

find the latter request somewhat strange since Professor Barnes has already reviewed the material and, although he did not agree with our general arguments, he did not take the opportunity to disagree with our diagnosis **before the publication of his world literature review!** However, with regard to the comments of both critics about the absence of microscopic or immunohistochemical data, we would assert that there is no histological or immunocytochemical difference between our types I and II (El-Silimy and Harvy, 1992). Moreover, we are in complete agreement with the view that the 'Zellballen' arrangement of tumour cells is of no diagnostic value with regard to paraganglioma and we would refer Professor Barnes and Dr Milroy back to our paper (El-Silimy and Harvy, 1992). In addition, we can confirm that immunoperoxidase stains for cytokeratin and CEA were done and proved negative – enabling us, as Professor Barnes notes, to distinguish the LPG from an atypical carcinoid.

Conclusion

Although we may now be able to improve our diagnostic ability with regard to paraganglioma, for example, we can distinguish it easily from neuroendocrine carcinoma, it is less easy to differentiate between metastatic (malignant) and non-metastatic paraganglioma. We would like to assure Dr Milroy that being vigilant and having a high suspicions index cannot be considered as overtreatment. However, the essence of our argument is to establish the existence of metastatic (malignant) paraganglioma, however we accept that an accurate estimate of the incidence of metastatic paraganglioma (our Type II) will necessarily, have to wait for the results of more research and/or the availability of more evidence.

Yours sincerely,
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References

- Barnes, L. (1991) Paragangliomas of the larynx. A critical review of the literature. *ORL* 53: 220–234.
El-Silimy, O., Harvy, L. (1992) A clinico-pathological classification of laryngeal paraganglioma. *Journal of Laryngology and Otology* 106: 635–639.

The value of head dressings for middle ear surgery

Dear Sir,

Mr Rowe-Jones and Mrs Leighton are to be congratulated for their brave questioning of the surgical dogma on post-operative head bandages. It is unfortunate that such a study may not be sufficiently powerful to convince colleagues that such dressings can safely be discarded. Perhaps the main concern is that head dressings reduce the incidence of post-operative haematomata, although these do occur despite 'pressure' bandaging. Ninety-five per cent confidence interval analysis shows that the difference in the incidence of haematoma between bandaged and non-bandaged patients in this study might be anywhere between 5.5 per cent more or less. A similar study of 1000 patients finding 10 haematomata in each group would still give 95 per cent confidence limits for the difference in incidence of haematoma between 1.7 per cent more or

less. To convince that there is no difference between treatments may be more difficult than to find a difference.

It would be interesting to know whether the findings of this study have affected the authors' or the authors' colleagues routine clinical practise.

Yours sincerely,
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Reference

- Rowe-Jones, J. M., Leighton, S. E. J. (1993) The value of head dressings for middle ear surgery. *Journal of Laryngology and Otology* 107: 17–19.

Acute tonsillectomy in the management of infectious mononucleosis

Dear Sir,

Enlargement of the pharyngeal tonsils in infectious mononucleosis (IM) is frequently an important component of the clinical picture but pronounced obstruction of the upper respiratory passages is rare. An analysis of 11 cases of infectious mononucleosis with varying degrees of pharyngeal obstruction is presented. During the acute phase of disease, tonsillectomy was performed and also adenoidectomy in four of the cases. The patients improved rapidly after the operation and were discharged after an average of four days. No noteworthy complications of the operation occurred. An unexpectedly great number of cases of abscess formation were found at operation. Histological examination of the tonsils revealed changes in the lymphoid tissue which were characteristic but not specific for infectious mononucleosis together with extensive necrosis of the tonsillar surface. On the basis of this investigation, the authors consider that acute tonsillectomy is indicated in infectious mononucleosis with threatening occlusion of the upper airway and in cases of suspected peritonsillar abscess. In cases of slight or moderate respiratory obstruction, acute tonsillectomy may be considered in the therapeutic deliberations if the course of the condition is protracted and steroid treatment does not have the desired effect.

The eleven patients who underwent operation were taken into the hospital between November 1986 and November 1987.

Later we did a control of 27 patients with infectious mononucleosis (IM), who did not need an operation and were not given steroids. The time of observation was seven months. We found four patients (15 per cent) who later required a tonsillectomy.

Our conclusion is that with, or without, treatment with steroids given to patients with a severe bout of IM, the condition seems to dispose to later recurrent tonsillitis and maybe this advocates a more active attitude to tonsillectomy under safe anaesthetic procedure.

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