inflammation, especially among patients with ongoing but now asymptomatic disease who are being monitored and treated following surgical intervention. This will help justify appropriate care that could include medical therapy, follow-up appointments, endoscopy, or even imaging. It enables our colleagues (eg, radiology and pathology) who may diagnose rhinosinusitis incidentally to use the term correctly and it prevents confusion in the medical record. This may encourage continued research of sinus inflammation broadly and not just in the case of symptomatic disease.

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References
by Hwang et al., published in your esteemed journal. The authors have been meticulous in carrying out the study, and I have enjoyed reading the same. I would, however, like to add to the authors’ conclusion for the benefit of the readers of your prestigious journal.

One of the reasons postulated for lingual tonsil hypertrophy is a persistent chronic low-grade infection. I have observed that patients having significant postnasal drip due to sinusitis often have associated hypertrophy of the lingual tonsils. Whether this association is coincidental or both lingual tissue hypertrophy and sinusitis are mediated by gastroesophageal reflex is open to discussion, and further studies would be needed to clarify this. I totally agree with the authors’ conclusion that higher reflux symptom index is associated with increased lingual tissue hypertrophy, which has also been proven in similar studies.

However, I would strongly like to differ from the authors’ conclusion that body mass index and obstructive sleep apnea syndrome are not associated with lingual tissue hypertrophy. It has been consistently proven in many studies that there is an association between body mass index and obstructive sleep apnea syndrome with lingual tissue hypertrophy. In fact, reduction of the lingual tonsil has proven to be effective in relieving the symptoms of obstructive sleep apnea syndrome in many studies.

A systematic review of all the previous studies regarding risk factors associated with hypertrophy of lingual tonsils with multivariate analysis of the same is warranted before a definitive conclusion can be arrived.

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References

Response to Commentary on “Factors Associated with Hypertrophy of the Lingual Tonsils”

Dear Dr Bakshi,

Thank you for your letter to the editor regarding our article. I cannot completely agree with your comments about the relationship among lingual tonsil hypertrophy (LTH), obstructive sleep apnea (OSA), and body mass index (BMI). Just because patients with LTH have OSA does not imply that patients with OSA have a higher incidence of LTH than do non-OSA patients. There is no doubt that the patients with significant LTH may have OSA and that lingual tonsillectomy would benefit these patients. This is similar to faucial tonsil hypertrophy, which may contribute to OSA, and classic tonsillectomy is helpful in those patients.

It is important to note that the majority of OSA patients do not have faucial tonsil grade III or IV, just as the majority of patients with OSA do not have LTH grade III or IV, as proven by this study. It follows, therefore, that lingual tonsillectomy will be beneficial for a very small percentage of patients with OSA. There are other factors that contribute to the pathogenesis of OSA, and lingual tonsillectomy will not treat those patients. This is especially important since lingual tonsillectomy in some centers has become a very common treatment of OSA.

The effect of BMI on LTH needs to be further investigated. Although it has been shown that larger BMI is associated with larger lingual tonsils, other unassessed factors may play a role in the development of LTH. While our study showed a wide range of BMI and OSA severities for each LTH grade, further studies with larger patient populations are needed to accurately assess the association of BMI and LTH.

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