The authors reported that “clinical follow-up averaged 30 months. Initial surgery resulted in an 82.1% success rate. The mean number of days between the injury and primary tympanoplasty was 197 days. . . . There was a 76% (29 of 38) successful closure rate for attempts at revision of tympanoplasty for persistent perforations.” The authors did not sufficiently describe the graft material or the status of the surgeon and compare the respective success rate among the 4 military service branches. The experience of the surgeon is vital to improve the graft intake success rate and hearing results after tympanoplasty. Large perforations are a risk factor for tympanoplasty failure of any other perforation mechanisms. Sprem et al showed tympanoplasty success rates of 91% with temporal fascia and 92% with perichondrium for blast-induced total or subtotal perforations. Angeli et al also reported a 91% success rate for near-total and total perforations of chronic otitis media. In addition, the temporalis fascia will typically degenerate and shrink over time, resulting in reperforation. Cartilage graft is not easily absorbed and can resist changes in middle ear pressure resulting from eustachian tube dysfunction, thereby avoiding reperforation. Peyvandi et al suggest that the majority of blast-induced TMPs had poor eustachian tube function. Eustachian tube dysfunction is a predictive factor for the failure of temporalis fascia tympanoplasty. Thus, the authors should evaluate eustachian tube function.

The authors described that “the mean number of days between the injury and primary tympanoplasty was 197 days (range, 3-1627 days)” in the Results section. This suggests that some perforations within 3 months postinjury were treated using tympanoplasty. It is known that small and medium traumatic TMPs tend to heal spontaneously. In addition, some authors have observed perforations that healed spontaneously even after 6 months. Using endoscopic techniques, foreign bodies and debris in the middle ear may be removed using microsuction and endoscopic guidance to avoid cholesteatoma of the middle ear, after which spontaneous healing can occur. Tympanoplasty is an invasive surgery that requires hospitalization. Growth factors have been used to repair traumatic TMPs, showing an improved closure rate and shortened closure time. Lou et al found that the closure rate did not differ between fibroblast growth factor 2 on blast and noninduced TMPs. Thus, topical application of growth factors on blast-induced TMPs should be recommended prior to tympanoplasty.

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References

About “Polypoid Change of the Middle Turbinate and Paranasal Sinus Polyposis Are Distinct Entities”
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We recently read the article entitled “Polypoid Change of the Middle Turbinate and Paranasal Sinus Polyposis Are Distinct Entities,” by Brunner et al, with great interest. They concluded that polypoid change of the middle turbinate (PCMT) is a unique physical finding with clinical associations that distinguish it from paranasal sinus polyposis and that PCMT has greater association with allergic rhinitis. We think that this is very interesting, as it is the first study to compare 2 diseases in which differences in characteristics are unknown. So, we are very grateful for the authors providing excellent information to the readers. However, we want to make some comments about this study.

First of all, we want to point out 3 minor mistakes. (1) In the Results section (lines 7-10), we think that the sentence was incorrectly described on the basis of the data in Table 1. The following sentence is correct: “Inhalant allergy was confirmed in 19 patients in the PCMT group and 15 patients in the [paranasal sinus polyposis] group.” (2) In the second paragraph of
the Results, the authors described Table 2 in detail. However, the \(P\) values are different from the \(P\) values described in Table 2. Which is right? (3) In the last sentence of the Results, the author wrote, “No difference was observed in mean total serum IgE, although because this information was obtained for only 21 of the 61 patients, that result may be difficult to interpret.” However, is the total number of patients 67, not 61?

Second, if the authors performed the punch biopsy at the clinic, we wonder if there was a histologic difference between the 2 diseases. Also, we wonder how to manage PCMT and whether it is normalized according to medical treatment. It would be better to recommend a treatment of PCMT.

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We thank Dr Kim and colleagues for their perceptive comments. Regarding the minor errors in the text of the Results section, the data in Table 1 and Table 2 represent the correct data. Indeed, inhalant allergy was confirmed in 19 patients in the polypoid change of the middle turbinate group and 15 patients in the paranasal sinus polyposis group. Moreover, the \(P\) values in the tables are correct. In the final sentence of the Results section, the total number of patients was indeed 67, not 61. We thank Dr Kim and colleagues for bringing to light these minor errors. Last, we did not perform biopsies for histologic analysis of tissue specimens for this study and have not yet evaluated treatment outcomes in patients with polypoid change of the middle turbinate. Both present exciting opportunities for future study.

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