Myringotomy/grommets and adjuvant adenoidectomy for the management of otitis media in children under 12 years

NHS Devon

Commissioning policy

Myringotomy/grommets

Myringotomy/grommets for the management of otitis media in children under 12 years will only be funded if the following criteria are met:

Otitis media with effusion (OME)

Persistent OME with documented hearing loss on 2 occasions assessed at intervals of 3 months or more* AND the child suffers from:

- Persistent bilateral OME with a hearing level in the better ear >20 dBHL (averaged at 0.5, 1, 2, and 4 kHz), confirmed over three months†.
- Persistent unilateral OME with a hearing level in the better ear >20 dBHL (averaged at 0.5, 1, 2, and 4 kHz), confirmed over three months ***AND*** the impact of the hearing loss on a child's developmental, social, or educational status is judged to be significant†.

OR

Children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent OME and the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant†.

*During the watchful waiting period, advice on educational and behavioural strategies to minimise the effects of hearing loss should be offered. The child's hearing should be re-tested at the end of this time.

†Good practice point: Ensure OME has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

Recurrent acute otitis media

5 or more documented episodes of acute otitis media in the same ear in the previous 12 months.

Adenoidectomy

Adenoidectomy should only be offered adjunctive to myringotomy/grommets when one or more of the following clinical criteria are met:

- The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement).
- The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion.
- The child is undergoing grommet surgery for treatment of recurrent acute otitis media.

Rationale for the decision

For persistent cases of **otitis media with effusion (OME)**, evidence shows that grommet insertion is more effective than no treatment at improving hearing levels. In addition, grommet insertion is more cost-effective than no treatment (at a willingness to pay threshold of £30,000 per QALY gain). NICE guideline NG233 recommends grommet insertion as a treatment option for persistent bilateral OME with a 3-month period of hearing loss (using the World Health Organisation definition of a hearing level >20 dBHL averaged at 0.5, 1, 2, and 4 kHz). NG233 also recommends treatment for persistent unilateral OME where the hearing impairment impacts on daily living or communication. Whilst there is no evidence for efficacy specifically for patients with unilateral OME, studies of children with both bilateral and unilateral OME indicate a benefit to hearing levels for the overall population (compared to no treatment).

NG233 also recommends adjuvant adenoidectomy for patients undergoing grommet insertion. Widespread provision of adjuvant adenoidectomy is associated with increased costs and an impact to surgical capacity through prolonged procedure times. Whilst grommet insertion with adjuvant adenoidectomy is more cost-effective than no treatment (at a willingness to pay threshold of £30,000 per QALY gain), minimal differences in ICERs compared to grommet insertion alone mean it is not possible to determine whether, compared to no treatment, grommet insertion with adenoidectomy or grommet insertion alone is more likely to be cost-effective. Whilst one study reports lower repeat surgery rates following adjuvant adenoidectomy (versus grommet insertion alone), savings from reductions in repeat surgery would be insufficient to outweigh the increase in costs associated with the wider use of adenoidectomy; a budget impact analysis estimates an increase in overall expenditure of approximately £110,000 per annum. NICE states that evidence for adjuvant adenoidectomy is very limited, inconsistent, and very low quality. NHS

Devon ICB considers that the balance of uncertainties (with the definite impact on surgical capacity and overall costs that offering routine adenoidectomy to all patients undergoing grommet insertion entails) favours only offering adjuvant adenoidectomy under the limited circumstances outlined in the NHS Devon commissioning policy.

Acute otitis media (AOM) is defined as the presence of inflammation in the middle ear, associated with an effusion and accompanied by the rapid onset of symptoms and signs of an ear infection. AOM may be caused by viruses or bacteria; commonly both are present at the same time. About 20–30% of children will experience recurrence of AOM; the frequency of recurrence reduces as a child gets older. Most people with AOM will not need antibiotic treatment as symptoms usually resolve spontaneously within a few days.

The policy for patients with recurrent AOM is in line with recommendations made in the NHS England Interim Clinical Commissioning Policy, Grommets (children and adults). A Cochrane review concluded that grommets have a significant role in maintaining a 'disease-free' state in the first six months after insertion. Further research is required to investigate the effect beyond six months. Clinicians should consider the possible adverse effects of grommet insertion before surgery is undertaken.

Guidance notes on exceptionality

Where the circumstances of treatment for an individual patient do not meet the criteria described above exceptional funding can be sought. Individual cases will be reviewed by the appropriate panel of the ICB upon receipt of a completed application from the patient's GP, consultant or clinician. Applications cannot be considered from patients personally.

Date of publication:	Version:
14.11.2024	Policy agreed by NHS Devon ICB