POST ADENOTONSILLECTOMY BLEEDING

Incidence: about 0.1 to 2% of patients after tonsillectomy. 0.06-1% of them require anaesthesia for exploration in OT

Causes:

a. Early; within 24 hrs likely due to inadequate haemostasis
b. Late; days - weeks, likely due to sloughing of eschar or infection

Problems:

- Hypovolaemia due to haemorrhage
- Full stomach and risk of pulmonary aspiration
- Airway obstruction from blood, potential difficult laryngoscopic view
- Anxious child/ parents
- Possible residual effects of anaesthetic/ analgesic medications

Management:

1. Pre-op assessment and management
    a. Volume status: estimate the amount of blood loss and the degree of hypovolaemia, ensure good venous access, resuscitate if necessary.
    b. Blood: GXM and ensure availability of packed red cells.
    c. Review previous anaesthetic chart for ease of intubation, size of ETT used, anaesthetic agents used, history of sleep apnea and post anaesthetic course.
2. Conduct of anaesthesia
    a. Preparation: skilled anaesthetic assistance, two large bore suction devices, ETT: previously used size and 0.5 to 1 size smaller readily available. Surgeon in OT.
    b. Technique: Rapid sequence induction (recommended) vs. inhalational induction. Dose and choice of induction agent

depends on the preference/experience of anaesthetist in charge, airway assessment and volume status of the patient.

3. Following control of the airway, empty the stomach using a large bore nasogastric tube.
4. Extubate awake in the lateral position.
5. Ensure adequate postoperative analgesia and anti-emesis

References:

1. Fields RG., Gencorelli FJ. and Litman RS. (2010), Anesthetic management of the pediatric bleeding tonsil. Pediatric Anesthesia, 20: 982–986.
2. Olutoye, O. A. and Watcha, M. F. (2012) Eyes, Ears, Nose, and Throat Surgery, in Gregory's Pediatric Anesthesia, Fifth Edition (eds G. A. Gregory and D. B. Andropoulos)