revision patients (n = 8), with 4 of them showing recurrence later. Therefore, we could not make a definite conclusion on the role of the skin incision approach in postoperative outcomes.

Finally, one point that needs to be emphasized in the study is that both traditional local wide excision and figure 8 incision provided adequate surgical field exposure to remove the entire inflamed soft tissue, but the latter achieved a more satisfactory cosmetic outcome.

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