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ate for physicians to base their treatment of patients on scientific data rather than personal feelings about what is good medicine.

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Long-term Nasal Mucosal Tissue Expansion Use

After reading the interesting Clinical Note on long-
term nasal mucosal tissue expansion by Romo et al.,1 I would like to expand the knowledge of the authors and the reviewers. When Romo et al, in the final paragraph of their article, state, “These studies are the first description of expanded mucosal surfaces to our knowledge,” they are mistaken.

Actually, on the other side of their region of interest—the nasal floor—in the mouth, mucosal tissue expansion has been performed and reported since 1986.2-4 Initially, intraoral subperiosteal tissue expansion was used for alveolar ridge augmentation purposes.2-4 Later on, palatal soft-tissue expansion was applied for facilitating the closure of oronasal fistulas in cleft lip and palate surgery.5-7 Longitudinal animal experiments on mucoperiosteal expansion have already been performed and were and casu quo are to be published.8-10 The results indicate that mucoperiosteal expansion is as feasible as skin expansion and that it yields at least a temporary soft-tissue area gain of 85% of the base surface of a hemispherical expander. However, side effects were retardation of bony palatal growth in sagittal and transverse direction and the development of a bathtub bony depression. Microscopically, thinning of the epithelial layer, reorientation of collagenous fibers in the reticular layer (parallel to the surface of the tissue expander), and formation of a fibrous capsule were noted.10 The bony palatal shelf at the center of the expander base almost completely disappeared. Increased vascularity and focal chronic inflammation at the respective limitations of the capsule were not notable.

Maybe the authors would like to comment on these findings and to report on the effects of nasal mucosal expansion on the underlying bone of the nasal floor?

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Drainage After Thyroid and Parathyroid Surgery

I eagerly read the recent article by Wax et al1 dealing with the necessity of drainage after routine thyroid and parathyroid surgery. Their straightforward article deals with an issue very common for surgeons: how to change something that “we’ve been doing for years and years and years.”

At the urging of an anesthesiologist, I stopped placing drains in patients undergoing routine thyroid and parathyroid surgery approximately 2½ years ago. During the last 150 cases, I have also noticed essentially no morbidity associated with this new practice.

Postoperative care is diminished and no increased adverse events have been noted.

Unlike some new special technique or anatomical exposure, this simple change in surgical habits would have been unthought of except for the urging of an observant anesthesiologist. This friend did not understand why abdominal surgery rarely requires a drain whereas head and neck surgery, uniformly, involves postoperative drainage.

I applaud Wax and his colleagues for publishing this article.

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Pseudomonas Ear Infections

I read the article by Dohar et al1 with interest. Their finding concerning the efficacy of piperacillin and tobramycin against aural isolates of Pseudomonas aeruginosa is consistent with the sensitivity data at our institution in Honolulu, Hawaii (piperacillin, 97%; tobramycin, 100%). In Hawaii, otitis externa caused by Pseudomonas is common because of tropical weather and frequency of year-round water sports. From 1993 to 1995, we found that several additional antibiotics were at least as effective as piperacillin for aural isolates of Pseudomonas: cefazidime (100%), imipenem (100%), and aztreonam (98%). These antibiotics are approved for children and are especially useful in patients who are allergic to penicillin. These antibiotics can be given by intramuscular or intravenous injection, and,