The AAFP endorses watchful waiting (in lieu of tonsillectomy) for recurrent throat infections if there have been fewer than seven episodes in the past year, fewer than five episodes per year during the past two years or fewer than three episodes per year during the past three years.

April 08, 2013 02:20 pm Matt Brown (mailto:aafpnews@aafp.org) – The AAFP recently gave qualified endorsements to clinical practice guidelines on tonsillectomy in children (http://www.aafp.org/content/dam/AAFP/documents/patient_care/clinical_recommendations/aaohns-tonsillectomy-in-children.pdf) and venous thromboembolism (VTE) prophylaxis (http://www.aafp.org/content/dam/AAFP/documents/patient_care/clinical_recommendations/acp-venous-thromboembolism.pdf) in hospitalized patients. The guidelines were developed by the American Academy of Otolaryngology–Head & Neck Surgery Foundation (AAO-HNSF) and the American College of Physicians (ACP), respectively.

Qualified endorsement signifies that the AAFP found a guideline to be of sufficient quality to endorse even though specific aspects of it fell short of the Academy’s stringent criteria for guideline development.

The tonsillectomy guideline, for example, provides evidence-based direction on identifying children who are the best candidates for tonsillectomy, as well as addressing perioperative management of children undergoing the surgery. Although the overall guideline development process was satisfactory by AAFP standards, the grading of some recommendations was not consistent with the evidence provided, according to the Academy’s review.

Eric Wall, M.D., M.P.H., of Seattle, the AAFP’s representative to the AAO-HNSF panel that issued the tonsillectomy recommendation, said the panel did not follow the rigorous evidence-based process the AAFP uses in developing guidelines, which includes linking the recommendation grade to the quality of evidence. Four of the 10 recommendations in the guideline, he said, were “upgraded based on lower-level evidence,” which is indicated on the Academy’s website.

“The evidence for the guideline was not systematic, but (the panel) did utilize the Cochrane Collaboration (an AAFP-recognized evidence-based resource) to gather evidence,” Wall told AAFP News Now. “The evidence for tonsillectomy for the treatment of recurrent throat infections is absent.

“(Subspecialist panel members) then turned to the use of tonsillectomy for sleep apnea in children, only to find that the diagnosis of sleep apnea in children is very problematic and controversial. So, the take-home message is that the indications for tonsillectomy are very few and, for FPs, almost absent.”

Regarding the recommendations in the ACP guideline on VTE prophylaxis in hospitalized patients, all three were upgraded based on lower-level evidence, according to the Academy, prompting the qualified endorsement. Despite an overall favorable evaluation of the guideline, there were concerns regarding the lack of evidence to support assigning a higher grade for the recommendations.

In addition, said Doug Campos-Outcalt, M.D., M.P.A., clinical policies analyst for the AAFP, the Academy’s reviewers had specific concerns about the first recommendation, which encourages physicians to assess medical patients — including those who have had a stroke — for the risk of thromboembolism and bleeding before initiating VTE prophylaxis.

“An assessment tool is needed to perform this appraisal, and one is not provided in the recommendation,” said Campos-Outcalt, who also is chair of the Department of Family, Community and Preventive Medicine at the University of Arizona College of Medicine, Phoenix, and the AAFP liaison to the U.S. Preventive Services Task Force.

Still, he added, the guideline provides advice based on the best available evidence that addresses a common situation and should lead to improvement in patient care.

Family physician Steven Brown, M.D., program director of the Banner Good Samaritan Family Medicine Residency at the University of Arizona College of Medicine in Phoenix, served as the AAFP representative to the ACP panel.

So, what are the guidelines as published?

One problem I have seen over the years in evaluating sore throat, is in documentation of cause. More often then not, when I use the nasal speculum to examine the nose, patients tell me that previous docs have not looked in their nose. Many sore throats are simply due to rhinitis or sinusitis, and the throat exam is normal.

How true! I see failed treatment attempts that finally come to urgent care. They are being treated for "sore throat" but not the cause which lies above the oropharynx. That is a "negative" area on the EHR's but obviously the untreated problem.