Response to letter to the editor: “is drug induced sedation endoscopy surgical decision making process objective and systematic?”

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Dear Editor,

The authors thank for the overall positive opinion expressed about our paper “The importance of drug-sedation endoscopy (DISE) techniques in surgical decision making: conventional versus target controlled infusion techniques—a prospective randomized controlled study and a retrospective surgical outcomes” in the letter to the editor entitled “Is Drug Induced Sedation Endoscopy surgical decision-making process objective and systematic?” and we wish briefly reply to the questions raised by the reader. (1) To the best of our knowledge, at least 16 DISE classification’s systems are reported up to now in the literature and each classification has positive aspects, but also limitation. Currently, there is not a DISE classification system universally accepted. Our NOHL classification system provides a scoring index for upper airways in awake and sleep stage setting, which can support the decision-making process for surgical treatment, as reported in our experience. We have introduced the NOHL classification system since 1996 in our clinical routine and we believe that the experience built in about 20 years represents the main reason for the postoperative AHI outcome obtained (TCI-DISE: from 27.5 ± 3.4 to 8.1 ± 4.2 ; C-DISE: from 27.1 ± 4.6 to 11.5 ± 4.2). (2) We strongly believe that the more otorhinolaryngologist and anesthesiologist deeply DISE experience is, the better candidate’s surgical selection is, and

the better postoperative AHI outcome is, as a consequence. (3) The candidate’s surgical selection begins before DISE performance. We should select OSA patients, in whom anatomical factors represent the main pathophysiological reason of obstructive events, by means of the PSG/PM analysis. After that, during DISE, we decide the single or combined surgical techniques to perform, observing the level, grade, and pattern of upper airways obstruction, taking into account the surgical technology available in our institution (conventional surgical procedures vs radiofrequency vs robotic surgery). (4) We concur with you about the need of make database of sleep centers available, including DISE videos. (5) We strongly suggest that the patient referral process for surgical treatment could be systematic and objective across the world if any sleep center and/or otorhinolaryngologist approaching a SBD patient in daily practice will perform or analyze a correct polysomnography/portable monitoring trace in which will be possible to distinguish OSA patient with anatomical reason of obstructive event (phasic desaturation pattern) from SBD patient no-OSA (prolonged desaturation pattern or overlap patterns). Moreover, a team of experienced otorhinolaryngologist and anesthesiologist should perform DISE, by means of the support of the best technology available (at least target controlled infusion pump). We also suggest organizing groups of study across the world, who could realize DISE analysis and standardization, providing results consistently comparable.

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Compliance with ethical standards

Conflict of interest Author Andrea De Vito declares that he has no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the author.

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