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Editorial

Faucial pillar suturing following tonsillectomy

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Tonsillectomy is often called the "bread and butter" of an ENT surgeon. Though it is simple and less time-consuming surgery, the complications may not only hamper a good night's sleep but may be taxing to the reputation of the surgeon.

It is a unique elective surgery, where the raw area is left to heal by secondary intention. The search for new and better techniques to reduce post-operative pain and haemorrhage is still going on.

I have tested traditional dissection method like snare with suture ligation of the bleeder, bipolar diathermy, Coblation, Bizact, and intra-operative infiltration. However, I am still exploring better approaches as the wound in the fossa takes a long time to heal by secondary intention, with the risk of infection, excessive granulation, persistent pain and secondary haemorrhage.

Learning from my own results from uvulopalatopharyngoplasty and expansion sphincter pharyngoplasty, where I routinely stitched together the anterior and posterior pillars, I decided to close the tonsillar fossa after tonsillectomy as well. This editorial is the result of my own reflected experience.

After suturing, the postoperative pain and difficulty in swallowing are obviously reduced, due to a lack of raw area/exposed sensory nerve endings. The risk of secondary haemorrhage is almost eliminated since there is no slough in the fossa. The wound healing is rapid by primary closure and epithelization.[1] The only complication that may arise is loosening of suture knot or tearing of pillars mucosa. It can be taken care of by meticulous suturing. I use 3'0 vicryl (absorbable, multifilament suture) on a round body, inverted knots and interrupted sutures. The technique of application is also critical. The sutures should be applied on both sides simultaneously i.e. starting from the upper end of the fossa, one applied on the right side, then another on the left side, before taking the second suture on right. This ensures that the pharyngeal wall doesn't get pulled on one side causing difficulty in closing the other fossa. An important pre-requisite is that the pillars should be intact and there should be no residual tonsillar tissue in the fossa. Also, adequate haemostasis should be achieved before suturing is started. The lower end of the fossa, near the base tongue, is left open, to avoid horizontal bar formation on the posterior wall. The patient should be told to avoid vigorous gargles.

I have experience in suturing the faucial pillars of adult patients only (surgery for Obstructive sleep apnea, styloidectomy, chronic tonsillitis, post peritonsillar abscess), but the same has been tried in children by others.[2] The suturing of the pillars is also recommended in controlling severe haemorrhage when other techniques fail.[3] The time spent suturing the pillars may appear significant, but the overall result is satisfactory. The procedure itself is simple, cost-effective and without any major complications.

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Conflict of Interest

None.

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