to medical students through lecture sessions has become a less fruitful endeavor in this day, as many students prefer to watch the recorded lectures (played back at $2\times$ speed) than attend them live. Personal contact now occurs chiefly through hands-on workshops (suture laboratory, physical examination sessions, problem-based learning sessions) or ambulatory clinical experiences. In addition, many medical schools have a mission to graduate physicians with a primary care focus, which competes for the attention of medical students.

Physician mentorship will continue to remain an important component of recruiting and advising residency applicants. How this mentorship is conducted has larger implications in not only increasing the quantity of applicants but also shaping the composition of that pipeline. If we prioritize equality and opportunity, this mentorship needs to be encouraging and welcoming, not discouraging and exclusive. For otolaryngology to remain vibrant and healthy, there needs to be continued mentoring that is mindful of our biases, years for what is good, looks beyond traditional metrics of meritocracy, and strives to achieve the very best of ourselves.

It is easy to talk the talk; we need the strength and boldness to walk the walk.

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Response to the Letter to the Editor: “Comparison of Medical Therapy Alone to Medical Therapy with Surgical Treatment of Peritonsillar Abscess”

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We thank Dr Ribeiro and his colleagues for their thoughtful letter to the editor.¹

The medical therapy (MT) protocol was designed with the reality in mind that patients with peritonsillar abscess (PTA) are almost uniformly diagnosed clinically in the Southern California Permanente Medical Group (SCPMG) emergency department (ED) without the aid of a computed tomography (CT) scan or an ultrasound. Controls were placed in the protocol to protect patients and minimize risk, the most important control being that patients must have uncomplicated PTAs and the next most important being that patients follow up with an otolaryngologist the next morning. Not all PTA patients are treated with MT. If there is any evidence of airway compromise, evidence of extension of the infection to the para- or retropharyngeal spaces, or evidence of bacteremia or sepsis, or if patients are not significantly improved within hours of starting MT, patients are surgically drained.

We also point out the weaknesses of the case series, which includes the fact that the MT group may have had less severe disease. However, to control for severity of the disease, we examined the subgroup of PTA patients with trismus given they were more likely to have an actual abscess. As with the overall group of PTA patients, we found that the trismus patients had no difference in complication or failure rates regardless of whether they were given MT or surgical therapy (ST). Instead, we found the trismus patients who were treated with ST required significantly more opioids.

Since the institution of the MT protocol in 2008, thousands of patients clinically diagnosed with PTA have been treated successfully with MT without a resulting mortality. Our latest data indicate that between 2015 and 2016, 89% of 1979 patients with PTA presenting to SCPMG EDs were treated with MT. While it is possible that most of these PTA patients did not have an actual abscess, it is very unlikely.² Rather, our data indicate that the average patient clinically diagnosed with an uncomplicated PTA in the ED can be safely and successfully treated with MT, regardless of whether a CT or ultrasound is performed.

Given the advantages of MT compared with ST outlined in our article and the success we have had with MT over the past 10 years, we encourage other head and neck surgery groups to adopt the MT protocol at least on a trial basis. If any questions arise, we are here to help and provide guidance at any time.

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