NHS
Cheshire and Merseyside

# Clinical Commissioning Policy

## Adenoidectomy

### Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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| Version: | 1 |
| Purpose | This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite. |
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| **Document control:** | | |
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| **Date:** | **Version Number:** | **Section and Description of Change** |
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# 1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication https://www.aomrc.org.uk/ebi/clinicians/removal-of-adenoids-for-treatment-of-glue-ear/.

# 2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

# 3. Summary of intervention

3.1 Adenoids are lymphatic tissue that reside in the postnasal space and arise from the roof of the nasopharynx. Adenoids are only usually present in children and tend to grow from birth, reaching the largest size when a child is between 3 and 5 years of age, before slowly shrinking away by adulthood. When the adenoids are enlarged or inflamed, they may contribute to glue ear (otitis media with effusion), which can affect hearing. They can also cause symptoms of nasal blockage, mouth breathing, obstructive sleep and other upper respiratory tract symptoms (e.g. persistent runny nose).

3.2 When children have persistent glue ear that affects hearing, one option for treatment of the hearing loss is with grommet insertions (ventilation tubes) and guidance for this intervention is already set out in the EBI guidance published in November 2018 – 'grommets for glue ear in children'.

3.3 In some circumstances, when a child is undergoing surgery to insert grommets, the adenoids may also be partially resected at the same time. This is a short procedure performed via the mouth to remove excessive adenoidal tissue (adenoidectomy) and is most commonly performed either by electrocautery (monopolar suction diathermy), cold steel dissection (curettage), or coblation. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.

3.4 **This guidance applies to children aged 18 years and under.**

# 4. Policy statement

4.1 Adenoidectomy is not routinely commissioned as an isolated procedure.

4.2 Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion unless one or more of the following clinical criteria are met:

4.2.1 The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)

**OR**

4.2.2 The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion.

**OR**

4.2.3 The child is undergoing grommet surgery for treatment of recurrent acute otitis media compliant with the criteria for the policy on “Insertion of grommets for glue ear (otitis media with effusion)”.

4.3 Adenoidectomy is routinely commissioned:

4.3.1 As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)

4.3.2 As part of the treatment of chronic rhinosinusitis in children

4.3.3 For persistent nasal obstruction in children and adults with adenoidal hypertrophy

# 5. Exclusions

5.1 In preparation for speech surgery in conjunction with the cleft surgery team.

# 6. Rationale

6.1 NICE guidance recommends that adjuvant adenoidectomy should not be performed for the treatment of glue ear in the absence of persistent and / or frequent upper respiratory tract symptoms. A recent systemic review demonstrated that whilst adjuvant adenoidectomy resulted in an improvement in resolution of the glue ear at 6 and 12 months compared to grommets alone, the benefit in hearing compared to grommets alone was very limited.

6.2 Adjuvant adenoidectomy is considered a low-risk procedure but does increase the length of surgery compared to inserting grommets alone. Risks include damage to teeth, lips or gums, bleeding (usually only minor and self-resolving), and rarely (around 1%) velopharyngeal insufficiency (VPI). VPI can result in speech problems such as hypernasal speech or audible escape of air out of the nose when talking and in some cases can cause nasal regurgitation.

6.3 If there is a history of cleft palate or palpable palate abnormality such as submucous cleft palate or a history of speech problems before the operation; full multidisciplinary assessment should be carried out before adenoidectomy.

# 7. Underpinning evidence

7.1 NICE Clinical guidance (2008) Otitis media with effusion in under 12s [CG60] surgery:https://www.nice.org.uk/Guidance/CG60.

7.2 Rosenfeld RM, Shin JJ, Schwartz SR, et al. Clinical practice guideline: Otitis media with effusion executive summary (update). Otolaryngol Head Neck Surg. 2016;154(2):201-214. doi: 10.1177/0194599815624407.

7.3 Schilder AG, Marom T, Bhutta MF, et al. Panel 7: Otitis media: Treatment and complications. Otolaryngol Head Neck Surg. 2017;156(4_suppl):S88-S105. doi: 10.1177/0194599816633697.

7.4 Van dA, Schilder A, Herkert E, Boonacker C, Rovers MM. Adenoidectomy for otitis media in children. Cochrane Database of Systematic Reviews. 2010(1). doi: 10.1002/14651858. CD007810.pub2.

# 8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

# 9. Coding

**Estimated activity**
— 2,778 episodes during 2018/19
— Age/sex std rate per 100,000 – 4.7
— Reduction opportunity: 1,426 (51%) based on 25$^{th}$ percentile of activity across CCGs.
— Variation (age/sex std rates):
— N-fold – 5.5
— 10th percentile – 1.6
— 25th percentile – 2.5
— 50th percentile – 4.4
— 90th percentile – 8.9

**Procedure codes**
E20.1 Total adenoidectomy
E20.4 Suction diathermy adenoidectomy
E20.8 Other specified operations on adenoid
E20.9 Unspecified operations on adenoid
With:
D15.1 Myringotomy with insertion of ventilation tube through tympanic membrane

**Diagnosis codes**
H65.2 Chronic serous otitis media
H65.3 Chronic mucoid otitis media
H65.4 Other chronic nonsuppurative otitis media
H65.9 Unspecified nonsuppurative otitis media
H66.1 Chronic tubotympanic suppurative otitis media
H66.3 Other chronic suppurative otitis media
H66.4 Suppurative otitis media, unspecified
H66.9 Otitis media, unspecified
H68.1 Obstruction of Eustachian tube

H69.8 Other specified disorders of Eustachian tube
H69.9 Unspecified Eustachian tube disorder

Exclusions:
G47.3 Sleep apnoea
J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinusitis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
Q35.1 Cleft hard palate
Q35.3 Cleft soft palate
Q35.5 Cleft hard palate with cleft soft palate
Q35.7 Cleft uvula
Q35.9 Cleft palate, unspecified
Q37.0 Cleft hard palate with bilateral cleft lip
Q37.1 Cleft hard palate with unilateral cleft lip
Q37.2 Cleft soft palate with bilateral cleft lip
Q37.3 Cleft soft palate with unilateral cleft lip
Q37.4 Cleft hard and soft palate with bilateral cleft lip
Q37.5 Cleft hard and soft palate with unilateral cleft lip
Q37.8 Unspecified cleft palate with bilateral cleft lip
Q37.9 Unspecified cleft palate with unilateral cleft lip
*(Note – cancer diagnoses are a global exclusion)*

**Any other criteria (e.g. patient age)**
Adult (aged >=19 years)
Exclude any patients admitted as a non-elective admission

**Will the procedure be carried out in OP or as APC?**
Admitted Patient Care

**Coding logic**
Procedure codes in any position are:
E20.1 OR
E20.4 OR
E20.8 OR
E20.9
AND
D15.1
AND
Primary diagnosis code is:
H65.2
H65.3
H65.4
H65.9
H66.1
H66.3
H66.4
H66.9
H68.1
H69.8
H69.9
AND
Diagnosis codes in any position are NOT:

G47.3 OR
J32.0 OR
J32.1 OR
J32.2 OR
J32.3 OR
J32.4 OR
J32.8 OR
J32.9 OR
Q35.1 OR
Q35.3 OR
Q35.5 OR
Q35.7 OR
Q35.9 OR
Q37.0 OR
Q37.1 OR
Q37.2 OR
Q37.3 OR
Q37.4 OR
Q37.5 OR
Q37.8 OR
Q37.9
AND
Patient age <19
AND
APCS.Admission_Method not like (‘2%’)

**SQL code**

```
WHEN apcs.der_procedure_all like '%E20[1489]%'
AND apcs.der_procedure_all like '%D151%'
AND (der.Spell_Primary_Diagnosis like 'H65[2349]%' OR der.Spell_Primary_Diagnosis like
'H66[1349]%'
OR der.Spell_Primary_Diagnosis like 'H681%' OR der.Spell_Primary_Diagnosis like
'H69[89]%')
AND (apcs.der_diagnosis_all not like '%G473%' AND apcs.der_diagnosis_all not like
'%J32%' AND apcs.der_diagnosis_all not like '%Q3[57]%')
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)<=18
AND APCS.Admission_Method not like ('2%')
THEN '2D_adenoid_removal'
```

**Global cancer exclusion**

```
APC
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
AND apcs.der_diagnosis_all not like '%D0%'
AND apcs.der_diagnosis_all not like '%D3[789]%'
AND apcs.der_diagnosis_all not like '%D4[012345678]%'
OR apcs.der_diagnosis_all IS NULL)
```

# 10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

# 11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

# Appendix - Core Objectives and Principles

# Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

# Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

# Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

# Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

# Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

# Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

# Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.