Thames Valley and Wessex
SURGERY IN CHILDREN
Operational Delivery Network

Best Practice Recommendation

Adenotonsillectomy Pathway for Obstructive Sleep Apnoea

SETTING

Thames Valley & Wessex Surgery in Children Operational Delivery Network (TV&W SIC ODN)

FOR STAFF

Staff involved in the pathways for children (under 18 years) undergoing adenotonsillectomy procedures for conditions including Obstructive Sleep Apnoea

PATIENTS

Children who are being considered for adenotonsillectomy procedures in organisations across the TV&W SIC ODN region

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Guidance

Summary

It is recommended nationally that 80% of tonsillectomies in children are performed as day case procedures[1,2]. The following recommendations are designed to support centres across Thames Valley & Wessex (TV&W) in optimising their day case pathways to achieve this. See *Appendix A*. This document is intended to provide a reference for what is considered best practice across our region and should be viewed alongside any locally agreed Standard Operating Procedures (SOPs) which should be followed by local clinical teams.

Patient Selection

- All Trusts must have an approved day case pathway/Standard Operating Procedure (SOP) for children undergoing adenotonsillectomy which meets existing published standards [2,3,14].
- Children should undergo a preassessment process where suitability for day case inclusion is considered, and parents are provided with accessible information on pre-operative, peri-operative and postoperative care including written / online information [14].

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- All children between 2 years 0 months old and 3 years 0 months, 12-15kg, not less than the 0.4th or above the 99.6th centile and without significant comorbidity should have their surgery in a hospital with level 1 Paediatric Critical Care (PCC) facilities as per the national guidance [3].

- Children under 2 years and 0 months and less than 12kg should have their surgery in a hospital with PCC Level 2 facilities or higher as per the national guidance [3].

- Children with severe cerebral palsy, achondroplasia, moderate to severe neuromuscular disorders, significant craniofacial anomalies, mucopolysaccharidosis or significant comorbidity (e.g. complex/uncorrected congenital cardiac disease, severe cystic fibrosis, home oxygen use) or those that require onsite tertiary services e.g. metabolic disorder should be operated on at a PCC Level 3 centre as per the national guidance [3].

- For all units, in the absence of relevant comorbidities or negative care-giver factors, children over the age of 3yrs and 14kg should be considered for a day case pathway. Tertiary centres, and DGHs with paediatric inpatient cover and HDU can consider this from the age of 2yrs and 12kg [15].

- Ensuring an adequate home environment for recovery from the operation is required and an appropriate plan for all families should they need to re-attend hospital with their child in an emergency. This should be discussed at the preoperative assessment [15].

- Children, who live greater than 45 minutes from an emergency department, may require to be admitted post-operatively, but geographical restrictions should not necessarily prevent children from being treated as a day case [4,14]. For those living >45mins from their nearest hospitals, specific management plans should be discussed with the ICB regarding location in the postoperative period [15].

- For children at extremes of weight (including >98th centile for BMI/Weight) consideration should be given to an overnight period of postoperative monitoring [15].

- Pre-operative oximetry is not required for patient selection between non-tertiary centres (15). Those with complex comorbidities will be decided on individually by the tertiary centre. Oximetry does not determine suitability for day case management [15].

Day of Surgery

- Coblation intracapsular adenotonsillectomy is recommended due to the significant reduction in post-operative bleeding, pain duration, and readmission [5,6,7,8] though for histological analysis, infective or revision cases extracapsular dissection may be considered. A post-

operative stay of a minimum of 3 hours is recommended for children post-procedure (starting from when the child leaves theatre) [9].

- The TV&W Surgery in Children ODN will support those trusts without coblation services currently with business case application and surgical training in this new technique. Each centre should audit their own results with this technique within their governance structures.

- It is estimated that that 0.52% of children will have respiratory complications postoperatively [10]. Every trust therefore needs a mechanism to admit day case patients overnight that have an oxygen requirement beyond the recovery area, desaturations requiring stimulation post-operatively or a nursing or doctor concern. These admissions should not be seen as a failure of the day case service.

- Persistent vomiting, inadequate pain relief, not tolerating solid food or failure to meet other routine trust level post-operative criteria may also need admission overnight.

Discharge

- Children should be observed for a minimum of 3 hours after their procedure prior to discharge (starting from the time the child leaves theatre) with continuous saturation monitoring [8, 15]. This may be extended to a period of 4-6hrs if temporary concerns regarding bleeding, pain, oral intake or oxygen requirement arise [15]. After this, overnight admission should be considered. A senior clinical decision maker should be involved in individual decisions regarding extension of monitoring or conversion to overnight stay.

- Appropriate, weight-based analgesia should be administered during and after the operative period and in recovery to ensure appropriate timely discharge is achieved. This should be weight-based dosing as per BNFC for post-operative pain management guidance [11,12,13].

- Appropriate weight-based analgesia and instructions should be given to the parents at discharge [15]. This must highlight the importance of giving regular paracetamol and ibuprofen [12]. Postoperative leaflets can be especially useful for this [15]. *See Appendix B*

Audit & Service Review

As part of the TV&W SIC ODN, centres should participate in audits of their adenotonsillectomy in children pathway against these recommendations to identify opportunities to improve safety, quality, and performance. Shared education and MDT team training to maintain competence, confidence and safety whilst providing a paediatric day case adenotonsillectomy service are key.

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Authorising Body	This document was shared with members of the TVW Paediatric ENT Clinical Forum for comment and approved at the TVW SiC Board on 9th June 2026. For further information regarding this group, please contact the TVW SIC ODN core team on the details below.
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Appendix A: Surgical destination by patient factors

Paediatric Coblation Intracapsular* Adenotonsillectomy for OSA

Surgical Destination by Patient Factors

- ✓ Age ≥ 3yrs
- ✓ Weight >14kg
- ✓ Weight > 0.4th centile
- ✓ Weight < 99.6th centile
- ✓ Otherwise well

→ **Secondary Care WITHOUT Paediatric HDU (Level 1)**

- ✓ Age 2 yrs to 3 yrs 0 months
- ✓ Weight 12-15kg
- ✓ Weight > 0.4th centile
- ✓ Weight < 99.6th centile
- ✓ Otherwise well

→ **Minimum Secondary Care WITH Paediatric HDU (Level 1)**

- ✓ Age < 2yrs
- ✓ Weight < 12kg
- ✓ Any BMI
- ✓ No high-risk factors (as below)

→ **Minimum Secondary Care WITH Paediatric HDU available (Level 2)**

- ✓ Severe cerebral palsy
- ✓ Achondroplasia
- ✓ Neuromuscular disorder (mod/severely affected)
- ✓ Significant craniofacial anomalies
- ✓ Mucopolysaccharidosis
- ✓ Significant comorbidity (e.g. complex/uncorrected congenital cardiac disease, severe cystic fibrosis home oxygen use)
- ✓ Onsite support from tertiary services is required e.g. metabolic disorder

→ **Tertiary Care Paediatric ICU available (level 3)**

*Coblation intracapsular adenotonsillectomy has significantly lower bleeding and readmission rates. Post-operative pain is reduced and recovery tends to be quicker

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Appendix B: Suitability for Obstructive Sleep Apnoea Day Case Pathway following Adenotonsillectomy

