

Post-operative Tonsillectomy Analgesia after discharge: A UK practice survey

Submitted to Association of Paediatric Anaesthetists Annual Scientific Meeting,

Aberdeen 2016

INTRODUCTION AND AIMS:

Adeno-tonsillectomy is renowned to cause significant post-operative pain, which will often have a secondary peak at days 3 to 5 once discharged home.

Use of codeine has been discouraged in children under 12 years since 2013, as advised by the MHRA, and is contraindicated in children undergoing adeno-tonsillectomy for obstructive sleep apnoea (OSA)¹. In a series of fatalities or life-threatening cases following codeine use, the majority were post adeno-tonsillectomy in children with OSA².

Previous work has shown that oral morphine may be a reasonable substitute for codeine after discharge home³. We aimed to provide a comprehensive review of current UK practice.

METHODS:

The survey was initiated and performed via PATRN (Paediatric Anaesthesia Trainees Research and audit Network).

All UK tertiary paediatric centres were invited to participate. Any district generals (DGHs) volunteering were included. The survey and instructions were distributed via email. Trainees applied for local audit approval as necessary. Data was uploaded onto an online database. No confidential data was collected. The PATRN committee collated the results.

RESULTS:

Twenty hospitals participated, fourteen tertiary and six DGHs. The annual tonsillectomy rates for tertiary centres was 197-1015, and for DGHs 71-580. Eleven centres have a formal protocol for discharge analgesia.

All centres prescribe regular paracetamol and a non-steroidal anti-inflammatory(NSAID). Nineteen centres use ibuprofen, one uses diclofenac. Ibuprofen dosing varies from 5mg/kg to 10mg/kg eight hourly.

Seven centres discharge patients with oral morphine, dose range 0.1-0.2mg/kg. Two centres modify doses for OSA cases.

One centre uses tramadol for children aged over 14 years in place of oral morphine.

Following the MHRA drug safety update, fourteen participating centres have changed their protocols, six to include and eight to remove opiate analgesia.

Seven have subsequently audited their practice; five achieving satisfactory analgesia. Of these, one centre does not provide morphine but does prescribe higher dose ibuprofen (10mg/kg). The two centres finding inadequate analgesia provide paracetamol and NSAID only.

DISCUSSION:

PATRN is a national collaborative network of anaesthetic trainees with an interest in paediatric anaesthesia. This pilot project launched our network and aimed to identify ways of refining our processes.

Our survey is the largest UK survey following the MHRA drug safety update. The data shows that many hospitals have consequently changed their practice, but there is a lack of consistency regarding NSAID doses and use of oral morphine at home.

Those auditing their practice have predominantly achieved adequate analgesia, and correspondingly prescribe oral morphine at home.

CONCLUSIONS:

There remains considerable variation in practice for analgesia post tonsillectomy. Oral morphine appears to provide adequate analgesia in those centres using it on discharge.

PATRN provides a powerful method of collecting national paediatric anaesthesia data whilst additionally involving trainees in multi-centre projects.

References:

1. <https://www.gov.uk/drug-safety-update/codeine-for-analgesia-restricted-use-in-children-because-of-reports-of-morphine-toxicity>
2. Kelly LE, et al. More codeine fatalities after tonsillectomy in North American children. Pediatrics 2012; 129: 1343–47
3. Syed MI, Magos TA, Singh J, Montague ML. A new analgesia regimen after (adeno)tonsillectomy in children: a pilot study. Clinical Otolaryngology Oct 2015
DOI: 10.1111/coa.12579 online published ahead of print.