

Tonsillitis

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If your doctor diagnoses tonsillitis in you or a member of your family, you may have many questions about this condition. No doubt you will wonder how he decides that this is the problem and, having decided, how he determines what is the best remedy. If an operation is necessary, what is involved and what problems can you expect to have after the surgery? How long will you be away from school or from work? With this in mind, we have prepared the following material to answer these and other questions so as to make you better informed and thus to relieve your anxieties.

Diagnosis

The tonsils are part of a ring of lymphoid tissue consisting of the palatine tonsils (those we are referring to here), the lingual tonsils, pharyngeal bands, and adenoids. The ring is called Waldeyer's ring. These structures are shown in Figure 1. Acute tonsillitis is typically demonstrated by a dry throat, thirst, fever, a feeling of fullness in the throat, difficulty in swallowing, pain radiating to the ears, headache, swelling of the lymph nodes below the ears, and sometimes altered speech. Although not all of these symptoms are seen in all patients, these are the most common complaints. The physician bases his diagnosis on a very careful and complete history and physical examination. It is important that your answers to the doctor's questions be as truthful and accurate as possible.

Indications for Operation

Although tonsillectomy is not nearly so common now as in earlier years, there are still approximately 350,000 such operations performed yearly in pediatric patients in the United States. Recurrent episodes of acute or chronic tonsillitis are a leading indication for surgery. A convenient rule of thumb in making this decision is that there must have been at least three episodes in each of three years or five episodes in each of two years or seven episodes in one year. These episodes must have been accompanied by temperatures of 101 °F or higher, enlarged lymph nodes, exudate (drainage) from the tonsils, or positive streptococcus cultures. Although chronic tonsillitis may be treated effectively with antibiotics, the occurrence of a number of episodes within a year may represent a significant loss of time from work or school and result in expensive courses of drugs and visits to the doctor. Tonsillitis may also result in convulsions owing to the sometimes high body temperatures. This, too, is an indication for surgery. An abscess involving the tonsils may develop, and enlargement of the tonsils may cause difficulty in breathing or swallowing. In both of these cases, surgery is likewise indicated.

The doctor must decide in other cases whether the number of episodes of sore throat and earache, the degree of mouth breathing, or simple failure of pediatric patients to thrive constitute sufficient reason for tonsillectomy.

In some patients, tonsillectomy is never recommended. In the presence of significant blood disorders, such as hemophilia or leukemia, or uncontrolled diseases (diabetes or heart disease, for example), tonsillitis must be managed by antibiotic therapy alone.

Admission to the Hospital

Although ambulatory (outpatient) surgery is being used increasingly to reduce hospital costs, the doctor must decide in each case whether inpatient or outpatient surgery will best serve the needs of the patient. In either case, blood work and urinalysis are performed after admission. The patient must have blood clotting studies to identify any abnormalities in this area. All patients must fast for 8-12 hours before surgery, but will usually be given fluids intravenously to prevent dehydration. Mild sedatives are sometimes given the night before to assure the patient a good night's sleep.

During the morning of surgery, other medications may be given as necessary, usually a tranquilizer or perhaps a narcotic or sedative. These drugs relieve the patient's anxiety and make him or her more receptive to the upcoming operation.

The Anesthetic

In children and uncooperative or unduly apprehensive patients, general anesthesia is usually given. Local anesthesia may be used in cooperative adults. The type of anesthesia and any potential complications will be explained by the anesthesiologist.

The Operation

Tonsillectomy can be done using either of two popular methods. These are described briefly below.

Dissection and Snare Method. One tonsil is grasped with a clamp and pulled toward the middle. A knife is used to cut into the structure referred to as the plica triangularis and into the supratonsillar fossa and posterior pillar. The tonsillar capsule can be split easily so that when the tonsil is pulled toward the middle the cut will gape and the clamp can be adjusted so as to grasp the capsule. The upper tonsillar pole is then freed by dissection with scissors. When the dissection reaches the inferior pole of the tonsil, a snare is passed around the tonsil. When the loop is closed, the tonsil is thereby amputated. The other tonsil is removed in the same fashion. Throughout the operation suction is used to remove blood from the surgical field. Small sponges are used to apply pressure to bleeding vessels. In case of excessive bleeding, vessels can be sewn or electrocoagulated by cautery. Although other methods may be used to control bleeding, they are usually not required.

Tonsil Guillotine (Slide) Technique. This technique is most often used in children, but is advocated by some surgeons in adults as well. It employs a surgical instrument called a tonsillotome and requires the surgeon's displacing the tonsil forward and inserting it through the tonsillotome. The blade is closed to amputate the tonsil. Surrounding lymphoid tissue must also be removed.

After the Operation

The patient is taken to an area called the recovery room so that careful observation by skilled nursing personnel is assured. These workers monitor the patient carefully, with special attention to removal of secretions from the mouth or throat. When the patient is fully awake, intake of fluids by mouth is begun. Ice collars may be applied to relieve neck pain and discomfort.

Mild sedatives or pain relievers are also used as necessary. Acetaminophen (Tylenol) is most commonly given. Children usually experience less postoperative pain than do adults. Rest and liquids are the cornerstone of care. Antibiotics are usually given as an infection-preventive measure. Most patients can be discharged within 24 hours, at which time they may begin a soft diet.

Recovery Period

The patient is usually able to resume normal activities within 2 weeks. Until healing is complete (approximately 3 weeks), the patient should avoid foods that have roughage and can injure the throat or induce bleeding. Smoking should also be avoided so as to prevent additional inflammation and prolonged healing. The doctor will wish to check the patient 1 week after surgery, again at 1 month, and thereafter as necessary.

Complications of Tonsillectomy

Hemorrhage may occur in either the immediate postoperative period (primary hemorrhage) or 7-8 days after surgery (delayed hemorrhage). Primary hemorrhage occurs in only approximately 1% of patients and is usually caused by a clotting defect or by blood vessels that are not in the typical location. Careful preoperative evaluation is generally adequate to prevent hemorrhage from coagulation defects and good surgical technique, with careful dissection and attention to anatomical detail, can in large measure avoid hemorrhage from aberrant vessels. delayed hemorrhage is usually mild, with only a few drops of blood. This results from the separation of the crust covering the surgical wound. If bleeding is excessive, the doctor should be notified.

Pain may involve the throat or ears and can usually be controlled with analgesics (for example, Tylenol).

Infections are not uncommon and can usually be controlled by saline or diluted peroxide gargles. Sometimes antibiotics are necessary.

Other complications have occurred but are far less common. These include facial edema (swelling), otitis media (earache), velopharyngeal insufficiency (hypernasal speech), and emotional upset.