Severe Post-Tonsillectomy Haemorrhage Treated with Selective Embolisation: A Pseudoaneurysm of the Lingual Artery

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ABSTRACT:
Severe post-tonsillectomy haemorrhage treated with selective embolisation: a pseudoaneurysm of the lingual artery

A 5-year-old female patient experienced massive oropharyngeal haemorrhages 13, 34, and 40 days after an adenotonsillectomy. Angiography performed because of a suspected vascular abnormality demonstrated a pseudoaneurysm of the right lingual artery. We performed coil embolisation of the affected artery. A vascular pathology should be considered the presumptive cause in delayed, severe post-tonsillectomy haemorrhage and angiography is an effective method for both diagnosis and treatment.

Keywords: Embolization, haemorrhage, pseudoaneurysm, tonsillectomy

INTRODUCTION

Tonsillectomy is the most common procedure performed by head and neck surgeons (1). Although it is a safe operation, it is always accompanied by the risk of arterial damage due to variation in the routes of the great arteries and their close proximity to the tonsillar lodges, the rich vascular supply of the tonsillar area, and an aberrant course of the internal carotid artery. Primary and secondary haemorrhages can occur postoperatively (1,2). The reported incidence of primary haemorrhage within 24 hours is 0.3-2.1% (3,4) and that of secondary haemorrhage is 2-10.3% (1). Arterial dissections and aneurysms are among the causes of severe post-tonsillectomy bleeding (5). We present the case report of a patient who was admitted with severe delayed postoperative bleeding secondary to formation of a pseudoaneurysm of the right lingual artery who was treated with arterial embolisation.

CASE

A 5-year-old female patient underwent an adenotonsillectomy in another hospital. Thirteen days later, she was brought to our emergency room
with a history of oropharyngeal bleeding. No active bleeding was observed. She was hospitalised and because no bleeding was seen during a 3-day follow-up period, she was discharged. Thirty-four days postoperatively, she was admitted to our hospital with copious oropharyngeal bleeding. She was examined by paediatricians, paediatric surgeons, and ear, nose, and throat (ENT) surgeons. No provocative event that initiated the bleeding was identified. She was bleeding actively, but the tonsillar fossae appeared to have healed and the blood seemed to be coming from an inferior location. Based on provisional diagnoses of delayed post-tonsillectomy bleeding and oesophageal variceal bleeding, she was examined under general anaesthesia. The bleeding stopped spontaneously. On the right side between the tonsillar area and tongue base, a protruding, non-pulsatile mass was observed. Abundant bleeding restarted during aspiration and was controlled by bipolar cauterisation. Blood transfusions were given to stabilise the patient haemodynamically. Suspecting a vascular abnormality, we decided to perform arteriography. Informed consent was obtained from the patient’s family. Bleeding recurred 1 day before angiography (day 40 postoperatively) and ceased spontaneously.

Angiography was performed through the right femoral artery. A 10x6mm pseudoaneurysm was seen on the proximal segment of the right lingual artery and embolised by coiling (Figure-1, 2). No complication followed this intervention. The patient was discharged 3 days later.

**DISCUSSION**

Post-tonsillectomy bleeding remains a problem for head and neck surgeons and is the leading cause of post-tonsillectomy morbidity (6). During the tonsillectomy, blunt or penetrating trauma or suturing for haemostasis can cause dissections of the intima and adventitia of an artery and formation of a progressively expanding periarterial haematoma. A potential space forms at the centre of the haematoma due to liquefaction, and this communicates with the injured artery, which causes circular dilation of the vessel called a pseudoaneurysm (2). Radiotherapy, peritonsillar abscesses, and local infections contribute to the formation of pseudoaneurysms in the neck. Although pseudoaneurysms secondary to tonsillectomies do not usually rupture, they typically present with bleeding (2). Pseudoaneurysms can occur either intraoperatively or in the very late postoperative period, 58 days postoperatively in one
case (7). Although Van Cruyden et al. (5), declared that post-tonsillectomy pseudoaneurysm haemorrhage is not observed in patients younger than 10 years, the literature includes cases of patients age 2 (8), 3 (9), 5 (7,10), 7 (11-13), 8 (14,15), and 9 (16) years. The first symptom is generally recurrent, massive, gushing, and spontaneously stopping haemorrhage. A pulsatile mass in the pharynx or neck is rarely seen (5). Arteriography, ultrasonography, and computed tomography with contrast are diagnostic tools. Of these, arteriography remains the first choice, since it has the advantage of treatment. Selective embolisation is important for decreasing the morbidity of post-tonsillectomy bleeding. Since it is more selective than ligation, it is strongly recommended in vascular pathologies (5,6). In cases of persistent bleeding, arteriography must be repeated, even if it appears normal at the first attempt. Maurer et al. (11) reported a patient who had normal arteriographic findings on postoperative day 10. A second arteriography performed following rebleeding 8 days after the first intervention showed a pseudoaneurysm.

In our case, arteriography was planned after the second massive bleed. A pseudoaneurysm was confirmed and obliterated with coils of various sizes.

**CONCLUSION**

Pseudoaneurysms must be kept in mind, especially when there are recurrent, massive, life-threatening haemorrhages following tonsillectomy that tend to stop spontaneously. Pseudoaneurysmal bleeding can cause haemorrhagic shock and death. Early diagnosis and treatment is life-saving. Suspicion is the crucial step in reaching a correct diagnosis. Pseudoaneurysms do not always present as pulsatile masses in the oropharynx or neck. Arteriography is a diagnostic and therapeutic intervention. Embolisation is more selective than ligation and very effective at decreasing post-tonsillectomy morbidity. This case reminds us that post-tonsillectomy bleeding can occur during the late postoperative period and we must suspect a vascular pathology and perform arteriography in cases of abundant, recurrent, spontaneously stopping haemorrhages.

**REFERENCES**

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