Letter to the Editor on “Myringotomy and Ventilation Tube Insertion with Endoscopic or Microscopic Technique in Adults: A Pilot Study”

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I am writing in reference to a study published in your journal titled “Myringotomy and Ventilation Tube Insertion with Endoscopic or Microscopic Technique in Adults: A Pilot Study,” by Martellucci et al.1 The article is well written, and I thoroughly enjoyed it. I would like to add our own experience to the conclusion derived by the authors for the benefit of the readers of your esteemed journal.

In our center, we routinely perform endoscopic myringotomy and ventilation tube insertion in both children and adults. While most of the adults are operated under local anesthesia, we prefer general anesthesia for the kids. The advantages of superior illumination, clarity, and magnification2 are a great attraction. This also helps us to demonstrate and teach our students and residents more efficiently.

However, there are a few conditions where endoscopic myringotomy is particularly challenging—for example, a narrow or very tortuous ear canal; excessive bleeding that keeps obstructing the endoscopic view; or the presence of a mass, such as a small asymptomatic osteoma—and I would advise caution in such cases. In these situations, I use the traditional technique of operating under the microscope. I would also like to highlight that a major disadvantage of the endoscopic technique is that we have only 1 hand to operate and insert the ventilation tube, which is difficult and entails a learning curve that takes time to acquire. This also slightly increases the operating time.

On retrospective review of the patient charts in our institution, we found no statistical difference between the operating times and complications for both techniques. However, I would like to emphasize that a cost-benefit analysis with a larger prospective randomized trial comparing both techniques is warranted before a definite conclusion can be arrived at regarding which technique is better.

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References

Re: “Myringotomy and Ventilation Tube Insertion with Endoscopic or Microscopic Technique in Adults”

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We thank Dr Bakshi for his interest in our article. Statistically, our experience proved no difference between microscopic and endoscopic techniques for myringotomy and ventilation tube insertion (M&T).1 However, in endoscopic approaches, we observed the same benefits highlighted by Dr Bakshi in his comment.

The magnified view of the surgical field represents, in our opinion, the greatest advantage of endoscopic M&T. We believe that this benefit is significant not so much for skilled ear surgeons as for residents, for which this procedure can be insidious. The endoscopic procedure ensures that both the

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junior surgeon and the tutor can see the same magnified images during surgery, thus facilitating the tutoring. Using a common surgical microscope instead, the surgeon benefits by 3-dimensional images, whereas the observers have a 2-dimensional view. The microscope therefore offers to the surgeon an immediate depth perception that the endoscope lacks. However, movements of the endoscope allow perception of a relative positional anatomy, which can minimize this limitation.²

Like all other endoscopic procedures, endoscopic surgery of the ear requires practice to develop the necessary hand-eye coordination and skills.² Even though M&T is a relatively simple procedure, we recommend avoiding it in difficult cases at the beginning of the learning curve. We agree that a narrow, very tortuous ear canal or the presence of osteomas may represent a challenging anatomic condition. Therefore, in these cases, we recommend to perform M&T using the technique with which the surgeon is more confident. Paradoxically, M&T in children could be easier than in adults because the child’s ear canal, though narrower, is shorter and straighter than that of adults, thus facilitating endoscopic surgery.³

Regarding intraoperative bleeding, even though this aspect could limit the endoscopic approach, we were not penalized by using a 1-hand technique. Indeed, complete control of the surgical field and reduced bleeding, typical of this procedure, limit the need to use the suction tip, allowing the surgeon to operate with the right hand without difficulty while the left hand supports the endoscope.

Finally, we totally agree with Dr Bakshi regarding a need of a larger prospective randomized trial comparing microscopic and endoscopic techniques for M&T.

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References

Clinically Significant Rhinosinusitis Can Be Asymptomatic
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We are writing to express significant concern over the definition of rhinosinusitis in the “Clinical Practice Guideline (Update): Adult Sinusitis.” Although this is an important document, we specifically disagree with the statement “Rhinosinusitis is defined as symptomatic [emphasis added] inflammation of the paranasal sinuses and nasal cavity.”1(p82)

By using the word symptomatic within the definition, the term is being used as a clinical indicator for treatment and not a true definition of a pathologic state. The presence of inflammation, whether symptomatic or asymptomatic, is abnormal. Such inflammation, however, is not an indication for medically supervised management, whether symptomatic or not. Depending on etiology, such inflammation may resolve spontaneously. In our opinion, the definition of the term rhinosinusitis should describe the pathologic condition consistent with medical usage of the suffix -itis as it is used across medicine: “a disease characterized by inflammation.”²,³ Like asthma, atherosclerosis, hypertension, hyperlipidemia, and many other diseases, rhinosinusitis may be silent. Examples of clinically significant asymptomatic rhinosinusitis that can be encountered include the following:

- Patients with ongoing treatment for chronic rhinosinusitis with nasal polyps whose symptoms are in remission but endoscopy shows minor edema or polyoid tissue. Discontinuance of medical therapy nearly always results in return or worsening of disease, leading to return of symptoms.
- Patients who exemplify “united airway disease” not infrequently deny nasal symptoms such as congestion or drainage (possibly a result of insidious onset): (1) mild asthmatics where computed tomography sinus workup reveals unsuspected rhinosinusitis; (2) cystic fibrosis patients where computed tomography sinus workup reveals unsuspected rhinosinusitis.
- During a general otolaryngologic examination, anterior rhinoscopy incidentally reveals asymptomatic small bilateral middle meatal nasal polyps.
- Preoperative imaging of pituitary adenoma identifies bilateral maxillary/ethmoid mucosal thickening with a small air fluid level.
- Silent sinus syndrome.
- Early/recurring antrochoanal polyps.
- Early mucocele formation.

In summary, we believe that the word symptomatic should be removed from the definition. This will eliminate the ICD coding dilemma for meaningful asymptomatic sinus