Policy for Tonsillectomy

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Policy Summary

A six month period of watchful waiting is recommended prior to referral for tonsillectomy to establish the pattern of symptoms and to allow the patient time to fully consider the implications of the operation.

Referral criteria for possible tonsillectomy

The CCG will **only** fund tonsillectomy when the following criteria have been met:

- Recurrent attacks of tonsillitis as defined by:
    - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning **AND**
    - 7 or more well documented, clinically significant *, adequately treated episodes in the preceding year **OR**
    - 5 or more such episodes in each of the preceding 2 years **OR**
    - 3 or more such episodes in each of the preceding 3 years
- Two or more episodes of Quinsy (peritonsillar abscess)
- Severe halitosis secondary to tonsillar crypt debris
- Failure to thrive secondary to difficulty swallowing caused by enlarged tonsils
- Sleep disordered breathing or obstructive sleep apnoea diagnosed by an overnight pulse oximetry or polysonography
- Biopsy/removal of lesion on tonsil

* A Clinically significant episode is characterised by at least one of the following:
    - Oral temperature of at least 38.30C requiring antibiotic treatment
    - Tender anterior cervical lymph nodes.
    - Tonsillar exudates.

Exceptions

Urgent hospital admission is required for patients with sore throat who have stridor, progressive difficulty in swallowing, increasing pain or severe systemic symptoms.

Background to the treatment

Just over half of operations are performed on children under the age of fifteen. From a clinical point of view, although tonsillectomy is a low risk operation, it has appreciable post-operative morbidity with a complication rate of around 2%. Tonsillectomy carries a risk of mortality estimated between 1 in 8,000 to 1 in 35,000. Complications can include difficulty swallowing, vomiting, fever and excessive pain. Post-operative bleeding may also occur; either soon after the operations while the patient is in hospital (primary haemorrhage) or after initial recovery, typically following discharge (secondary haemorrhage). However tonsillectomy remains a highly effective intervention in appropriate patients, not only in elimination of severe sore throats or upper airway obstruction but also in terms of patient and parental reported quality of life.

Rational behind the decision

A Cochrane review of tonsillectomy found that, in more severely affected children, tonsillectomy will avoid three unpredictable episodes of any type of sore throat, including one episode of moderate or severe sore throat, in the next year. Less severely affected children may never have had another severe sore throat anyway and the chance of them so doing is modestly reduced by tonsillectomy. For them, surgery will mean having an average of two rather than three unpredictable episodes of any type of sore throat[1]. In less severely affected children, the average numbers of sore days were reduced from 22 to 17 days on average.

References

1. Burton MJ, Glasziou PP. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD001802. First published online: July 26 1999. Available from: http://www.cochrane.org/reviews/en/ab001802.html (accessed 2017)

2. Paradise JL, Bluestone CD, Bachman RZ. Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of parallel randomized and non-randomized clinical trials. N England J Med 1984:310(11):674-83

3. SIGN. Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010 http://www.sign.ac.uk/assets/sign117.pdf (accessed 2017)