# Tonsillectomy

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Acknowledgements

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1 Introduction

Tonsillectomy is the surgical removal of the tonsils (glands at the back of the throat). Sometimes it is conducted at the same time as adenoidectomy, the removal of the adenoids (glands at the back of the nose). Tonsillectomy is a common ear nose and throat (ENT) operation with opinion divided on whether the benefits of surgery outweigh the risks (Burton, et al. 2014). This policy document outlines the clinical commissioning criteria for tonsillectomy in Norfolk.

2 Criteria for Commissioning

2.1 Policy Statement

Tonsillectomy for recurrent tonsillitis or its complications (e.g. quinsy) in children <16 and in adults:

Unequivocal indications for tonsillectomy

Patients with the following are exempt from this policy and immediate referral for treatment is recommended:

- Peri-tonsillar abscess (Quinsy) – one episode of quinsy with history of recurrent tonsillitis OR 2nd episode of quinsy
- Acute upper airways obstruction
- Suspected tonsillar malignancy

Tonsillectomy for recurrent tonsillitis

This procedure** will be funded for the treatment of sore throats in adults and children if the following criteria can be met:

1. Sore throats are due to acute tonsillitis

AND

2. Episodes of sore throats are disabling and prevent normal functioning (documented absence from school or work)

AND

3. Seven or more documented, clinically significant, adequately treated sore throats in the previous year* OR five or more such episodes in each of the preceding two years* OR three or more such episodes in each of the preceding three years* (Paradise Criteria) OR Severe recurrent tonsillitis in adults that results in two or more hospital admissions.

*Each of the episodes must be of a debilitating nature (for example documented absence from school or work ≥ 3 days + visit to GP) and be well documented in the patient’s notes.
Detailed documentation of the criteria that are fulfilled is required in the GY&W referral letter (GY&W referral form), where available; clinically inappropriate referrals will be sent back to the GPs.

**For Norfolk CCGs, the procedure is also subject to Prior Approval**

**Tonsillectomy for sleep disordered breathing due to obstructive sleep apnoea syndrome (OSAS) in children (<16 years)**

This procedure** will be funded for the treatment of OSAS in children if the following criteria can be met:

1. There is a strong history suggestive of obstructive sleep apnoea such as witnessed obstructive apnoea, difficulty breathing while asleep, sleeping in an unusual position (with head extended), secondary enuresis, frequent daytime mouth breathing, and behavioural or concentration problems. With documented evidence of significant impact on quality of life (for example behavioural or concentration problems, failure to thrive, slowing of weight gain).

AND

2. Clinical diagnosis of obstructive sleep apnoea by a designated ENT consultant with documented clinical features such as adenotonsillar hypertrophy and mouth breathing, with or without evidence of desaturation from a sleep study.

In all cases, please attach the clinic letter (referral form) which should indicate the evidence that has been evaluated to indicate a significant impact on quality of life (e.g. GP letter, secondary care clinical examination by secondary care consultant, letter from school, sleep study results).

**For Norfolk CCGs, the procedure is also subject to Prior Approval**

**Tonsillectomy is not routinely funded for the treatment of sleep apnoea in adults.**

**Tonsillectomy will not be funded as a treatment for snoring.**

**Tonsillectomy for pathological airway (type 2) halitosis due to chronic caseous tonsillitis (CCT) with tonsilloliths**

This procedure** will be funded for the treatment of severe airway (type 2) halitosis due to CCT if the following criteria can be met:

1. Pathological halitosis (offensive smelling breath) which has been demonstrated to be due to CCT with tonsil crypt debris (tonsilloliths) with diagnosis confirmed by ENT specialist

AND
2. CCT has not responded to medical management over a period of three months. Medical management can include irrigation, saline gargling, topical antiseptic spray, anti-inflammatories.

**For Norfolk CCGs, the procedure is also subject to Prior Approval**

### 2.2 Plain Language Summary

The tonsils (glands at the back of the throat) help to fight germs and act as a barrier to infection, but become less important for this role as children get older and become adults.

Tonsillitis is inflammation of the tonsils. Tonsillitis is usually caused by a viral infection, or less commonly due to a bacterial infection. Tonsillitis can be infectious depending on the cause. Tonsillitis often only lasts a few days, but in some cases can result in a high temperature (fever) and feeling unwell (malaise) for a longer period.

Tonsilloliths are granular 'stone like' material in the tonsils, often with to chronic tonsillitis, and associated with severe halitosis (bad breath)

Sleep apnoea is the cessation of breathing for 10 seconds during sleep.

Obstructive sleep apnoea syndrome (OSAS) is a condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing, because airflow is blocked for 10 seconds or more.

Tonsillectomy is surgical procedure to remove the tonsils (glands at the back of the throat). Sometimes as well as the tonsils the adenoids (glands at the back of the nose) are removed at the same time, this procedure is known as adenotonsillectomy.

Based on the evidence of clinical and cost effectiveness provided in this document, tonsillectomy is not routinely commissioned for the treatment of tonsillitis, except in cases where a person has many cases of tonsillitis over time (Chronic Tonsillitis) that meet specific criteria.

Based on the evidence of clinical and cost effectiveness provided in this document tonsillectomy is routinely commissioned for the treatment of obstructive sleep apnoea in patients under 16 years of age that meet specific criteria. Tonsillectomy is not routinely commissioned for the treatment of obstructive sleep apnoea in patients over 16 years of age or for patients who do not meet the specific criteria.

### 2.3 Equality Statement

The Clinical Policy Development Group is committed to ensuring equality of access and non-discrimination as enshrined in the Health and Social Care act 2010. In carrying out its functions, the CPDG will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998.
2.4 Clinical Governance Statement

It is important that the implementation of this policy is seen as an opportunity to encourage team working and cooperation between commissioners, primary, secondary care providers and at the interface between them. Providers should consider the resources needed for successful implementation, tailoring support to suit local circumstances, taking into account any potential barriers. It is expected that implementation of this policy will be monitored through a professionally-led clinical review and audit cycle. Providers should discuss this with their clinical effectiveness lead in the first instance. For guidance in conducting an audit or review you may also contact the Public Health team at Norfolk County Council at hphprojects@Norfolk.gov.uk

3 Background

3.1 Aim

This updates the Norfolk and Waveney CCGs Policy for tonsillectomy in light of recent evidence.

3.2 Definitions of Condition and Treatment

- The tonsils - glands at the back of the throat
- Tonsillitis – Inflammation of the tonsils
- Tonsilloliths – Tonsilloliths are oropharyngeal concretions stemming from a reactive foreign nidus such as bacteria and organic debris within a palatine tonsillar crypt (Oda, et al. 2013).
- Sleep Disordered Breathing - Obstruction of the upper airway during sleep may result in the generation of noise (snoring), reduction (hypopnoea) or cessation (apnoea) of airflow at the nostrils and mouth (Lim & McKean, 2009).
- Sleep apnoea is the cessation of breathing for 10 seconds during sleep (Lam, et al 2010).
- Obstructive sleep apnoea syndrome (OSAS) is a condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing, because airflow is blocked for 10 seconds or more (Lim & McKeann, 2009).
- Hypopnoea is a 50% or greater decrease in the amplitude of nasal/oral airflow often accompanied by hypoxaemia or arousal (Lim & McKeann, 2009).
- OSA is the most severe end of a spectrum of sleep-disordered breathing problems which also includes primary snoring, upper airway resistance and obstructive hypopnea syndromes (Lim & McKeann, 2009).
• Tonsillectomy is a surgical procedure in which the tonsils are removed from either side of the throat. The tonsils are two almond-shaped glands situated one on each side of the fauces (the opening between the mouth and the throat).

• Adenoidectomy is a surgical procedure to remove the adenoids (glands at the back of the nose).

• Adenotonsillectomy is the removal of both the tonsils and adenoids.

• Apnoea Hyponea Index (AHI)

• Halitosis (clinically detectable odour)

• Chronic Caseous Tonsillitis is retention and/or discharge of cheese-like, semi-solid whitish material from tonsil crypts

• Tonsilloliths is due to mineralization of tonsil crypt material

### 3.3 Epidemiology

It is estimated that one in 100 children have obstructive sleep apnoea in the UK (Powell, 2011). The number of tonsillectomy submissions CCGs in Norfolk for prior approval in 2014 indicates that the majority of cases are due to chronic tonsillitis (Table below).

<table>
<thead>
<tr>
<th>Tonsillectomy &amp; Tonsillectomy with Sleep Apnoea Prior Approval requests received between April 2014 and January 2015, all ages (For Norfolk excluding Great Yarmouth)</th>
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<td>Tonsillectomy with Sleep Apnoea – Total</td>
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<td>Total</td>
<td>338</td>
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4 Evidence review

4.1 Clinical Effectiveness

Surgical removal of the tonsils, with or without adenoïdectomy (adeno-/tonsillectomy), is a common ear nose and throat (ENT) operation with opinion divided on whether the benefits of surgery outweigh the risks (Burton, et al. 2014). The literature is consistent in the findings that children fulfilling the ‘Paradise Criteria’ gain the most benefit from tonsillectomy for sore throat (Burton, et al. 2014; Baugh, et al. 2011; Paradise, et al. 1984).

Tonsillectomy for treatment of tonsillitis

For the treatment of tonsillitis tonsillectomy offers relatively small clinical benefit compared with non-surgical treatment.

- In the first year after tonsillectomy children undergoing surgery had an average of 18 days of sore throat (between five and seven on average in the immediate postoperative period), compared with 23 days in the control group. A statistically significant difference of 5.1 days, 95% CI 2.2 to 8.1 (Burton, et al. 2014).

- Evidence for adults found that tonsillectomy results in a 3.6 fewer episodes (95% CI 7.9 fewer to 0.70 more) within six months post-surgery compared to controls, which may be due to chance (Burton et al. 2014).

- Any potential benefits of tonsillectomy surgery must be carefully weighed against the possible harms as the procedure is associated with a small but significant degree of bleeding either during or after the surgery (Burton, et al. 2014). In addition, even with good pain relief medication, the surgery is particularly uncomfortable for adults.

- Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats that do not meet the ‘paradise’ criteria (SIGN, 2010; Burton, et al. 2014).

Tonsillectomy / adenotonsillectomy for Sleep disordered breathing

Tonsillectomy with or without removal of the adenoids (adenotonsillectomy) is a common surgical treatment for obstructive sleep apnoea in children due to perceived efficacy and cost effectiveness (Lim & McKean, 2009).

- A recent well-designed and conducted randomized controlled trial (CHAT) provides evidence of the effectiveness of adenotonsillectomy compared to watchful waiting for the treatment of obstructive sleep apnoea in children aged 5 to 9 years of age (Marcus, et al. 2013).

- Adenotonsillectomy was not associated with a statistically significant improvement in children’s cognitive function after seven months, which improved in both groups (Marcus, et al. 2013).

- Compared to watchful waiting adenotonsillectomy was associated with a statistically significant reduction in OSAS symptoms (AHI) and improvements in
child behaviour and quality of life measurements (Marcus et al. 2013).

- The CHAT study also found that adenotonsillectomy resulted in a significant increase in children’s body weight (BMI z-score), including among children who were overweight or obese (Katz et al., 2014). This is consistent with previous evidence from non-randomised trials indicating that adenotonsillectomy improves symptoms of OSAS but is commonly not curative in children who are overweight or obese (Cost & Mitchell, 2009; Praud & Dorion, 2008; Friedman, et al. 2009, Witmans & Shafazand 2013). Weight loss interventions should therefore be considered for children with OSAS that are overweight or obese in addition to tonsillectomy/adenotonsillectomy (Katz, et al. 2014; Dary, et al. 2009).

Tonsillectomy for Halitosis associated with chronic caseous tonsillitis (CCT) and tonsilloliths

Severe halitosis can result from sulfurous compounds released by tonsilloliths forming due to chronic caseous tonsillitis (Fergusen, et al. 2014; Oda, et al. 2013). There is no good quality evidence for the effectiveness of different forms of conservative, medical or surgical interventions for the management of halitosis due to tonsilloliths. Evidence for the effectiveness of tonsillectomy for treating halitosis from case series data which might be subject to chance, bias or confounding (Fergusen, et al. 2014). It is important to reliably distinguish objective halitosis due to tonsilloliths from subjective complaints, because patients with subjective halitosis will not benefit from treatments designed to eliminate odour (Fergusen, et al. 2014).

4.2 Safety

NICE Interventional Procedure Guidance

NICE has published Interventional Procedure Guidance regarding safety of surgical techniques for tonsillectomy and found that the evidence on the safety and efficacy of tonsillectomy using these three procedures appeared adequate to support the use of these techniques provided that normal arrangements were in place for consent, audit and clinical governance.

1. Electrosurgery (diathermy and coblation) for tonsillectomy (NICE, IPG 150).
2. Tonsillectomy using ultrasonic scalpel (NICE, IPG 178).
3. Tonsillectomy using laser (NICE, IPG 186).

Consensus statement of a UK multidisciplinary working party (APA, BAPO, RCPCH, RCA): Tonsillectomy and adenoidectomy in children with sleep related breathing disorders.

This consensus position statement represents a summary of expert opinion, based on

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i APA: Association of Paediatric Anaesthetists  
ii BAPO: British Association for Paediatric Otorhinolaryngology  
iii RCPCH: Royal College of Paediatrics and Child Health  
iv RCA: Royal College of Anaesthetists
limited evidence, to provide clinical guidance on which children might potentially safely undergo AT in a general hospital setting, and which should be referred to centres with paediatric intensive care unit (PICU) facilities.

- Otherwise-well children requiring surgery (usually tonsillectomy and/or adenoidectomy) for symptoms suggestive of mild obstructive sleep apnoea/hypopnoea, can generally be managed safely in a District General Hospital (DGH) setting.
- At risk children (for example severe nocturnal symptoms including a history of witnessed apnoea) should be referred for further investigation by a specialist centre with PICU facilities.

4.3 National /Local Guidelines


CCG policies:
3. Cambridgeshire and Peterborough CCG: Tonsillectomy Policy: In addition to similar policy regarding tonsillectomy for recurrent tonsillitis, this policy also funds tonsillectomy for “severe and recurrent tonsillitis resulting in two or more hospital admissions”, “severe halitosis due to tonsil crypt debris (tonsilloliths)”, and “intractable cough with a high level of streptococcal antibody (teenagers or adults only)”

4. West Essex CCG Tonsillectomy Policy: Recommends a six month period of watchful waiting prior to tonsillectomy to establish that pattern of symptoms. Criteria for tonsillectomy differ slightly to Norfolk, in that only five or more episodes of sore throat due to tonsillitis are required for year, symptoms must last for at least a year, the episodes of sore throat are disabling and prevent normal functioning. There is a statement that all non-urgent patients with a BMI above 30 should be offered advice and support by their GP to help them lose weight.

4.4 Key Findings

1. There is evidence that tonsillectomy can be effective as a treatment of severe recurring tonsillitis.
2. Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats. Because the modest benefit from tonsillectomy along with risk of secondary bleeding tonsillectomy surgery should usually be avoided.
3. There is evidence that tonsillectomy /adenotonsillectomy can be effective as a treatment of severe obstructive sleep apnoea syndrome.
4. The evidence for the effectiveness of tonsillectomy, medical or alternative surgical management for the treatment of severe halitosis due to tonsilloliths is of poor quality, with no well-designed randomised controlled trials
References


Appendix 1

Tonsillectomy Pathway

RCS Commissioning Guide: Tonsillectomy (2013):

1. Pathway for recurrent tonsillitis or its complications (quinsy)

Primary care assessment
- Carefully assess (history and examination) a patient with sore throat symptoms and document diagnosis of significant sore throat or tonsillitis.
- Carefully assess and document impact on quality of life.

Referral
- Consider referral if there are seven or more significant, adequately treated sore throats in the preceding 12 months or 5 or more episodes in each of the preceding two years, or 3 or more in each of the preceding three years.
  - NOTE: a requirement for a fixed number of episodes may not be appropriate for adults with prolonged severe or uncontrolled symptoms.
- Some cases with a specific clinical condition or syndrome may require tonsillectomy as part of a patient’s on-going treatment strategy (for example psoriasis, nephritis, PFAPA syndrome).
- The referral letter should document that GP has discussed with patient or parent/carer the benefits and risks of tonsillectomy versus watchful waiting.

Secondary care
- Confirmation of primary care assessment, fulfilment of SIGN criteria for tonsillectomy and impact on quality of life and ability to work/attend school.
- Consultation with patient about management options using shared decision making strategies and tools where appropriate.
- Management options: tonsillectomy, or referral back to primary care for on-going monitoring.

Surgical setting
- Children: Ideally within a paediatric surgical facility as a day case, although day case care may be contraindicated in the presence of significant sleep apnoea.
- Adults: Ideally as a day case.

2. Pathway: Children (<16) with sleep disordered breathing

Primary care assessment
- Carefully assess (history and examination) a child with symptoms of significant snoring and disruptive breathing patterns whilst asleep. Make note of large tonsils with or without nasal obstruction.
- Carefully assess and document impact on development, behaviour and quality of life.

Referral
- If sleep disordered breathing is suspected, refer to secondary care.
Secondary care

- Confirmation of primary care assessment, either on basis of history and examination or, if necessary, findings from further investigations (e.g. Sleep study)
- Consider impact on quality of life, behaviour and development.
- Consultation with parent/carers about management options using shared decision making strategies and tools where appropriate.
- Management options: tonsillectomy or adenotonsillectomy, or, if appropriate, referral to paediatrician or discharge back to primary care.

Surgical setting

- Within a paediatric surgical facility. Children with severe symptoms will need access to paediatric intensive care facilities.
Appendix 2

This draft policy has been developed through consultation with the following:

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<tr>
<th>Name</th>
<th>Designation</th>
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<td>Barbara James</td>
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<td>Queen Elizabeth Hospital Kings Lynn</td>
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**Public Health Team**

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<th>Name</th>
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<tbody>
<tr>
<td>Dr Abhijit C Bagade</td>
<td>Consultant in Public Health</td>
<td>Norfolk County Council and Suffolk County Council</td>
</tr>
<tr>
<td>Dr Shamsher Diu</td>
<td>Consultant in Public Health</td>
<td>Norfolk County Council</td>
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<tr>
<td>Dr Boaventura Rodrigues</td>
<td>Consultant in Public Health</td>
<td>Norfolk County Council</td>
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<tr>
<td>Dr Suzanne Meredith</td>
<td>Consultant in Public Health</td>
<td>Norfolk County Council</td>
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<tr>
<td>Joanne Creaser</td>
<td>Clinical Audit Officer</td>
<td>Norfolk County Council</td>
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<tr>
<td>Dr David Edwards</td>
<td>Specialty Registrar</td>
<td>Norfolk County Council</td>
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