South Thames Paediatric Network
Transforming Healthcare for Children and Young People

Follow-up Clinical Protocol: ENT

Version	1.3
Circulated	02/05/2024
Approved Date	01/04/2024
Review Date	

Contributors		
Name	**Title**	**Organisation**
Kiran Varadharajan	Consultant ENT /Paediatric ENT Surgeon	South Thames Paediatric Network STPN
Hamid Daya	Consultant Paediatric ENT Surgeon	St. George's Hospital
Victoria Possamai	Consultant Paediatric ENT Surgeon	Evelina Children's Hospital
Anastasia Rachmanidou	Consultant Paediatric ENT Surgeon	Lewisham Hospital

1. Purpose and Scope

- This protocol is a general description of patients who are agreed to be suitable for discharge or patient initiated follow-up (PIFU). It has been produced as a template to aid trusts in their implementation of standardising discharges and implementing PIFU and is designed to complement local guidance and professional judgement.
- This protocol should be considered alongside existing trust policies and processes such as Standard Operating Procedures (SOPs) and other PIFU documentation

2. Discharge Criteria

The following criteria should be used to assist the clinician in deciding whether to discharge a patient. This is at the discretion of the clinician but in most instances, the following patients should not be routinely followed-up.

Any decision regarding discharge or follow-up needs to be communicated to the patient and/or carer and the patients GP. Trust level policies should be considered and can provide guidance on the wording of patient and GP communications.

Pathway/Condition	Discharge if the patient meets the below criteria
Post tonsillectomy/adenoidectomy	Discharge immediately postop, unless high risk*
Post adenoidectomy for nasal obstruction	• Discharge after postoperative review • If no improvement postoperatively consider trial of intranasal corticosteroids / referral for allergy testing or assessment (RAST/Skin prick testing)/ consider flexible nasendoscopy/ to assess for other anatomical causes (e.g. large turbinates/ septal deviation)
Tonsillectomy for histology	Discharge if histology normal/benign
Post Grommet Insertion	As per NICE guidelines 2023 • Hearing test at 6 weeks postop and discharge if hearing loss resolved (NICE Guidelines 2023) • consider a 1-year follow up with a hearing test if there are concerns a potential recurrence of hearing loss could be missed **or** • consider an individualised follow-up plan if the child has an increased risk of unrecognised OME with hearing loss (for example, children with a learning disability or craniofacial anomalies)

Children with CRS Symptoms	• CRS symptoms in children are usually due to adenoidal hypertrophy and rarely Primary CRS (e.g. Cystic fibrosis, PCD, Primary immunodeficiency). In some cases, the diagnosis may be due to non CRS causes e.g. Allergic Rhinitis. • Paediatric CRS pathways as per EPOS should be followed.[1] • Most children will respond to INCS (intranasal corticosteroids) with some requiring antibiotics and surgery (adenoidectomy and occasionally endoscopic sinus surgery in older children). • In otherwise well children who respond well to treatment consider discharge to GP.
Epistaxis	• Discharge once treatment completed (e.g. topical creams/ cautery) • *Consider PIFU if concerns / high risk e.g. on anticoagulants / coagulopathy †*
Reactive Cervical Lymphadenopathy	• Discharge if clear evidence of reactive cervical lymphadenopathy with no red flag or B symptoms. • Consider PIFU/repeat interval US scan if any other concerns†
Thyroglossal duct anomalies	• Discharge after postoperative review (safety net to seek GP assessment if any new neck swelling/infections in the future).

*Severe OSA, BMI Extremes, Cerebral Palsy, Achondroplasia, Neuromuscular disorders, Craniofacial anomalies, Mucopolysaccharidosis, Significant co-morbidity (e.g. complex or uncorrected congenital cardiac disease. Home Oxygen, severe cystic fibrosis), children with significant metabolic/haematological issues needing onsite support.

†See PIFU criteria below

3. PIFU Criteria

If a patient is not suitable for discharge, clinicians should consider if they are suitable for PIFU. ***PIFU is not to be used where patients would otherwise have been discharged***

Shared decision making is key to this process. Patients need to understand PIFU and how to access the service if needed. Clinicians need to ensure that patients understand how to manage their medication and cope with flare ups.

Any decision regarding discharge or follow up needs to be communicated to the patient and/or their carer and the patients GP. When using PIFU both the patient and GP need to be aware of the PIFU timeframe and subsequent review or discharge.

Trust level policies should be considered and can provide guidance on the wording of patient and GP communications.

The following criteria should be used to assist the clinician in deciding whether to consider PIFU (see table overleaf)

Pathway/ Condition	Suitable for PIFU if	PIFU timescale	Triggers for apt	Apt type
Sleep apnoea/ sleep disordered breathing	Post tonsillectomy and adenoidectomy and high risk comorbidities* Children with suspected sleep disordered breathing (not requiring tonsillectomy/adenoidectomy) but clinician concern that symptoms may worsen in near future (this will largely be higher risk children*)	12 months	Worsening of apnoeic symptoms Sternocostal recession/tracheal tug/cyanosis	F2F
Post Adenoidectomy for Nasal Obstruction	Children who do not improve completely post adenoidectomy (may have trial of intranasal CS/ allergy testing/ flexible nasendoscopy evaluation to rule out other anatomical cause)	6 months	Worsening of nasal blockage symptoms/sleep disturbance	F2F
Paediatric CRS	Children with nasal polyps / PCD/CF/Primary immunodeficiency Children with improvement with intranasal CS where there is a suspicion that symptoms may recur (e.g. if known adenoidal hypertrophy)	6 months – unlimited	Worsening of nasal symptoms/CRS symptoms	F2F
Post grommet insertion	Children with concerns of a potential recurrence of hearing loss that could be missed. If the child has an increased risk of unrecognised OME with hearing loss (for example, children with a learning disability or craniofacial anomalies).	1-2 yrs. Refer for paediatric audiology 1 year post grommet (discharge of grommet extruded/normal hearing)	Ear infections, persistent otorrhoea, worsening of hearing. Perforation noted by other healthcare professional.	F2F
Recurrent acute otitis media	<3 infections per year and improved with watch wait approach/ prophylactic antibiotics	6 months	Increase in frequency of ear infections / increased severity of ear infections	F2F

Epistaxis	Children with high risk of recurrent bleeding e.g. coagulopathy / on anticoagulant or antiplatelet medication	6 months- 1 year	Recurrence / worsening of nose bleeds	F2F
Wax impaction	Children with learning disabilities/ conditions that increase the risk of hearing issues e.g. cleft palate/ craniofacial issues, use of long term hearing aid	24 months	Recurrent significant wax/ear pain/ hearing loss	F2F
Laryngomalacia	Normal baby, thriving with no red flags i.e. no significant airway compromise (significant sternocostal recession/ tracheal tug/ severe stridor at rest) / weight loss/ underlying syndromic/ neurodevelopmental issues Post supraglottoplasty where there is a concern the baby may regress symptom wise e.g. with co-morbidities	6-12 months	Dropping in >2+ centiles in growth. Airway compromise/cyanosis/feeding issues/ parental concern	F2F
Recurrent Croup	Children that do not meet the criteria for an MLB being managed with a watch/wait approach or conservative medical treatment e.g. antireflux	6-12 months	Worsening of croup severity/frequency Such as frequent admissions/ repeated review in accident and emergency /requirement of steroids. Children with airway symptoms (e.g. stridor/recession) in between croup episodes.	F2F

PIFU exclusion criteria

This protocol is for benign conditions only.

Ideal waiting time between initial patient request and PIFU appointment

1-6 weeks (max waiting time of 6 weeks)

Equality considerations that may necessitate amendments to the protocol

- Ensuring that the decision for the patient to be moved/discharged onto a PIFU pathway is a shared decision between patient and/or their carer and the clinician
- Ensure that patient and/or their carer understand where and how to access the service when they need to
- Ensure that the patient and/or their carer can understand the relevant patient leaflets and information provided

4. Follow-up Frequency

Pathway/Condition	Follow-up frequency	Apt type

References

1. https://www.rhinologyjournal.com/Documents/Supplements/EPOS2020_executive_summary.pdf