Southern Adelaide Local Health Network Clinical protocol

Tonsillectomy elective paediatric

Division: SAPOM **Clinical Unit: ENT** **MR:334**

Outpatients

Indications for elective tonsillectomy are:

- Clinical suspicion of underlying tonsil malignancy (e.g. unilateral enlargement, ulceration, accompanying 'B' symptoms)
- Obstructive Sleep Apnoea (OSA) or sleep disordered breathing
- Recurrent tonsillitis
  - Sore throats due to acute tonsillitis
  - Disabling episodes preventing normal functioning
  - ≥ 7 episodes per year in the preceding year
  - ≥ 5 episodes per year in the preceding two years
  - ≥ 3 episodes per year in the preceding three years
- Refer children under the age of 2 years or under 12 kg to the Women's and Children's Hospital
- Children with the following risk factors should also be referred for tertiary level care at WCH
  - Failure to thrive (weight <5th centile for age)
  - Obesity: BMI (Body Mass Index) >99th centile for age and gender
  - Severe cerebral palsy
  - Hypotonia or neuromuscular disorders
  - Significant craniofacial anomalies
  - Mucopolysaccharidosis and syndromes associated with difficult airway
  - Significant co-morbidity (e.g. congenital heart disease, chronic lung disease. ASA 3 or above)
  - ECG or echocardiographic abnormalities
  - Severe Obstructive Sleep Apnoea (described by polysomnographic indices including Obstructive Index >10, respiratory Disturbance Index >40, and Oxygen saturation nadir <80%)
- Book children between the ages of 2 and 3 years old on a named consultant waiting list rather than the pooled list.
- Book children over the age of 3 years onto the pooled waiting list for their surgery.
- Obtain consent when booking for surgery

Preadmission Clinic

Routine PAC

- Anaesthetic, nursing and surgical assessment. Surgical admission.
- Check that consent was obtained in Outpatients. If not done – contact RMO or Reg to obtain
- No routine blood tests are required unless the patient has a previous or family history of bleeding diathesis or coagulopathy
- Order regular post operative analgesia (children up to 12 years - paracetamol 15 mg/kg every 4-6 hours and nurofen 5-10 mg/kg 3 or 4 times a day with no more than 4 doses in 24 hours) is preferred as codeine is now contraindicated in children[3] – if in doubt, consult anaesthetist)
- Ensure that the patient has stopped taking any medications that may cause excess bleeding, for example, aspirin, warfarin, anti-inflammatories, fish and omega 3 oils. Refer to Preadmission perioperative medication guidelines for more details.

Pre op day 0 (Day of surgery)

- Review nursing assessments from PAC
- Check consent
- Ensure patient is not taking any anti-coagulant or any other blood thinning medications
- Baseline physiological observations – (refer to pre-operative care procedure CC1.163)
- Fast for minimum of 6hrs pre op
- Can mobilise as tolerated
- Commence pre-op checklist

PRINT WARNING: – Content is continually being revised. ALWAYS refer to the electronic copy for the latest version. Users must ensure that any printed copies of this document used for an individual patients' medical record are of the latest version.

This protocol has been developed for SALHN practice setting only. It is intended to guide practice and does not replace clinical judgement. Modification will occur according to internal audit processes and literature review. First issued September 2010

Intra op

- Routine antibiotics are not required on induction
- Give IV dexamethasone stat dose 0.5mg/kg, maximum of 8mg dose peri-operatively (reduces the rate of post-op nausea and vomiting)
- Cold steel and ties method is recommended for surgical trainees unless under direct supervision or by individual agreement with the Head of ENT Department
- Bipolar diathermy is recommended for electrocautery haemostasis due to lower secondary haemorrhage rate
- Coblation tonsillectomy may be performed by consultants or juniors with the necessary training and mentor sign-off. Direct supervision is required for other surgeons. Saline should be chilled.

Post-op day 0 (day of surgery)

- Children between the ages of 2 and 4 years of age shall receive close monitoring with a minimum of 1:4 nurse to patient ratio on the paediatric ward with continuous overnight pulse oximetry (includes pulse rate). Contact the ENT on-call RMO if the pulse oximetry falls below 92%. IV access to be protected and replaced for the first 6 hours post op. Post op observations (respiratory and pulse rates) recorded half hourly overnight, Record any significant events noted outside the regular recording times which trigger alarms. Document who was notified and any action(s) taken. Temp to be checked 4 hrly throughout patient stay unless a problem develops that requires an increased frequency
- For children over 4 years, routine post op observations (resps, pulse and $Sa0_2$) half hourly for two hours, then hourly overnight (if stable) until reviewed on day 1, then 4 hourly (if stable). Temp to be checked 4 hrly throughout patient stay unless a problem develops that requires an increased frequency.
- BP not needed routinely unless there is a clinical indication
- Call ENT RMO if pulse or resps exceed pre-set parameters for age and/or exhibit a concerning trend – on the RDR chart
- Observe patients for bleeding (from the nose or mouth) and excessive swallowing. If bleeding occurs, contact ENT RMO urgently. A paediatric MET call might be required if bleeding is excessive.
- Normal diet can commence as tolerated and should be encouraged as soon as possible post-operatively
- Patient can mobilise as tolerated
- Explain procedure to child and parents once recovered from anaesthesia
- Provide oral analgesia regularly (again note warning on use of codeine in children[3]), 4 hourly Paracetamol and 6 hourly Nurofen. (See page 1 for dosages) Consider Oxycodone (0.1mg/kg up to a maximum of 5mgs) for breakthrough pain if severe.

Prepare for discharge on Day 0 for children over 4 years if:

- The operation was in the morning and the child is well 6 hours post-op
- Patient lives within 15kms of FMC
- Patient has a telephone and access to a car at home

Discharge ready when

- Observations stable, no excessive bleeding, no nausea or vomiting and adequate pain control with oral analgesia
- Medical staff have reviewed
- Tolerating free fluids and eating

Discharge preparation

- Complete nursing discharge checklist
- Ensure patient has adequate analgesia prescribed (paracetamol)
- Routine follow up is not usually required unless:
  - The patient is having a tonsillectomy for histology – 2/52 appointment with results
  - The operation is for OSA – 6/52 appt for review
- Provide patient/parent with tonsillectomy discharge information sheet and explain content. Ensure the patient/parent knows what action to take if problems arise. Explain that scabs on the tonsils are expected

References

1. Management of Sore Throat and Indications for Tonsillectomy: A National Clinical Guideline. Scottish Intercollegiate Guidelines Network. April 2010
2. Tonsillectomy and adenoidectomy in children with sleep related breathing disorders: consensus statement of a UK multidisciplinary working party. 2009 Blackwell Publishing Ltd • Clinical Otolaryngology 34, 61–63
3. US Food and Drug Administration Drug Safety Communication: Safety review update of codeine use in children; new Boxed Warning and Contraindication on use after tonsillectomy and/or adenoidectomy, February 2013

PRINT WARNING: – Content is continually being revised. ALWAYS refer to the electronic copy for the latest version. Users must ensure that any printed copies of this document used for an individual patients' medical record are of the latest version.
This protocol has been developed for SALHN practice setting only. It is intended to guide practice and does not replace clinical judgement. Modification will occur according to internal audit processes and literature review. First issued September 2010

Government of South Australia | Health Southern Adelaide Local Health Network

PROTOCOL:

Title:	Tonsillectomy Elective - Paediatric			
Approval date:	09/03/2017			
Next review due:	09/03/2022			
Sponsor:	Head of ENT Unit			
Author:	Head of ENT Unit			
Division of Sponsor:	Surgery & Perioperative Medicine			
Overseeing Committee:	ENT unit meeting			
Approved at Committee:	SALHN Policy Procedure Guideline Protocol Committee			
Risk level:	☐ Extreme	☐ High	☐ Moderate	X Low
Evaluation scheduled:	X On Audit Program	☐ Not scheduled for audit		
Title and ID of Parent SA Health Policy:	N/A			
Summary:	Management of paediatric patients requiring tonsillectomy			
Key words:	Tonsillectomy, tonsils,			
Supersedes:	Tonsillectomy Elective – Paediatric CC1.916 Version 5.0			
Scope:	SALHN			

National Safety and Quality Health Service Standards

Clinical Governance	Partnering with Consumers	Preventing & Controlling Infections	Medication Safety	Comprehensive Care	Communicating for Safety	Blood Management	Recognising & Responding to Acute Deterioration
X	X	X	X	X	X		X

Version control and change history:

Version	Date from:	Date to:	Amendment
1.0	Sept 2010	Sept 2012	
2.0	Sept 2012	Oct 2013	Reviewed and updated
3.0	Oct 2013	Sept 2015	Restriction on codeine use added
4.0	14/04/2016	09/03/2017	Reviewed and updated
5.0	09/03/2017	09/03/2020	Lower weight limit for patients requiring surgery at WCH Removed requirement to credential anaesthetists for paediatric surgery. Added regular analgesia of paracetamol and nurofen, with oxycodone for breakthrough pain. Changed dexamethasone dose to 0.5mgs per kgs to a maximum of 8mgs
5.1	11/05/2023	09/03/2022	Review date realignment

Intranet lodgement date:	May 2023
Identifier:	CC1.916

PRINT WARNING: – Content is continually being revised. ALWAYS refer to the electronic copy for the latest version. Users must ensure that any printed copies of this document used for an official record is the latest version.