

Adenoidectomy

Surgical Information



ENT Bowling Green

Adenoidectomy Information

Indications:

Adenoidectomy may be recommended when:

- Enlarged adenoids are blocking the airway, which may be suspected if the child:
 - Has enlarged adenoids
 - Snores excessively
 - Has trouble breathing through the nose (nasal obstruction)
 - Has episodes of not breathing during sleep (sleep apnea)
 - Has orofacial or dental growth problems

Adenoidectomy may be recommended if the child has chronic ear infections that:

- Interfere with child's education
- Persist despite antibiotic treatment
- Recur 5 or more times in a year
- Recur 3 or more times a year during a 2-year period

Adenoidectomy may be recommended if the child has chronic or repeated bouts of tonsillitis.

The adenoids normally shrink as the child reaches adolescence and adenoidectomy is rarely needed after reaching the teenage years.

Adenoidectomy is the surgical procedure in which the adenoids are removed. Adenoids are lymphoid tissue located in the back of the nose. They often are not understood by the lay public or by physicians who are not otolaryngologists because they are not observed during routine physical examinations because of their location. Although the tissue composition of adenoids is the same as that of the tonsils, the diseases associated with infected adenoids differ from the diseases associated with infected tonsils, based on their location. This causes additional confusion because the adenoids are often simultaneously grouped with the tonsils.

Adenoids are on the posterior nasopharyngeal wall posterior to the nasal cavity. They are a component of the Waldeyer ring of lymphoid tissue, which is a ring of lymphoid tissue in the oropharynx and nasopharynx that consists mainly of the adenoids, the palatine tonsils, and the lingual tonsils.

Adenoids are present at birth and then begin to enlarge. They, along with the tonsils, continue to grow until individuals are aged 5-7 years. The adenoids usually become symptomatic, with snoring, nasal airway obstruction, and obstructed breathing during sleep, when children are aged approximately 18-24 months. Children in daycare or children with allergies may become symptomatic earlier. By the time children reach school age, the adenoids normally begin to shrink, and, by the time children reach preteen or teenage years, the adenoids are usually small enough for the child to become asymptomatic.

Recurrent or persistent middle ear effusion

Recurrent or persistent otitis media is multifactorial and age-dependent. The 2 main features accounting for disease in the middle ear are immune function and the function of the eustachian tube. Infants have a natural lack of immune function and poorer eustachian tube function, both of which improve over time. Many children outgrow their ear infections because of this maturity. Persistent ear infections or fluid problems in children are usually related to persistent immature eustachian tube function, dysfunction related to chronic adenoid infection, or dysfunction of the eustachian tube related to congestion from allergic rhinitis. Several studies indicate that eustachian tube function is improved and fluid collection is prevented following adenoidectomy, independent of the size of the adenoids.

Chronic sinusitis

For patients with chronic sinusitis, the adenoid appears to act as a reservoir of infection. This is based on the improvement observed following adenoidectomy independent of the weight of the adenoids in children with symptoms of chronic sinusitis.

Nasal airway obstruction

Enlarged adenoids can also cause nasal airway obstruction, with clinical symptoms of nasal congestion, snoring, and breathing through the mouth, by physically blocking the back of the nose. Symptoms of nasal airway obstruction may overlap with chronic sinusitis symptoms, and the physical obstruction may add to sinusitis itself by blocking normal nasal flow posteriorly, resulting in a stasis of secretions and an obstruction in the sinus outflow tract.

Often, enlarged adenoids (with the tonsils) can obstruct breathing patterns in children and can cause obstructive breathing, including apneas, at night. Obstruction is based on their size alone. However, when enlarged, the adenoids may have a chronic infection.

Dental and Orofacial growth problems

Enlarged adenoids may cause problems with dental or orofacial growth of some patients. If this is suspected adenoidectomy may be removed to assist with palatal growth or other facial bone growth patterns.

Post-op Adenoidectomy Instructions

1. Throat discomfort may persist for one to two weeks. An earache may occur due to referred pain from the throat.
2. Tylenol is usually adequate for pain relief. If pain is not relieved, notify your physician.
3. Do not take aspirin, or aspirin-containing medications. They increase the incidence of bleeding. You may take Ibuprofen if needed for breakthrough pain.
4. Small children should drink one and a half quarts of liquids daily; older children and adults should drink two to three quarts of liquids daily. (1 quart = 32 ounces)
5. Report inability to drink adequate liquids to your physician.
6. Do not participate in sports or vigorous exercise or return to strenuous work until approved by the physician.
7. It is not uncommon to develop a fever (sometimes up to 102 °F) in the first few days after surgery. Increased fluid intake and Tylenol as needed will usually control the fever. Notify the physician if fever persists.
8. The breath frequently develops a foul smell to it that may last up to 2 weeks. This results from formation of a scab or eschar over the adenoid bed and is not a sign of infection.
9. The scab will dislodge in 7-10 days and may cause a small amount of bleeding. If bleeding is brief and resolves spontaneously, try gargling ice water and observe closely. If bleeding is heavy (more than ½ cup) and persistent, go immediately to the nearest ER and notify physician (in transit, if possible).

If you have any questions or problems, please call ENT of Bowling Green at **(270) 782-7768**.