

LETTER TO THE EDITOR

Odds and evens for endoscopic adenoidectomy

H.M. INANCLI, M. ENOZ¹

Department of ORL & Head and Neck Surgery, Ankara Oncology Training and Research Hospital, Ankara;

¹ Department of ORL & Head and Neck Surgery, Special Yenibosna Safa Hospital, Istanbul, Turkey

Dear Editor,

We read with a great interest the article by Costantini et al.¹ entitled *Videoendoscopic adenoidectomy with microdebrider* (*Acta Otorhinolaryngol Ital* 2008;28:26-9). This procedure offers several advantages: an improved field of vision, continuous suction of blood, and extreme precision in removing the adenoid tissue. In their study, the validity and safety of this videoendoscopic adenoidectomy with microdebrider has also been demonstrated¹. The advantages of endoscopic adenoidectomy were mentioned in several studies but there wasn't enough emphasis on the disadvantages of this technique.

Pagella et al. reported that no significant intra-operative bleeding, post-operative haemorrhage or other complications have occurred². Over the years, there have been advances in the techniques of adenoidectomy, from the conventional trans-oral to endoscopic trans-nasal/trans-oral adenoidectomy. Also Jong and Gendeh emphasized

the advantages of this procedure with respect to that of the conventional technique³.

But there are some disadvantages that we would like to mention. The endoscopic procedures need more operating time than the conventional methods. Adenoidectomy patients are usually children thus the operating area is relatively narrow and the surgeon has to be experienced before performing the operation. This new technique needs a set of endoscopic surgical instruments. Management of local complications, due to this new technique, such as bleeding, can be difficult on account of the narrow surgical area.

Videoendoscopic adenoidectomy with microdebrider is a supply to control tissue removal but it must be performed alone or combined with the conventional method for selected cases. In our opinion, interest should be focused on some of the disadvantages of videoendoscopic adenoidectomy.

References

¹ Costantini F, Salamanca F, Amaina T, Zibordi F. *Videoendoscopic adenoidectomy with microdebrider*. *Acta Otorhinolaryngol Ital* 2008;28:26-9.

² Pagella F, Matti E, Colombo A, Giourgos G, Mira E. *How we do it: a combined method of traditional curette and power-assisted endoscopic adenoidectomy*. *Acta Otolaryngol* 2008;8:1-4.

³ Jong YH, Gendeh BS. *Transoral endoscopic adenoidectomy: initial experience*. *Med J Malaysia* 2008;63:81-3.

Received: December 10, 2008

Address for correspondence: Hasan Mete Inancli M.D., Bilkent Çamlık Sitesi, D3 Blok, Daire 1, Bilkent, 06800, Ankara, Turkey.
Fax: +90 2123439040. E-mail: hminancli@yahoo.com

The Author's reply

Dear Editor,

I am writing to provide additional considerations concerning our procedure of endoscopic adenoidectomy with microdebrider in reply to the letter of Dr. Hasan Mete Inancli, and Dr. Murat Enoz.

Operating time is the same as with traditional instru-

ments (adenotome or curette); only the setting time is a little longer: two or three minutes with a good organization; if one used only endoscopy to control and eventually remove residual tissue after traditional adenoidectomy, the duration of the whole procedure would likely be longer.

The difficulties of this procedure are negligible for anyone who practices endoscopic sino-nasal surgery. Surgeons with little experience can be easily trained, both because they can observe the procedure on the video display and because their work can be supervised by a tutor on the screen.

The narrow nasopharyngeal space in very young children is not a problem, in fact it is an advantage because in a small field the vision is better and the shaving manoeuvres are easier.

One needs, of course, endoscopic instruments, but these are the same as those used routinely in sino-nasal surgery; while the 70° endoscope is the optimal tool, the 45° endoscope offers an adequate view.

Treatment of incidental intra-operative bleeding complications is easier since suction-coagulator under endoscopic vision can be employed. In our practice, it was never

necessary to perform nasopharyngeal package to stop bleeding.

In conclusion, considering that over 300 patients have been treated, we are even more convinced of the effectiveness of this technique that combines the advantages of endoscopy, i.e., good vision of the operating field with the safety and manageability of a powered instrument, such as the microdebrider. Given the availability of endoscopy, a blind procedure, such as that with the adenotome, is no longer advisable.

Further confirmation of the validity of this technique stems from the fact that we have not observed any recurrence in a period of over five years.

Thank you for the opportunity to reply and to further describe personal findings.

Yours sincerely

F. Costantini

Received: January 16, 2009

Address for correspondence: Dr. F. Costantini, Unità Operativa di Otorinolaringoiatria, Casa di Cura S. Pio X, Via F. Nava 31, 20100 Milano, Italy.