

TONSILLECTOMY

1. **Definition** : Removal of palatine tonsils

2. **Indications**:

Children or Adults:

Infection indications: 3 or more bacterial infections per year. Strep test not mandatory. NB: (Paradise group) mandatory in some countries to take the adenoids of children out at the same time but not recommended as a standard procedure.
Peritonsillar abscess (hot tonsillectomy might be performed)

Hypertrophy indications:

Hypertrophy causing deglutition problems
Hypertrophy causing airway obstruction (SAS)

3. **Pre-operative assessment (clinical description)**

Description of the oropharynx and tonsils, their aspect, their size after Mallampati scoring:

Tonsil 0: Tonsils fit within tonsillar fossa
Tonsil 1+: Tonsils <25% of space between pillars
Tonsil 2+: Tonsils <50% of space between pillars
Tonsil 3+: Tonsils <75% of space between pillars
Tonsil 4+: Tonsils >75% of space between pillars

Clinical signs (children): Heavy snoring, Quality of sleep, Dysphagia, Reduced growth, Cardio-pulmonary disorders, Speech- hot potato voice

4. **Method/Operative technique**

Tonsillectomies are performed generally under general anaesthesia. Different techniques are used, the most common being **Cold knife (steel) dissection with or without electrocautery**.

Others include **Harmonic scalpel** (uses ultrasonic energy to vibrate its blade at 55,000 cycles per second, transferring energy to the tissue, and providing simultaneous cutting and coagulation), **Radiofrequency ablation** (monopolar radiofrequency transfers energy to the tonsil tissue through probes inserted in the tonsil, procedure recommended for treating enlarged tonsils and not chronic or recurrent tonsillitis), **Carbon dioxide laser** (hand-held CO₂ or KTP laser to vaporize and remove tonsil tissue), **Bipolar Radiofrequency Ablation (Coblation)** (produces an ionized saline layer that disrupts molecular bonds without using heat. As the energy is transferred to the tissue, ionic dissociation occurs).

Tonsillectomies will be performed as an in patient or day-case procedure with great variations over EU. Patients may stay from 1-8 days depending on patient status and distance from the hospital.

5. **Information/Consent**

Written consent recommended to the patients/parents, including risks of anaesthesia, risks of bleeding (from 1.5% in children to 3% in adults) mostly at the 3rd day or at the 7th day including need for re-operation, infection. Mentioning the death risk can be discussed but probably not written in the information / consent form. Special care during post-operative period, abundant fluids, ice creams and cold diet initially, followed by soft diet for about 3 weeks.

The consent must be signed by the patient/parent and question asked if the procedure and complications have been understood.

6. **Outcome measures**

No consensus about a precise calendar, depending on the demand of patient: if necessary and if problems. Outcome measurement obvious.