Clinical Practice Guidelines:
Trauma/Post-tonsillectomy haemorrage

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Date	September, 2024
Purpose	To ensure a consistent appproach to the management of a patient with a traumatic brain injury.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Post-tonsillectomy haemorrhage

September, 2024

Post-tonsillectomy haemorrhage (PTH) is a potentially life-threatening complication that can occur following the surgical removal of the palatine tonsils. Briefly, it is characterised by postoperative bleeding into the oropharyngeal cavity from the tonsillar fossa.[1–2]. In clinical practice, the severity of PTH can range from self-limiting blood-streaked saliva to uncontrolled torrential haemorrhage.

The vast majority of PTHs occur following the premature dislodgement of the fibrin clot that forms at the surgical site.[3] This typically occurs in the five to ten days following the tonsillectomy and can occur spontaneously or may be precipitated by trauma, vomiting or an underlying infection.[4–6]

Approximately 1.6% of all patients that have a tonsillectomy performed subsequently experience a PTH requiring surgical intervention and readmission to hospital.[7] Annually, the QAS attends approximately 350 patients that present with a PTH, with the estimated blood loss ranging from 10 mL to 1,100 mL.

Clinical features

- Blood in the oropharynx/mouth
- Haematemesis
- Haemoptysis
- Hypovolemic shock (in instances of severe blood loss)
- Epistaxis

Risk assessment

- All patients must receive a thorough clinical assessment that determines the following pertinent information:
  - When the tonsillectomy was performed / number of days post operations
  - Past medical history and family history (in particular, a history of bleeding disorders)
  - Current medications (identify if prescribed antibiotics)
  - Current analgesia regime (identify if recently administered NSAIDS or aspirin)
  - Estimated blood loss
- All patients that present with evidence of a PTH must be transported to hospital for further assessment. This includes instances where the patient is not actively bleeding on examination.
- Blood loss in paediatric patients is often underestimated as they typically swallow blood rather than expelling it from their mouth.[8]

Additional information

- Patients with minor bleeding are twice as likely to experience a severe PTH in the hours following.[9]
- All patients that present with a PTH should be nil by mouth, as a proportion will require surgical intervention.
- Where practical, patients should be returned to the hospital where the surgery was performed. This includes instances where the tonsillectomy was performed at a private facility.
- Ambulance clinicians should consider pre-notifying the receiving hospital facility, as these patients often require clinical review by an Ear, Nose & Throat (ENT) specialist.
- Patients should be positioned upright to avoid aspiration.
- Direct haemorrhage control techniques are not recommended in the out-of-hospital setting.
- If available, patients may be encouraged to suck on ice if minor bleeding is present.
- The recommendation to administer tranexamic acid (TXA) has been adopted from the Queensland Children's Hospital treatment guideline. The administration of TXA should not delay transport to hospital for definitive care.

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