Chronic tonsillitis

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Chronic tonsillitis usually results from repeated attacks of acute tonsillitis in which the tonsils become progressively damaged by inflammatory processes and provide a reservoir for infective organisms. Tonsillectomy The indications for a tonsillectomy are either diagnostic, ther apeutic or for surgical access. Recurrent acute tonsillitis is the most common relative indication for tonsillectomy in children and adolescents, although it is important that these attacks are well documented, frequent and do not simply constitute a minor viral sor e throat. Chronic tonsillitis more frequently a ff ects young adults, in whom it is important to establish that chronic mouth breathing secondary to nasal obstruction is not the main problem rather than the tonsils themselves. Tonsillectomies are occasionally performed as a means to gain surgical access to the parapharyngeal space laterally in the oropharynx or to access an elongated styloid process. Absolute indications for tonsillectomy are when the size of the tonsils is contributing to airway obstruction or a malignancy of the tonsils is suspected (Table 52.1). Ideally , the procedure should be undertaken when the ton sils are not acutely infected, and it is important to discuss fac tors that may increase the tendency to bleed. Blood transfusion is rarely required, but it is normal practice to type and screen blood for cross-match in children under 15 /uni00A0 kg in weight. /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF β - Dissection tonsillectomy is carried out under general anaes - thesia. The mucosa of the anterior faucial pillar is incised and the tonsil capsule identified. Using blunt dissection, the tonsil is separated from its bed until only a small inferior pedicle is left (Figure 52.27). It is then separated from the lingual tonsil. A - tonsil swab is placed in the tonsillar bed and pressure applied for some minutes, following w hich bleeding points may be controlled by ligature or by bipolar diathermy . (Coblation and laser dissection is commonly used in the resource-rich world in an attempt to reduce postoperative pain and bleeding.) Following surgery , the patient is kept under close obser - vation for any systemic or local evidence of bleeding, with regular pulse and blood pressure measurements and observa - tion to monitor whether the patient is swallowing excessively (Figure 52.28). Postopera tively , patients are encouraged to eat normally and take regular oral analgesics. Patients are allowed home on the same or following day and are warned that they may experience otalgia as a result of referred pain from the glossopharyngeal nerve and that secondary haemorrhage may occur up to 10 days following the surgery . - Haemorrhage is the most common complication in the - immediate postoperative period. Local pressure may help in mild cases, but reactionary haemorrhage usually requires return to theatre f or definitive treatment, particularly in

Absolute Sleep apnoea, chronic respiratory tract obstruction, cor pulmonale Suspected tonsillar malignancy Relative Documented recurrent acute tonsillitis Chronic tonsillitis Peritonsillar abscess (quinsy) Tonsillar asymmetry Tonsillitis resulting in febrile convulsions Diphtheria carriers Systemic disease caused by -haemolytic Streptococcus (nephritis, rheumatic fever) Figure 52.27 Removal of the tonsils.

younger patients. Under general anaesthesia, it may be possible to identify a bleeding spot, but often a more generalised ooze is observed and suturing of the tonsil bed combined with the application of haemostatic gauze and bipolar diathermy is often more successful than attempted placement of ligatures. Late haemorrhage is sometimes secondary to infection and patients are usually started on broad-spectrum intrave nous antibiotics. Any residual clot in the tonsil fossa should be removed and regular gargling with a dilute solution of h ydrogen peroxide may be beneficial. Significant or persistent bleeding may requir e a further general anaesthetic and hae mostasis, which may require diathermy and/or undersewing of the granulating, sloughy tonsil fossa. Postoperative tonsillar haemorrhage is still a serious and life-thr eatening complication and should not be underestimated, particularly in the younger patient. Summary box 52.6 Complications of tonsillectomy /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Figure 52.28 Positioning of the patient after tonsillectomy. Haemorrhage (immediate or late) Infection Pain/otalgia Postoperative airway obstruction Velopharyngeal insuf /f_i ciency Injury to oral cavity and oropharyngeal structures

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