South Thames Paediatric Network

Best Practice Recommendations

ADENOTONSILLECTOMY/TONSILLECTOMY

DAYCASE PATHWAY

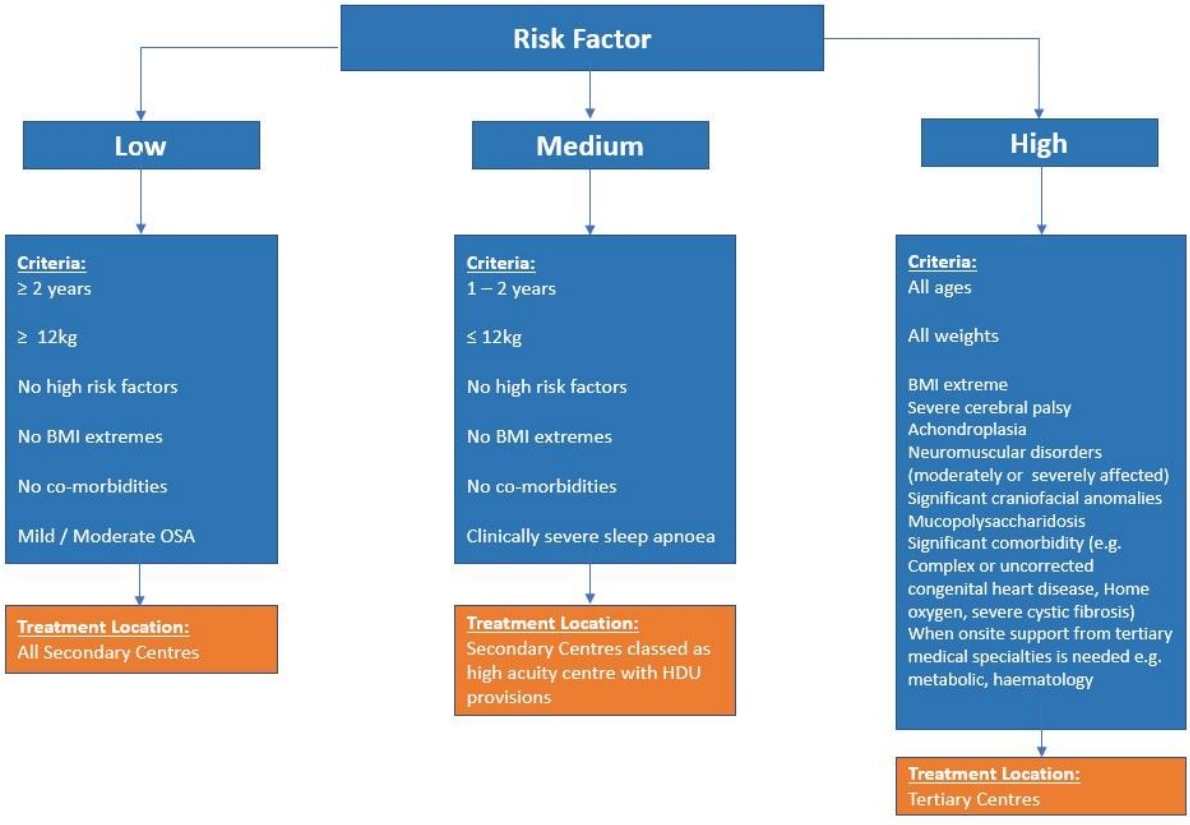
SETTING	South Thames Paediatric Network (STPN)
FOR STAFF	All tertiary & secondary centre staff involved in the pathways for children (under 16 years) undergoing adenotonsillectomy/tonsillectomy procedures.
PATIENTS	Children who are being considered for adenotonsillectomy/tonsillectomy procedures in organisations across the STPN region.

This document provides a reference for what is considered best practice across the South Thames region. It is best practice guidance only and is subject to clinical discretion.

LOCATION OF TREATMENT

Overview

In recent years there has been a significant change in UK practice of Paediatric ENT surgery with many more children being referred to tertiary centres. This strategy has a number of unintended consequences. Patients and families are travelling further for treatment, incurring both social and financial cost. The section of this document is to provide clarity on when secondary centres should treat patients for an adenotonsillectomy/tonsillectomy procedure.



SURGERY VALIDATION

For patients waiting more than 6 months there should be a mechanism to validate the need for surgery.

DAY CASE PATHWAY

Overview

The majority of children can be safely operated on in day case units. Maximising day case rates supports efficiency to the pathway; avoiding the cost of an overnight stay, keeping ENT services more resilient to bed pressures, particularly during winter surge, and allowing capacity to be freed for other specialties. It is of course beneficial to the child and family to avoid the inconvenience or worry of an overnight stay.

It is recommended nationally that 80% of tonsillectomies in children are performed as day case procedures (1, 2). The following recommendations are designed to support centres across the South Thames Network in optimising their day case pathways to achieve this. This document section is intended to provide a reference for what is considered best practice across the South Thames region and should be viewed alongside any locally agreed Standard Operating Procedures (SOPs) which should be followed at all times by local clinical teams.

Patient Selection

1. All departments must have an approved day case pathway for children undergoing tonsillectomy which meets existing published standards (2, 3)
2. All children ≥ 12kg, ≥ 2 years old and without significant comorbidity should be considered to have their procedure as a day case, including those with mild/ moderate Obstructive Sleep Apnoea (OSA) (4). For children with Sleep disordered breathing, the referral criteria for inpatient care are:

<12kg and/or <2 years of age
BMI >99.6th centile or <0.4th centile
Severe Cerebral Palsy
Achondroplasia
Neuromuscular Disorders
Mucopolysaccharide diseases
Significant co-morbidity (uncorrected CHD, home oxygen, severe cystic fibrosis, severe asthma
Need for onsite tertiary speciality (metabolic, haematology, cardiology)
Clinically suspected severe obstructive sleep apnoea – prolonged apnoeas, sternal recession

3. Recent BAPO guidance suggests that in children aged 2-3 and between 12-14kg should be considered for day case in hospitals with a level 2 HDU (5, 6). This recommendation seeks to empower day case practice nationally, however there needs to be a balance between current practice and new recommendations. Both BAPO and the STPN are of the opinion that this should not restrict current practice for units without a level 2 HDU. Thus, we suggest that units without a level 2 HDU can still undertake day case surgery in this cohort if there is already a gold standard of local practice. It is important that units are guided by current practice, complication rates, and local data.
4. Children, who live, or can stay within 1 hour of an Emergency Department with ENT Cover, can be assessed as suitable for day case surgery (7). A family's social circumstances should also be considered when assessing suitability for day surgery. If other children are at home, then there will need to be another adult at home in case there is a need to attend A&E in the event of bleeding.
5. Categorisation of severe obstructive sleep apnoea should be a clinical diagnosis and pre-operative sleep studies may be poorly sensitive for OSA and should only be considered in children with significant comorbidities, or where there is doubt about the diagnosis of OSA (3), or for children who do not seem to have responded to surgery. Only severe OSA should preclude a child from suitability for day surgery.
6. Whilst surgical technique should not impact on day case rates, evidence suggests that the Intracapsular Coblation technique results in less pain in the immediate post-operative period and reduces readmissions in children undergoing adenotonsillectomy/tonsillectomy (3, 8, 9). We note that the SWL ICB recommend against the use of curettage and cold steel for adenotonsillectomy surgery (10). The choice of technique however is at the discretion of the operating surgeon with appropriate discussion with the family.
7. There should be a local pathway for emergency admissions.

Preassessment

All children undergoing tonsillectomy should be seen face to face to review medical history and overall health, especially those with sleep disordered breathing. Preassessment also supports the psychological preparation of children pre-operatively.

Day of Surgery

Children undergoing tonsillectomy can be booked onto both morning and afternoon ENT theatre sessions, and day case can still be facilitated. A post-operative stay of a minimum of **3 hours** (5, 6) is recommended for children post-procedure (starting from when the child leaves theatre).

Post-op Observation

Routine observations for a minimum of 3 hours after surgery
Monitor oral intake
Monitor for signs of bleeding

Discharge

Adenoidectomy (and Grommet Insertion)	1-2 hours
Tonsillectomy - Coblation and bipolar diathermy	3 hours minimum
Assuming standard discharge criteria are met:	

- Early Warning Score 0 on discharge
- Pain controlled with non-opiate analgesia
- Tolerating oral intake
- No active vomiting
- No bleeding concern
- No persisting oxygen requirement
- (Reliable) caregiver confidence to continue observations at home
- Mobilised

Analgesia

1. Appropriate analgesia should be administered during the operative period and in recovery to ensure appropriate timely discharge is achieved. This should be weight-based dosing as per BNFC for postoperative pain management guidance (11, 12)
2. To minimise risk of readmission for pain management - all children undergoing Tonsillectomy, regardless of technique should be advised to use alternating Paracetamol and Ibuprofen at a **weight adjusted dose**
3. This analgesia should be provided regularly for a **minimum for 5-7 days**, but may be required for as long as 14 days
4. Minimum recommended dosing should be:

    - Paracetamol 15mg/Kg qds
    - Ibuprofen 7.5mg/kg tds

    And you may wish to consider higher post-operative dosing of:

    - Paracetamol 18mg/Kg qds (or 75mg/kg/day)
    - Ibuprofen 7.5mg/kg qds (or 10mg/kg tds)

5. Analgesia should be dispensed by the hospital. Consider prescription and dispensing in the preassessment clinic to support a smooth discharge post-op
6. Where hospital policy/process does not allow the dispensing of post-op analgesia, weight-based dosing is still recommended. Written discharge information should be provided with explicit dosing information for each child, including the volume of medicine to administer. Highlighting the concentration is critical.
7. Rescue analgesia, such as Oramorph, should be prescribed with caution. It may be required for the immediate post-operative period, if techniques other than intracapsular coblation are used (13) and in older children.
8. Services should gather post-op pain control feedback from children and/or their families to make assessment that the advice they provide is effective.

Parental Instructions

Supply appropriate instructions to parents at discharge, highlighting:

- The importance of regular analgesia dosing. Provide a written schedule with the times for doses ○ Encouragement of oral intake
- Avoiding others with coughs/colds where feasible ○ Avoiding smoky atmospheres
- Recommendations on return to school/ activity
- To attend the Emergency Department for bleeding, uncontrolled pain or poor oral intake ○ In case there are complications, it is best not to plan any long distance travel or flying within 3 weeks post surgery

Follow Up and Return to School Recommendations

Follow up guidelines by procedure	Time off of school/day-care
Uncomplicated Tonsillectomy and /or adenoidectomy No routine ENT follow up. Discharge.	Adenoidectomy- 1-2 days off Tonsillectomy -7-14 days off Some children will be ready earlier.
For histology results: Virtual follow up or write to parents (unless high suspicion warranting F2F)	

Audit

As part of the STPN, departments should participate in audits of their tonsillectomy pathway for children against these recommendations to identify opportunities to improve safety, quality and performance.

Document Conception	
Document type	Principles
Document name	Best Practice Recommendations - ADENOTONSILLECTOMY/TONSILLECTOMY PATHWAY
Document Audience	All tertiary and secondary centre staff involved in the pathways for children (under 16 years) undergoing adenotonsillectomy/tonsillectomy procedure: adult ENT surgeons in DGHs operating on children and paediatric ENT surgeons, anaesthetists, children ward nurses
Summary	Paediatric tonsillectomy is among the most common elective children's surgery in the UK. The document provides a reference for what is considered best practice across the South Thames region.
Reason for development	There is a lack of guidance in routine elective ENT procedures particularly with regard to minimum age and weight; these are the most frequently quoted reason for referral to a tertiary centre.
	In recent years there has been a significant change in UK practice of Paediatric ENT surgery with many more children being referred to tertiary centres. This strategy has a number of unintended consequences. Patients and families are travelling further for treatment, incurring both social and financial costs and has an impact on the day case rate which falls very significantly with distance from home.

	A huge backlog of Paediatric ENT patients have accumulated on both admitted and non-admitted waiting lists, and this is the principal cause for concern in the Elective Recovery effort for CYP nationally. All efforts to make the Adenotonsillectomy/ Tonsillectomy Pathway as efficient as possible are crucial in the effort to increase activity in this speciality.
Document Benefits	
Key Improvements / Benefits	The predictable nature of paediatric ENT surgery and large numbers involved allow hospitals to develop regular paediatric surgical services
	Anaesthetists can maintain their competency in paediatrics
	The hospital is far better placed to deal with emergencies when they arise, particularly the occasional case where immediate transfer is not possible
	Families have the advantage of local care which they value very highly
	Increase Day Case Rates to maximise efficiency within the pathway
	Clearly define discharge criteria and timings to maximise efficiency within the pathway
	Families aren't inconvenienced by additional time in hospital or an overnight stay, where not necessary
Project Evaluation	
Evaluation	% of low risk patients ≥2 years ≥12kg operated in local hospital
	Clinical outcomes: Frequency of re-admittance and re-attendance (in A&E). Reason for both.
	Day Case rate improvement
	Number of tonsillectomies/ adenotonsillectomies performed (activity)
Implementation / Recommendations: Next Steps	
Overview: In order for the implementation of the Tonsillectomy principles to be successful across the network we need to ensure they are circulated widely across the whole network, to ensure all clinical staff performing these procedures are familiar with the agreed standards to be following. The Network would provide support through education and training to centres who aren't meeting expected standards. Reviewing the current data and repeating the process each year will allow us to ensure the principles are having the intended outcomes.	
Step 1	Each Trust should align local guidelines and policies with the principles set in this document.
Step 2	STPN collects data on a bi-annual basis and discusses with the STPN ENT working group.
Step 3	STPN identifies training and workforce needs.
Document Contributors	
Created & reviewed by	Initially developed by the South West Surgery in Children ODN and adapted for the STPN by the South Thames Surgery in Children ENT specialty group in 2021, significantly developed and modified in Nov 2023.
Consultation provided by	STPN ENT specialty group. / Date of document approval: December 2023

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