1 Background information

Quick info:
Scope:
• assessment, diagnosis, and primary care management of acute tonsillitis in:
  • children greater than age 4 years
  • adults
• management of recurrent tonsillitis
• includes peritonsillar abscess (also known as quinsy) and laryngeal oedema
• covers pharmacological and non-pharmacological treatment
Out of scope:
• tonsillectomy in children younger than age 4 years
Definition:
• tonsillitis is an acute infection and inflammation of the palatine tonsils [4]
• acute tonsillitis, pharyngitis, laryngitis, or acute exudative tonsillitis may all cause sore throat and therefore, for the purpose of non-surgical management, these are considered together under the term ‘sore throat’ [1,5]
• average total illness length of acute sore throat/acute pharyngitis/acute tonsillitis is 5-14 days [4]
Aetiology:
• can be caused by either bacterial or viral infection – most common bacterial cause is group A beta-haemolytic streptococcus (GABHS) also known as *Streptococcus pyogenes* (*S. pyogenes*) [1]
• other common infectious causes include [1]:
  • rhinovirus
  • coronavirus
  • parainfluenza virus
  • influenza types A and B
  • adenovirus
  • herpes simplex virus type 1
  • Epstein-Barr virus
• rare infectious causes include [1]:
  • *Haemophilus influenza* (*H. influenza*)
  • coxsackie A virus – herpangina
  • HIV-1
  • *Neisseria gonorrhoeae* (*N. gonorrhoeae*)
  • *Corynebacterium diphtheria* (*C. diphtheria*)
  • *Corynebacterium ulcerans* (*C. ulcerans*)
  • *Arcanobacterium haemolyticum* (*A. haemolyticum*)
  • *Yersinia enterocolitica* (*Y. enterocolitica*)
  • *Francisella tularensis* (*F. tularensis*)
  • *Chlamydia pneumonia* (*C. pneumonia*)
  • *Mycoplasma pneumonia* (*M. pneumonia*)
  • candida
  • *Neisseria meningitidis* (*N. meningitidis*)
• non-infectious causes include:
  • gastro-oesophageal reflux [7]
  • physical irritation, eg from a nasogastric tube, chronic irritation from cigarette smoke [7]
  • hayfever – rarely [1]
  • Stevens-Johnson syndrome [1]
  • Kawasaki disease [1]
• oral mucositis secondary to radiotherapy or chemotherapy, which may become secondarily infected [1]
• haematological disorders, such as leukaemia, aplastic anaemia [1]
• some medications that can cause blood disorder, which predispose the individual to infections, eg cytotoxic drugs, carbimazole, and sulfasalazine [1]
• tonsillar cancer [7]

Incidence and prevalence:
• a GP with 2000 patients will see around 120 people with an acute throat infection every year [14]
• most people with sore throat do not visit their GP and only 1 in 18 episodes of sore throat are seen by GPs [5]
• GABHS causes 15-30% of sore throats in children and 10% in adults [1]
• streptococcal infection is:
  • most likely in patients age 5-15 years [5]
  • progressively less likely in younger or older patients [4]
  • attacks are common in children – frequency reduces with age [4]
  • attacks are less common in adults – however, may be as frequent and more severe than in children [4]
• acute throat infections most commonly occur in children aged 5-10 years and in young adults aged 15-25 years [1]

Risk factors:
• viral upper respiratory tract infections (URTI) are common in toddlers, babies with older siblings, and children
• children age 5-10 years [1]
• young adults age 15-25 years [1]

Prognosis:
• if caused by viral or bacterial infection, symptoms resolve within [1]:
  • 3 days in 40% of patients
  • 1 week in 85% of patients
• symptoms of infectious mononucleosis (glandular fever) usually resolve within 1-2 weeks although mild causes may resolve within days; lethargy may continue for months or years in rare cases
• other factors to note regarding prognosis include [5]:
  • underlying psychosocial influences in patients presenting with sore throat

References:
Please see the care map's Provenance.

2 Information resources for patients and carers

Quick info:
Recommended resources for patients and carers, produced by organisations certified by The Information Standard:
• Sore throat (URL) from NHS choices at http://www.nhs.uk/conditions/
• ‘Tonsillitis’ (PDF) from Patient UK at http://www.patient.co.uk
For details on how these resources are identified, please see Map of Medicine's document on Information Resources for Patients and Carers (URL).

3 Updates to this pathway

Quick info:
Local pathway enhanced by wording from international map. Date of publication: 31-Jan-2015

4 Suspected tonsillitis - clinical presentation

Quick info:
The cause of sore throat may be viral, bacterial, or unknown [1]:

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• between 50-80% of infective sore throat is viral in cause [5]:
  • rhinovirus, coronavirus, and parainfluenza virus (the common cold) cause 25% of sore throats [7]
  • influenza types A and B cause 4% sore throats [7]
  • adenovirus responsible for 4% sore throat [7]
  • herpes simplex virus type 1, and more rarely 2, cause 2% sore throats [7]
  • an additional 1-10% are caused by Epstein-Barr virus (EBV) [5]
• group A beta-haemolytic streptococcus (GABHS) is the most common bacterial pathogen, causing 15-30% of infections in children and 10% in adults [1]

Tonsillitis:
• in children [4]:
  • attacks are common
  • frequency may reduce with age
  • can impact significantly on education as loss of time at school is usually 3-5 days per attack
• in adults [4]:
  • less common than in children
  • attacks can be as frequent and more severe than in children
  • can cause significant loss of work due to illness
  • a severe complication which occurs mainly in adults is peritonsillar abscess or quinsy:
    • often requires admission for treatment and pain control

Typical features of tonsillitis include:
• fever [4]
• headache [7]
• malaise [4]
• nausea and occasionally vomiting – especially in children [4,7]
• severe throat pain [4]
• white spots on the tonsils [4]
• enlarged lymph glands [4]:
  • commonly in the neck
  • may also occur in the abdomen
• nasal features suggest a viral aetiology such as the common cold [7]

See 'Consider differential diagnoses' care point for descriptions of other features associated with particular causes of sore throat.

References:
Please see the care map's Provenance.

5 History

Quick info:

Enquire about:
• frequency and duration of sore throats, eg five or more episodes of recurrent sore throat during 1 year – note whether the frequency of episodes is increasing or decreasing [5]:
  • patients with very frequent infection (greater than eight episodes per year) may need intervention within a year of the onset of symptoms [7]
• severity, does the episode prevent normal day-to-day functioning [5]
• is there difficulty swallowing [1]
• is there reluctance to take fluids [1]
• presence of fever during episodes – suggestive of infective cause [1]
• length of symptoms – pharyngeal complaints usually subside in 3-4 days [1]
• snoring, obstructive sleep apnoea – suggestive of enlarged adenoids or tonsils [4]
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- presence of other symptoms that may indicate a particular aetiology, e.g. hepatosplenomegaly, rash, etc [7]
- take into account other medical conditions and medication which may suggest an increased susceptibility to infection and lower the threshold for treatment [5]
- contact with cases of invasive group A streptococcal disease [3]

References:
Please see the care map's Provenance.

6 Examination

Quick info:
Occasionally, a sore throat may be a presenting symptom in acute epiglottitis:
- do not examine the throat if suspected, as this may cause complete airway obstruction [1]
- suggested by [1]:
  - respiratory distress
  - stridor
  - drooling
  - muffled voice
- systemically unwell children prefer to sit leaning forward, but adults may sit erect
- see 'RED FLAG! – admit to hospital' care point for further information

Examine for:
- signs of dehydration [7]
- inflamed tonsils or pharynx [1]
- enlarged erythematous tonsils – with or without exudate [1]
- enlarged lymph glands in the neck and sometimes abdomen [4]
- peritonsillar abscess (quinsy) or cellulitis [1]
- changes of the oral mucosa and tongue [7]
- rashes [7]

References:
Please see the care map's Provenance.

7 RED FLAG! – admit to hospital

Quick info:
If a patient presents with breathing difficulty, or has suspected epiglottitis, or other serious upper airway disease [5,7]:
- do not attempt to examine the throat [5]
- immediately admit to hospital via ambulance [7]
- suspect acute epiglottitis when the patient [1]:
  - has respiratory distress or stridor
  - is drooling
  - is systemically very unwell
  - has dysphagia
  - has a muffled voice

Immediate admission to hospital is recommended if the patient has:
- a sore throat with any of the following:
  - stridor or respiratory distress [1]
  - progressive difficulty swallowing or drooling [7]
  - increasing pain [5]
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• severe systemic symptoms [5]
• any features suggestive of epiglottitis [1]
• suspected severe suppurative complications which carry a risk of airway compromise or rupture of the abscess, and may require parenteral antibiotics [1]:
  • peritonsillar cellulitis or abscess (quinsy)
  • parapharyngeal abscess – not common
  • retropharyngeal abscess
  • Lemierre's syndrome
• suspected Kawasaki disease [1]
• dehydration or reluctance to take any fluids [1]
• signs of being markedly systemically unwell and is at risk of immunosuppression [1]
• suspected diphtheria – characteristic tonsillar or pharyngeal membrane [1]
• signs of being profoundly unwell and the cause is unknown or a rare cause is suspected, such as [1]:
  • Stevens-Johnson syndrome
  • Yersinial pharyngitis
• embedded foreign body as object might be sharp [7]
Seek specialist advice or consider referral to a specialist if:
• patient is immunosuppressed [1]
• patient has severe oral mucositis [1]

References:
Please see the care map's Provenance.

9 Complications of tonsillitis

Quick info:
Suppurative complications:
• acute otitis media – see 'Acute otitis media in children and adolescents' pathway [1]
• acute rhinosinusitis – see 'Rhinosinusitis' pathway [1]
• peritonsillar abscess (also known as quinsy) presents a risk of airway compromise, aspiration of pus from the abscess, or death due to vascular involvement. Symptoms include:
  • severe pharyngeal pain [1]
  • fever [1]
  • dysphagia [1]
  • drooling [1]
  • 'hot potato' voice [1]
  • red and swollen soft palate [1]
  • peri-tonsillar cellulitis – the pre-abscess stage of peri-tonsillar abscess [7]
• parapharyngeal abscess – may compromise breathing or cause rupture of the carotid artery [1]
• retropharyngeal abscess – common in young children, rare in adults – presents with [1]:
  • neck stiffness and tenderness
  • cervical lymphadenopathy
  • pain when swallowing
• mastoiditis [1]
• suppurative cervical adenitis [1]
• Streptococcal pneumoniae (S. pneumoniae) [1]
• metastatic infection, eg brain abscess, endocarditis, meningitis, osteomyelitis, or liver abscess [1]
• streptococcal toxic shock syndrome [1]
• Lemierre's syndrome (acute septicaemia and jugular vein thrombosis) – affects healthy young people, but rare [1]
10 Diagnosis

Quick info:
In practice, it is not possible to distinguish between different types of sore throat based on clinical features alone [1]. Distinguishing between a viral and bacterial aetiology is one of the main considerations [5].

Typical features of viral sore throat include:
• severe throat pain [1,4]
• fever [1,4]
• malaise [1,4]
• headache [1]
• cough [1]
• the pharynx may look normal or show a mild amount of redness and oedema [1]

Features of streptococcal sore throat:
• cannot be diagnosed on clinical features alone [1]
• pharyngeal pain [1]
• painful swallowing [1]
• headache [1]
• high temperature [1]
• nausea, vomiting, and abdominal pain are common in children [1]
• a patchy grey-yellow exudate is often present on the tonsils and the uvula is often oedematous [1]
• the cervical lymph nodes are enlarged and tender [1]
• absence of cough [5]
• infection with certain strains of streptococci produces a rash characteristic of scarlet fever [1]
• there is an exudative pharyngitis and tonsillitis – there may be a small red haemorrhagic spots on the hard and soft palate [1]

References:
Please see the care map's Provenance.

11 Consider differential diagnoses

Quick info:
Consider differential diagnoses:
• epiglottitis – see ‘Epiglottitis (adult)’ pathway [1,5]:
  • alteration in voice
  • severe sore throat
  • severe dysphagia
  • stridor
  • drooling
  • children prefer to sit leaning forward, but adults may sit erect
• infectious mononucleosis (glandular fever) [1]:
  • most often caused by Epstein-Barr virus (EBV) [7]
  • a fever of 38-39°C usually present [1]
  • cervical lymphadenopathy is symmetrical [1]
• tonsils are enlarged [1]
• the pharynx may be erythematous with exudate [1]
• may present with splenomegaly, jaundice, and rashes [7]
• there is usually moderate bradycardia [1]
• often unable to swallow [5]

• scarlet fever [1]:
  • caused by streptococcal infection
  • associated with characteristic erythematous rash that later desquamates
  • tongue is initially covered with a white coat – enlarged red papillae (strawberry tongue) may be seen

• acute herpetic pharyngitis [1]:
  • primary infection with herpes simples virus may present as acute sore throat
  • pain is moderate to severe
  • may be cervical lymphadenopathy, fever, and exudate
  • may see vesicles and shallow ulcers on the palate with gingivostomatitis

• rhinosinusitis [2]:
  • pruritus of the eyes, nose, palate, and ears [6]
  • watery rhinorrhea [6]
  • sneezing [6]

• cancer [1]:
  • persistent sore throat
  • vague discomfort on swallowing
  • neck mass due to cervical node metastases
  • progressive dysphagia
  • in oropharyngeal cancer, an ulcer is usually visible on examination
  • unilateral tonsillar enlargement without symptoms of acute infection is a possible sign of malignancy [7].

• less common causes which may be serious or life threatening [1]:
  • Kawasaki disease:
    • most cases in children under age 4 years
    • usually present with fever
    • associated with conjunctivitis, changes to the lips and oral cavity and rash
  • herpangina
  • HIV
  • gonococcal pharyngitis
  • arcanobacterial pharyngitis
  • chlamydial pharyngitis
  • yersinial pharyngitis
  • mycoplasmal pharyngitis
  • diphtheria

NB: Certain conditions are very rare and may be difficult to diagnose in primary care [7].

References:
Please see the care map's Provenance.

12 Consider investigations

Quick info:
Investigations:
• neither throat cultures or rapid antigen testing (RAT) can differentiate between carrier states and invasive infection [5]:
  • the asymptomatic carrier rate for group A beta-haemolytic streptococcus (GABHS) is up to 40% [5]
13 Management

Quick info:
Tonsillitis is primarily managed through symptom control [1]. Antibiotics should only be used in severe cases where the practitioner is concerned about the clinical condition of the patient [5]. The Centor scoring system is recommended to help categorise a patient's risk for group A beta-haemolytic streptococcus (GABHS) infection and aid the decision to prescribe antibiotics [5]:

- one point is awarded for each of the following [5]:
  - tonsillar exudate
  - tender anterior cervical lymph nodes
  - history of fever
  - absence of cough

- the likelihood of GABHS increases with increasing score [5]:
  - score of 3 or 4 suggests a 40-60% likelihood of GABHS and the patient may benefit from antibiotics [1]
  - a score below 3 indicates infection with GABHS is unlikely and antibiotics are unlikely to be necessary [1]
  - although the Centor score can aid management, it is not a diagnostic tool [7]

- NB: Score is not valid for children younger than age 3 years [5]
- NB: Likelihood also depends on age, local prevalence, and seasonal variation [5]:
  - streptococcal infection is most likely between ages 5 to 15 years and is progressively less likely in younger and older patients

The Centor scoring system may result in high antibiotic use due to its low specificity for bacterial infection [15].

References:
Please see the care map's Provenance.

14 Symptom management

Quick info:
Adults [5]:
- ibuprofen is recommended for relief of fever, headache, and throat pain in adults with sore throat:
  - ibuprofen has shown to be superior to paracetamol and aspirin in reducing throat pain as early as 1 hour post dose
  - paracetamol may be used as an alternative to ibuprofen in cases of intolerance
- ibuprofen should not be routinely given to adults with, or at risk of dehydration due to concerns regarding renal toxicity – rare
Children [5]:
- an adequate dose of paracetamol should be used as first-line treatment for pain relief
- ibuprofen may be used as an alternative to paracetamol
- ibuprofen should not be routinely given to children with, or at risk, of dehydration
- see 'Fever in infants and children under age 5 years' care map for further information

References:
Please see the care map's Provenance.

15 Immunosuppressed patients

Quick info:
If patient is immunosuppressed, seek urgent specialist advice and consider referral [1]:
- if the patient is taking a disease-modifying anti-rheumatic drug (DMARD) and immediate admission is not appropriate:
  - take a full blood count (FBC) – arrange to contact patient later with the result
  - withhold the DMARD whilst awaiting the result and until discussed with the hospital rheumatology service – or follow local protocols
  - seek urgent specialist advice/referral if the patient's white cell count is low or deteriorates
  - provide symptomatic relief
  - consider prescribing an antibiotic while taking into account the potential interactions with DMARDs
- if the patient is taking carbimazole – can cause idiosyncratic neutropenia:
  - take an urgent FBC and withhold carbimazole until the result is available
  - seek specialist advice
  - consider prescribing an antibiotic
  - seek immediate specialist advice or referral and check the FBC urgently if any of the following apply:
    - taking chemotherapy
    - known or suspected leukaemia, asplenia, aplastic anaemia, or HIV/AIDS
    - taking immunosuppressive drug following a transplant
Refer or seek urgent specialist advice for any patient who has severe oral mucositis [1].

References:
Please see the care map's Provenance.

16 Consider antibiotics

Quick info:
Antibiotics should only be used in severe cases where the practitioner is concerned about the clinical condition of the patient [5]:
- unnecessary prescribing for minor self-limiting illness should be avoided

Antibiotics should not be used for:
- symptomatic relief in sore throat or to prevent suppurative complications [5]:
  - antibiotics have been found to have a beneficial effect on both suppurative and symptom reduction however, the effect on symptoms is small [8]
  - the duration of symptoms is usually 1 week, with or without antibiotics, and the absolute benefit of antibiotics at this time and beyond is very small [8]
  - prophylaxis for recurrent sore throat [5]
  - treatment of sore throat specifically to prevent the development of rheumatic fever and acute glomerulonephritis [5]
  - to prevent cross infection with group A beta-haemolytic streptococcus (GABHS) in the general community [5]:
    - may be considered in closed institutions, eg barracks or boarding schools
Immediate antibiotic prescription is indicated for patients in whom any of the following apply [2]:
- systemically very unwell
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- symptoms and signs suggestive of serious illness and/or complications, eg peritonsillar abscess or cellulitis
  - these patients should be admitted immediately and receive antibiotics in secondary care [1]
- there is a high risk of serious complications due to pre-existing co-morbidity, including:
  - significant heart, eg valvular heart disease, lung, renal, liver, or neuromuscular disease [7]
  - immunosuppression [2]
  - cystic fibrosis (CF) [2]
  - young children who were born prematurely [2]
- the patient has an acute cough and is older than age 65 years and two or more of the following apply, or older than age 80 years and one or more of the following apply [2];
  - hospitalised in the previous year
  - has diabetes mellitus
  - history of congestive heart failure
  - current use of oral glucocorticoids
Consider a delayed prescribing strategy for patients with sore throat where it is felt safe not to prescribe immediately [1]
- provides a safety net for those who genuinely need antibiotics [1]
- reassure the patient that antibiotics are not needed immediately as they will make little difference to symptoms and may have adverse effects [1,7]
- the patient should be advised to use a prescription if symptoms do not settle after 3 days or worsen within 3 days [1]
- advise about the need for review if symptoms worsen despite using the delayed prescription [1]

Patients with a sore throat and a Centor score of 3 or 4 should be considered for either [1]:
- immediate antibiotics; or
- a 2- or 3- day delayed prescription

A low threshold for prescribing an antibiotic should be maintained in patients who [1]:
- are at an increased risk of severe infection, eg diabetes or immunocompromised
- are at risk of immunosuppression, eg on disease modifying anti-rheumatic drugs (DMARDs) or carbimazole
- have a history of rheumatic fever

If antibiotics are to be prescribed, phenoxymethylpenicillin (penicillin V) for 10 days is recommended first-line [5]:
- a macrolide can be considered as an alternative in line with local guidance:
  - a 5-day course of clarithromycin is recommended by Public Health England [16]
  - a 10-day course of clarithromycin is recommended in the British National Formulary (BNF) [17]
- ampicillin-based antibiotics, including co-amoxiclav, should not be used for sore throat because these antibiotics may cause a rash when used in the presence of glandular fever

Close contacts of patients with invasive group A streptococcal disease should be treated with antibiotics if they have symptoms of localised infection which may include [3]:
- sore throat
- fever
- skin infection

References:
Please see the care map's Provenance.

17 Provide information and advice

Quick info:
Provide the following information and advice to patients and/or carers:
- the usual natural history of the illness, including average total length of illness – 1 week [2]
- that recurrent sore throat is a treatable condition [5]
- the different treatment options available [5]
- how to relieve symptoms and manage pain at home [5]:


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Tonsillectomy and adenoidectomy (PLCV)

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• an information leaflet should be provided
• advise patient to see a healthcare professional if they do not improve or seek urgent medical attention if they develop [1]:
  • any difficulty breathing
  • stridor
  • drooling
  • severe pain
  • dysphagia
  • unable to take fluids

Patients not being prescribed antibiotics [2]:
• reassure the patient and/or carer that antibiotics are not needed immediately because they are likely to make little difference to
  the patient’s symptoms and may have side effects, eg diarrhoea, vomiting, and rash
• offer a clinical review if the condition worsens or becomes prolonged

Patients being prescribed a delayed antibiotic prescription [2]:
• reassure the patient and/or carer that antibiotics are not needed immediately because they are likely to make little difference to
  the patient’s symptoms and may have side effects, eg diarrhoea, vomiting, and rash
• advise the patient to use the delayed prescription if:
  • symptoms are not starting to settle as expected; or
  • there is significant worsening of symptoms
• advise the patient to re-consult if there is significant worsening of symptoms despite antibiotic use

Patients prescribed immediate antibiotics [6]:
• improvement in symptoms should be seen within 48-72 hours
• advise the patient to contact their GP if symptoms have not improved after 72 hours

Emphasise the importance of completing the full course of antibiotics who are given a prescription [5,6].

References:
Please see the care map’s Provenance.

18 Persistent symptoms

Quick info:
If symptoms have not improved, re-evaluate the patient and consider differential diagnoses (see ‘Consider differential diagnoses’
care point) [1,6]:
• glandular fever:
  • suspect if sore throat and lethargy persist into the second week, especially if age 15-25 [1]
  • request the following investigations [1]:
    • full blood count (FBC)
    • differential white cell count (WCC)
    • blood film to look for mononuclear leucocytosis
    • monospot test to look for heterophile antibodies – if the patient wishes to be tested
  • consider liver function tests [7]
  • patients are advised to abstain from [7]:
    • contact sport to minimise the risk of splenic rupture
    • hepatotoxic medication and alcohol
  • NB: While testing may be appropriate, tests may not be positive until several days into the illness [6]
• other complications [6]:
  • such as peritonsillar abscess or cellulitis
  • see ‘Complications of tonsillitis’ care point
• cancer – if sore throat is persistent, and especially if there is a neck mass [1]
• non-infectious causes of sore throat, such as [1]:


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latest clinical information.
19 Recurrent symptoms

Quick info:
Advise [5]:
• that recurrent sore throat is a treatable condition
• can be managed in primary care

References:
Please see the care map's Provenance.

20 Indications for urgent referral

Quick info:
Urgent referral to a specialist is indicated for patients with any of the following features of suspected cancer [1]:
• an unexplained, persistent (3-4 weeks) sore or painful throat
• red, or red and white, patches, ulceration, or swelling of the oral/pharyngeal mucosa for more than 3 weeks
• pain on swallowing or dysphagia for more than 3 weeks

References:
Please see the care map's Provenance.

21 Indications for tonsillectomy

Quick info:
Tonsillectomy should be considered for adults and children with:
• recurrent sore throat who meet the following criteria [5]:
  • sore throats are due to acute tonsillitis; and
  • the episodes of sore throat are disabling and prevent normal functioning; and
  • seven or more well documented, clinically significant, adequately treated sore throats in the preceding year; or
  • five or more such episodes in each of the preceding 2 years; or
  • three or more such episodes in each of the preceding 3 years
• enlarged tonsils which are suspected to be causing obstruction of the airway [4,9]:
  • may be the cause of obstructive sleep apnoea [4]
  • has serious effects on health and wellbeing [4]
  • possible malignant disease in the tonsils [4]
  • a small proportion of patients with specific conditions which require tonsillectomy as part of their on going management, eg those presenting with psoriasis or nephritis [9]

Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats [5].

NB: If in doubt as to whether tonsillectomy would be beneficial, a 6-month period of watchful waiting is recommended to firmly establish the pattern of symptoms and allow the patient to consider fully the implications of the operation [5].

Before a referral to secondary care is made, ensure the following have been performed [9]:
• significant symptoms should have been documented [9]
• discuss the benefits and risks of tonsillectomy compared to watchful waiting with the patient and/or carer [9]:

References:
Please see the care map's Provenance.
23 Eligibility criteria

Quick info:
Please read the referral criteria before referring the patient.
The CCG will fund tonsillectomy for indications A or B in adults or children.
At least one of the following criteria must apply:

- **A)** Suspected malignancy.
- **A)** More than one episode of peri-tonsillar abscess (quinsy).
- **A)** Acute upper airways obstruction.
- **B)** Recurrent sore throat where **criteria 1 and 2 both apply** and the principal cause is tonsillitis:

**Criteria 1** – At least one of the following criteria must apply:

- 7 or more eligible episodes in the last year.
- 5 or more eligible episodes in each of the last 2 years.
- 3 or more eligible episodes in each of the last 3 years:
  - NB. An “eligible episode” must have three of the following criteria [Centor Clinical Prediction score]:
    - Tonsillar exudates.
    - Tender anterior cervical lymph nodes.
    - History of fever (>38 C).  #
    - Absence of cough.

**Criteria 2** – The following criteria must apply:

- A significant and documented impact on quality of life e.g. absence from school/ work.

The CCG will fund tonsillectomy and/or adenoidectomy for indication C in **children only**.

- **C)** The CCG will fund for tonsillectomy and/or adenoidectomy for any of the following indications (at least one of the following must apply):
  - Failure to thrive due to difficulty eating solid foods.
  - A strong clinical history suggestive of sleep apnoea.
  - A significant impact on quality of life e.g. loud and persistent noisy/ mouth breathing leading to social difficulties, difficulty eating solid foods that creates unreasonably slow eating, difficulty exercising.

**Additional Information:**

- NB: The case is much more likely to be approved where there is supporting evidence such as growth charts, letters from GPs, employer or school.

The following additional patient information must apply:
• The patient is willing to undergo a surgical procedure should it be offered.
• I have discussed with the patient the fact they will be referred for a possible procedure but there is no guarantee that a surgical intervention will be the preferred outcome following the consultation with the secondary care specialist.
Provenance certificate

Provenance certificate for this International Map of Medicine pathway for Tonsillectomy and adenoidectomy published on 31 January 2015.