

## Uvulectomy to prevent throat infections

B. E. J. HARTLEY, B.Sc., M.B.B.S., J. ROWE-JONES, F.R.C.S.

### Abstract

It is common practice in many parts of Africa for traditional healers to remove the uvula to prevent infections and other disorders associated with the throat.

We report two cases of children presenting with recurrent tonsillitis. On examination both children showed complete absence of the uvula and prominent tonsils. It was later revealed that they both had undergone uvulectomy, performed by traditional healers in Eritrea. We report this because this practice, although commonly performed, is little known to otolaryngologists practising outside Africa. In addition, although velopharyngeal competence seems to be maintained after uvulectomy, it may theoretically be at risk if adenoidectomy is performed in these patients.

**Key words:** Uvula, surgery; Tonsillitis; Velopharyngeal insufficiency

### Case reports

#### Case 1

A six-year-old Eritrean girl was referred to the ENT department complaining of recurrent bouts of severe tonsillitis, occurring at least four times a year and associated with dysphagia. She also complained of left otalgia although her hearing was thought to be normal. The family initially denied that she had undergone any previous surgery but later informed us that the whole family had undergone uvulectomy. This was performed on them as young children or infants without anaesthesia by traditional healers who are mainly barbers. There was no history of nasal regurgitation or speech difficulties.

On examination she had an abnormal appearing soft palate with complete absence of the uvula and large inflamed tonsils (Figure 1). In addition she had bilateral middle ear effusions.

She successfully underwent tonsillectomy and bilateral grommet insertion and is symptomatically much improved.

#### Case 2

A five-year-old girl also from Eritrea presented a few weeks later with recurrent tonsillitis. Her family were also reluctant to admit that she had undergone uvulectomy but did describe the procedure being carried out under similar circumstances to Case 1. There was no history of feeding or speech difficulties.

Clinical examination revealed an absent uvula and prominent tonsils but was otherwise normal.

She also successfully underwent tonsillectomy.

### Discussion

The operation of uvulectomy is rarely carried out in the United Kingdom. It has been common practice however in parts of Africa for many years. It was described in Nairobi by Jarvis and Mwathi (1958), in Tanzania and Sierra Leone by Haddock and Chidue (1965) and in Nigeria by Ijaduola (1981). There is a widespread belief by the local populations of these areas that the uvula is responsible for all problems related to the throat. Uvulectomy has also been described by Nalin (1985) as being carried

out in order to prevent diarrhoea. In this case the patient died shortly afterwards. Post-operative inhalation of blood was thought to be contributory.

Usually Western trained surgeons in these areas are reluctant to carry out this procedure and the demand from the local population is considerable. As a result the majority of these operations are carried out by local healers (who are usually barbers)

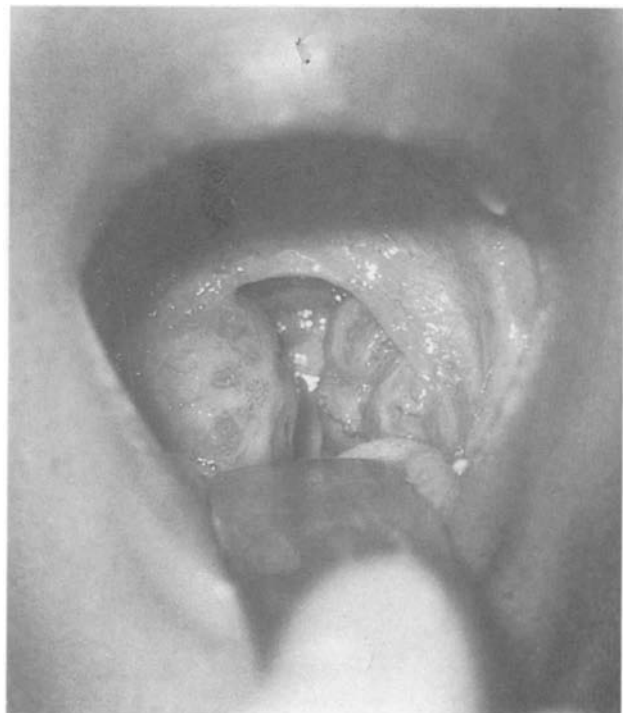


FIG. 1

Acute tonsillitis in a patient who had previously undergone uvulectomy.

with a sickle knife (Ijaduloa, 1981). The complication rate is high and many complications have been described. These include haemorrhage, septicaemia, cellulitis of the neck, peritonsillar and pharyngeal abscess, upper airway obstruction and pharyngo-laryngocoele with pneumothorax (Ibekwe, 1983).

It is of interest to consider whether the removal of the uvula might cause nasal regurgitation of food or speech escape. Furthermore velopharyngeal competence could be further compromised by adenoidectomy which may well be indicated in addition to tonsillectomy in these patients. Ijaduloa (1987) compared 15 subjects who had undergone uvulectomy with normal controls. He found that uvulectomy had no statistically significant effect on velopharyngeal status. These patients were all adults however and therefore unlikely to be subjected to adenoidectomy. The possible risk of velopharyngeal incompetence should be born in mind when considering adenoidectomy in patients who have undergone previous uvulectomy.

In these two cases uvulectomy was unsuccessful in preventing recurrent throat infections. As the uvula contains very little or no lymphoid tissue there seems no reason to suspect that its removal should have any effect on local infection.

We report these cases to draw attention to a practice which many otolaryngologists in this country are unaware of. Furthermore it seems that patients are often reluctant to admit having it performed.

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Address for correspondence:

Dr B. E. J. Hartley,  
84 Bramfield Road,  
Clapham,  
London SW11 6PY.