T13 Tonsillectomy

Instructions for use:

To GPs: Please refer to the above policy and complete the following form prior to referral and provide evidence to support the criteria.

To Consultants: Please complete the box below and ensure there is evidence that the criteria are met.

A six month period of watchful waiting is recommended prior to referral for tonsillectomy to establish the pattern of symptoms and to allow the patient time to fully consider the implications of the operation.

The CCG will only fund a tonsillectomy when the following criteria have been met:

(please tick).

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG’s Individual funding request policy for further information.

NB For possible malignant disease in the tonsils – typically squamous cell carcinoma or lymphoma1 - refer under 2-week wait

Recurrent attacks of tonsillitis as defined below in a), b), c) and symptoms have been occurring for at least a year AND

Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning AND

The clinician has discussed the advantages and disadvantages of tonsillectomy including the natural history of resolution with the parent/ patient

a) 7 or more well documented, clinically significant*, adequately treated episodes in the preceding year OR

b) 5 or more such episodes in each of the preceding 2 years OR

c) 3 or more such episodes in each of the preceding 3 years

* A clinically significant episode is characterised by at least one of the following:

1. Oral temperature of at least 38.30C requiring antibiotic treatment

2. Tender anterior cervical lymph nodes.

3. Tonsillar exudates.

4. Positive cultures of group A beta haemolytic streptococci.

OR ANY of the following

Obstructive sleep apnoea in children due to excessively enlarged tonsils and adenoids which is demonstrated by home pulse oximetry**

**Pulse oximetry monitoring is to be carried out at home and the results are then reviewed by a nurse specialist prior to onwards referral.

OR

Clinical diagnosis of obstructive sleep apnoea in children due to excessively enlarged tonsils and adenoids with documented evidence of:

No weight gain or weight loss over the past 6 months

AND
Persistent irritability **OR** evidence that the child’s school performance has suffered due to enlarged tonsils.

**OR**

Obstructive sleep apnoea in adults which has been diagnosed by sleep study/overnight polysomnography, in the presence of large tonsils **OR**

**OR**

The child has guttate psoriasis which is exacerbated by recurrent tonsillitis **OR**

2 or more episodes of documented Quinsy (peritonsillar abscess) **OR**

Patient with very large tonsils (hypertrophy) who develops dysphagia and or dehydration, as a result of this **OR**

Grade IV tonsils **AND** in the opinion of the ENT consultant is posing risk to airway for those patients without OSA **AND**

Who have documented evidence of disrupted sleep (waking >3 times per night) and persistent irritability

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG’s Individual funding request policy for further information.

If the above criteria are not met, does the patient meet the following exceptions (please tick).

<table>
<thead>
<tr>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider if urgent hospital admission is required for patients with sore throat who have any of the following symptoms; stridor present, progressive difficulty swallowing, increasing pain or severe systemic symptoms if clinically indicated.</td>
</tr>
</tbody>
</table>

**Consultant use only**

- Please complete the following and file for future compliance audit.
- Referral criteria is met and the patient will benefit from the proposed treatment: yes / no
- Signature: ...........................................
- Consultant name: ..............................
- Hospital: ..................Date...........

**GP use only**

- Practice stamp/address

**Referring clinician: ............................
- Date: .............................................

**Commissioner’s use only**

- Criteria met as per policy: yes / no
- Compliance with notes: yes / no
- Audit date: ..........................................
- Audited by: ........................................... Please print

(GP/Cons)