LETTERS TO THE EDITOR

Reply to ’’Reconstruction of the Oropharynx and Hypopharynx. What Have We Learned?’’

Réplica a «Reconstrucción de orofaringe e hipofaringe. ¿Qué hemos aprendido?»

Dear Sir,

Last August, Acta Otorrinolaringológica Española (Number 4, volume 61, pages 272–276) published an article entitled ’’Reconstruction of the Oropharynx and Hypopharynx. What Have We Learned?’, by the authors Jesús Herranz González-Botas, Mercedes Alvarez Buylla and Carlos Vázquez Barro. The signatories of this reply, members of the ENT Department of the Hospital Complex of A Coruña, believe it necessary to make some clarifications of the ENT Department of the Hospital Complex of A Coruña, believe it necessary to make some clarifications on the activities, results and philosophy of our service regarding the reconstruction of defects in the aerodigestive tract following surgery in cancer patients, given the profound disconnect between the publication and our data on patients intervened between October 1995 and October 2008 at the ENT Department at the University Hospital of A Coruña.

According to data collected by us, there were 111 reconstructive procedures in 104 patients, 58 pedicled flaps and 53 microvascular flaps. All were performed by members of the ENT service and members of other services (plastic and reconstructive surgery, maxillofacial surgery and general surgery) when cooperation was necessary or indispensable. This collaboration took place in 4 of the pedicled flaps and in 11 of the microvascular flaps, 8 of them before August 1999, the date on which microvascular reconstruction began to be performed by the ENT service (with Dr. Pablo Parente Arias and Dr. Mario Fernández Fernández being in charge of all cases). Although there are significant discrepancies with the data on pedicle flap reconstruction, we will focus primarily on microvascular flaps, in which we are directly involved.

The reconstruction area (location of the tumour) in microvascular surgery was the oral cavity in 9 cases, the oropharynx in 27 procedures and the hypopharynx in 17.

If we focus on the oropharynx and hypopharynx (the main objective of the article published), the number of microvascular flaps during this period was 44, instead of the 29 referred by Herranz et al.

Similarly, in this period, the total number of reconstructive processes with microvascular flaps performed completely by otolaryngologists was 42; this means that, since the beginning of the reconstruction program, there has been one every 2.2 months. This data differs greatly from the average of one every 5.5 months published in ACTA. The average hospital stay of patients was 49.7 days for free flaps and not 54 days, as reflected by Herranz et al.

Regarding postoperative complications, according to our review, at least one postoperative complication out of those mentioned appeared in 52.8% of the interventions with free flaps, rather than 75.8% as reflected in the article. The number of free flap necrosis cases was 14.81%, either by failure of microsutures, by primary complications of the vascular pedicle (3/53 cases) or by cervical infection affecting the pedicle (5/53 cases). This percentage drops to 11.36% if we focus on only the microvascular cases of the oropharynx and hypopharynx, and not to 20% as reflected by Herranz et al. If we review the procedures performed in coordination with other services (11 procedures), necrosis of the graft occurred in 3 cases (27.2%) and pharyngostoma/orostoma appeared in 54.5% of cases.

In light of these data, which we will present extensively in a forthcoming study to be submitted for publication, the surgeons who have performed the microvascular procedures on the patients in the series state the following:

1. We do not know the reason why the review of Herranz et al. ignored such a large number of patients, which inevitably leads to errors in the results and conclusions. We therefore believe that the article is not representative of the experience of our ENT service, and has no validity in learning anything from it.
2. We do not know the reason why the experience of the service in microvascular reconstruction is evaluated in light of the number of free flaps performed only in the oropharynx and hypopharynx, ignoring the free flaps in other regions, which clearly provide reconstructive experience.
3. We do not know why the authors conclude that the flaps should be performed in conjunction with services that are more accustomed to microvascular surgery, such as plastic surgery and maxillofacial surgery, but do not provide data on the previous experience of the service in...
collaborating with these services or on the complications occurred, or provide a comparison with ours.

4. We feel uncomfortable observing how other authors collect our experience (partially) and publish it without explaining who performed the reconstructions and without bearing us in mind. We believe ourselves to be the professionals best authorised to communicate the results of this technique in our department and discuss it. In addition, the findings of the authors, who have not carried out any of the microvascular reconstructions studied, deal with the working philosophy of our service, which we have manifested at congresses and annual meetings of the specialty, both in panels and in training courses (as our community is aware), and where we have made a place for ourselves over many years.

In short, in addition to communicating an experience that the authors have not had, the data collection of the article is totally defective. Consequently, the results obtained are logically wrong and the conclusions are incorrect: it is not possible to learn from it.

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Reply to the Letter ‘‘Oropharynx and Hypopharynx Reconstruction. What Have We Learnt?’’

Dear Sir,

We appreciate the comments on the article ‘‘Reconstruction of the Oropharynx and Hypopharynx. What Have We Learned?’’ As its author, I wish to clarify that the views expressed in it are reflections based on experience, subject to analysis and critique. In any case was there no intention to perform an assessment of individuals; instead, we attempted to analyse the evolution of patients undergoing reconstructions, most of which I have been involved in and therefore partly responsible for. Although we believe that review articles can be elaborated by any service or unit member, it is also true that the rules of courtesy advise commenting the work with all those who were somehow involved or followed the patients included in it; from this point of view, we understand that the article may have raised sensitivities. At any rate, we believe that reviews are a good method, arguably the best, for improving clinical practice.

While we believe that multidisciplinary teams are vital in this type of surgery, we understand that other individuals may have different opinions. Contrasted analysis of data and opinions enriches knowledge and, ultimately, clinical practice. At any rate, we insist that the opinions expressed are subjective and subject to criticism.

We regret and apologise to Doctors Fernández, Parente and Martínez if the contents of the article have put them out; there was no intention whatsoever of raising individual controversy. The only intention has been to analyse the data that advances in obtaining the best possible results by making an appropriate use of available means and resources. If the latter objective is achieved, either from this position or any other, it is possible that we may all learn something.

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