Response by the Authors of Original Article

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J Neurol Surg B 2019;80:332.

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We thank the authors for their interest in our study and for their comments about the similarities and differences with the combined transseptal/transnasal approach, described by their own group. We acknowledge the similarities in the two techniques and we believe the main advantages are consistent between the two; we believe this general approach will gain more popularity over time.

Regarding the subject of postoperative cerebrospinal fluid (CSF) leak, inadequate flap length may theoretically be a contributing factor in certain instances; however, we believe other patient risk factors were likely more contributory in our population. Such risk factors include, among others, diabetes mellitus, obesity, degree of extension of approach, redo cases, prior radiation, choice of sealant available, and raised intracranial pressure.

In our experience, a full-size nasoseptal flap is still not required in the overwhelming majority of routine pituitary surgeries. The posterior half of the septal mucosa up to the level of the osteocartilaginous junction, as described in our papers,^{1,2} will usually provide adequate bony coverage up to the level of the planum sphenoidale and will avoid the problems of excessive flap bulk and donor site morbidity.

The hemitransseptal approach was initially devised and adopted due to its polyvalence in allowing a greater number of reconstructive options at the end of the case, when it becomes evident that the initial flap is inadequate. There is no significant disadvantage to harvesting a full-size flap at any time with our approach. Our concern harvesting a full-size flap in all cases is the risk of inducing cartilage devitalization and necrosis, particularly if some parts of the septal cartilage are separated from their feeding perichondria bilaterally at the same time, even if only temporarily.

In our practice, a decision to harvest a full-size nasoseptal flap is made at the beginning of surgery when this is anticipated to be necessary and the contralateral posterior septal mucosa is fashioned into an anteriorly-based flap which is flipped anteriorly over the cartilage donor site.³ This results in a posterior septectomy which very rarely causes any symptoms and significantly speeds up the healing process postoperatively.

Whatever the philosophy of the operating team, the most important factor is the experience and comfort of that team in adequately treating the primary pathology and minimizing morbidity postoperatively. The hemitransseptal approach has served us well over the past 6 years, with swift and excellent surgical access, as well as rapid healing. Improvement in our preoperative patient selection for full-size nasoseptal flap harvest has further decreased our postoperative CSF leak rate to 3.2% over the last 18 months. Future studies should further elucidate the criteria to aid in this decision making.

Conflict of Interest

None.

References

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