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Pediatric Adenoidectomy: A Most Common Surgery in Children

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Editorial

A multitude of surgical methods can be used to achieve an adenoidectomy. Curettage is a traditional adenoidectomy procedure that is still used by many surgeons, albeit its use is diminishing as more surgeons choose for suction cautery and microdebrider adenoidectomy. Another typical procedure is to ablate and suction away the lymphoid tissue while removing the adenoid tissue with a suction cautery device. Following myringotomy with tube implantation and adenotonsillectomy, adenoidectomy is the third most common paediatric ambulatory operation in the United States. Obstructive sleep apnea, nasal blockage, chronic otitis media, adenoid hypertrophy, and chronic adenoiditis are all common reasons for adenoidectomy. Surgery is most commonly performed on children between the ages of 2 and 5.2 Several surgical procedures for adenoidectomy have been described.

Pediatric Chronic Rhinosinusitis (PCRS) is characterised as two or more symptoms of purulent rhinorrhea, nasal blockage, facial pressure/pain, or cough lasting at least 90 days. To make the diagnosis, endoscopic symptoms of mucosal edoema, purulent discharge, or nasal polyposis must be present, as well as CT scan changes revealing mucosal abnormalities within the ostiomeatal complex and/or sinuses. Most patients respond to first-line medical therapy, which includes nasal saline irrigations, nasal steroid sprays, and antibiotics targeted at the most frequent sinonasal infections. Removing children from a daycare setting reduces exposure to upper respiratory infections and reduces the incidence of sinusitis disease.

The ideal adenoidectomy procedure would make it easier for the surgeon to see the adenoid pad and allow for efficient tissue removal with minimal blood loss. The ideal equipment would be able to accomplish these objectives while minimising costs and complications. In many types of paediatric outpatient operations, reducing unnecessary variance in common surgical procedures may save waste and enhance total value while retaining optimal outcomes. Surprisingly, despite the great frequency with which this procedure is performed, there is a scarcity of data comparing newer approaches for adenoidectomy. Despite the fact that there are numerous adenoidectomy methods available, few research compare more than two types of tools in a single study. There is a scarcity of data comparing the effects of electrocautery, microdebrider, and coblation on surgical time and expense, as well as postoperative problems and adenoid regrowth. Charges for the amount of time to use the facilities are not included in the direct costs. In younger children with severe obstructive sleep apnea, spending more time under anaesthesia increases the risk of postoperative complications such pulmonary edoema and hypovolemia.

Adenoidectomy in children is generally well tolerated, with few problems. There is a modest risk of haemorrhage, which can be classified as primary (during the first 24 hours after surgery) or secondary (more than 24 hours after surgery). The risk of primary haemorrhage is about 0.5–0.8 percent, while the risk of subsequent haemorrhage is quite low. The risk of main bleeding appears to be additive in each procedure, since adenotonsillectomy has twice the risk of one of the procedures done alone. Surprisingly, children with OSA have a higher rate of postoperative respiratory impairment but a lower prevalence of postoperative haemorrhage. Nasopharyngeal stenosis occurs when the tonsillar pillars and soft palate fuse to the posterior pharyngeal wall, obliterating normal communication between the nasopharynx and the oropharynx. This is a very unusual complication caused by severe excision of the posterior tonsillar pillars or excessive electrocautery. Preventing nasopharyngeal stenosis requires meticulous technique, judicious use of electrocautery, and proper preoperative evaluation [1-5].

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