

Patients patients were
placed in supine
position with

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patients & method study design: A prospective descriptive study of 100 cases of tonsillectomy carried out in ENT center in Sulaimaniya teaching hospital over a period of 8 months (Jan .

2017-Aug. 2017). to compare the two methods of securing the lower pole , snaring & ligation regarding the post tonsillectomy complication

Inclusion criteria: · patients of any age · chronic tonsillitis · sleep

apnea syndrome exclusion criteria: · adenoid hypertrophy · patients

with episode of acute tonsillitis · parent refused to participate · patient

with bad follow up · history of coagulopathy disorder · history

of immunodeficiency disorder · orofacial anomalies as submucous cleft

palate · Chronic systemic illnesses as DM, epilepsy, heart

failure · equinus · tonsillar unilateral enlargement · part

of palatoplasty · upper & lower respiratory tract infection · Pregnancy and

lactation. sampling: convenient sample of 100 patients of different ages ,

complaining of chronic tonsillitis prepared for tonsillectomy was taken, after

dissection , the tonsil on the right side was removed by a snare , but on the

left side the lower pole secured by ligation method Data collection: the data

collected pre & postoperatively through direct interview with the patient &

their parents filling of a special questionnaire prepared for this study Each case

after being screened from the outpatient department of ENT center at

Al Sulaimaniya teaching hospital the patients were admitted one day

before the operation underwent history taking include demographic data,

otolaryngologic symptoms, past history, and family & drug history sp

for drugs as ibuprofen, aspirin, warfarin, ENT, examination. All the patients

investigated to determine their fitness for general anaesthesia and the procedure.

Haemoglobin level, viral screening and coagulation profile was tested in all the patients. Each patient or their parent signed an informed consent regarding the operation, & the possible complications. Next day the patient transferred to operation room underwent tonsillectomy operation, the technique was uniform to all the patients of various ages operated by the same surgeon using cold steel dissection.

The procedure done under general anesthesia using endotracheal intubation. The patients were placed in supine position with a sand bag between the shoulders (Rose Position). The mouth was held open by a Boyle's Davis Gag supported by Draffin Bipod Stand. The tonsil was grasped with the tonsil-seizing forceps and medially retracted gently the mucosa is then incised using Woods tonsil scissors. Then the peritonsillar loose areolar plane was identified.

The tonsil were dissected using a Gwynne Evans dissector until reaching the lower pole which is crushed using a tonsil artery forceps before being cut with the same pair of scissors mentioned above. and silk ties were used to secure hemostasis. The fossa was packed with cotton swabs. On the right side these things done but the inferior pedicle was snared with Eve's snare.

On removal of gauze, bleeders if any were secured by point coagulation or ligated. Suction was applied to nose and nasopharynx. The mouth gag is then

relaxed for 3 minutes, the oropharynx re-examined for evidence of bleeding & the procedure is terminated.

The operative time was measured from the start of palatoglossal incision to the attainment of hemostasis and was recorded separately for each side. The time taken to operate on each side was recorded in minutes. After operation, the patients were taken to the recovery room, All the patients were given instruction about eating ice cream and cold fluids & diet during the 1st 24 hours then shifting to warm fluid diet and back to normal diet gradually within three days & received prophylactic antibiotic therapy in the postoperative period for 7 days and analgesics for 7 days discharge after receive advice for diet & AB, analgesia & planned for the schedule of follow up follow up: the patients were followed for postoperative complication through direct interview or by cell phone for 4 periods, 1st, 2nd, 7th, 14th & after 1m asking about pain, fever, & doing Full otolaryngologic examination to detect evidence of infection in the tonsillar bed and the occurrence of post-tonsillectomy bleeding & looking for the presence of tonsillar remnant. The patient or their family given instruction to present to our emergency department if they had any complication occurred & call the researcher. Bleeding: Each bleed was graded as: false alarm (no actual evidence of bleeding eg. vomited clots), Minor bleed as blood-tinged sputum (no action needed apart from observation), Moderate bleed, there is Coagulum upon inspection (active non surgical intervention eg. drip, xmatch, clot removal, I. V.

antibiotics were needed) · major bleed Bleedingactively under examination (required exploration, blood transfusion). PainThepatients were asked about the intensityof their postoperative pain for assessment by a graded index classified as: · Mild- Pain withswallowing alone. · Moderate-Painwith tongue movements and swallowing. · Severe-Painpresent at rest, movement of tongue and Swallowing tonsillarremnant.

During each visit particular attention was given tosmoothness of tonsillar fossathe questionnairecontain the following information:-
demographicinformation , name, age, sex,, adres-preoperatine sign& symptomsfever, sorethroat, odenophyphagia, dysphagia, otalgia, cough, trismus, enlarged tonsil, cervical LAposttonsillectomycomplications: bleeding, pain, fever, tonsillar remnanttimeof op