Tonsillectomy

NHS Devon

Commissioning policy

Tonsillectomy will only be routinely commissioned in adults and children in Devon in the following circumstances:

- Recurrent (two or more) episodes of peritonsillar abscess (quinsy)
- Tonsillar enlargement causing or contributing to acute upper airways obstruction
- Recurrent acute sore throat due to tonsillitis with the following criteria:

  Documented evidence of:

  - 7 or more episodes of tonsillitis in the last year; **OR**
  - 5 or more such episodes per year in the preceding two years; **OR**
  - 3 or more such episodes per year in the preceding three years;

  AND

  - There has been significant impact on quality of life indicated by documented evidence of symptoms that act as a barrier to employment or education or carrying out carer activities; **OR**
  - Failure to thrive

In line with NHS England guidance (2018), after appropriate specialist assessment tonsillectomy may be considered at a lower threshold than the above for the following indications:

- Acute and chronic renal disease resulting from acute bacterial tonsillitis (assessment to include renal specialist)
- As part of treatment of severe guttate psoriasis (assessment to include dermatology specialist)
- Metabolic disorders where periods of reduced oral intake could be dangerous to health (assessment to include paediatrician or endocrinologist)
- PFAPA (periodic fever, aphthous stomatitis, pharyngitis, cervical adenitis) (assessment to include paediatrician)

- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous (assessment to include paediatrician, or haematology or immunology specialist)

Tonsillectomy/adenotonsillectomy will be funded in children under 16 where obstruction of the airway results in obstructive sleep apnoea syndrome, and the following apply:

- A significant impact on development, behaviour and/or quality of life demonstrated by supporting evidence such as growth charts, letters from GPs; **OR**
- A strong clinical history (± sleep studies) suggestive of sleep apnoea

Tonsillectomy is not routinely commissioned solely for the management of snoring.

Tonsillectomy is not routinely commissioned for the treatment of tonsilloliths (tonsil stones).

Head and Neck cancer services are commissioned by NHS England as part of specialist cancer services; treatment of malignancy is therefore out of scope of this policy.

Rationale for the decision

The frequency of sore throat episodes and upper respiratory infections reduces with time whether or not tonsillectomy has been performed.

Moderate quality evidence shows that tonsillectomy gives an additional, but small, reduction of sore throat episodes, days of sore throat associated school absence, and upper respiratory infections compared to watchful waiting. This benefit needs to be weighed against the risk surgical complications.

The Royal College of Surgeons (RCS) commissioning guide for tonsillectomy (2013) indicates that tonsillectomy should be considered when SIGN criteria are met (i.e. 7 or more clinically 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).

Peritonsillar abscess (quinsy) is a rare and potentially serious complication of tonsillitis; in recurrent cases, tonsillectomy may be indicated to prevent further episodes.

Moderate quality evidence shows that in otherwise healthy children with mild to moderate obstructive sleep apnoea syndrome, adenotonsillectomy provides benefit in terms of quality of life, symptoms and behaviour as reported by caregiver.

This policy has been reached after considering guidance for tonsillectomy for recurrent tonsillitis published by NHS England in November 2018 and recognises those conditions that they consider to have a lower threshold for tonsillectomy.

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.

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