University Hospitals of Derby and Burton NHS Foundation Trust

Post-Operative Haemorrhage following Tonsillectomy & / or Adenoidectomy - Paediatric Full Clinical Guideline - Derby & Burton

Reference no.: CH CLIN S 09

1. Introduction

This guideline is formulated to ensure timely recognition of post-operative haemorrhage following tonsillectomy and/or adenoidectomy and prompt the appropriate action by the health care professionals involved in the child/young person's care.

2. Aim and Purpose

This guideline applies to all children and young people undergoing tonsillectomy and/or adenoidectomy at the Royal Derby Hospital (Dolphin Ward) and Queen's Hospital, Burton (Ward 1).

3. Definitions

Postoperative bleeding following tonsillectomy and/or adenoidectomy remains a most serious complication. It is potentially an emergency situation and can result in acute airway compromise. There are 2 types of haemorrhages:

1) Primary haemorrhage, which occurs within 24 hours of operation

2) Secondary haemorrhage, which occurs 24 hours after procedure. It usually presents 5-10 days after the operation when the fibrin clot sloughs off/becomes infected.

4. Main body of Guidelines

Assess Bleeding

Children/young people will present with either:

- History of bleeding prior to attendance to CED (parents sometimes report blood on the pillowcase, haemoptysis or haematemesis).

- or current active bleeding from the tonsillar fossa.

Examination

1) Perform a full ENT examination. Pay particular attention when examining the patient's throat for bleeding. It is expected for the throat to look yellow or sloughy post-op. Try to localise the source of the bleeding (superior/inferior, left/right pole, and whether there is any evidence of blood clots or an old bleeding point)
2) Perform an initial set of observation, including a pulse rate and a blood pressure.
3) Monitor visual blood loss, evidenced by persistent spitting of fresh blood, constant nasal bleeding or vomiting of fresh blood.

If present, I**MMEDIATELY** contact

- On call ENT SHO/Registrar - (if unavailable, contact ENT consultant on call).
- On call Paediatric registrar
- On call anaesthetist mobile via switchboard

Patient is actively bleeding

1) Airway management: Sit patient up, and encourage them to spit in a bowl. Record and monitor blood loss. Keep all evidence of blood loss for review. Consider suctioning, as appropriate.

2) Record pulse, respiratory rate and blood pressure every 5 minutes until stable. Monitor trend with observations (pulse, respiration and blood pressure, pallor/colour and level of consciousness), indicative of hypovolaemic shock. Once stable, record as per post operative guidelines.

3) If airway significantly compromised or clinical condition warrants – consider transfer to Dolphin Unit or paediatric ward at Queen's Hospital Burton.

Treatment

- Nursing staff to ensure contact details of Next Of Kin are readily available if required forconsent purposes
- Reassure patient; a sense of calmness helps
- Ensure nil by mouth until otherwise instructed.
    - Clear fluids are usually given up until 1hr pre-operatively and may help the patient feel more comfortable. Please check with the anaesthetic team
- Ensure a patent intravenous cannula is in situ. FBC, coagulation, group & save (crossmatch if bleeding is severe) and a venous blood gas (VBG) to be performed.
- In most cases an IV cannula will be inserted intra-operatively, however, in the absence of a cannula, please assess the situation with regard to the application of Ametop. In this emergency situation, it may be necessary to obtain blood samples as soon as possible, therefore omitting the use of Ametop).
- If the child needs initial fluid bolus, resuscitation fluid 0.9% sodium chloride to be commenced in a dose of 10 – 20 ml/kg. Infusion at a rate that is recommended by the Derbyshire Children's Hospital Resuscitation Committee and Queen's Hospital Burton.
- Otherwise commence intravenous maintenance fluids as per paediatric guidelines.
- If required, ensure the child is as prepared for theatre as possible, as per protocol.

- Discuss with ENT on call regarding starting IV antiobiotics, IV tranexamic acid, analgesia, hydrogen peroxide gargles and ice packs

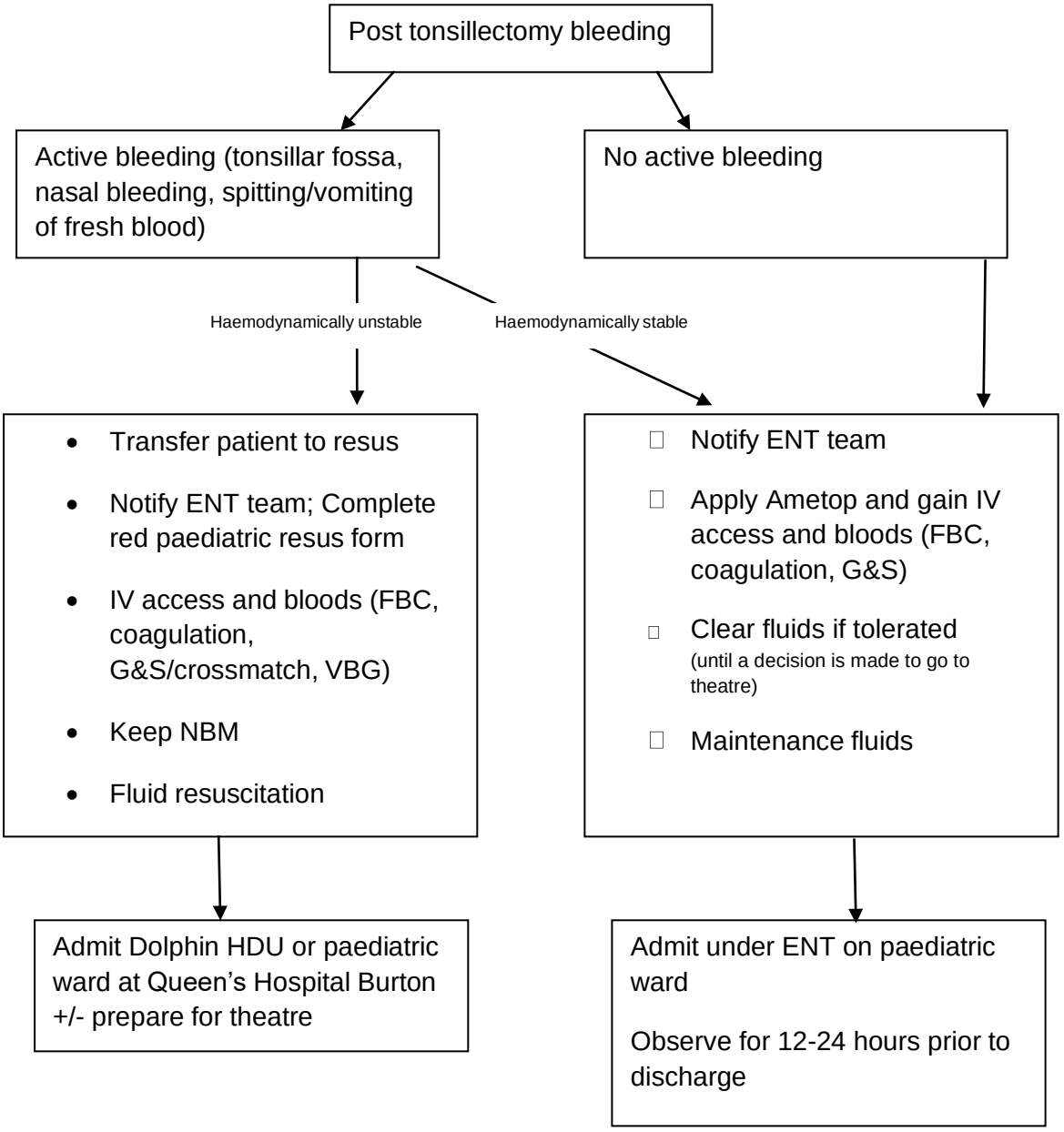
- Ensure the team leader completes the red paediatric resuscitation form. (Record of event).

Patient is not actively bleeding

1) Notify ENT team.

2) Apply Ametop. Gain IV access, and send off FBC, coagulation and G&S.

3) All children who have presented with a post tonsillectomy bleed need to be admitted under ENT on a paediatric ward for a 12-24 hour observation period. They need to be reviewed by ENT prior to discharge.



5. References (including any links to NICE Guidance etc.)

- Samir Gendy (2018) Audit of Secondary Post Tonsillectomy Bleeding. Annl Otolarinl 2: 006.
- Audit NP (2008) Impact of NICE guidance on rates of haemorrhage after tonsillectomy: an evaluation of guidance issued during an ongoing national tonsillectomy audit. Qual Saf Health Care 17: 264-8.
- Royal College of Paediatrics and Child Health. (Nov 2012) Evidence Statement: Major Trauma and the use of tranexamic acid in children.

6. Documentation Controls

Reference Number	**Version: 5**		**Status** Final	
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	5	Aug 2020	Dr Priyanka Prossor	Review and update
	5.1	Dec 2023	Dr T Kamani	Review and update
Intended Recipients: Paediatric Consultants & Nursing staff at Derby Hospital				
Training and Dissemination: Cascade the information via BU newsletter and address training				
Development of Guideline: Miss T Kamani				
In Consultation with: Paediatric Consultants ENT Consultants - Mr Bindy Sahota & Dr Tawakir Kamani-Appleyard Anaesthetic Consultants				
Linked Documents: (Nice guidance/Current national guidelines)				
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