
The authors present 6 cases in which endoscopic procedures were performed for palliative intent in patients with sinonasal/base-of-skull tumors. The only patient who did not benefit from the procedure had symptoms of near blindness. The other 5 patients had nasal obstruction associated with others symptoms, such as epistaxis, pain, and hyposmia. Their symptoms were controlled after surgery for 1 to 6 months. As expected, 4 patients died from 6 weeks to 6 months after the last procedure (1 patient had 4 procedures, including an open procedure), and the other 2 are alive with disease at 7 months.

In recent years, we have seen an increasing demand to improve the quality of life of patients afflicted with incurable disease. The authors suggest that a palliative surgical procedure should only be considered if some criteria are met. These include a reasonable expectation of symptoms relief, a possible life prolongation, and the ability of the patient to medically tolerate the procedure. The authors add that such an intervention should not be considered if death is imminent. There was no clear definition of the meaning of reasonable, possible, and imminent. This is not surprising given the difficulty of the situation. I do not believe that we can easily come up with a clear recipe to manage these patients.

In their conclusion, the authors mention that, in light of the challenges associated with end-of-life care, a multidisciplinary approach encompassing medical, social, and spiritual issues is advised. There is no doubt that this is a difficult issue and every patient should be considered individually. Other measures of palliation, such as pain therapy, radiation therapy, and chemotherapy, also need to be considered. The cost of these interventions should also be considered. The jury is deliberating.

Pierre Lavertu, MD


This is a retrospective review of 11 patients who underwent endoscopic laryngotraheal cleft closure at the Armand Trousseau Children’s Hospital in Paris, France. The clefts were repaired under spontaneous ventilation, without endotracheal intubation. The edges of the cleft were excised using the laser (carbon dioxide or thulium), followed by 2-layer closure (if possible). The patients were not admitted to the intensive care unit after surgery. Eight patients had not had an attempt at previous repair and underwent endoscopic repair as a primary procedure. Of these 8 patients, 4 had type III clefts (into the first and second tracheal rings), 2 had type I clefts (into the cricoid), and 2 had type II clefts (through the cricoid). Six of these 8 patients had successful closure of the cleft and resolution of aspiration symptoms after a single endoscopic procedure. Two of these 8 patients (both with type III cleft) required an additional endoscopic procedure to resolve residual supraglottic clefting and aspiration symptoms. Three patients had a previous attempt at an open approach for cleft repair and underwent endoscopic repair as a secondary procedure. Of these 3 patients, 1 had a residual type I cleft, and 2
had residual type II clefts. Two of these 3 patients had successful closure of the cleft and resolution of aspiration after a single endoscopic procedure. One of these 3 patients (with bilateral vocal cord paralysis) required 2 additional endoscopic procedures to resolve residual supraglottic clefting but continued to have aspiration symptoms, albeit improved compared to preop. The authors concluded that the endoscopic technique is a suitable primary procedure for the treatment of type I, II, and III (extending to cervical trachea) laryngotracheal clefts.

Eli Grunstein, MD

OTOLOGY


The purpose of this study was to examine the effect of temporal bone resection on temporomandibular joint dysfunction (TMD) and the impact of both facial paresis and TMD resulting from temporal bone resection on quality of life (QOL).

A retrospective chart review was performed for patients who underwent temporal bone resection during the previous 5 years at Manchester Royal Infirmary. Of 30 consecutive patients identified, 16 had died and were excluded from the study. One additional patient was excluded due to stroke, leaving 13 patients for chart review. Once identified, the patients were invited to attend a clinic to assess their temporomandibular joint function and to complete the University of Washington QOL questionnaire. Among other variables, joint mobility, pain, appearance, swallowing, speech, shoulder function, anxiety, taste, and ability to chew were assessed. Facial paresis was also assessed, but the degree of it was not discussed. Statistical software was used to compare groups of patients with or without TMD to those who listed good versus poor QOL.

All patients had received radiotherapy. Ten patients had undergone lateral temporal bone resection; 3 patients had undergone subtotal petrosectomy. Eight patients had intact temporomandibular joints; 5 had undergone extirpative surgery on the mandibular condyle. It was found that 8 patients had TMD in the ipsilateral joint and none had TMD in the contralateral joint. Resection of the joint did not relate to development of TMD. Six patients had difficulty chewing. Three had severe trismus. One patient reported very good QOL, 8 patients reported good QOL, 3 patients reported poor QOL, and 1 reported very poor QOL. Pain, appearance, and anxiety were the most important factors influencing QOL. Facial paresis was not found to affect QOL and correlated poorly with the other variables.

The authors conclude that TMD is present in a significant number of patients who had undergone TBR in this preliminary study and that it does not significantly influence QOL, despite the fact that it does lead to longstanding problems with appearance and mastication.

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