Post-tonsillectomy haemorrhage following traditional uvulectomy in an adult patient

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Case presentation

A 28-year-old IsiPedi-speaking black South African male patient presented with recurrent attacks of dry throat, dry cough, sore throat and globus pharyngeus. When asked what he thought was responsible for his symptoms, he said that he suspected an infection of the uvula (*lelingwana*) and according to 'Pedi' culture would require surgical removal. After the physical examination, a clinical assessment of chronic tonsillitis and laryngopharyngeal reflux disease was made. The attending surgeon informed him that there was no indication for the removal of the uvula but he would benefit from tonsillectomy and anti-reflux medication. The patient reluctantly agreed to the suggested procedure and a day-case tonsillectomy under general anaesthesia using dry mono-polar diathermy dissection technique was performed. The procedure was successful with dry tonsillar fossae. When the patient recovered from anaesthesia, he immediately enquired if his uvula was removed but was informed that the tonsils were the only tissues removed as indicated and consented to. He was discharged and placed on amoxycillin and Myprodol (an analgesic). Later in the day (19h00), he was rushed back to the casualty department with marked oropharyngeal bleeding and in severe hypovolaemic shock. He was immediately resuscitated and prepared for examination under anaesthesia in the theatre. The main finding was bleeding from a freshly cut uvula but the tonsillar fossae showed no active bleeding (Fig. 1). Cauterization of the bleeding uvula was successfully done. When the patient regained consciousness, he informed the surgeon that he visited a traditional healer after leaving the hospital on the same day, who cut his uvula to 'complete' the operation done in the hospital.

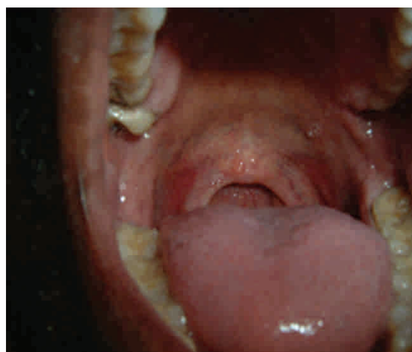

Fig. 1: Photo of the patient's throat following traditional uvulectomy

Discussion

Traditional uvulectomy is an African traditional surgical practice well documented in Kenya, Sierra Leone, Tanzania, Ethiopia and Nigeria.[1] It is routinely performed in children due to the traditional belief that an elongated uvula is responsible for all throat problems, including suffocation during sleep in the neonatal period. Occasionally, it is done during ethnic identification ritual practices.[2] The commonest complications following this procedure include haemorrhage, anaemia, upper airway obstruction, neck abscesses, cellulitis, septicaemia and HIV infection.[3,4] It is usually performed by traditional healers, elderly laymen and barbers using either a pair of scissors or sickle knife without anaesthesia and under non-sterile conditions.[2] In modern day practice, post-tonsillectomy haemorrhage is uncommon due to safer surgical techniques and post operative management. The prevalence rate of primary post-tonsillectomy haemorrhage using the diathermy technique is 1.2%.[5] A review of the literature indicates that traditional uvulectomy in children is an unknown practice in Southern Africa. However, anecdotal evidence suggests that this procedure is practiced amongst the Isipedi-speaking black South African adults for various throat complaints, as seen in this patient. From this case study, a number of important issues concerning the doctor-patient relationship emerge namely:

a. The doctor's failure to explore and address the patient's ideas, concerns and expectations regarding his illness
b. Relegation of the patient's belief system in the decision making process
c. Suppression of the patient's agenda by the doctor's agenda i.e. paternalism
d. Inadequate awareness of local traditional medical practice that has impact on Western medical practice

It is important to remember that complications may occur from Western or Traditional medical interventions. Patients may not volunteer their intentions to utilize both at the same time resulting in inappropriate or delayed management. Uvulectomy is rarely performed in Western medical practice. Nevertheless, if the tonsillectomy (medically indicated) and uvulectomy were performed during the same operation, the patient's expectations would have been met and most probably, the complication prevented. This case study highlights the importance of listening to each patient's story, reason(s) for visit, ideas, expectations and concerns in order to avoid a dysfunctional doctor-patient relationship. Otorhinolaryngologists and family practitioners practising in Africa should always consider traditional uvulectomy as one of the causes of post tonsillectomy haemorrhage, and learn to address patients' ideas, concerns and expectations. This is the first reported adult case of traditional uvulectomy presenting with massive primary haemorrhage following routine tonsillectomy in our setting.

References

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