E. Hultcrantz, E. Ericsson, Linköping: After reading this chapter, we seem to be back where we were 2008. Very interesting to go into detail in the article by Czarnetzki et al. [1] and discuss the statistical variables including power and level of significance.

J.P. Windfuhr, Mönchengladbach: The conclusions drawn from a meticulous statistical analysis of Czarnetzki’s study are alleviating for those who administer dexamethasone routinely. However, another weak point of the study was that numerous procedures were standardized, except one major aspect: the surgical technique. As said before, different surgeons operated on different children with different underlying diseases with unmeasured electric energy applied to the more or less infected mucosa. It remains unclear, how a single-dose administration of dexamethasone should impede wound healing for so many days on the one hand and provoke bleeding complications on the other. In contrast, infiltration of local anesthetics with ‘topical vasoconstrictors’ is definitely associated with a significant bleeding risk [2].

S. Sarny, Graz: The administration of intra-operative dexamethasone during tonsillectomy is recommended as it prevents postoperative nausea and vomiting especially in children. A possible increased haemorrhage risk with dexamethasone is questionable and not confirmed by the current literature. As such, intra-operative steroid use during tonsillectomy can be supported. However, the authors point out that the intra-operative dosage of dexamethasone is yet not standardized. It should be decided for the individual patient whether to administer dexamethasone intra-operatively or not. As some patients might not be in need of it, possible adverse effects on the individual’s health and – besides – increased costs for the health system should be kept in mind when treating patients routinely with steroids.

References
