East of England Surgery in Children ODN
(Hosted by Cambridge University Hospitals)

Clinical Guideline: East of England Paediatric Tonsillectomy Provision

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For use in: EoE Paediatric Units, ENT Departments
Guidance specific to the care of children undergoing tonsillectomy

Used by: ENT units, paediatric surgical departments, paediatric pre and post op wards

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Clinical Lead Milind Kulkarni	**Milind Kulkarni**

Ratified by ODN Board:

Date of meeting	**December 2022**

Audit Standards:
Departments are expected to regularly audit their practice against the 12 standards set out in this document.

Audit points

Good Practice Guidance East of England Tonsillectomy Provision

Tonsillectomy is one of the commonest surgical procedures performed in childhood and makes up a significant proportion of work in both secondary and tertiary level care. This guideline has been produced to help standardise care across the region to reflect 2 major changes in national guidance:

1) The proposed target set by the British Association of Day Case Surgery of 80% of tonsillectomy case being performed as day case procedures[i]
2) Reducing referral of routine tonsillectomy in otherwise healthy children to tertiary level services when care can be safely deliver locally, specifically repatriating the care of 2yrs and older and 12kg and over to secondary care

This guidance was produced following consultation with relevant parties throughout the East of England. The standards of practice outlined within this guidance have been agreed by consensus opinion following evidence review and formal discussion with ENT, Anaesthetics and nursing support teams across the region.

Section 1 Location of surgery

Throughout the East of England the procedure is delivered in the following unit types:

- *Secondary care day case unit with no facility for overnight stay*
- *Secondary care unit with facility for overnight stay*
- *Secondary care unit with High Dependency Unit (HDU) or equivalent facilities.*
- *Tertiary care unit with access to HDU/Paediatric Intensive Care Unit (PICU) facilities.*

The level of care that can be delivered at each unit differs due to the staffing mix and out of hours provision. Patients undergoing tonsillectomy fall into 2 main groups

- the well child with recurrent tonsillitis or obstructive sleep apnoea (OSA),
- children with other comorbidities who require surgery for the same reason.

The vast majority of these children are otherwise well (please see section 6 for guidance on those with comorbidities) and can be treated in secondary care.

Standard 1

For those units with appropriate anaesthesia provision[ii] [iii] in secondary care with overnight facilities – units should provide surgery in children 2yrs and older with equivalent weight of 12kg and above with no major comorbidities (as per table 1) regardless of indication for tonsillectomy.

For those units without appropriate provision for cases of 2-3 yr old or without access to overnight stay, a formal pathway should be established to local hub secondary care unit to facilitate surgery, or overnight admission.

Section 2 Planning of surgical lists

Standard 2
To streamline workforce within the pre, peri and post-operative environments departments should plan purely paediatric lists. It is recommended that anaesthetists job plans reflect a regular commitment in staffing such lists especially for children <5 years of age.

Standard 3
Planned daycase tonsillectomy should take place in the morning or early afternoon to provide adequate post-operative observation and thus timely discharge. Departments to work with administrations and theatre management teams to ensure access to regular morning operating lists. Where historical reluctance is a barrier, departments should work to review the evidence base and audit current practice to explore avenues for improvement. If necessary, discuss with the paediatric ENT and anaesthetic ODN workstream leads where required.

Section 3 Pre-operative assessment

Standard 4
All children should undergo pre-operative assessment as per the Association of Paediatric Anaesthetists [vi] guidelines, ideally 2weeks before surgery. Departments should screen patients on listing for surgery in order to promote timely referral to a higher-level unit where applicable. Each unit will have individual expertise and thus are encouraged to produce their own screening questionnaire.

Standard 5
Routine overnight pulse oximetry is not recommended for risk stratification (or clinical evaluation) of OSA cases[iv]. Where doubt exists regarding the suitability of delivering safe care the unit should consider cardiorespiratory sleep analysis or formal polysomnography. It is recommended that children who are being considered for these studies be referred to a tertiary unit for overall management and surgery.

Section 4 Day of surgery

Standard 6
Ward and recovery staff should be trained in the care of the post-tonsillectomy child in particular counselling families on pain relief and recognising a post-tonsillectomy bleed.

Section 5 Length of stay

The rates of day case tonsillectomy varies widely across units. The GIRFT report (2019) [i] investigated this and found that levels of day case surgery are not influenced by case mix. Planning of theatre lists and identification of appropriate patients is key.

Standard 7
For well children over 2 years old with OSA or tonsilitis the aim should be to facilitate day case surgery whenever possible.

Standard 8
Departments may wish to explore the use of the intracapsular tonsillectomy method which is associated with lower rates of post-operative haemorrhage and quicker recovery [iv, v]

Section 6 Patients requiring treatment in tertiary unit

Standard 9
Patients with the comorbidities documented in Table 1 should be referred to a tertiary unit. This list is not exhaustive and where required the lead consultant should discuss cases with an anaesthetist with onward referral if applicable. Such referrals should be treated in a timely manner (eg not join the back of the referral queue given children may waited for some time for surgery).

Section 7 Discharge from hospital

Standard 10
Units should aim to establish a nurse-led discharge criteria and include this instruction in the post-operative plan if patient suitable. Safe discharge is dependent on many variables and should remain patient-centred. Discharge should be criteria-dependent rather than time-dependant. Review by surgeon and/or anaesthetist should take place if criteria not met and/or patient not suitable for nurse-led discharge to determine suitability for daycase discharge.

Standard 11
Patient information should be made available outlining how post-operative complications are addressed. Parents should be provided with a written record of Paracetamol and Ibuprofen dosing as per BNFC; teams may want to provide additional Oramorph. Families should be provided with a contact number for advice following discharge.

Section 8 Departmental governance

Standard 12
Departments should regularly audit their practice against these standards to facilitate continual opportunity for improvement and improved safety.

Table 1 Risk Factors
Severe cerebral palsy
Achondroplasia
Neuromuscular disorders (moderately or severely affected)
Morbid Obesity
Significant craniofacial anomalies
Mucopolysaccharidosis
Significant comorbidity (e.g Complex or uncorrected heart disease, Home oxygen, severe cystic fibrosis)
When onsite support from tertiary medical specialities is needed e.g. metabolic, haematology

References

[1] A Marshall. Ear, Nose and Throat Surgery; GIRFT Programme National Speciality Report. Published November 2019

[1] **Chapter 10: Guidelines for the Provision of Paediatric Anaesthesia Services 2022**

[1] *The staff and equipment as recommended in the Guidelines for the Provision of Paediatric Anaesthesia Services (GPAS) 2019 document should be available*

[1] Safe Delivery of Paediatric ENT Surgery in the UK: A National Strategy. A Report of a Combined Working Party of the British Association for Paediatric Otolaryngology (BAPO), ENT UK, The Royal College of Anaesthetists (RCoA) and the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI)

[1] Amin, N, Bhargava, E, Prentice, JG, Shamil, E, Walsh, M, Tweedie, DJ. Coblation intracapsular tonsillectomy in children: A prospective study of 1257 consecutive cases with long-term follow-up. *Clin Otolaryngol*. 2021; 46: 1184– 1192. https://doi.org/10.1111/coa.13790

[vi] B*est Practice Guidance:* Association of Paediatric Anaesthetists of Great Britain and Ireland. *Preassessment Services for Children undergoing Surgery or Procedures***.** Spring 2022.

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