# MANAGEMENT

# TREATMENT OF ADENOIDS

- When symptoms are not marked , breathing exercises, decongestant nasal drops and antihistaminics for any co-existent nasal allergy can cure the condition without resort to surgery
- When symptoms are marked, adenoidectomy is done.

# Adenoidectomy

- Adenoidectomy may be indicated alone or in combination with tonsillectomy
- Adenoids are removed first and the nasopharynx packed before starting tonsillectomy

# INDICATIONS

- 1. Adenoid hypertrophy causing snoring, mouth breathing, sleep apnoea syndrome or speech abnormalities, i.e. (rhinolalia clausa)
- 2. Recurrent rhinosinusitis
- 3. Chronic otitis media with effusion associated with adenoid hyperplasia
- 4. Recurrent ear discharge in benign CSOM associated with adenoiditis/adenoid hyperplasia.
- 5. Dental malocclusion. Adenoidectomy does not correct dental abnormalities but will prevent its recurrence after orthodontic treatment.

# CONTRAINDICATIONS

- 1. Cleft palate or submucous palate.
- 2. Haemorrhagic diathesis.
- 3. Acute infection of upper respiratory tract.

# ANAESTHESIA

- Always general, with oral endotracheal intubation

## POSITION

Rose's position

Patient lies supine with head extended by placing a pillow under the shoulders. A rubber ring is placed under the head to stabilize it.Hyperextension should always be avoided

# STEPS OF OPERATION

- Boyle–Davis mouth gag is inserted
- Before actual removal of adenoids, nasopharynx should always be examined by retracting the soft palate with curved end of the tongue depressor and by digital palpation, to confirm the diagnosis, to assess the size of adenoids mass and to push the lateral adenoid masses towards the midline
- A laryngeal mirror helps to assess the size and extent of adenoid mass

- Proper size of “adenoid curette with guard” is introduced into the nasopharynx till its free edge touches the posterior border of nasal septum and is then pressed backwards to engage the adenoids.
- At this level, head should be slightly flexed to avoid injury to the odontoid process
- With gentle sweeping movement, adenoids are shaved off
- Lateral masses are similarly removed with smaller curettes; small tags of lymphoid tissue left behind are removed with punch forceps

- Haemostasis is achieved by packing the area for sometime.
- Persistent bleeders are electrocoagulated under vision

# COMPLICATIONS

- Haemorrhage
- Injury to eustachian tube opening
- Injury to pharyngeal musculature and vertebrae.
- Grisel syndrome.
- Velopharyngeal insufficiency
- Nasopharyngeal stenosis
- Recurrence

# TREATMENT OF ACUTE TONSILLITIS

- Patient is put to bed and encouraged to take plenty of fluids
- Analgesics (aspirin or paracetamol) are given according to the age of the patient to relieve local pain and bring down the fever.
- Antimicrobial therapy. Most of the infections are due to Streptococcus and penicillin is the drug of choice. Patients allergic to penicillin can be treated with erythromycin. Antibiotics should be continued for 7–10 days.

# TREATMENT OF CHRONIC TONSILLITIS

- Conservative treatment consists of attention to general health, diet, treatment of coexistent infection of teeth, nose and sinuses
- Tonsillectomy is indicated when tonsils interfere with speech, deglutition and respiration or cause recurrent attacks

# Tonsillectomy

- INDICATIONS

ABSOLUTE

- Recurrent infections of throat.
- Peritonsillar abscess
- Tonsillitis
- Hypertrophy of tonsils
- Suspicion of malignancy

- RELATIVE
  - Diphtheria carriers, who do not respond to antibiotics.
  - Streptococcal carriers
  - Chronic tonsillitis with bad taste or halitosis which is unresponsive to medical treatment.
  - Recurrent streptococcal tonsillitis in a patient with valvular heart disease.

# AS A PART OF ANOTHER OPERATION

Palatopharyngoplasty which is done for sleep apnoea syndrome.

- Glossopharyngeal neurectomy. Tonsil is removed first and then IX nerve is severed in the bed of tonsil.
- Removal of styloid process.

# CONTRAINDICATIONS

- Haemoglobin level less than 10 g%.
- Presence of acute infection in upper respiratory tract, even acute tonsillitis
- Children under 3 years of age
- Overt or submucous cleft palate
- Bleeding disorders, e.g. leukaemia, purpura, aplastic anaemia or haemophilia.
- At the time of epidemic of polio.
- Uncontrolled systemic disease, e.g. diabetes, cardiac disease, hypertension or asthma.
- Tonsillectomy is avoided during the period of menses

# ANAESTHESIA

- Usually done under general anaesthesia with endotracheal intubation. In adults, it may be done under local anaesthesia.

## POSITION

- Rose's position, i.e. patient lies supine with head extended by placing a pillow under the shoulders. A rubber ring is placed under the head to stabilize it .Hyperextension should always be avoided

# STEPS OF OPERATION (DISSECTION AND SNARE METHOD)

- . Boyle–Davis mouth gag is introduced and opened. It is held in place by Draffin's bipods or a string over a pulley
- Tonsil is grasped with tonsil-holding forceps and pulled medially.
- Incision is made in the mucous membrane where it reflects from the tonsil to anterior pillar. It may be extended along the upper pole to mucous membrane between the tonsil and posterior pillar

- A blunt curved scissor may be used to dissect the tonsil from the peritonsillar tissue and separate its upper pole
- Now the tonsil is held at its upper pole and traction applied downwards and medially. Dissection is continued with tonsillar dissector or scissors until lower pole is reached
- Now wire loop of tonsillar snare is threaded over the tonsil on to its pedicle, tightened, and the pedicle cut and the tonsil removed.

- A gauze sponge is placed in the fossa and pressure applied for a few minutes
- Bleeding points are tied with silk. Procedure is repeated on the other side.

# COMPLICATIONS

## IMMEDIATE

- Primary haemorrhage
- Reactionary haemorrhage
- Injury to tonsillar pillars, uvula, soft palate, tongue or superior constrictor muscle due to bad surgical technique
- Injury to teeth.
- Aspiration of blood.
- Facial oedema.
- Surgical emphysema.

# DELAYED

- Secondary haemorrhage.
- Infection- parapharyngeal abscess or otitis media
- Lung complications
- Scarring in soft palate and pillars
- Tonsillar remnants.
- Hypertrophy of lingual tonsil.

# THANK YOU