South Thames Paediatric Network

Post-Tonsillectomy Bleed Guideline for Children

Document Conception	
Document type	Best Practise Guidance
Document name	POST TONSILLECTOMY BLEED GUIDANCE
Document Audience	All tertiary and secondary centre staff involved in Emergency Medicine or ENT surgical pathways for children (under 18 years): PEM Clinicians and Nurses, Day Surgery and Paediatric Ward Nurses, Anaesthetists and ODPs (especially those on call, covering paediatric emergencies), and ENT surgical trainees. ENT Surgeons and Paediatric ENT surgeons, may wish to share this guidance within their teams to support a standardised approach to this emergency.
Summary	Tonsillectomy is a common paediatric procedure. Post-operative bleeding is a potentially life-threatening complication, with a morbidity rate of 2-4% and a mortality rate of 1 in 15,000. Bleeding typically occurs 5-10 days post-op due to sloughing of the eschar and secondary infection. All bleeds should be taken seriously, regardless of volume. The document provides a reference for what is considered best practice across the South Thames region.
Reason for development	Day Surgery Unit nursing staff have reported feeling isolated in remote units, especially once lists have concluded. Primary bleeds are quite rare, therefore staff feel less equipped to deal with these emergencies when they do happen. Clinical guidance can promote confidence and empower decision making.
	ENT surgeons have varying preferences for the management of their patients. This guidance seeks to support standardisation in the initial stages of managing a postoperative bleed, which in itself promotes familiarity and therefore safety.
	Healthcare professionals in Emergency Medicine face a wide variety of situations that require competent management. Clinical guidance helps these professionals confidently and safely handle this diversity.
Document Benefits	
Key Improvements / Benefits	**Standardised Care**: Ensures consistent and evidence-based management across different practitioners and settings
	Improved Patient Safety: Provides clear protocols to quickly identify and address bleeding, reducing complications
	Enhanced Decision-Making: Offers step-by-step guidance to support clinical judgment in urgent situations
	Efficiency: Helps prioritise interventions and appropriate referrals, optimising use of emergency and surgical resources
	Reduced Anxiety: Increases confidence among healthcare providers by clarifying roles and actions during emergencies

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Document Benefits	
Key Improvements / Benefits (continued)	**Better Communication**: Facilitates clear communication within multidisciplinary teams through shared guidelines
	Faster Response Times: Promotes timely recognition and treatment, potentially improving patient outcomes
	Training and Education: Serves as a tool for educating new staff or updating existing personnel on best practices
Project Evaluation	
Evaluation	**Adherence to the Guidance**: Percentage of cases where healthcare professionals follow the guideline steps correctly
	Patient Outcomes: Rates of complications, rebleeding, and patient recovery time
	Response Time: Time taken from identification of bleeding to initiation of appropriate management
	Healthcare Professional Confidence: Surveys or assessments measuring staff confidence and knowledge before and after guideline implementation
	Resource Utilisation: Analysis of admissions, surgical interventions, and use of emergency services related to post-tonsillectomy bleeds
	Communication Effectiveness: Feedback on multidisciplinary team coordination and clarity of roles during management
	Training Uptake: Number of staff trained and competency demonstrated in guideline application
	Patient Satisfaction: Feedback from patients and families on their experience and care quality during post-tonsillectomy bleed management
Implementation / Recommendations: Next Steps	
Overview: In order for the implementation of the Post Tonsillectomy Bleed Guidance to be impactful across the network we need to ensure they are circulated widely across the whole network, to ensure all clinical staff responding to this emergency are familiar with the agreed standards to be following. The Network would provide support through education and training. 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 identifies training and workforce needs.

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Background

Tonsillectomy is a common paediatric procedure. Post-operative bleeding is a potentially life-threatening complication, with a morbidity rate of 2-4% and a mortality rate of 1 in 15,000. Bleeding typically occurs 5-10 days post-op due to sloughing of the eschar and secondary infection. All bleeds should be taken seriously, regardless of volume.

01

Initial Actions on Presentation

- Ensure ABC assessment
- Immediate senior support from ENT and paediatrics
- If the child is actively bleeding or has had two episodes of vomiting blood, consider this a medical emergency
- Lean the child forward to avoid aspiration and allow them to spit blood into a bowl
- Administer high-flow oxygen via non-rebreather if compromised

02

Resuscitation & Immediate Management

- IV access: 2 large bore cannulae
- Bloods: FBC, U&E, LFTs, clotting, Group & Save
- IV fluids: Begin resuscitation if shocked Cross-match blood early, consider O negative if critical

Resuscitation & Immediate Management

- Analgesia (avoid NSAIDs)
- IV antibiotics:
  - Co-amoxiclav 30 mg/kg/dose TDS (max 1.2g)
- Consider tranexamic acid:
  - 15 mg/kg IV over 10 minutes (max 1g)
  - Then 10 mg/kg every 8 hours if needed

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03

Examination

- Use a tongue depressor and headlight if available
- Look for:
  - Active bleeding
  - Clot overlying fossa
  - Small grey patches (clot or scab)
- Do NOT dislodge a clot unless fully prepared for active bleeding

If Clot Seen But Not Bleeding

04

- Prepare for potential re-bleed
- Encourage the child, where possible, to gargle Hydrogen Peroxide (1:6 dilution). Repeat 4 hourly. Where unavailable, use Difflam.
- NBM and admit with IV fluids
- Inform ENT registrar urgently

05

If Bleeding Actively

- ENT and Anaesthetics must be called immediately
- Adrenaline 1:10,000 soaked gauze can be applied with Magill's forceps (under supervision only)
- Prepare for theatre
- Consent (if possible) for examination under anaesthetic and possible return to theatre

Communication & Documentation

06

- Be assertive yet polite when escalating
- Document:
  - Time of bleed
  - Estimated volume
  - Observations
  - Interventions
  - People involved and time called

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Anaesthetic Considerations

- Ensure adequately resuscitated prior to giving induction drugs
- Good IV access
- Recognise risk of possible full stomach (blood)
- Administer an anti-emetic
- Have 2 suction units available, in case one blocks
- May need blood prior to induction or available perioperatively
- Beware of the difficult airway
- Consider need for Consultant Anaesthetist presence, or on site as a minimum
- Rapid sequence induction- consider Fentanyl/ Ketamine/ Rocuronium

Key Learning Points

- All bleeds post-tonsillectomy should be taken seriously
- Escalate. Call for senior help early
- Be prepared for rapid deterioration
- Communication with ENT, anaesthetics, and family is vital

References

1. Starship Children's Hospital. Tonsillectomy - management of post-tonsillectomy bleed in CED. https://starship.org.nz/guidelines/tonsillectomy-management-of-post-tonsillectomy-bleed-in-ced/
2. RCEMLearning. Post-tonsillectomy Bleed. https://www.rcemlearning.co.uk/reference/post-tonsillectomy-bleed/
3. ENT SHO. Post-tonsillectomy Bleed. https://entsho.com/post-tonsillectomy-bleed

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Transforming Healthcare for Children and Young People

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Flowchart: Management of Post-Tonsillectomy Bleed

Child presents with suspected post-tonsillectomy bleed

Intial Assessment
ABC
High flow 02
2 x IV access
Bloods: FBC, U&E, LFTs, Clotting G&S

Start IV Co-amoxiclav
30mg/kg/dose TID (max 1,2 g)
Avoid NSAIDs

Consider Tranexamic Acid
15mg/kg IV over 10 mins (max 1g)
Then 10mg/kg q8h if needed

Actively bleeding or vomiting blood?

YES
Resuscitate
Call ENT and Anaesthetics
Cross match blood
Prepare for theatre

NO
Observe
ENT review
Admit if necessary

Clot visible on tonsillar fossa?

YES
H202 gargle q4h (1:6)
NBM and IV fluids
Monitor closely

NO
Safety net and monitor

ENT Review
Conservative vs Surgical

Document findings/ actions
Update and inform parents

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