

find the latter request somewhat strange since Professor Barnes has already reviewed the material and, although he did not agree with our general arguments, he did not take the opportunity to disagree with our diagnosis **before the publication of his world literature review!** However, with regard to the comments of both critics about the absence of microscopic or immunohistochemical data, we would assert that there is no histological or immunocytochemical difference between our types I and II (El-Silimy and Harvy, 1992). Moreover, we are in complete agreement with the view that the 'Zellballen' arrangement of tumour cells is of no diagnostic value with regard to paraganglioma and we would refer Professor Barnes and Dr Milroy back to our paper (El-Silimy and Harvy, 1992). In addition, we can confirm that immunoperoxidase stains for cytokeratin and CEA were done and proved negative – enabling us, as Professor Barnes notes, to distinguish the LPG from an atypical carcinoid.

Conclusion

Although we may now be able to improve our diagnostic ability with regard to paraganglioma, for example, we can distinguish it easily from neuroendocrine carcinoma, it is less easy to differentiate between metastatic (malignant) and non-metastatic paraganglioma. We would like to assure Dr Milroy that being vigilant and having a high suspicion index cannot be considered as overtreatment. However, the essence of our argument is to establish the existence of metastatic (malignant) paraganglioma, however we accept that an accurate estimate of the incidence of metastatic paraganglioma (our Type II) will necessarily, have to wait for the results of more research and/or the availability of more evidence.

Yours sincerely,
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References

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El-Silimy, O., Harvy, L. (1992) A clinico-pathological classification of laryngeal paraganglioma. *Journal of Laryngology and Otology* 106: 635–639.

The value of head dressings for middle ear surgery

Dear Sir,
Mr Rowe-Jones and Mrs Leighton are to be congratulated for their brave questioning of the surgical dogma on post-operative head bandages. It is unfortunate that such a study may not be sufficiently powerful to convince colleagues that such dressings can safely be discarded. Perhaps the main concern is that head dressings reduce the incidence of post-operative haematomata, although these do occur despite 'pressure' bandaging. Ninety-five per cent confidence interval analysis shows that the difference in the incidence of haematoma between bandaged and non-bandaged patients in this study might be anywhere between 5.5 per cent more or less. A similar study of 1000 patients finding 10 haematomata in each group would still give 95 per cent confidence limits for the difference in incidence of haematoma between 1.7 per cent more or

less. To convince that there is no difference between treatments may be more difficult than to find a difference.

It would be interesting to know whether the findings of this study have affected the authors' or the authors' colleagues routine clinical practise.

Yours sincerely,
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Reference

- Rowe-Jones, J. M., Leighton, S. E. J. (1993) The value of head dressings for middle ear surgery. *Journal of Laryngology and Otology* 107: 17–19.

Acute tonsillectomy in the management of infectious mononucleosis

Dear Sir,

Enlargement of the pharyngeal tonsils in infectious mononucleosis (IM) is frequently an important component of the clinical picture but pronounced obstruction of the upper respiratory passages is rare. An analysis of 11 cases of infectious mononucleosis with varying degrees of pharyngeal obstruction is presented. During the acute phase of disease, tonsillectomy was performed and also adenoidectomy in four of the cases. The patients improved rapidly after the operation and were discharged after an average of four days. No noteworthy complications of the operation occurred. An unexpectedly great number of cases of abscess formation were found at operation. Histological examination of the tonsils revealed changes in the lymphoid tissue which were characteristic but not specific for infectious mononucleosis together with extensive necrosis of the tonsillar surface. On the basis of this investigation, the authors consider that acute tonsillectomy is indicated in infectious mononucleosis with threatening occlusion of the upper airway and in cases of suspected peritonsillar abscess. In cases of slight or moderate respiratory obstruction, acute tonsillectomy may be considered in the therapeutic deliberations if the course of the condition is protracted and steroid treatment does not have the desired effect.

The eleven patients who underwent operation were taken into the hospital between November 1986 and November 1987.

Later we did a control of 27 patients with infectious mononucleosis (IM), who did not need an operation and were not given steroids. The time of observation was seven months. We found four patients (15 per cent) who later required a tonsillectomy.

Our conclusion is that with, or without, treatment with steroids given to patients with a severe bout of IM, the condition seems to dispose to later recurrent tonsillitis and maybe this advocates a more active attitude to tonsillectomy under safe anaesthetic procedure.

Yours sincerely,
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References

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*Author's reply***Acute tonsillectomy in the management of infectious mononucleosis**

Dear Sir,

Dr Winther details an approach to managing severe infectious mononucleosis (IM) tonsillopharyngitis similar to that outlined in our paper. Their series, not previously recorded in the English language literature, supports our contention that acute tonsillectomy is of value in selected cases of IM tonsillopharyngitis.

There are however differences between our respective approaches to this condition. We feel there is insufficient evidence to support using acute tonsillectomy to treat the majority of patients admitted with IM tonsillopharyngitis. We continue to advocate a management protocol which reserves acute tonsillectomy for the management of patients with severe upper airway obstruction whose condition does not improve rapidly after the administration of parenteral corticosteroids. Patients with lesser symptoms can normally be treated and discharged within two to three days. A protracted hospital stay is likely to be shortened by acute tonsillectomy and we thus would consider this a further indication for surgery.

With regard to recurring episodes of tonsillitis after a bout of infectious mononucleosis, we currently feel this outcome does not occur with sufficient frequency to advocate acute tonsillectomy for all patients admitted with IM tonsillopharyngitis. In a similar fashion to using acute tonsillectomy, or interval tonsillectomy, to manage peritonsillar abscesses an overly aggressive approach to management is likely to lead to patients undergoing surgery who are at low risk of subsequent infections.

In time, we may be able to define more clearly other groups of patients suffering IM tonsillopharyngitis who would clearly benefit from acute tonsillectomy.

Yours sincerely,

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Diagnostic laryngoscopy and bronchoscopy aided by the laryngeal mask airway

Dear Sir,

We read with interest the short communication by Maroof *et al.* (1992) on the use of the laryngeal mask airway (LMA) for difficult diagnostic laryngoscopy and bronchoscopy. Following failed rigid bronchoscopy under anaesthesia the LMA was inserted by the anaesthetist and the procedure performed fibreoptically via the LMA. The

discussed advantages of the technique were: that it was easy to perform, provided excellent views of the larynx and bronchial tree and caused minimal haemodynamic disturbance. We would support the use of the LMA in fibreoptic laryngoscopy/bronchoscopy and would like to make some further comments about the technique.

It may be of interest to your readers to know that the LMA can also be inserted in awake patients. In a recent study, 50 patients underwent awake diagnostic bronchoscopy through the LMA following topical spray and a crico-thyroid puncture, supplemented with sedation, as required (Brimacombe *et al.*, 1992). In all patients bronchoscopy was successfully performed and no patient found the technique unacceptable. In two patients, unsuspected laryngeal pathology was diagnosed. Only minor problems were encountered, such as recurrent swallowing and these were easily controlled with further sedation or topical anaesthesia.

The unique feature of the LMA for combined fibreoptic laryngoscopy/bronchoscopy is that a complete view of the cords is possible whilst a secure airway is maintained. The clear, sealed, airway provided by the LMA means that respiration can be monitored with a capnograph or spirometer, or by observation of the reservoir bag, which increases patient safety. The presence of an LMA also facilitates the administration of high oxygen concentrations and/or continuous positive airway pressure (CPAP) if the patient becomes hypoxic.

Although there are no studies comparing fibreoptic laryngoscopy/bronchoscopy through the LMA with other established techniques, the LMA does have some potential advantages and has been used successfully in both awake and anaesthetized adults (Tuck *et al.*, 1991) and in anaesthetized children (Walker and Murrell, 1991). Maroof *et al.* (1992) comment that fibreoptic laryngoscopy/bronchoscopy was easy to perform despite no prior experience with the technique. LMA insertion is also an easy skill to acquire and we would like to suggest that all clinicians who are involved in performing fibreoptic laryngoscopy/bronchoscopy under topical anaesthesia and sedation should consider becoming experienced in LMA insertion, under the supervision of an anaesthetist. The technique may be particularly useful for patients who are at risk of developing low arterial oxygen saturation or an obstructed airway and where respiratory monitoring is important.

Yours sincerely,

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