

## Letters to the Editor

### Verrucous carcinoma of the maxillary antrum

Dear Sir,

Regarding the article by Ram *et al.* (*Journal of Laryngology and Otology* 112: 399–492) I wish to comment on their statement that only three cases of verrucous carcinoma of the maxillary sinus have been reported so far in the English literature. Actually this particular article would be the sixth one published in the English literature instead of the fourth as claimed by the authors, the fourth and the fifth being published by Agrawal and Martin, (1992) and Indudharan *et al.*, (1996) respectively. Sometimes such omissions occur inadvertently during literature search and I thought it would be appropriate to highlight the mistake.

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### Oro-nasal transfer of nasogastric tube following endoscopic placement

Dear Sir,

I would like to commend the method of oro-nasal transfer of nasogastric tube following endoscopic placement described by Alderson and O'Sullivan (*Journal of Laryngology and Otology* 112: 644–646). I have used an essentially similar method for several years, after struggling over many years with a variety of less elegant manoeuvres, as the authors describe. Hitherto I have used the larger tube as the retrieving tube as, with the larger tube over the smaller, the shoulder at the join is directed away from the direction of retrieval, and less likely to catch on the mucosa. This would appear not to be a serious consideration. In most cases I have used a 14FG tube through the endoscope, and a 18FG through the nose. As always, it is important to ensure that there is no loop of tube kinked in the nasopharynx after the tube has been drawn through the nose. I tie the red thread from the bundle of swabs firmly round the tube close to the nostril and then fix the thread carefully to the nose with tape.

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### A prospective evaluation of the feasibility of day-case microlaryngeal surgery

Dear Sir,

We read with interest the article by Ah-See *et al.* (1998) evaluating the feasibility of day-case microlaryngeal surgery. They prospectively examined 100 consecutive patients and observed them overnight and the day after surgery. They conclude that 80 per cent of the patients satisfied the street-fit criteria for discharge on the evening of surgery. Significantly, the commonest reason for failure of the discharge criteria was not the presence of medical complications, but the lack of an accompanying adult to take the patient home. Only one patient (one per cent) suffered respiratory distress during the immediate post-operative period.

These data are consistent with other previous findings. Hill *et al.* (1987) reported that 13 of 626 patients (two per cent) required reintubation in the recovery room after laryngoscopy. Robinson (1989) in a series of 294 patients admitted to the hospital after microlaryngeal surgery and observed for at least one night, found an entirely uncomplicated post-operative course in 98 per cent of them. These studies concluded that significant post-operative complications after microlaryngeal surgery are rare. Based on these results we have recently analysed the possibility of moving selected patients to the out-patient setting (Maestre *et al.*, 1995).

We agree with the point made by Ah-See *et al.* (1998) in that most of the patients were deemed fit for discharge on the evening of surgery. In our study 95 per cent of the patients were discharged home the same day as the procedure. Two had mild or moderate laryngospasm after extubation of the trachea in the operating theatre that disappeared after a few minutes with oxygen via face mask. No other complications were seen in the immediate post-operative period. They were all interviewed 12 and 24 hours after the operation. Only two suffered from a mild sore throat and another two from a headache. One American Society of Anesthesiologists (ASA) score III patient (five per cent) presented with severe laryngospasm in the operating theatre, followed with bronchospasm in the recovery room. He was admitted to the hospital overnight, having not presented further complications. We conclude that microlaryngeal surgery can be carried out safely on an out-patient basis, provided the patient has no significant systemic disease or an unfavourable social situation.

In our study we excluded large masses and subglottic lesions, due to the risk of inflammatory reaction or haemorrhage that could produce airway compromise. The trachea was intubated in all of our patients. No exclusions were applied by Ah-See *et al.* and only 15 of their patients required intubation reflecting their practice of jet ventilation. However, we also considered the clinical criteria the most reliable method of discharge assessment. We performed an oropharynx direct visualization and an indirect laryngoscopy or fibroscopy before discharge.

Although 80 per cent of the patients studied by Ah-See *et al.* were suitable for discharge home regardless of the ASA score, 11 of the 13 patients (85 per cent) that required reintubation in the Hill *et al.* (1987) series had underlying chronic obstructive pulmonary disease. The only patient we had to admit overnight also had chronic obstructive pulmonary disease. Eight of nine patients admitted after laryngoscopy had abnormal airways pre-operatively in a recent report by Armstrong *et al.* (1997). These results suggest that a large number of cases should be studied before considering patients in physical status III (non-incapacitating severe systemic disease) or IV (incapacitating systemic disease) of the ASA classification as appropriate candidates.

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#### European Consensus Statement on Neonatal Hearing Screening

Dear Sir,

I wish to inform you of the final consensus produced at the European Consensus Development Conference on Neonatal Hearing Screening, 15–16 May, 1998.

1. Permanent childhood hearing impairment<sup>1</sup> (PCHI) is a serious public health problem affecting at least one baby in 1,000. Intervention is considered to be most successful if commenced

in the first few months of life. Therefore, identification by screening at or shortly after birth has the potential to improve quality of life and opportunities for those affected.

2. Effective programmes of intervention are well established.
3. Methods for identification of PCHI in the neonatal stage are now accepted clinical practice. They are effective and can be expected to identify at least 80 per cent of cases of PCHI whilst incorrectly failing two to three per cent of normally hearing babies in well-controlled programmes.
4. Neonatal testing in maternity hospitals is more effective and less expensive than behavioural screening conventionally carried out at seven to nine months.
5. Targeting neonatal testing on only the six to eight per cent of babies at increased risk<sup>2</sup> of PCHI reduces costs but cannot identify more than 40–50 per cent of cases. Targeted neonatal hearing screening in parallel with seven to nine month behavioural testing is more expensive and less effective than universal neonatal screening.
6. Hearing screening in the neonatal period cannot identify acquired or progressive hearing loss occurring subsequently. Surveillance methods are required to identify those cases, which may be 10–20 per cent of all permanent childhood hearing impairment.
7. Risks associated with neonatal hearing screening include anxiety from false positive results and possible delayed diagnosis from false negative results, but these risks are acceptable in view of the expected benefits.
8. Neonatal hearing screening should be considered to be the first part of a programme of habilitation of hearing impaired children, including facilities for diagnosis and assessment.
9. A system of quality control is an essential component of a neonatal hearing screening programme. Quality control includes training of personnel and audit of performance. The person responsible for quality control should be identified.
10. Although the healthcare systems in Europe differ from country to country in terms of organization and funding, implementation of neonatal hearing screening programmes should not be delayed. This will give new European citizens greater opportunities and better quality of life into the next millennium.

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<sup>1</sup>Defined here as a bilateral permanent hearing impairment greater than or equal to 40 dB averaged over the frequencies 0.5, 1, 2 and 4 kHz.

<sup>2</sup>Examples include neonatal intensive care and family history of hearing impairment.