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## Comments

### Comments to ORL 2013;75:175–181 (DOI: 10.1159/000342319)

*M.T. Brigger, San Diego, Calif.:* While the deaths of 5 children in 2006 and 2007 likely represent an unfortunate aggregation within the statistical bounds of the known risks of tonsillectomy, the introspective opportunity demanded by the occurrence provides valuable insight and evidence into pediatric tonsillectomy. In particular, the lack of standardization of defining and monitoring complications is a failure of the academic community. As many of the articles in this issue acknowledge, the lack of clear definitions and severity measures in defining postoperative complications greatly limits interpretation of our data and making true evidence-based recommendations. Dr. Sarny and colleagues provide an excellent narrative of how the deaths changed indications and reporting practices in a meaningful way in their country. The classification scheme devised by Dr. Stammberger is a useful and quantitative method to record bleeding outcome data and should be considered in future investigations of tonsillectomy bleeding rates. The overall experience illustrates the prime importance of precise data collection in an efficient, yet useful manner that is actively monitored and made available for self-evaluation by surgeons.

*E. Hultcrantz, E. Ericsson, Linköping:* We love this paper and hope that all countries will learn the lesson without having to go through the same deadly events!

With regard to the grading of the bleedings, we think that it is not suitable for a young age group. Most clinicians do not even try to inspect or suck away blood from the throat of a 3- to 4-year-old if the child starts to spit blood after surgery. Instead you bring the child back to the theatre and put him/her under again. This can be seen in figure 3 where return to the theatre does not necessarily mean that the bleeding has been substantial.

*D. Lowe, Middlesbrough:* The efforts of the Austrian ENT Society to clarify the facts surrounding tonsillectomy, adenotonsillectomy and adenoidectomy are unique and the authors to be congratulated for their work. However, children younger than 6 years of age may also suffer from recurrent episodes of tonsillitis and are therefore candidates for tonsillectomy too. This statement is supported by the studies of Paradise [1] who included children 3–15 years of age or van Staaïj [2] including children aged 2–8 years. Indication for surgery

should rely on the grade, and how seriously the quality of life in that particular individual is impaired rather than counting episodes of tonsillitis or years. It should be noted that no scientific papers have ever supported the hypothesis of an immunological dysfunction resulting from tonsillectomy in children at a certain age. Concerning tonsillectomy and tonsillotomy, restriction by age reflects more a subjective attitude than findings from high-level studies. The sophisticated classification system is another highlight of the Austrian study and should be used as a standard now. However, it should be realized that primary (<24 h) and secondary (>24 h) posttonsillectomy haemorrhages are assessed differently, because the midnight hour distinguishes between primary and secondary bleeding in the Austrian classification system.

*C. Gysin, Zurich, P. Dulguerov, Geneva:* While a prospective study certainly assesses complication rates more thoroughly, we tend to find the reported rates of posttonsillectomy bleeding in this article alarming: 12% in this article and 19% reoperation in another publication [3] of the same group should mandate an audit, as discussed in our paper in this issue (pp. 123–132).

It still remains unclear to us why the Austrian Society of ORL-HNS decided to favor tonsillotomy for young children prior to a double-blinded randomized trial. Similarly, hospital stay beyond 1 day has little scientific basis.

Although the authors do not dwell on it, the lower observed posttonsillotomy bleeding rates seem to confirm the authors' point of view. The readers should be reminded that the populations undergoing tonsillotomy and tonsillectomy are completely different: tonsillectomies were performed in an older group in which the main indication is recurrent infections, rather than obstruction. High rates of posttonsillectomy bleeding have been associated with these two patient characteristics in numerous studies. Detailed statistics are not provided, but a cursive evaluation of the bleeding rates in the 5- to 7-year-olds does not reveal obvious differences (fig. 2 and 3).

On a more methodological standpoint, we fail to understand why 50% of the patients discussed in this article had not undergone tonsil removal! In addition, since patients either had no, minor, or severe bleeding, we fail to understand figures 2 and 3, where the total of each column should be 100%!

## References

- 1 Paradise JL, Bluestone CD, Bachman RZ, Colborn DK, Bernard BS, Taylor FH, Rogers KD, Schwarzbach RH, Stool SE, Friday GA, et al: Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of parallel randomized and nonrandomized clinical trials. *N Engl J Med* 1984;310:674–683.
- 2 Van Staaik BK, van den Akker EH, Rovers MM, Hordijk GJ, Hoes AW, Schilder AG: Effectiveness of adenotonsillectomy in children with mild symptoms of throat infections or adenotonsillar hypertrophy: open, randomised controlled trial. *BMJ* 2004;329:651.
- 3 Sarny S, et al: Tonsillar haemorrhage and re-admission: a questionnaire-based study. *Eur Arch Otorhinolaryngol* 2011;268:1803–1807.