Letter to the Editor

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Commentary on "Comparing Flexible Nasal Endoscopy and Lateral Neck Radiography When Diagnosing Children with Adenoid Hypertrophy"

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Dear Editor,

I read with interest the recent article by Hosri et al. (1), entitled "Comparing Flexible Nasal Endoscopy and Lateral Neck Radiography When Diagnosing Children with Adenoid Hypertrophy" published in the Turkish Archives of Otorhinolaryngology. The authors are to be commended for addressing an important diagnostic issue in pediatric otorhinolaryngology.

Adenoidectomy is one of the most frequently performed procedures in the pediatric population worldwide. Adenoid hypertrophy is a significant condition associated with nasal congestion, recurrent middle ear infections, chronic mouth breathing, and craniofacial changes in children. In this context, one of the first steps in clinical practice is to assess adenoid hypertrophy. However, due to its location, it can be difficult to assess the size and extent of the adenoids during clinical examination (2).

I would like to raise several additional points that may complement the authors' discussion and underscore the broader diagnostic and safety advantages of direct nasopharyngeal visualization.

Lateral radiography, although widely used as a non-invasive alternative to endoscopy for evaluating adenoid hypertrophy in children, inevitably involves radiation exposure. Moreover, physiological variations during image acquisition, including changes in the respiratory cycle related to inspiration, expiration, phonation or swallowing patterns may also lead to incorrect assessment of the nasopharyngeal airway. Importantly, not only is image interpretation, but the acquisition of an optimal radiograph itself also requires technical expertise to ensure appropriate penetration and direct lateral projection without soft palate elevation (2).

Flexible nasal endoscopy provides direct visualization of the nasopharyngeal airway. Although uncommon, a range of benign or malignant nasopharyngeal pathologies may be encountered in the pediatric population. Endoscopic examination can help

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identify the causes of airway narrowing that may clinically mimic adenoid hypertrophy. Evaluating a patient solely through radiological imaging such as lateral radiography may lead to overlooking benign or, in rare cases, malignant nasopharyngeal pathologies (3). Nasal endoscopy also allows for the assessment of the anatomical extent of the adenoid tissue prior to performing surgery, which may be clinically important given that the distribution of hypertrophy could affect symptomatology (4).

Endoscopic evaluation is also crucial for detecting rare vascular anomalies, such as an aberrant internal carotid artery (ICA). Unrecognized nasopharyngeal ICA aberrancy may lead to life-threatening hemorrhage during adenoidectomy. Nasal endoscopy may show a submucosal pulsatile mass in such cases (5). These considerations underscore the importance of thorough preoperative examination by otorhinolaryngologists before surgery.

I congratulate the authors for their contribution and believe these considerations may further strengthen the message of their study.

Footnotes

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Reply

Dear Editor,

We would like to thank the author for their interest in our article entitled "Comparing Flexible Nasal Endoscopy and Lateral Neck Radiography When Diagnosing Children with Adenoid Hypertrophy" and for their thoughtful and constructive comments.

We appreciate the emphasis on several important aspects of adenoid evaluation in pediatric patients. In particular, the points raised regarding the limitations of lateral neck radiography, including radiation exposure and potential variability during image acquisition, are well taken. These factors are indeed relevant in daily clinical practice and should be considered when selecting diagnostic modalities.

We also agree that flexible nasal endoscopy offers significant advantages by enabling direct visualization of the nasopharynx. As highlighted, endoscopic assessment may provide additional diagnostic information beyond the estimation of adenoid size, including the identification of alternative causes of nasopharyngeal obstruction. Furthermore, the role of endoscopy in preoperative evaluation, particularly in recognizing rare but potentially critical conditions such as vascular anomalies, is of clear clinical importance.

At the same time, we would like to emphasize that lateral neck radiography may still have a role in selected clinical settings. In situations where endoscopic examination is not feasible, limited, or not well tolerated, radiography can serve as a useful adjunctive tool. Therefore, rather than considering these modalities as mutually exclusive, they may be better viewed as complementary, depending on the clinical context and available resources.

Overall, we believe that the author's comments enrich the discussion and highlight important diagnostic and safety considerations in the evaluation of adenoid hypertrophy.

We thank the author again for their valuable contribution.

Sincerely,

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