Reply to Letter to the Editor

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We indeed are thankful for the Chi-Tan Hu, for giving a review on our study. We would like to respond to some of the comments made about the study done in ENT-HNS dept at this tertiary care teaching institute. We acknowledge the study done by author 2 years back and the same has been well referred to in our study reference 5. However, it needs to be understood that the context in which the study was done in both the circumstances were different. The study done by Chi-Tan Hu earlier, though addressed issue of nasal anesthesia it was meant for patients undergoing flexible EGD. In EGD, the flexible scope passes through the inferior meatus of nasal cavity. Our study was meant specifically for diagnostic nasal endoscopy, and thus all the areas of nasal cavity need to be anesthetized to help the ENT surgeon diagnose pathology in middle meatus, sphenoid sinus, posterior choana and axilla of middle turbinate. Thus, we believe that local anesthesia required for diagnostic nasal endoscopy is much different than that needed for a flexible EGD, and in this context, we did not find any article addressing issue of nasal anesthesia in diagnostic nasal endoscopy.

Regarding the query of sample size, it was very much based on the number of endoscopies done in our center. Approximately 550–650 diagnostic nasal endoscopies are done in our department annually and based on that a value of 100 was derived as the sample size. As for randomization, each patient was asked to select an envelope randomly with the intervention written, and thus had two groups with near equal samples. Too many details have been avoided as it increased the length of article. Statistical tests have been

done where feasible and a proper significance value has been derived.

We appreciate the point of difference in concentration of Lignocaine has been brought. This point was addressed during the review process of the article too. This study aimed to compare two common methods used to anesthetize nasal cavity during diagnostic nasal endoscopy. The commonly used preparation for spray is 10 % and that for packing is 4 %, so the concentration has not been changed in study. We wanted the result of this study to be of practical importance than that of theoretical importance.

None of the patients who were sprayed had any bleed in our study. In packing we did have eight patients who bleed. The reason has been explained in the discussion that most of the diagnostic nasal endoscopies are done in cases of sinusitis, and the mucosa is inflamed. Thus, inflamed mucosa does bleed in some cases during packing, though utmost care was taken. The packing in our case was done endoscopically and by a well trained ENT specialist, so the reason mentioned by above author of unstable hand and nervous hand is ruled out. In our case, the nasal bleed did not require repacking, all of them stopped without intervention.

However, we appreciate the use of gauze strip applicator by the author. A person who is not well trained in packing nasal cavity might cause mucosal trauma and thus nasal bleed, which the authors claims reduces with flexible forceps. Though we have not used such forceps yet, but will like to use it and give our comments after that. I believe another randomized control trial comparing the nasal forceps (Tilley's nasal packing forceps) with that of the flexible one might be the correct way to go about.

This has the concurrence of all the corresponding authors of the main article (Maitri kaushik, Arun Dehadaray, Haris Qadri, A Raichurkar, Tanvi Seth).

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