How to put an end to the guillotine

This article concerns the “Sluder guillotine”, used by generations of ENTs to remove the palatine tonsils. In contrast to the “widow” of Doctor Guillotin, it does not cut, as it is a forceps that permits the enucleation and subsequent removal with the fingers of the child’s palatine tonsil. Of the guillotine it retains only its shape. Sluder tonsillectomy seems to living its final moments after being recently condemned to abolition by the Haute Autorité de Santé (High Health Authority).

However, it was welcomed with enthusiasm in France in 1930s, one or two decades after the United States. It was rapidly recognized as representing considerable progress. André Lemariey, one of the founders of pediatric ENT, chief of department of the Trousseau hospital in Paris, wrote thus in a 1956 book on pediatric ENT: “This sure, fast method which removes instruments from dangerous cervical zones, assures the compression and elongation but not the transsection of vascular pedicles, has practically eliminated the redoubtable risk of tonsillar hemorrhage”. Nevertheless, there are two criticisms that one could make. It trivialized tonsillectomy in children to the point that during the post-war period, in the eyes of certain parents, it was an almost ritual operation with certainly some abuse surrounding its indications. However, it has saved lives especially those of children with a pharynx obstructed by voluminous tonsils. Another criticism was the necessity to impose a relatively long learning period, in the best tradition by accompaniment by a senior colleague. Over decades the surgeon found himself being an orchestral conductor, having to manage the mask anesthesia and the operation at the same time. The less dare-devil individuals did not require anesthesia to be performed, possibly influenced by certain work that suggested that “tonsillectomy is a non-painful operation, general anesthesia is rarely necessary…it could be useful in a particularly non-docile child”. The writer Michel Tournier was probably not “non-docile” enough to benefit from anesthesia when he was operated at the age of 4 years, as he expresses his nightmarish memories, narrated in *Vent Paraclet*. In this autobiographic book the author describes the tonsillectomy as a throat cutting scene. Sluder tonsillectomy has permitted many ENTs to carry it out on patients in the clinic as well as in the hospital without fear of hemorrhagic complications. The next step for operative comfort was collaboration with an anesthesiologist, offering better adapted anesthesia, and allowing the surgeon to concentrate on the operation itself. The comfort was even greater when the anesthesiologist was always the same, permitting a true partnership, where everyone knew at what stage he/she must step in. Such collaboration was not always easy to perform in the hospital.

Then full time hospital work arrived. For this new generation tonsillectomy lost its routine character. In hospitals the mastery of the Sluder decreased over time. Intubation permitted to the anesthesiologist entering the ENT department to work without the fear felt by the ignorant person in training before his/her first Sluder tonsillectomy. The surgeon-in-training had all the time in the world to dissect the tonsil. Last but not least, the patient did not have any painful memories, in contrast to certain

unfortunates in whom the surgeon once preferred light anesthesia because of the risk of syncope. Quickly Sluder tonsillectomy was no longer taught, with the exception of some departments where the operation was performed under intubation. In the clinics, the Sluder procedure progressively lost ground, retaining bastions within some very experienced and competent teams. It was sufficient to wait a few years for the name of Sluder to disappear spontaneously.

One of the first attacks against the Sluder tonsillectomy was in *First lessons from the mortality survey* SFAR-INSERM in 1999. The Sluder was denounced for being associated with deaths after tonsillectomy, without precisely describing the cause of death. To drive the nail in further, the *Assurance Maladie* (Health Insurance System) interfered some years ago. Tonsillectomy was registered in the Common Classification of Medical Acts (CCMA) under two headings. To understand fully, it is necessary to translate the wording of the CCMA. A denomination error was added to anatomical errors, since the Sluder procedure was named a *tonsillotomy*. The Sluder is a forceps, which does not cut, in contrary to the tonsilltome, which allowed since the 19th century the resection of a portion of a hypertrophied tonsil, thus performing tonsilltomy and not tonsillectomy. If the instrument was called for many years the “Sluder guillotine”, it was not due to its function but because of its shape. To simplify, the CCMA distinguishes the Sluder tonsillectomy and tonsillectomy by dissection. The Health Insurance asked the HAS whether the Sluder tonsillectomy should be still registered with the CCMA. An ad hoc working group of ENTs was gathered. The experts have concluded that it is necessary to encode all tonsillectomy techniques using a single wording… The HAS in their press release dated 12 March, 2007 gave “unfavorable opinion about the registration of tonsillectomies performed with the Sluder tonsillotome to the list of interventions reimbursed by Assurance Maladie. It has been transmitted for use as on a scientific basis by the Assurance Maladie, which has the regulatory power to decide on the suppression of procedures from this list.” Was the case already settled before the working assemblies? We could give the benefits of the doubt. This decision did not refer to real accidents, which took place in the course of last years in France. It summarised a large bibliographic analysis of all the literature, which was in fact hard to use because there were not many deaths. And yet, if it is easier to have recourse to “precautionary principle” to condemn, it is more rational for insurers to learn from declared accidents in order to come to effective conclusions.

At the time of the conference, organized on the 6th of June by *the National Association for the Prevention of Medical Risk*, 34 suspicious reports had been made to the *SOU* and the *MACSF (french insurance companies)* between 1997 to 2006, comprising 28 reports regarding tonsillectomy, from which there were 10 deaths, and 6 of adenoidectomies from which there were 3 deaths and one vegetative coma. Anesthesia was an exclusive cause in 10 cases and a partial cause in one. Thus, 60% of all deaths were linked to anesthesia. There were no accidents due to absence of protection of the airways during the intervention. The cause of five other deaths connected with tonsillectomy was massive hemorrhage, one case occurred one month after the intervention. This late appearance is very probably a consequence of the technique

of dissection due to a pseudo-aneurysm of internal carotid; a complication that is not seen with the Sluder.
André Lemariey had already demonstrated in the cohort of more than 10,000 operated patients that the arterial risk was more prominent with dissection. This does not imply that all surgeons must be obliged to use Sluder but to consideration well the specific arterial risk of the dissection technique. These 5 deaths from massive hemorrhage should be compared with deaths reported in a publication from 1987 that referred to declarations by three insurance companies from 1976 to 1986, which also reported 10 deaths of which two were caused by hemorrhage at the time when tonsillectomy was performed by the Sluder technique and in greater numbers than during the last decade.

What can be concluded ?
The phrase as printed in the text of the *HAS* concerning the *Evaluation of the act of tonsillectomy by tonsilltome* should be written with golden letters on the wall of the institution: "The choice of technique is made by the ENT surgeon rather than by someone else according to the indication, the age of patient and the experience of the surgeon." How to choose when the *HAS* proposes to suppress one of the two techniques recognized by the CCMA? Is it necessary to oblige the surgeon experienced in the Sluder tonsillectomy, to begin to use the dissection technique? As for risk evaluation, is it better to study known complications of French insurers than knowledgeable analyses of the literature of all continents?

What could be proposed?
Firstly, it seems important to set the CCMA straight regarding tonsillectomy, to use correct anatomical terminology, adequate instrument names, and to meet once more.
Another suggestion. The tonsillotomy, a favorite intervention of 19th century, is the subject of renewed interest abroad for pediatric hypertrophic tonsils and is performed by modern means such as laser, ultracision and radiofrequency. Demonstrating at least the risks of tonsillectomy, the registration of this intervention by the CCMA would help in the prevention of medical risk, which is the primary objective of all.

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