Tonsillectomy yet again!

The NICE systematic review of haemorrhage rates for various tonsillectomy techniques is summarized on pages 95 to 102 and confirms that in deciding which technique has the lower haemorrhage rate, one has to balance which is more important to avoid; primary or secondary haemorrhage. A technique that avoids primary haemorrhage causes more secondary haemorrhage and vice-versa. One way of trying to balance this is to look at the overall return to theatre rate for control of haemorrhage. This has the advantage of being an objective outcome and balances equally the severity of primary and secondary haemorrhage. Overall cold steel dissection with diathermy rather than ties occasions fewer returns to theatre than other methods of dissection including coblation (approximately 50% fewer).

So what technique should ORL trainees require to be competent in performing to be awarded their Certificate of Completion of Specialist Training? The answer is relatively simple. They have to be competent in cold steel dissection with diathermy and in addition be able to ties knots down that deep dark hole because not all bleeding can be controlled by diathermy.

Should an ORL departments wish to use other dissection techniques or coblation tonsillectomy then they require to audit their haemorrhage rates, initially retrospectively and then continue with this prospectively. If this is done, departments will then have data to justify (or otherwise) their continued usage of their technique. Such an audit is reported on page 156.

What of course is missing in the above debate is a discussion of the other deleterious outcomes of tonsillectomy including pain and difficulty in eating. To-date coblation tonsillectomy has yet to be shown to be superior in these aspects, so it seems unclear what the advantages if any are of using this technique even by trained surgeons with an acceptable haemorrhage rate.

Finally, but perhaps even more relevant, is recognition that the easiest way to reduce the number of patients with post-tonsillectomy haemorrhage is to perform fewer tonsillectomies. From trials, the benefit form tonsillectomy over natural resolution in children with between three to six episodes of sore throat per year is small; less than one episode of throat infection every 2 years as reported by the parents. So perhaps too many tonsillectomies are being carried out in children in this category.

Flamingo Flush

Textbooks emphasise the rare and as an otologist I cannot recall seeing a flamingo flush/Schwartze sign in a patient with clinical otosclerosis. Equally, I have never made the diagnosis of cochlear otosclerosis in the absence of a conductive impairment but maybe this is because I have never looked for a Schwartz sign in patients with sensorineural impairment. From the Japanese paper on page 110, it seems probable that a Schwartz sign is caused by an elevated blood flow over the promontory in association with otosclerosis. So perhaps we should be looking more carefully at the ears of patients with a sensorineural hearing impairment.

Watchful waiting for growth of acoustic tumours may be based on imprecise radiological measures

Increasingly, small acoustic neuromas (vestibular schwannomas) are being diagnosed by MRI in relatively asymptomatic patients. As such, an increasing number of patients are being followed up with surgery being confined to large tumours or those whose small tumours show evidence of enlarging, most frequently on repeat radiology or less commonly by deterioration in the hearing.

In general, neuro-otologists and neuro-surgeons rely on the neuro-radiologist to report a change in size of a tumour and do not take measurements themselves. It is therefore rather alarming to realise from the paper on page 123 that the test/retest error of measurement of schwannomas can be large and include the range of changes in size that have previously been taken to indicate a material enlargement.

Because so many patients with vestibular schwannomas are currently being monitored radiologically, the sooner the test/retest errors of the various methods of measurement are clarified the better.

Electroneurography in Bell’s palsy and Ramsay-Hunt’s syndrome.

The conclusions of the study on page 144 are perhaps worth repeating verbatim.

‘The electroneurography value performed between day 7 and 10 for Bell’s palsy or day 10 and 14 for herpes zoster oticus is not a precise prognostic indicator. The
clinical implications of its use are possibly to counsel and relieve the patients' psychosocial distress. However, it is not accurate or reliable enough to determine the prognosis of facial paralysis quantitatively.

**Lubricating your nasendoscope**

Nasendoscopy seems to be getting easier to do all the time. First we can dispense with routine topical anaesthetics because they do not make it less uncomfortable. Now from the RCT on page 134 we can dispense with these messy lubricants that block the view and use water instead. Water gives a better image and may make endoscopy easier.

**References**

1 Philpot CM, Wild DC, Mehta M *et al.* (2005) A double-blind randomised controlled trial of coblation versus conventional dissection tonsillectomy on post-operative symptoms. *Clin. Otol.* 30, 143–148

2 Browning GG. (2005) An important randomised controlled trial of adenotonsillectomy. *Clin. Otol.* 30, 58–59

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