

organism. They concluded, 'Interestingly, the control group of normal, healthy volunteers was 100% culture positive for fungi'. As fungi are ubiquitous in the inspired air, this should be neither a surprise nor of interest! Any fungal reactions may be related to the underlying inflammation, which it may exacerbate.

Bacteria such as *Staphylococcus aureus*, *Mycoplasma arthritides* and *Yersinia pseudotuberculosis* may produce superantigens and superantigens are found in several conditions including toxic shock syndrome and atopic dermatitis.⁴ They stimulate both a Th₂ response directly and act as a conventional allergen. Two recent reviews have summarized their role.^{5,6}

Bachert and colleagues claim that this is what happens in the nose in patients with nasal polyps.³ They studied 20 patients and compared the findings with 20 patients who had pieces of the inferior turbinate removed surgically. The polyp patients were divided into three groups on their results. Groups one and two both had five patients and had no evidence of a response to superantigens. The third group where a response was found had eight patients with asthma. It is well recognized that asthma is associated with increasing recurrence and thus a more severe clinical course. Because an antigen is demonstrated it does not imply a causal relationship and may be a reflection of increased inflammation found in certain clinical subgroups.

We can reject the two theories doing the rounds with little difficulty. The necessary conditions do not exist for these conditions to produce chronic sinusitis with and

without nasal polyposis in the majority of patients. Patients with sinusitis with and without nasal polyps must have a complex condition depending on the individual, environment and cellular factors. If subgroups can be found and recurrence matched to this, an advance in treatment should be possible.

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Letters to the Editor

Interobserver perceptual analysis of smokers voice

28 July 2004

Dear Editor,

We read with great interest the article by Deditis *et al.*, 'Interobserver perceptual analysis of smokers voice', published in the April issue of *Clinical Otolaryngology*.¹ Although we agree on the importance and relevance of such studies, we feel that there were significant methodological problems in the analysis of results. The authors assessed the interobserver variability of rating of the voices of 48 smokers. Three judges were asked to grade the voices using GRBAS scale – essentially grade each voice from 0 to 3 in five different areas – degree of hoarseness, roughness, breathiness, asthenic and strained

quality. The authors then proceeded to assess the concordance between pairs of examiners in each of the five scales.

It is clear from the description of their methodology, and indeed confirmed from previous studies,² that they are assessing concordance between pairs of ordinal variables. Kappa statistic is a measure of interrater agreement in classification studies – in other words, a way of assessing whether raters agreement in the classification of binomial or nominal variables exceeds what would be expected by chance – for example, in the case of classification of a benign laryngeal lesion. In this study, the

authors are assessing the correlation between two ordinal variables – and the use of kappa statistic (at least without weighting) is inappropriate. It appears that the concordance between the three examiners was generally high, with a difference that never exceeded one point in the four-point scale. However, by ignoring the ordered nature of their variables (and treating all disagreement in the same way), the authors present kappa values between 0.01 and 0.23 – in other words poor interrater correlation. This contradicts their assertion in the discussion section that ‘There was no severe disagreement between the observers’.

Additionally, in the results section they state that when agreement was 100% kappa could not be calculated – which is not the case, as it can well be calculated (and would be equal to 1).

Interjudge variance is always difficult to assess, however we feel that the use of simple Pearson’s correlation coefficient, or Cronbach’s alpha (intraclass correlation coeffi-

cient) would have given a clearer picture of the results of this study. Alternatively, if the authors insisted on the use of kappa, weighted kappa would have been appropriate.

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Use of Disposable Curette in the Treatment of Chondrodermatitis Nodularis Helicis

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Dear Editor,

Chondrodermatitis Nodularis Helicis, or painful nodule of the ear, is a common benign lesion that is seen and treated by the otolaryngologists and dermatologists. Patients are generally middle aged or elderly. The lesions are discrete, grey to red in colour; oval-shaped with raised rolled edges and a central crust or depression, which often contains crust or scale (Fig. 1). The lesions frequently present with exquisite tenderness that interferes with sleep. The characteristic histopathologic features are epithelial hyperplasia, collagen degeneration, focal fibrinoid necrosis and inflammatory components. The perichondrium often is inflamed, and a focus of cartilaginous degeneration may be present, although it is usually minimal.

Chondrodermatitis Nodularis Helicis is assumed to be caused by pressure necrosis of protuberant cartilage and thus is primarily not a skin disease.¹ Surgical treatment by wide excision with removal of underlying cartilage is generally recommended.² Various surgical techniques including wedge excision, flaps,³ ellipse excision, curettage and cautery⁴ and Lasers⁵ have been described for its

removal. Cartilage excision alone has also been demonstrated to be an effective technique in the treatment of Chondrodermatitis Nodularis Helicis.² Recurrences usually occur because of inappropriate removal of the cartilage leading to painful nodules at the excised margins. The other reason for the recurrence is removal of skin alone or disproportionate removal of cartilage in relation to skin.³ To minimize the risk of recurrence, an adequate removal of cartilage along with the smooth trimming of the ends is desired. This can be difficult to obtain with a normal scalpel blade.

We use a 4 mm disposable curette (Fig. 2) to get this desired effect. The nodule is removed along with underlying cartilage through an elliptical incision with a no.15 surgical blade. The rest of the cartilage is curetted and smoothed with a disposable curette (Fig. 3) until no sharp edges are left behind. The skin is sutured over the defect with excellent cosmetic results.

Our surgical technique combines minimal skin removal and adequate cartilage resection, thus describing a simple surgical technique, avoiding the need for more elaborate and deforming surgical procedures. This technique also