

TONSILLOTOMY (PARTIAL) & COMPLETE TONSILLECTOMY - SURGICAL TECHNIQUE

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Acute tonsillitis is treated with steroids *e.g.* dexamethasone, NSAIDs *e.g.* ibuprofen and beta-lactam antibiotics *e.g.* penicillin or cefuroxime. Only 10 days of antibiotic therapy has proven to be effective to prevent rheumatic fever and glomerulonephritis.

Tonsillectomy is only done for recurrent acute bacterial tonsillitis, or for noninfectious reasons such as suspected neoplasia.

Partial tonsillectomy (tonsillotomy) is the 1st line treatment for snoring due to tonsillar hyperplasia. It is low-risk, and postoperative pain and risk of haemorrhage are much less than with tonsillectomy. It is immaterial whether the tonsillotomy is done with laser, radiofrequency, shaver, coblation, bipolar scissors or monopolar electrocautery, as long as the crypts remain open and some tonsil tissue remains.

Pain and haemorrhage are the main morbidity of tonsillectomy. Bleeding may occur anytime until the wound is completely healed, which is normally at 2-3 weeks. Patients have to be informed about what to do in case of haemorrhage. Life threatening haemorrhage often is preceded by smaller bleeds, which can spontaneously cease. That is why every haemorrhage, even the smallest, has to be treated as an inpatient. Massive haemorrhage is an extreme challenge for every paramedic or emergency doctor because of difficult airway management.

Function and anatomical structure of tonsils in childhood and adolescence

Tonsils allow one to acquire immunity and provide immune defence by antigen presentation. This is why they contain T-lymphocytes, germinal centres of B-lymphocytes¹ and macrophages. They are the

first and easiest-to-reach station of the *mucosa associated lymphoid tissue system* (MALT)²⁻⁴. As the main phase of the immune acquisition continues until the age of 6yrs, the *palatine tonsils* are physiologically hyperplastic at this time^{5, 6}. This is followed by involution, which is reflected by regression of tonsil size until age 12yrs⁷.

The lymphoid tissue is separated by a capsule from the surrounding muscle (superior pharyngeal constrictor)⁸. The blood supply originates from four different vessels, the *lingual artery*, the *ascending pharyngeal artery* and the *ascending* and *descending palatine arteries*. These vessels radiate mainly to the upper and lower tonsillar poles, as well as to the centre of the tonsil from laterally⁹. The tonsils have deep crypts that create a large surface area to provide a docking surface for potential antigens¹⁰.



Figure 1: Hyperplastic tonsils in a child

Tonsil diseases

Sore throat episodes (R07.0)

Synonyms include “acute sore throat”, and “throat infection”. “Sore throat” is an imprecise term and does not clinically distinguish between acute tonsillitis and pharyngitis. Neither the cause nor the exact loca-

tion is determined ¹¹. In “sore throat” it remains unclear whether one is dealing with acute (bacterial) tonsillitis which, if recurrent, is an indication for tonsillectomy ¹².

Acute tonsillitis (J03.0 - J03.9)

Also known as “severe tonsillitis” ¹³, “true tonsillitis”, or “acute sore throat” ¹¹, this refers to viral or bacterial tonsillitis with odynophagia, swelling and redness of the tonsils, possibly with a tonsillar exudate, cervical lymphadenopathy and fever >38.3°C (rectal) ^{14, 15}. Odynophagia for 24-48 hours, as part of prodromal symptoms of a common cold (viral infection of upper respiratory tract), is excluded from the term “acute tonsillitis” ¹¹. Depending on the stage and appearance of the tonsillar deposits or exudate, one can distinguish *catarrhal angina* with redness and swelling of the tonsils (early stage), from *follicular angina* with stipple-like fibrin deposits, from *lacunar angina* with confluent deposits (late stage) ^{16, 17}. “Acute tonsillitis” can be diagnosed by a specialist purely on clinical grounds ¹⁸. Smears, blood tests or viral evidence are unnecessary in most cases ¹⁹⁻²³. Penicillin or another beta-lactam antibiotic is the first line of treatment.

Chronic tonsillitis (J35.0 and J35.9)

Also called “chronic (hyperplastic) tonsillitis”, it is not well-defined and thus should not be used ²⁴. It is better to speak of (chronic) recurrent tonsillitis ^{25, 26}, because true chronic tonsillitis with persistent symptoms lasting >4 weeks with adequate treatment and recovery of the mucosa (as in rhinosinusitis) does not exist.

Recurrent acute tonsillitis (J35.0)

Also called “recurrent tonsillitis” or “recurrent throat infections” ²⁷, this refers to recurrent bouts of acute tonsillitis. In contrast to a single attack of acute tonsillitis, it is usual-

ly caused by many different bacterial pathogens ^{28, 29} and flare up again a few weeks after cessation of antibiotic therapy ³⁰. Depending on the frequency and severity of such episodes, **this is an indication for tonsillectomy.**

Peritonsillar abscess (J36)

This is also called “peritonsillitis”, or “quinsy” ^{31, 32}, and is acute tonsillitis complicated by an abscess, typically unilateral ³³. The abscess may form in the intratonsillar, para-peritonsillar or retrotonsillar spaces. The pathogens are typically staphylococci ³⁴, streptococci and fusobacterium necrophorum ³⁵. In contrast to acute tonsillitis, viruses play no role in abscesses ³⁶. A peritonsillar abscess is drained by aspiration or drainage or by unilateral tonsillectomy.

Tonsil hyperplasia (J35.1 and J35.3)

Tonsil hyperplasia ³⁷, also known as (idiopathic) tonsillar hypertrophy ³⁸, refers to abnormal enlargement of the palatine tonsil. It has to be distinguished from *physiological paediatric palatine tonsil hyperplasia* ^{39, 40} which is not a sign or consequence of recurrent inflammation ^{41, 42}. Also, children with tonsil hyperplasia do not suffer from acute tonsillitis ^{43, 44} or middle ear infections ⁴⁵. A paediatric tonsil is only “pathologically” hyperplastic if snoring (with or without obstructive sleep apnoea) or rarely dysphagia ⁴⁶ or even more rarely dysphonia ⁴⁷ occur.

Surgical procedures

Tonsillectomy

(Extracapsular) tonsillectomy means that the entire tonsil, including its capsule, is removed from the tonsil fossa; no lymphatic tissue remains between the anterior and posterior palatal arches ⁴⁸. Since the late 1960s, with the realisation that the tonsil is

a focus of infection⁴⁹⁻⁵², this form of tonsil operation has been the gold standard and is still the most common surgery done in the world⁵³.

[Video 1: Extracapsular tonsillectomy](http://youtu.be/V_tloYXfwQ)
(http://youtu.be/V_tloYXfwQ)

Tonsillotomy (partial tonsillectomy)

Only the medial part of the tonsil is removed. It requires that the (well-perfused) lymphatic tissue is resected, and that the remaining crypts remain open to the oropharynx^{54, 55}. Active lymphatic tissue, with secondary follicles and crypts, is left in the tonsil fossae⁵⁶. Tonsillotomy can be done with most dissecting and coagulating methods. The most common are laser tonsillotomy and radiofrequency tonsillotomy and are described in detail in this chapter.

[Video 2: Laser tonsillotomy](http://youtu.be/2AUzLY3rewM)
(<http://youtu.be/2AUzLY3rewM>)

[Video 3: Radiofrequency tonsillotomy](http://youtu.be/eQ7bbT0mj0k)
(<http://youtu.be/eQ7bbT0mj0k>)

Intracapsular tonsillectomy



Intracapsular, subcapsular or subtotal tonsillectomy describes a method in which the lymphatic tissue of the tonsil, including all crypts and follicles, is removed^{57, 58}, but the capsule of the tonsil is preserved; thus the underlying muscles are not exposed⁵⁹. At the end of the operation there is an empty tonsil fossa without typical subsequent scarring⁵⁹. Indications for intracapsular tonsillectomy are *foetor ex ore* (halitosis) and recurrent detritus (debris) in the tonsillar crypts. It differs from tonsillotomy in which a lot more tonsillar tissue is left behind.

[Video 4: Intracapsular tonsillectomy with radiofrequency](http://youtu.be/4A6JhQJlabg)
(<http://youtu.be/4A6JhQJlabg>)

Thermal- or cryotherapy of palatine tonsil

The tonsil tissue is heated (or cooled) interstitially; subsequent scarring causes shrinkage of the lymphoid tissue. No tissue is removed and a large part of the lymphoid tissue allegedly remains functional. The indication is mild tonsillar hyperplasia. Synonyms and different techniques include interstitial (electro)coagulation, laser coagulation, thermal coagulation, and cryocoagulation of the palatine tonsil^{60, 61}, photodynamic therapy, ultrasound therapy⁶², radiofrequency-induced thermotherapy⁶³, temperature-controlled tonsil treatment⁶⁴, and tonsil thermotherapy.

Preoperative evaluation, swabs & diagnosis

Pathogens, biofilms, and normal findings

With the discovery of rheumatic fever, group A streptococci (GAS) were primarily blamed for all ills in the upper respiratory tract in the 70's⁶⁶⁻⁷³. However more recently, anaerobes, *e.g.* *Fusobacterium necrophorum*, *Streptococcus intermedius* and *Prevotella melaninogenica* and *Histococcus* have also been incriminated^{28, 74, 75}.

Children up to 8yrs of age have a tendency towards diffuse intracellular pathogen enrichment with interstitial abscesses, while in adults or adolescents a more superficial bacterial accumulation at the edge of the crypts occurs. Particularly in the case of recurrent tonsillitis, several pathogens and microorganisms play a joint role. These can jointly form biofilms and bacterial clusters and thus evade antibiotics⁷⁶. The oral cavity and especially the furrowed tonsil is a reservoir for multiple pathogens (viruses and bacteria), parasites⁷⁷ and fungi⁷⁸. However, all these microbes belong to resident flora with which we have lived symbiotically for aeons^{28, 79}. Streptococci still play the largest role in acute tonsillitis (30%)⁸⁰,

followed by Haemophilus Influenzae and Neisseria²⁸. Mostly, however, mixed infections (viral and bacterial initially) are responsible⁸¹.

Diagnosis

"Acute tonsillitis" in children and adults is a clinical diagnosis⁸². In viral tonsillitis, in addition to pain and fever, primarily cough, hoarseness, and rhinorrhoea occur, while in bacterial tonsillitis, in addition to pain with lymph node swelling, there is mainly a tonsillar exudate and fever $>38.3^{\circ}\text{C}$ ⁸³. A streptococcal antigen test can confirm the diagnosis and is 98% specific for streptococci, although not particularly sensitive. A problem with these tests is the high number of asymptomatic chronic carriers of staphylococci and streptococci (10% of healthy children), who are definitely not in need of therapy⁸⁴⁻⁸⁹. In the early stages, a distinction between viral and bacterial tonsillitis is often difficult to make, especially when one considers that in 97.5% of cases, at least one virus, even in bacterial tonsillitis, is found (adenovirus and parainfluenza virus respectively in 47.5%^{90,91})⁸¹.

Conservative Treatment

Antibiotic therapy: In clinically apparent or proven bacterial tonsillitis associated with distress, antibiotics (beta-lactam) are justified. Beta-lactam antibiotic therapy also provides relatively reliable protection against the dreaded rheumatic fever and glomerulonephritis which often cause, especially in developing countries, arthritis, myocarditis and death. Studies have shown that antibiotic therapy can prevent sequelae such as peritonsillar abscesses, acute otitis and sinusitis. The penicillins, particularly in children and adolescents, have the greatest benefit at the lowest cost. There is no difference to cephalosporins. Macrolides and clindamycin have more side-effects with the same efficacy and should be reserved

for patients with proven penicillin allergy^{92,93}.

Postoperative antibiotic therapy is not indicated as it neither reduces pain nor postoperative bleeding^{94,95}.

Steroids: In acute tonsillitis or after tonsillectomy, oral or intramuscular steroids (dexamethasone 10mg), as well as betamethasone (8mg) and prednisolone (60mg), significantly improve symptoms with minimal side effects and no adverse effects relating to disease progression⁹⁶⁻⁹⁸.

Analgesics: Nonsteroidal anti-inflammatory drugs have been used successfully for pain relief for >40 yrs⁹⁹. For acute tonsillitis, ibuprofen has the best efficacy with minimal side-effects compared to paracetamol and acetylsalicylic acid (ASA)¹⁰⁰. Another advantage of ibuprofen is its longer duration of action (6-8hrs) compared to paracetamol. Both substances have a large therapeutic range and at the correct dosage, the safety is comparable^{101,102}. Diclofenac and ketorolac are very effective, but in children have fewer docking sites and are metabolised more quickly, which is why the dose should be adjusted to a higher level than in adults¹⁰³. In postoperative management these substances play a role in opioid reduction, but as first-line therapy in paediatrics are not suitable for a sore throat^{104,105}. Metamizol is not recommended as first or second choice analgesic in children due to a small but real risk of agranulocytosis¹⁰⁶.

Complications of tonsillitis

In general, acute tonsillitis runs its course without complications and heals within 3-4 days. Rare but serious complications after streptococcal tonsillitis are **glomerulonephritis** and **rheumatic fever**, which triggers **cardiomyopathies** and rheumatic-like joint pain¹⁰⁷. Early and a long course (10 days) of antibiotics (penicillin or cephalo-

sporin) reduces the frequency of both these complications by 70%¹⁰⁸. In parts of the developing world where rheumatic fever is more common, preventing this complication is the main argument in favour of penicillin therapy¹⁰⁸.

Peritonsillar abscess is a second, more frequent complication. It is typically unilateral, although bilateral abscesses occur in up to 4%¹⁰⁹. It is preceded by acute tonsillitis in only 1/3 of cases¹¹⁰. Even correctly administered antibiotic treatment of acute tonsillitis cannot really prevent peritonsillar abscesses (in contrast to rheumatic fever)¹¹¹. Since peritonsillar abscesses can rapidly spread to the soft tissues of the neck and are potentially life-threatening, the primary therapy is urgent and surgical¹¹²⁻¹¹⁴. It does not matter whether the abscess is needle aspirated, incised or treated by tonsillectomy¹¹⁵. But the surgeon has to keep in mind that a stab incision can fail to drain inferiorly-located abscesses^{109, 116}. Before the operation, high-dose steroid therapy, as well as penicillin should be administered, as is often done for mixed infections¹¹⁷.

Indications for tonsil surgery



Surgery is done for infections, to relieve airway obstruction, for halitosis and for diagnosis when a tumour is suspected. Surgery for recurrent tonsillitis depends on its frequency and severity, and the presence of additional diseases (antibiotic allergies, immunosuppression and PFAPA syndrome).

Paradise criteria for tonsillectomy¹¹⁸

Paradise (1984) reported that tonsillectomy significantly lowers the frequency of severe recurrent sore throats in children aged 3-15yrs. Most published guidelines incorporate the so-called *Paradise criteria for tonsillectomy*:

- 7 episodes of tonsillitis per year in one year or,

- 5 episodes of tonsillitis per year in 2 consecutive years or,
- 3 episodes of tonsillitis per year in 3 consecutive years

A diagnosis of "purulent tonsillitis" must however be documented and confirmed by an elevated temperature ($>38.3^{\circ}\text{C}$), tonsillar exudate, enlarged lymph nodes at the angle of the jaw, and antibiotic treatment^{119, 120}. The authors also reported that on average only a few (not all) throat infections can be prevented by tonsillectomy in the following 2 years; 47 of 187 patients withdrew from the planned three-year follow-up¹²¹. For less severe sore throat inflammation or less frequent throat inflammation, the risk of tonsillectomy does not outweigh the benefits¹²².

While tonsils contribute to immune competence until 12yrs, a negative long-term effect on the immune system cannot be proven¹²³. Nevertheless, in children under 8yrs, the indications for complete removal must be strictly adhered to, as the risks of serious or fatal bleeding are higher¹²⁴.

With tonsillotomy (unlike tonsillectomy), some active lymphatic tissue is retained; it continues to grow in about 15% of cases, but rarely causes problems such as renewed snoring or recurrent tonsillitis¹²⁵. The fear that frequent tonsillitis or peritonsillar abscesses will occur after tonsillotomy is unfounded¹²⁶⁻¹²⁸. All crypts remain open during laser, ultrasound, shaver, high- and radiofrequency technique^{129, 130}.



Surgical technique

Extracapsular tonsillectomy

Cold steel dissection is the most commonly performed surgical technique in children and adults, and is described in detail in the chapter on [Paediatric Tonsillectomy](#). The technique is similar in adults.

The tonsils are dissected from the tonsil bed partly sharply and partly bluntly with a raspatorium and scissors. The feeding vessels, especially at the upper and lower tonsil pole, are pinched off and then selectively ligated. After removal of the tonsil, a dry swab is pressed for about 1 minute into the tonsil bed to stop bleeding from small vessels. Some surgeons perform additional suturing of the lower pole (so-called “pole suturing”, a controversial method ¹³¹).

This method of tonsillectomy has been known for decades and has been very commonly used, especially in the 70s and 80s with the discovery of that tonsils are a source of infection ¹³². Optical magnification (microscope or loupes), makes it possible to specifically identify the smaller vessels and perform bipolar coagulation before dissection ¹³³.

Due to its good long-term results and low morbidity and mortality, *cold steel dissection* is still the most common method of tonsillectomy ¹³⁴.

Tonsillotomy (partial tonsillectomy)

The tonsil is not completely removed, but only the portion that bulges into the throat, which due to its size causes functional problems. By preserving some tonsil tissue a lymphatic and immunologically active rudiment is retained.

The tonsil has a rich blood supply and has to be sufficiently cut and coagulated (not crushed) during surgery so that there is no postoperative bleeding, infection or pain. To this end, several dissection procedures have been developed (in principle, a tonsillectomy can also be performed with all these methods):

- CO₂ laser ^{135 136}
- Monopolar high frequency current ¹³⁷
- Ultrasound scalpel ¹³⁸
- Bipolar radiofrequency coblation ¹³⁹

- Bipolar scissors ¹⁴⁰
- Argon gas-assisted monopolar needle ¹⁴¹
- Microdebrider ¹⁴²

Advantages of tonsillotomy (regardless of what method is used to reduce the tonsils) are significantly less pain ¹⁴³ and a lower postoperative bleeding rate ¹⁴⁴ compared with tonsillectomy.

The quickest and easiest way to perform tonsillotomy is with monopolar high frequency dissection ([Video 3](#)). Instrumentation is shown in *Figure 2*.



Figure 2: Instruments to perform radio-frequency dissected tonsillotomy / partial tonsillectomy

- Following induction of general anaesthesia the patient is positioned supine with neck slightly extended
- Select an appropriate length Boyle Davis blade and insert the gag to retract the tongue and expose the tonsils (*Figure 1*)
- Grasp a tonsil with a broad tonsil holding forceps and gently pull it toward the midline. Avoid pulling too hard to avoid doing a complete tonsillectomy
- Insert a Colorado needle into the tonsil at the edge of the anterior faucal pillar
- Spare the mucosa of the velopalatinal arch to avoid bleeding and pain in the incision line

- Amputate the protruding part of the tonsil by dissecting with continuous movements of the needle. Do not remain too long in the same place with the cutting needle as it may burn holes in the tonsil
- Pack the wound with a gauze swab for at least 1 minute
- Minor bleeding stops spontaneously. Larger bleeding vessels can be coagulated with bipolar forceps. A suture or ligature is not required
- Repeat the process on the contralateral side

Intracapsular (subtotal) tonsillectomy

The tonsil capsule covering the underlying muscle remains in the tonsil fossa ¹⁴⁵. Slightly less postoperative pain and earlier food intake have been reported ¹⁴⁶. The instrumentation and technique is similar to tonsillotomy. All the methods of tonsillotomy previously listed may also be used. The microdebrider has been reported to be a useful tool ¹⁴⁷⁻¹⁵².

- The surgeon has to pull harder on the tonsil to sublunate the capsule, but the capsule itself has to remain in place and not be breached
- It may be very difficult to determine the exact proportion of residual tonsil that remains in the fossa
- After tonsillitis with subsequent scarring it is difficult even with loupes or a microscope to identify the exact plane of the tonsil capsule and only to remove only the active lymphatic tissue
- Because the vessels are bigger in the abyss of the crypts and near the capsule, bleeding has to be controlled with bipolar forceps more often than with (more superficial) tonsillotomy

Postoperative pain

Tonsillectomy is very painful, especially if the capsule is breached and the muscle is

exposed. Severe pain and superinfection of the wound bed can cause delayed healing and prolong hospital stay. Especially adolescent and adult patients report pain, exhaustion and fatigue weeks after surgery. In tonsillectomy the wound remains open and heals in 2-3 weeks secondarily by granulation. Sealing the wound beds postoperatively *e.g.* with fibrin glue ¹⁵³ or sucralfate ¹⁵⁴ has no advantage in terms of postoperative bleeding or pain.

With tonsillotomy, however, pain was reported as only around 2-3 on the numerical analogue scale.

Intracapsular tonsillectomy is allegedly less painful than tonsillectomy ¹⁵⁵. However, it is unlikely that intracapsular tonsillectomy produces as little pain as tonsillotomy. Pain is perceived very differently by individuals. In children and adults, the differences, regardless of surgeon and method, can be enormous ¹⁵⁶⁻¹⁵⁸. Children of African descent have more postoperative pain than Europeans and respond better to opiates ¹⁵⁹. This complicates both objective pain measurement (which does not exist), as well as a standard therapy. Pain therapy must therefore be individualised and adjusted, especially in children. Questionnaires (*e.g.* Ramsay Sedation Scale ¹⁶⁰) for analgesic use, food intake, otalgia, and downtime use popular surrogate parameters.

Because pain is perceived and processed multimodally, the treatment must be multimodal. Firstly, a local long-lasting pain reliever (*e.g.* Bupivacaine or Ropivacaine ¹⁶¹) should be injected into the wound postoperatively or perioperatively to prevent activation of the early pain pathway ¹⁶²⁻¹⁶⁴. Then already perioperatively it should be cooled locally by a cold compress ¹⁶⁵ and later a lot of ice should be eaten (local cooling and calorie intake) ¹⁶⁶. Mouth-washes with gincaine, benzocaine or tetracaine also provide pain relief, but also numb the

taste buds and respiratory flow receptors, which is often perceived as very unpleasant.

The perioperative and postoperative administration of high-dose steroids (dexamethasone or prednisolone) is clearly recommended in all guidelines. This reduces postoperative nausea and analgesic consumption significantly ¹⁶⁷⁻¹⁶⁹.

A fixed analgesic regimen with ibuprofen or diclofenac makes sense in adults and adolescents, but for children and infants rescue medication is often enough ^{170, 171}. An increased risk of bleeding due to non-steroidal anti-inflammatory drugs, (except for aspirin) should not be feared ^{172, 173}. One should therefore adhere to the WHO staging system ¹⁷⁴ (<http://www.who.int/cancer/palliative/painladder/en/>). After tonsillectomy, it may well be that in the first days WHO stage III drugs (strong opioid, e.g. piritramide iv) or even a pain pump must be administered to ensure pain under 4 on the visual analogue scale and adequate food intake ¹⁷⁵. Pain and nausea (with and without vomiting) after tonsillectomy are often trivialized by both nurses as well as physicians and therefore it is more likely that few analgesics will be administered postoperatively ¹⁷⁶⁻¹⁷⁸.

Post-tonsillectomy bleeding

Early and late postoperative bleeding

Postoperative bleeding can occur anytime until the wound is completely healed, despite careful intraoperative haemostasis and dissection; usually after 2-3 weeks.

Postoperative bleeding occurs either as so-called early bleeding within the first 24 hours, or in the form of late bleeding with a peak incidence between the 5th and 8th day after surgery. From the 3rd postoperative week bleeding occurs only very rarely. Therefore late postoperative bleeding pre-

sents a special problem because it often occurs only at home and therefore the time factor to get a professional play a major role.

The most common cause of late bleeding is the physiological detachment of the fibrin layer from the open wound bed and usually results in harmless bleeding. This bleeding almost always ends spontaneously, or due to local icing (sucking ice cubes, applying an ice cravat) or by tranexamic acid intravenously or locally (rinsing) ¹⁷⁹. If bleeding does not spontaneously subside because a larger vessel is bleeding, vessel ligation or suturing under anaesthesia is required. Massive haemorrhage is an extreme challenge for every paramedic or emergency doctor because of the difficult airway management. Intubation is only possible with suctioning the airway with suction tubes (*Figure 3*).

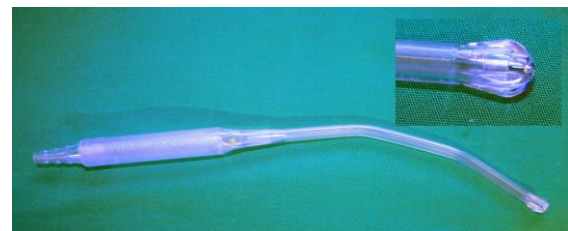


Figure 3: Rigid tonsil or thoracic suction device manufactured by Cardinal Health, IL, USA (Medi-Vac ® Yankauer Suction Handle, REF KEX80)

During induction and intubation, the ENT doctor should be present and prepared to perform emergency [Cricothyroidotomy](#). Aspirated blood or incorrect intubation is the most common clinical complication of postoperative bleeding. Intraoperatively the surgeon must decide whether targeted bipolar coagulation and swab pressure are sufficient or whether suturing or ligation are necessary. If that fails, either the lingual artery, ascending pharyngeal artery, facial artery or even the external carotid artery must be ligated from externally or embolisation the feeding vessels by interventional

radiology should be done. Such massive bleeding is signalled in most cases by a minor "warning bleeding"^{180, 181}, so any bleeding must be taken seriously and the patient must be hospitalized.

Postoperative bleeding depending on method of surgery

In principle, intraoperative and postoperative bleeding can occur with all interventions involving the tonsils. However, for the tonsillotomy the postoperative bleeding rate is, by a factor of 5-10, lower than that for tonsillectomy¹⁸². In cryptolysis and thermotherapy of the tonsils postoperative bleeding is a rarity^{183, 184}. Only extracapsular tonsillectomy remains problematic. "Cold dissection" with ligature or suturing has the lowest postoperative bleeding rates. Significantly more severe late bleeding has been reported after laser, coblation, monopolar or bipolar techniques¹⁸⁵⁻¹⁸⁷.

Videos

Video 1: Extracapsular Tonsillectomy:

http://youtu.be/V_tloYXfwQ

Video 2: Laser Tonsillotomy:

<http://youtu.be/2AUzLY3rewM>

Video 3: Radiofrequency Tonsillotomy:

<http://youtu.be/eQ7bbT0mj0k>

Video 4: Intracapsular Tonsillectomy:

<http://youtu.be/4A6JhQJlabg>

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