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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 Anesthiologists (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.

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