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| **2D — Removal of adenoids for treatment of glue ear** |
| **Summary of Intervention** |
| Adenoids are lymphatic tissue that reside in the post nasal 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).  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’.  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.  **This guidance applies to children aged 18 years and under.**8/19 |
| **Number of interventions in 18/19** |
| **2,778** |
| **Proposal** |
| Adjuvant adenoidectomy should not be routinely performed in children  undergoing grommet insertion for the treatment of otitis media with effusion.  Adjuvant adenoidectomy for the treatment of glue ear should only be offered  when one or more of the following clinical criteria are met:  — The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)  — The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion  — The child is undergoing grommet surgery for treatment of recurrent acute otitis media.  This guidance only refers to children undergoing adenoidectomy for the  treatment of glue ear and should not be applied to other conditions where  adenoidectomy should continue to be routinely funded:  — As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)  — As part of the treatment of chronic rhinosinusitis in children  — For persistent nasal obstruction in children and adults with adenoidal hypertrophy  — In preparation for speech surgery in conjunction with the cleft surgery team. |
| **Rationale for Recommendation** |
| 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.  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.  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. |
| **References** |
| 1. NICE Guidance:https://www.nice.org.uk/Guidance/CG60.  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. https://doi.org/10.1177/0194599815624407. doi: 10.1177/0194599815624407.  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 [doi].  4. Van dA, Schilder A, Herkert E, Boonacker C, Rovers MM. Adenoidectomy for otitis media in children. Cochrane Database of Systematic Reviews. 2010(1). https://doi.org//10.1002/14651858.CD007810.pub2. doi: 10.1002/14651858.CD007810.pub2. |