Policy statement:	**Tonsillectomy/Adenoidectomy**
Status:	**Individual Prior Approval**

Suspected or confirmed malignancy – should be referred via a two week pathway. Tonsillectomies required as part of treatment for malignancy do not need prior funding approval. No prior approval required for patients with tonsillar asymmetery or diagnostic tonsillectomy for suspicion of cancer.

M&SECCGs commission tonsillectomies on a restrictive basis for those patients who meet criteria as outlined in SIGN Guidance 117 (April 2010) or one of the conditions listed below:

Individual prior approval for funding is required in all cases. GPs should not refer unless the criteria below have been met, and referrals must include objective information to demonstrate this.

A period of 6 months watchful waiting by the GP is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of operation. For recurrent tonsillitis in children <16 years old, before referral to secondary care, the GP should discuss with patient/parents or carers the benefits and risks of tonsillectomy vs. active monitoring. Sign post patients to relevant information and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. The Right Care Shared Decision Aid for recurrent sore throats should be used

deciding-what-to-do-about-recurrent-sore

(http://sdm.rightcare.nhs.uk/pda/).
This discussion should be documented.

Patients must meet the following criteria:
(the answers to 1 and 2 must be 'Yes' and then the answer to any one criteria 3-6 must be 'Yes'):

1. Sore throats that are due to acute tonsillitis
   AND
2. Episodes of sore throat that are disabling and prevent normal functioning
   AND
3. Seven or more well documented clinically significant, adequately treated sore throats in the preceding year.
   OR
4. Five or more such episodes in each of the preceding two years.
   OR
5. Three or more such episodes in each of the preceding three years.
   OR
6. Failure to thrive in paediatric patients where recurrent tonsillitis is considered a contributory factor.

OR

the patient should have one of the following conditions:

- intractable cough with a high level of streptococcal antibody for longer than one year-test results to be included with referral;
- severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year (diagnosed by an ENT surgeon).
- peritonsillar abscess not responding to antibiotics and incisional drainage.

ME&SCCGs commission tonsillectomy with or without concurrent adenoidectomy for Obstructive sleep apnoea (OSA) in

- adults who has been diagnosed by sleep study/overnight polysomnography, in the presence of large tonsils-see also Sleep Studies policy

- children where OSA is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive as assessed using NICE guidance NG75.

Adenoidectomy as a separate procedure will not be funded. See also Grommets.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding for these procedures can be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs' website.

Rationale

This policy has been developed using the criteria within the Royal College of Surgeons commissioning guide for tonsillectomy. Evidence for the benefits of tonsillectomy is poor. In children surgery may be beneficial in selected cases. In adults, limited evidence suggests that tonsillectomy may benefit people with recurrent infection. (NICE evidence summaries).

The potential benefits of tonsillectomy in reducing recurrent or chronic throat infection need to be weighed against complications and operative risks and the possibility that the throat infections may resolve without intervention (watchful waiting). A period of watchful waiting is more appropriate for children with mild sore throats (SIGN 2010).

The Royal College of Surgeons advise that before referral to secondary care a discussion should take place of the benefits and risks of tonsillectomy vs. watchful waiting for both recurrent tonsillitis and sleep disordered breathing. Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

For recurrent tonsillitis in children <16 years old the Right Care Shared Decision Aid for recurrent sore throats should be used before referral into secondary care (http://sdm.rightcare.nhs.uk/pda/).

Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

The impact of recurrent tonsillitis on a patient's quality of life and activities of daily living should be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe or uncontrolled symptoms, or if complications (e.g. quinsy) have developed (Royal College of Surgeons 2013).

There is a lack of published evidence demonstrating the benefit of performing tonsillectomy for the treatment of tonsilloliths (evidence review April 2015) and therefore this has not been included as an indication for tonsillectomy

References:

SIGN guidance

Commissioning guide:Tonsillectomy
https://www.entuk.org/sites/default/files/files/ENT%20UK%20Tonsillectomy%20revised%20commissioning%20guide%202016%20PUBLISHED.pdf