General Commissioning Policy

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Adenoidectomy</th>
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<td>For the treatment of</td>
<td>Otitis Media with Effusion and Sleep Apnoea</td>
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</tbody>
</table>

**Background**

NHS Scarborough and Ryedale CCG commissions' healthcare on behalf of its local population across primary, secondary and tertiary care sectors. Commissioning policy including clinical referral pathways and thresholds have been developed and defined using appropriate NICE guidance and other peer reviewed evidence and are summarised here in order to guide and inform referrers.

This policy defines the SCRCCG commissioning position for adenoidectomy for the management of otitis media with effusion (OME) and/or sleep apnoea.

**Commissioning position**

Adenoidectomy combined with grommets may be considered in children who fulfil the criteria for grommets as follows:

The CCG will only agree to fund treatment with grommets for children under 12 years old with bilateral otitis media with effusion (OME) under the following circumstances:

There has been a period of 3 months watchful waiting from the date of the first appointment with an audiologist AND OME persists after 3 months and the child suffers from at least one of the following:

- At least 5 recurrences of acute otitis media in a year
- Evidenced delay in speech development
- Hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1, 2, & 4 KHZ (or equivalent dBH where dBHL not available)
- Hearing loss of less than 25-30 dBHL where the impact on a child’s development, social or educational status is judged to be significant*
- A second disability such as Down’s syndrome or cleft palate

**OR**

OME is overlaying sensorineural deafness or is delaying diagnosis or treatment with aids or cochlear implants (this would be an indication for immediate grommets).

*Evidence from GP or Community Healthcare professional that symptoms prevent the child from carrying out vital educational activities or symptoms prevent the child from carrying out other vital activities.
### Requirements for approval

Two sets of hearing results through audiologist assessment three months apart. Documented evidence of the impact of hearing loss on the child’s development as defined above.

**All other reasons for grommets in children are not funded.**

Other indications for adenoidectomy in conjunction with tonsillectomy that can be considered include:

**Sleep apnoea**

All referrals for Sleep Apnoea must comply with NICE TAG 139 and have completed an Epworth Sleep Score (see separate threshold)

A literature review by Ryan\(^6\) in 2005 was published in Thorax. This found that, in children, including those that are obese, “adenotonsillectomy was curative for 75-100%”. However, a Cochrane review\(^7\) (2006) noted that there is no randomised trial data relating to adenotonsillectomy for obstructive sleep apnoea in children and more research is needed.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

### Effective from

October 2015

### Summary of evidence / rationale

Clinical Evidence, last updated in November 2005\(^8\), states that: ventilation tubes (grommets) and adenoidectomy represents a trade-off between benefits and harms:

- Adenoidectomy on its own is of unknown effectiveness.
- In a Cochrane review of grommets\(^9\), the reviewers note some improvement in outcomes that look at adenoidectomy and grommet insertion compared to grommet insertion alone.
- In 2005, in a randomised control trial (n=193) comparing watchful waiting with adenotonsillectomy for otitis media, Oomen et al\(^10\) found no significant difference in the occurrence of otitis media between the Adenotonsillectomy group and the watchful waiting group.

### Information to include in the Referral letter

The GP referral letter should contain:

- Details of how the patient meets the above criteria OR demonstrates clinical exceptionality
- Impact on activities of daily living
- Treatments and interventions tried including the results
- Drug history (prescribed and non-prescribed)
- Relevant past medical/surgical history
- Current regular medication
- BMI
References:

4. Paradise, J.L (2001). Effect of early or delayed insertion of tympanostomy tubes for persistent otitis media on developmental outcomes at the age of three years. NEJM (344);16;1179-1187.
5. Paradise, J.L (2005). Developmental Outcomes after Early or Delayed Insertion of Tympanostomy Tubes. NEJM (353);6;576-587.