

## Reply

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### EDITOR:

Drs Eipe and Doherty's letter demonstrates a lack of understanding of the aims of our study [1] and a limited knowledge of the term oncoplastic surgery.

Firstly, there were no patients with oro-pharyngeal malignancies in our study because the primary objectives were to measure cough at emergence and postoperative sore throat for a flexible laryngeal mask group (FLMA) vs. reinforced tracheal tube group (RTT) [1]. Both symptoms would have been very difficult to evaluate in case of oro-pharyngeal surgery.

Secondly, in the University Hospital of Bellvitge there is a Head and Neck Committee comprised of oncologists, anaesthesiologists, otolaryngologists and plastic and maxillofacial surgeons. This Committee plans and performs several major cancer procedures with microvascular reconstructive techniques in a week. We therefore have a lot of experience in excision and microvascular reconstructive surgery of major head and neck tumours and also in difficult airway management. We concur with Drs Eipe and Doherty that these major tumours often result in anticipated difficult airways and may require nasotracheal fiberoptic intubation or perioperative tracheotomy [2], usually take more than 8 h of surgery and need postoperative ventilatory support and ICU stay [3]. The expected time of surgery in our study (methods section) was less than 3 h and the real time (results section) was  $112 \pm 32$  min for the FLMA vs.  $117 \pm 42$  min for the RTT, which means that our study did not include major head and neck surgery with microsurgical reconstructive techniques. Our procedures included skin tumours on the head, face or neck and breast cancer with local flap reconstruction as well as sentinel lymph node biopsy when indicated.

Thirdly, in all of our patients the airway devices were removed in the operating room at the conclusion of the surgery and patients were then transferred to the post-anaesthetic care unit and 1 h later to the ward without respiratory problems [1].

Fourthly, no other authors except Eipe and colleagues [4,5] have used the term oncoplastic surgery for major head and neck tumours followed by reconstruction using microvascular free tissue flaps. The term oncoplastic surgery is more frequently used to describe surgical conservative treatment for breast cancer [6,7]. We therefore used this term in our study because about 60% of our procedures were for breast cancer. It was not possible to describe all procedures in detail due to the need to be concise in a publication.

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