Response to "Management and Outcomes in Patients Affected by Malignant Otitis Externa"
Andrew A. McCall, Candace E. Hobson, Jennifer D. Moy, Karin E. Byers, Yael Raz and Barry E. Hirsch
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Management and Outcomes in Patients Affected by Malignant Otitis Externa

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We read with great interest the recent article from Hobson et al., who studied a retrospective case series of patients diagnosed with the rare manifestations of malignant otitis externa (MOE).

We commend the authors for their efforts in trying to identify a sample as homogeneously as possible. However, we highlight some important methodological issues that unfortunately may undermine the scientific rigor of the study, and therefore the clinical evidence provided, more so in light of the very limited sample size (only 15 eyes at final follow-up).

While a strict adherence to the Cohen criteria may be no longer fundamental to the diagnosis of MOE, given the use of computed tomography (CT) that documents the presence of bone erosion (osteomyelitis), we feel that it is nowadays mandatory to avoid CT for assessing the progression and documenting the resolution as bone changes persist after treatment of the disease.

We would have expected that the authors had provided information regarding their changed practice during the study period if it really occurred, or at least suggested that readers adopt Ga-67 scintigraphy, whether or not combined with single-photon emission computed tomography (SPECT)/CT, for the follow-up of these patients. We also point out that some of the patients included were not treated for at least 6 weeks, as per current recommendations of best practice guidelines.

Lastly, perhaps it would have been more appropriate to exclude the 3 patients who underwent combined medical and surgical treatment.

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We thank Drs Carifi, Napolitano, and Morandi for their interest in our paper and for their inquiries.

Computed tomography (CT) imaging has been used by some to evaluate for disease resolution (by documenting the resolution of soft tissue changes) in malignant otitis externa (MOE). While we commonly use CT imaging to help establish the diagnosis, we generally now limit the use of follow-up CT imaging to cases of suspected disease progression. As pointed out, some authors advocate for nuclear imaging methodologies (such as gallium scanning) for establishing disease resolution.

Regarding treatment duration, we posit that, like many other bacterial disease processes, the optimal duration of antibiotic therapy for MOE is not clearly established. The treatment

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guidelines referenced rely on relatively low-level evidence studies (level 3 and 4 studies), which is not surprising given the rarity of the disorder. Unfortunately, trials with high levels of evidence are nearly universally lacking for many rare disease processes (including MOE). Ultimately, treatment duration is determined by the treating physician. Nevertheless, as documented in our paper, our default treatment duration for MOE is 6 weeks, which is then tailored to the clinical picture.

Despite the fact that we generally do not recommend surgical intervention (aside from canal debridement or biopsy) in the setting of MOE, we included patients who had undergone mastoidectomy during their treatment course for MOE because, at the time of treatment, the treating physician had documented a reasonable concern, such as a suspected malignancy or the presence of sequestered bone, for intervening. We will once again stress that, except under unusual circumstances, we do not recommend surgical intervention in cases of MOE.

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References

We were delighted to see the excellent report in the journal by Sidell and colleagues highlighting the importance of exercise-induced laryngeal obstruction (EILO) as a key differential diagnosis for respiratory symptoms in young individuals.

Their report is in keeping with the prior published work and acts to strengthen the data, underpinning both diagnostic and therapeutic options in this important condition. Moreover, the work adds to the literature, by indicating that exercise laryngoscopy is easily performed and well tolerated in young individuals (ie, in those aged under 15 years).

To date, the field of exercise laryngoscopy has been dogged by a complicated and oft overlapping nomenclature. To this end, a great number of terms have been employed to effectively describe the larynx closing during exercise. The same is true of test methodologies employed. This undoubtedly clouds methodological comparison and can confuse clinicians wishing to perform the procedure and inform treatment strategies.

The current study, unfortunately, now adds to the bank of available nomenclature; namely, continuous laryngoscopy during exercise (CLE) is described as exercise stress laryngoscopy (ELS). It is acknowledged that the latter may differ, in part, from other work in the literature, but adaptations might be best described with the term modified or adapted rather than with additional terminology.

Guidance on terminology is in process from an European Respiratory Society/European Laryngological Society–led task force; however, we would encourage globally accepted “consensus-obtained” nomenclature to be adopted for future work in this field to ensure that we facilitate interpretation of findings and perhaps most importantly to highlight the fact that in this field of research we are all speaking the same language.

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