South Thames Paediatric Network

Best Practice Recommendations

ADENOTONSILLECTOMY/TONSILLECTOMY 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.

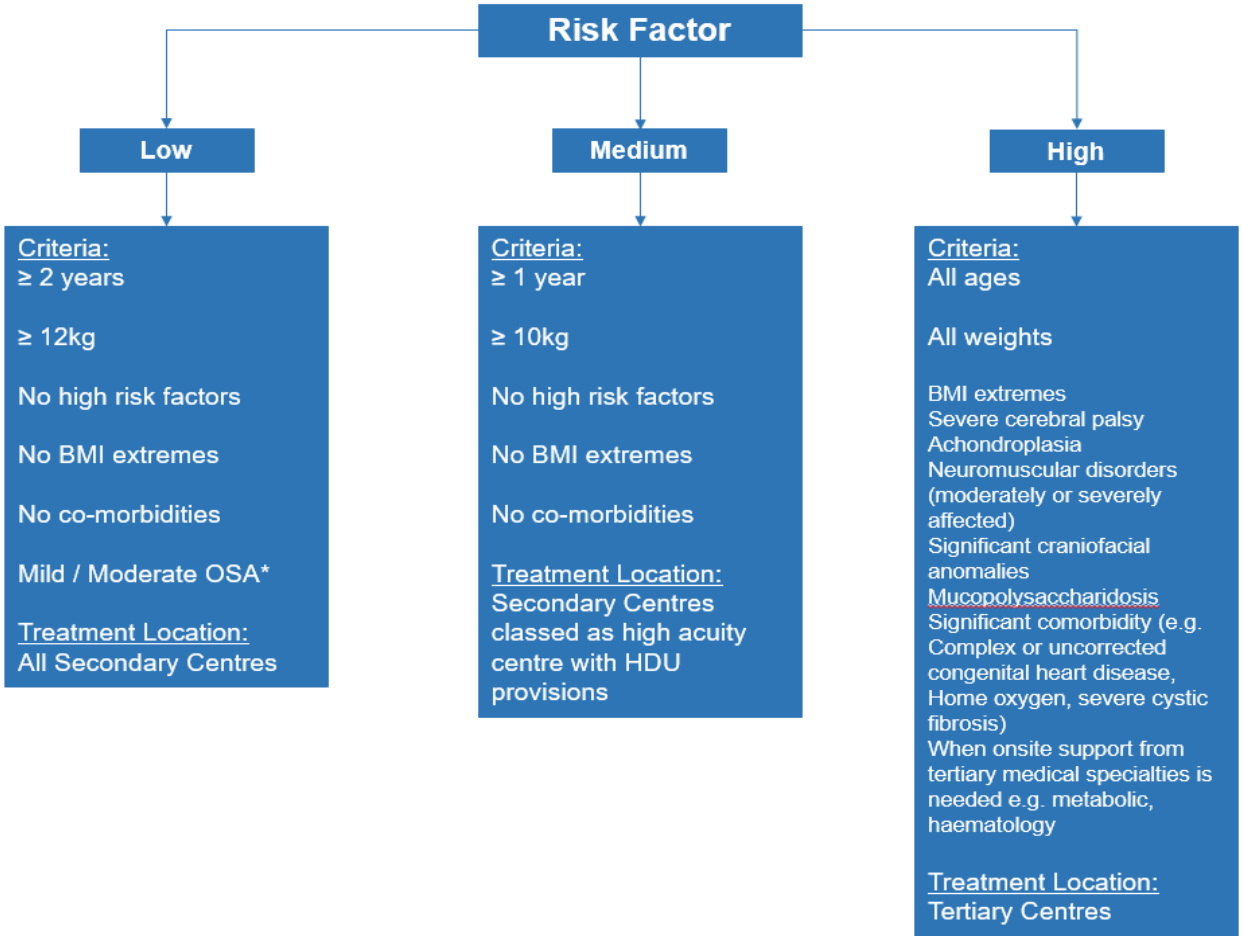
PATIENTS Children who are being considered for adenotonsillectomy/tonsillectomy procedures in organisations across the STPN region.

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.



DAY CASE PATHWAY

Summary

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).
3. Children, who live greater than 1 hour from the hospital delivering the procedure, may require to be admitted post-operatively, but geographical restrictions should not necessarily prevent children from being treated as a day case (5).
4. Certain types of 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)

Day of Surgery

5. Children undergoing tonsillectomy should be preferentially booked onto morning ENT theatre session; children could be booked on an afternoon session, ideally at or near the start of the list to facilitate day case. A post-operative stay of 4 hours is recommended for children post procedure (starting from when the child leaves theatre) (6).
6. Whilst surgical technique should not impact on day case rates, evidence suggests that coblation results in less pain in the immediate post-operative period and reduce readmissions in children undergoing adenotonsillectomy/tonsillectomy (3, 7, 8).

Discharge

7. Children should be observed for a minimum of 4 hours after their procedure prior to discharge (starting from the time the child leaves theatre) (6).
8. 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 post-operative pain management guidance (9, 10).
9. Appropriate analgesia and instructions should be given to the parents at discharge. This must highlight the importance of giving regular paracetamol and ibuprofen. Rescue analgesia, e.g. oramorph, is also often prescribed for the immediate post-operative period. (11).

Follow up

10. 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.

Reference

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