
Comments

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M.T. Brigger, San Diego, Calif.: Despite the well-publicized findings of the National Prospective Tonsillectomy Audit (NPTA), hot techniques remain commonplace particularly in the USA. Many US trainees have a marginal exposure to exclusively cold techniques. Despite the NPTA experience, a survey of otolaryngologists in the USA in 2009 and 2010 demonstrated that monopolar cautery was by far the most common technique in academic training centers [1]. Publications of varying degrees of quality have reported low bleeding rate outcomes for a variety of hot techniques. While the feasibility of an audit approach in the US health care system would face extremely difficult logistical hurdles, the widespread use of monopolar cautery would provide an interesting comparison to the NPTA data. Ultimately, I believe there is value in using the available data as a benchmark in one's own practice with frequent self-appraisal, and critical review is essential to deliver the best tonsillectomy procedure to our patients.

E. Hultcrantz, E. Ericsson, Linköping: This paper is a bit confusing: the state of the art still demonstrates that cold dissection and cold hemostasis are connected with fewer bleedings, but in spite of that the authors recommend hot techniques for patients where the risk for bleeding could be important (young, small children with low weight). This is every clinician's dilemma. Maybe the indication for surgery per se for the younger/smaller children should have been discussed? Maybe tonsillotomy could have been an option in many cases instead of use of a hot technique?

J.P. Windfuhr, Mönchengladbach: It is extremely important to realize that the postoperative course is significantly depending on the diathermy power settings. Although the different surgical tonsillectomy techniques are associated with a higher rate of primary (cold) or secondary (hot) hemorrhage, the surgical principle to remove the tonsils is the same. Newer instruments (Coblation[®], harmonic scalpel) comply with this surgical philosophy which has not changed for many decades now. It appears that the surgical philosophy changed for the first time with vessel-sealing instruments since the providing blood vessels are dissected (preferably with the use of a microscope) before they are transected, sometimes with self-limiting electrosurgical devices. This newer philosophy may close the gap between cold dissection and minimizing the amount of electric energy required to achieve hemostasis.

C. Gysin, Zurich, P. Dulguerov, Geneva: This article repeats the data and conclusions of the British NPTA. While a lot of statistical power is gained from the inclusion of 34,000 cases, the readers should be reminded that such an audit represents at best evidence level III. Thus, we find it surprising that the authors would recommend changing clinical practice and resident training based on this level of evidence.

Nevertheless, such an audit might be seen as an evaluation of the ‘real practice’ and concur with the authors’ recommendations on: (1) the use of lower diathermy power settings and (2) the preference of bipolar diathermy for small children where the small circulating volume limits the tolerable blood loss. The problem remains for older patients, especially in the context of the so-called recurrent tonsillitis, where hemostasis is difficult to achieve without some form of diathermy. One possible advantage, falsely attributed to the cold dissection, is the use of a ligature at the lower tonsillar pole: this indirectly stops the dissection before extending too far in the base of the tongue and lateral pharyngeal wall, where the majority of serious hemorrhages occur.

S. Sarny, Graz: The British Audit on tonsil surgery conducted in 2003 and 2004 on a large national cohort was novel and renewed opinions on posttonsillectomy haemorrhage risks and the surgical techniques used for tonsillectomy. The present article reports unpublished data which adds to the understanding of haemorrhage rates for various surgical techniques. Emphasis is put on the Coblation technique. The authors take not only the bleeding rate but also the performance, the hospital setting and the learning curve of residents into account. These circumstances were paid less attention in former studies, but substantially influence the interpretation of postoperative bleeding rates. Furthermore, recommendations for surgical techniques according to the patient’s age are given which depict a practical approach for all surgeons.

Reference

- 1 Setabutr D, Adil EA, Adil TK, Carr MM: Emerging trends in tonsillectomy. *Otolaryngol Head Neck Surg* 2011; 145:223–229.