BMJ 2004;329:1045 (30 October), doi:10.1136/bmj.329.7473.1045-b

Letter

Adenotonsillectomy in children with mild symptoms

Authors' reply

EDITOR—Although we excluded children with a Brouillette score of more than 3.5 from our trial, it is likely that some children with obstructive sleep apnoea participated.[1] Of the 37 children in our trial with a Brouillette score between -1 and 3.5, indicating possible obstructive sleep apnoea, 18 were allocated to adenotonsillectomy and 19 to watchful waiting. At three months' follow up, parents reported obstructive symptoms during sleep in 0.9 *v* 11.8% of children, respectively. At 12 and 24 months, these percentages were 1.1% *v* 5.2% and 1.7% *v* 1.5%, indicating only a short term effect of surgery. In the absence of a long term effect on this outcome, an effect on behavioural and neurocognitive outcomes is unlikely.

Moreover, a watchful waiting strategy includes not only educating parents about the favorable natural course of obstructive symptoms, but also ensuring follow up if symptoms persist or increase; in those cases adenotonsillectomy should be reconsidered.

International practice varies with respect to adenotonsillectomy,[2] and some children selected for surgery in Dutch practice would be managed non-surgically in the United Kingdom. Although most UK departments for ear, nose, and throat medicine use 1999 guidelines of the Scottish Intercollegiate Guidelines Network (SIGN), the large variation in tonsillectomy rates across the health authorities shows that doctors still differ in their criteria for diagnosis of tonsillitis and indications for tonsillectomy and adenoidectomy.

The SIGN guidelines acknowledge that there is a paucity of high quality evidence for surgical intervention. Our trial adds to this evidence and shows that in children with mild symptoms of throat infections or adenotonsillar hypertrophy adenotonsillectomy offers no major clinical benefits over watchful waiting.

Anne G M Schilder, *otorhinolaryngologist*

A.Schilder@wkz.azu.nl , Department of Otorhinolaryngology, Wilhelmina Children's Hospital, University Medical Center, Utrecht PO Box 85090, 3508 AB Utrecht, Netherlands

Maroeska M Rovers, *clinical epidemiologist*, **E Henriette van den Akker**, *otorhinolaryngologist*, **Birgit K van Staaij**, *general practitioner*, **Arno W Hoes**, *professor of clinical epidemiology*

Department of Otorhinolaryngology, Wilhelmina Children's Hospital, University Medical Center, Utrecht PO Box 85090, 3508 AB Utrecht, Netherlands

Competing interests: None declared.

References

1. Akker van den EH, Hoes AW, Burton MJ, Schilder AGM. Large international differences in (adeno)tonsillectomy rates. *Clin Otorhinolaryngol* 2004;29: 161-4.

2. Capper R, Canter RJ. Is there agreement among general practitioners, paediatricians and otolaryngologists about the management of children with recurrent tonsillitis? *Clin Otolaryngol* 2001;26(5): 371-8.[CrossRef][ISI][Medline]