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# Uvulectomy in Nigeria

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## Abstract

THE removal of the uvula for minor pharyngeal lesions is unusual in Western otorhinolaryngological practice. However, uvulectomy is a common procedure for 'throat problems' in Nigeria and some other African countries by traditional surgeons. This is because it is believed that the elongated uvula is the root cause of all throat problems. These traditional surgeons are usually barbers by profession and only practice surgery on a part-time basis. Most of their patients do well but some have to be rushed to the hospital with severe post-operative bleeding. Attention of Europeans and other foreign otolaryngologists who may find themselves practising in any part of Arica is hereby drawn to the procedure.

## Introduction

The operation of uvulectomy or staphylectomy is an uncommon procedure in Western otolaryngological practice. As far back as 1948, this operation, also called uvulotomy (McKenzie, 1870) had been described by St. Clair Thompson and Negus as one of the rarest operations in laryngology. It is hardly mentioned nowadays in standard textbooks of otolaryngology. But John Jacob Ballenger (1977) still gave good illustrative drawings of the procedure in the twelfth edition of his book *Diseases of the Nose, Throat and Ear.*

In Nigeria, however, uvulectomy by traditional methods is a very popular operation indeed. Haddock and Chidue (1965) stated that it was a common form of traditional treatment in coastal Tanzania and Sierra Leone. Jarvis and Mwathi (1958) also described a similar experience in Nairobi. Usually Western-trained surgeons are unwilling to remove the uvula unnecessarily despite persistent requests from patients, thus the local people have come to believe that only the traditional surgeons are competent uvulectomists.

During routine examination in the ENT Clinic of Lagos University Teaching Hospital, many of our patients are observed to have had uvulectomies. Some also report to the Casualty department with severe, post-uvulectomy bleeding, necessitating intervention by the otolaryngologist. In these instances the traditional surgeons not only fail to accompany their patients, but are also impossible to locate. This prompted an investigative study of this procedure.



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## Materials and Method

Fifty centres all over the country where they are currently performing traditional uvulectomies were visited. Detailed information about the surgeons, their indications for operation, procedures and post-operative management, were collected.

## Results

All the surgeons interviewed were middle-aged males. They all practised native surgery on a part-time basis, pursuing other trades in addition. Their primary occupations are shown in Table I. This shows that

TABLE I

OCCUPATIONS OF TRADITIONAL LOCAL SURGEONS

| Occupation | Number | Percentage |
|---|---|---|
| Barber | 35 | 70 |
| Arabic teacher | 10 | 20 |
| Petty trader | 5 | 10 |

seventy per cent are barbers, twenty per cent Arabic teachers and ten per cent petty traders. The reasons most often cited by surgeons for the removal of the uvula are shown in Table II. All of them are agreed on the first three indications, eighty percent on the fourth and sixty per cent on the last.

TABLE II

INDICATIONS FOR UVULECTOMY BY THE TRADITIONAL SURGEONS

| Indication | Percentage of traditional surgeons in agreement |
|---|---|
| Long uvula | 100% |
| Persistent sore throat | 100% |
| Irritating cough | 100% |
| Loss of voice | 80% |
| Prevention in neonates | 60% |

### *Operative procedure*

The procedure varies little from surgeon to surgeon. The commonest operative technique is described below:

*Pre-medication*—None is given.

*Anaesthesia*—No actual anaesthetic is given. The patient is made to believe that the operation is brief and not very painful. Most of the patients are stoics any way.

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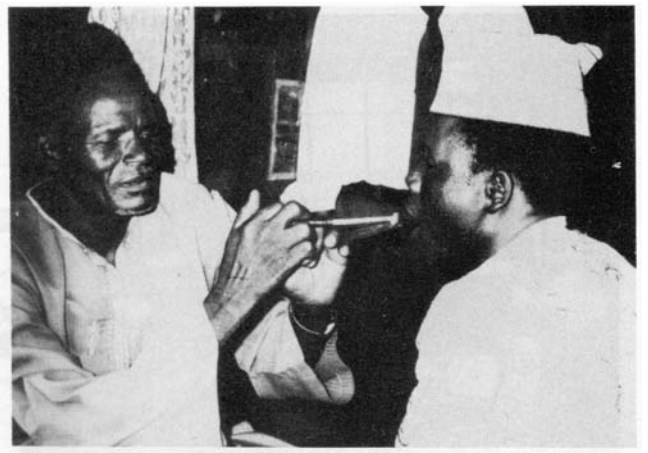


FIG. 1

Traditional surgeon demonstrating the use of the instruments for uvulectomy with the patient sitting on a separate stool facing him.

*Position*—Patients are seated upright on a bench. The surgeon either sits on the same long bench with the patient or on a separate stool facing him (Fig. 1).

*Instruments*—These consist of (a) a tongue depressor and (b) a curved knife (Fig. 2). These instruments are laid out along with others which are

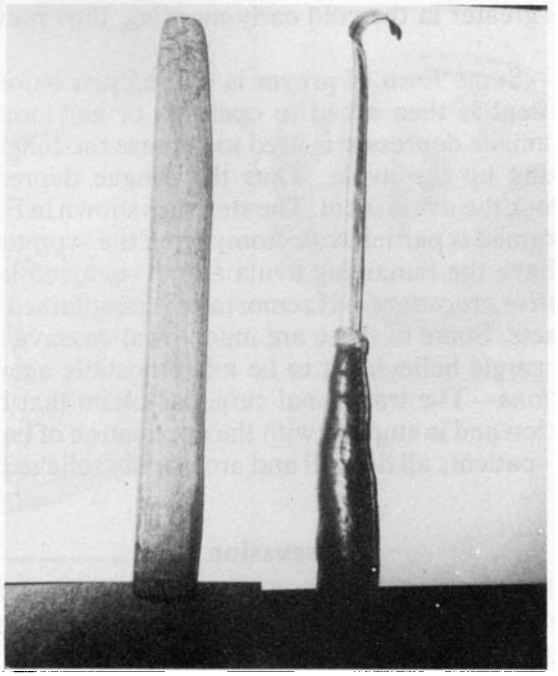


FIG. 2

Instruments for uvulectomy (tongue depressor and curved knife).

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FIG. 3

A barber's uvulectomy operation trolley with shaving knives and animal horns for 'blood letting'.

used for circumcision and 'blood letting'. Those who are barbers often have shaving knives laid out on the same trolley (Fig. 3).

*Time of operation*—The operation is usually done early in the morning, at about six o'clock, because the surgeons believe that viscosity of the blood is greater in the cold early morning, thus preventing severe haemorrhage.

*Operation*—Some form of prayer is offered just before the surgeon starts. The patient is then asked to open his or her mouth as wide as possible. The tongue depressor is used to depress the tongue while at the same time lifting up the uvula. Thus the tongue depressor acts as a platform on which the uvula is cut. The steps are shown in Fig. 4. Often the operation performed is partial uvulectomy but if the symptoms persist, the patient could have the remaining uvula stump removed later.

*Post-operative procedure*—Haemostasis is maintained by application of herbal extracts. Some of these are made from cassava leaves. Others use 'Gin' as a gargle believing it to be a haemostatic agent.

*Complications*—The traditional surgeons claim that bleeding is the only complication and is stopped with the application of herbs. They also claim that their patients all do well and are usually relieved of their throat problems.

## Discussion

Most of the traditional uvulectomists are barbers by profession operating only on a part-time basis. This is reminiscent of early British surgeons. Charges for the operations are relatively low.

While practising traditional surgeons are males, in families in which surgery is passed down, women are taught. The women however do not

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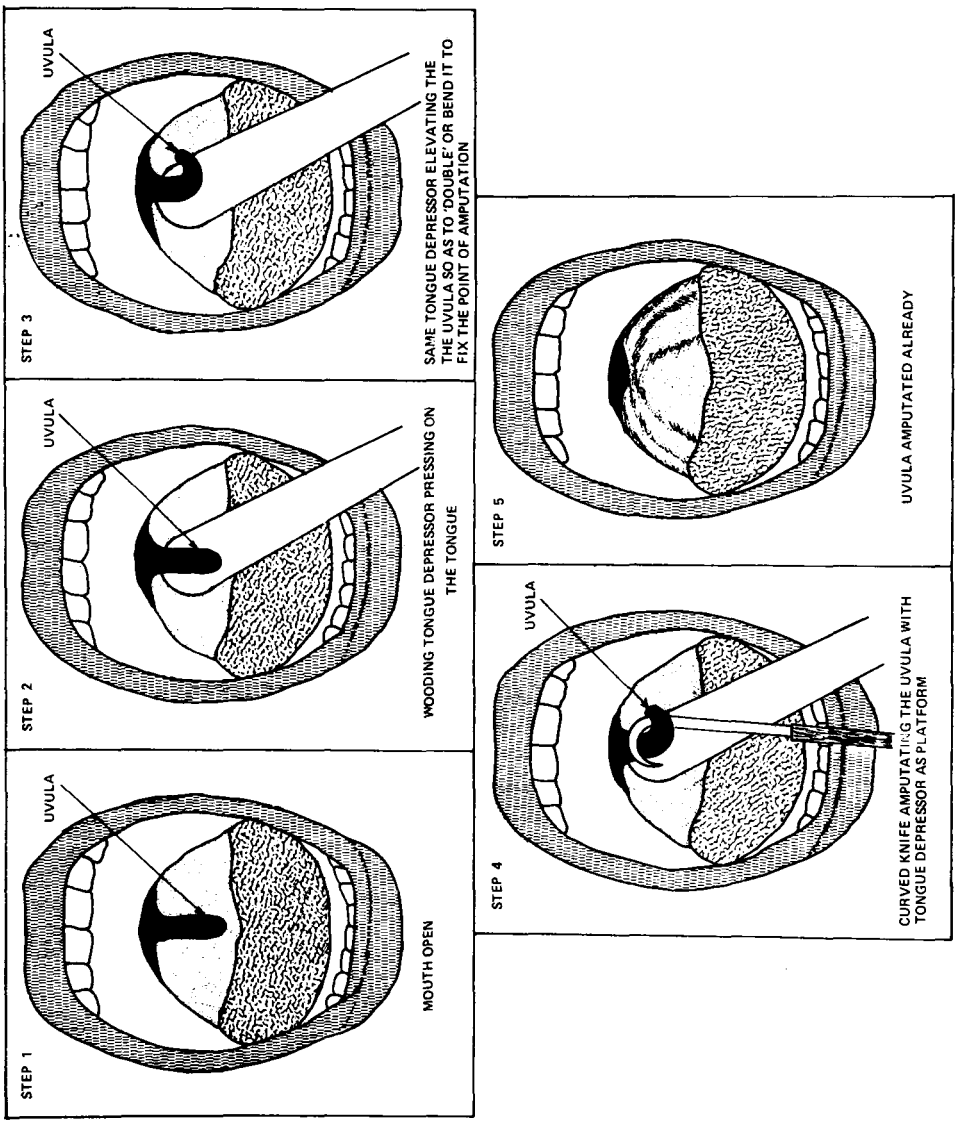



FIG. 4
Steps in uvulectomy

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practise openly, restricting their practice to close relatives, when the male surgeons are not available.

The rationale for the operation appears to be based on the assumption that the long uvula is responsible for medical problems in the throat. Some surgeons, approximately sixty per cent, go as far as to advocate early removal of the uvula in neonates, as a preventive measure against throat infections and chronic coughs in later life. A long uvula is the commonest indication for traditional uvulectomy. It is said to tickle the throat, causing an irritating cough. They believe that this could be spasmodic, leading to death. Consequently people are goaded into having the uvula cut out for fear of death. Wives are good at coercing their husbands to have this done. Actually most of the symptoms ascribed to the long uvula, such as a sensation of having a foreign body in the throat, irritating cough or persistent sore throat, are caused by lesions of the palate or various parts of the pharynx (Imperatori and Burman, 1947; Jackson and Jackson, 1959).

Diagnostic facilities of traditional surgeons, however, are very limited as regards other lesions. Thus some patients suffering from tuberculosis have had uvulectomies unnecessarily performed (Haddock and Chidue, 1965). The pre-operative assessment made by traditional surgeons is not usually adequate; consequently anaemic patients and those with bleeding diathesis may be operated upon unknowingly. The procedure itself does not ensure that the raw surface of the remnant uvula is situated posteriorly, to prevent further irritation by food material, as advocated by Ballenger (1977). Post-operative haemorrhage, when profuse, makes it necessary for the patients to be rushed to Westernized hospitals. Occasionally, patients die even before reaching the hospital. When confronted with their inability to cope with severe post-operative bleeding, the traditional surgeons state that they could have dealt with it effectively if only their patients had reported back to them, and they claim that they see many patients who have been unsuccessfully treated by Western practitioners.

Where do we go from here? The truth is that many people, both educated and otherwise, tend to believe in both traditional and Western medicine, thus applying both types of medication *pari-passu* or simultaneously. Unfortunately, the ratio of Western-trained doctors to the population is very low, and that of ENT surgeons even lower. With continuous education of the people and dialogue between Western-trained and traditional surgeons, the situation will surely improve.

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