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Author's reply

Acute tonsillectomy in the management of infectious mononucleosis

Dear Sir,

Dr Winther details an approach to managing severe infectious mononucleosis (IM) tonsillopharyngitis similar to that outlined in our paper. Their series, not previously recorded in the English language literature, supports our contention that acute tonsillectomy is of value in selected cases of IM tonsillopharyngitis.

There are however differences between our respective approaches to this condition. We feel there is insufficient evidence to support using acute tonsillectomy to treat the majority of patients admitted with IM tonsillopharyngitis. We continue to advocate a management protocol which reserves acute tonsillectomy for the management of patients with severe upper airway obstruction whose condition does not improve rapidly after the administration of parenteral corticosteroids. Patients with lesser symptoms can normally be treated and discharged within two to three days. A protracted hospital stay is likely to be shortened by acute tonsillectomy and we thus would consider this a further indication for surgery.

With regard to recurring episodes of tonsillitis after a bout of infectious mononucleosis, we currently feel this outcome does not occur with sufficient frequency to advocate acute tonsillectomy for all patients admitted with IM tonsillopharyngitis. In a similar fashion to using acute tonsillectomy, or interval tonsillectomy, to manage peritonsillar abscesses an overly aggressive approach to management is likely to lead to patients undergoing surgery who are at low risk of subsequent infections.

In time, we may be able to define more clearly other groups of patients suffering IM tonsillopharyngitis who would clearly benefit from acute tonsillectomy.

Yours sincerely,

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Diagnostic laryngoscopy and bronchoscopy aided by the laryngeal mask airway

Dear Sir,

We read with interest the short communication by Maroof *et al.* (1992) on the use of the laryngeal mask airway (LMA) for difficult diagnostic laryngoscopy and bronchoscopy. Following failed rigid bronchoscopy under anaesthesia the LMA was inserted by the anaesthetist and the procedure performed fibreoptically via the LMA. The discussed advantages of the technique were: that it was easy to perform, provided excellent views of the larynx and bronchial tree and caused minimal haemodynamic disturbance. We would support the use of the LMA in fibreoptic laryngoscopy/bronchoscopy and would like to make some further comments about the technique.

It may be of interest to your readers to know that the LMA can also be inserted in awake patients. In a recent study, 50 patients underwent awake diagnostic bronchoscopy through the LMA following topical spray and a crico-thyroid puncture, supplemented with sedation, as required (Brimacombe *et al.*, 1992). In all patients bronchoscopy was successfully performed and no patient found the technique unacceptable. In two patients, unsuspected laryngeal pathology was diagnosed. Only minor problems were encountered, such as recurrent swallowing and these were easily controlled with further sedation or topical anaesthesia.

The unique feature of the LMA for combined fibreoptic laryngoscopy/bronchoscopy is that a complete view of the cords is possible whilst a secure airway is maintained. The clear, sealed, airway provided by the LMA means that respiration can be monitored with a capnograph or spirometer, or by observation of the reservoir bag, which increases patient safety. The presence of an LMA also facilitates the administration of high oxygen concentrations and/or continuous positive airway pressure (CPAP) if the patient becomes hypoxic.

Although there are no studies comparing fibreoptic laryngoscopy/bronchoscopy through the LMA with other established techniques, the LMA does have some potential advantages and has been used successfully in both awake and anaesthetized adults (Tuck *et al.*, 1991) and in anaesthetized children (Walker and Murrell, 1991). Maroof *et al.* (1992) comment that fibreoptic laryngoscopy/bronchoscopy was easy to perform despite no prior experience with the technique. LMA insertion is also an easy skill to acquire and we would like to suggest that all clinicians who are involved in performing fibreoptic laryngoscopy/bronchoscopy under topical anaesthesia and sedation should consider becoming experienced in LMA insertion, under the supervision of an anaesthetist. The technique may be particularly useful for patients who are at risk of developing low arterial oxygen saturation or an obstructed airway and where respiratory monitoring is important.

Yours sincerely,

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