Humber Coast and Vale

Tonsillectomy Commissioning Policy

Intervention	**Tonsillectomy for recurrent tonsillitis in adults and children**
OPCS codes	F34 Excision of tonsil F341 Bilateral dissection tonsillectomy F342 Bilateral guillotine tonsillectomy F343 Bilateral laser tonsillectomy F344 Bilateral excision of tonsil NEC F345 Excision of remnant of tonsil F346 Excision of lingual tonsil F347 Bilateral coblation tonsillectomy F348 Other specified excision of tonsil F349 Unspecified excision of tonsil
For the treatment of:	**Recurrent tonsillitis**
Commissioning position	**Humber Coast and Vale CCGs routinely commission treatment for Red Flag conditions - urgent referral or admission is required for[1, 2]** • Peritonsillar abscess (quinsy) • Adult obstructive sleep apnoea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful). • Severe neck infection • Excluding possible malignancy eg lymphoma • Witnessed episodes in children of apnoea exceeding 10 seconds OR choking episodes during sleep • Patients with sore throat who have stridor, progressive dysphagia, bleeding, increasing pain or severe systemic symptoms (may require hospital admission) • Tonsil bleeding **Referral criteria for possible tonsillectomy** Tonsillectomy will only be commissioned in accordance with the criteria specified below for recurrent acute sore throat in adults and children in the following circumstances: Consider referral if SIGN criteria are met[4] • 7 or more clinically significant, adequately treated sore throats in the preceding 12 months confirmed by a GP **OR** • 5 or more episodes in each of the preceding two years, treated with antibiotics confirmed by a GP **OR** • 3 or more episodes in each of the preceding three years confirmed by a GP **AND** • There has been significant severe impact on quality of life and normal functioning, as indicated by documented objective evidence (e.g. absence from school, failure to thrive) The impact of recurrent tonsillitis on a patient's quality of life must be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe symptoms. Other indications for tonsillectomy may include: • Marked tonsillar asymmetry, which there is clinical suspicion of sinister pathology

	• Adult obstructive sleep apnoea with tonsillar enlargement (if trials of CPAP or mandible advancement devices are unsuccessful) Humber Coast and Vale CCGs will also consider funding via IFR in **children (aged <16) with sleep disordered breathing** if **ANY ONE** of the following applies: • A positive sleep study • Significant impact on quality of life (daytime behaviour/sleepiness) Tonsillectomy for the treatment of halitosis associated with tonsillar debris is NOT routinely commissioned. Within secondary care, there should be: [3] • Confirmation of primary care assessment, fulfilment of SIGN criteria for tonsillectomy and impact on quality of life and ability to work/attend school. • Management options: tonsillectomy, or referral back to primary care for on-going monitoring. **Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request Panel.**
Summary of evidence / rationale	The literature on surgery for recurrent tonsillitis is limited. Most published studies refer to a paediatric population. The quality of the evidence for tonsillectomy in children is poor, but it suggests that surgery may be beneficial in selected cases. The small amount of information about adult sore throat and the effect of tonsillectomy is not scientifically robust but suggests that surgery can be beneficial for recurrent sore throats. The benefits of surgery compared to non-surgical treatment was the subject of a Cochrane Collaboration review (since updated) which provided additional evidence for the SIGN guidance[4, 5]. The consensus is that these criteria help to identify patients most likely to gain benefit from surgical intervention but the evidence level is low at 3/4 and clinical judgement is needed to identify patients where exceptionality applies. The Cochrane review found no randomised trials in adults and found that the evidence in children was limited by the lack of studies. Two randomised trials were found, but it was not possible to draw conclusions because many of the children also underwent adenoidectomy [Burton and Glasziou, 2009]. The authors of the Scottish Intercollegiate Guidelines Network (SIGN) guidance commented on[5]: 1. Four randomised clinical trials. One trial (which was included in the Cochrane review) found that there was no significant difference between the group that had a tonsillectomy and the group who did not. The other three studies had all taken place before 1972 and no conclusions could be drawn because of methodological flaws. 2. Three additional non-controlled studies. These suggested benefit of tonsillectomy for both reducing the number of sore throats, and improving general health. The evidence on referral criteria for sore throats is based on evidence from a paediatric population. At the time that the referral criteria were written there were no randomised controlled trials concerning the management of recurrent

	sore throats in adults[3]. A randomised trial in adults (people over 15 years of age) compared tonsillectomy (n = 36) with watchful waiting (n = 34) [Alho et al, 2007]: Criteria for entry to the trial were three or more episodes of pharyngitis in 6 months, or four or more episodes in 12 months. The primary end point was the proportion of people with an acute episode of group A streptococcal pharyngitis during the 90 days' follow up, as determined by signs and symptoms of acute pharyngitis and a positive result of throat culture. At 90 days streptococcal pharyngitis had recurred in 24% (8/34) of the control group and in 3% (1/36) of the tonsillectomy group (difference 21%, 95% CI 6 to 36). The number of people needing to undergo tonsillectomy to prevent one recurrence of streptococcal pharyngitis during the few months after tonsillectomy was five (NNT = 5). The authors concluded that tonsillectomy is an effective alternative for adults with a documented history of recurrent episodes of pharyngitis.
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References:

1. Baugh, R.F., Archer, S.M., Mitchell, R.B. et al. (2011) Clinical practice guideline: tonsillectomy in children. Otolaryngology - Head and Neck Surgery 144(1 Suppl), S1-S30. [Abstract]
2. NICE (2005) Referral for suspected cancer (NICE guideline) Clinical guideline 27. National Institute for Health and Clinical Excellence.www.nice.org.uk [Free Full-text]
3. Royal College of Surgeons Commissioning guide: Tonsillectomy Sept 2013
4. Cochrane Review of Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis (Cochrane Review) Nov 2014
5. Scottish Intercollegiate Guideline Network (SIGN) guideline: Management of sore throat and indications for tonsillectomy, a national clinical guideline [SIGN, 2010 report number 117] and the Centor clinical prediction score [Centor et al, 1981; Aalbers et al, 2011; ESCMID Sore Throat Guideline Group et al, 2012].
6. NICE CKS Management of acute sore throat and evidence base for tonsillectomy July 2015 NHS England Tonsillectomy Policy 2013
7. Royal College of Surgeons. National prospective tonsillectomy audit: final report of an audit carried out in England and Northern Ireland between July 2003 and September 2004. London: Royal College of Surgeons of England; 2005.
8. Burton MJ, Glasziou PP, Burton MJ, Glasziou PP. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. [Review] [20 refs][Update of Cochrane Database Syst Rev. 2000;(2):CD001802; PMID: 10796824]. Cochrane Database of Systematic Reviews 2009;(1):CD001802.