

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)