

# Suction diathermy adenoidectomy

HealthTech guidance

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[www.nice.org.uk/guidance/htg209](https://www.nice.org.uk/guidance/htg209)

# Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations wherever possible](#).

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This guidance replaces IPG328.

# 1 Recommendations

- 1.1 Current evidence on the safety and efficacy of suction diathermy adenoidectomy is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.
- 1.2 This procedure should be carried out only by surgeons with specific training in the use of diathermy for adenoidectomy because thermal damage to surrounding tissues can, rarely, cause Grisel's syndrome (subluxation of the atlantoaxial joint).

## 2 The procedure

### 2.1 Indications and current treatments

- 2.1.1 Adenoidectomy is usually carried out in children, for conditions including nasal obstruction, recurrent otitis media with effusion and obstructive sleep apnoea. Depending on the indication, it is often combined with tonsillectomy and/or grommet insertion.
- 2.1.2 Traditional adenoidectomy is carried out by 'cold' curettage. A potential problem with this technique is persistent bleeding, which may require control by electrocautery or packing of the nasopharynx.

### 2.2 Outline of the procedure

- 2.2.1 Suction diathermy adenoidectomy (also known as suction electrocautery or suction coagulation) aims to remove the adenoids while minimising intraoperative blood loss and risk of secondary haemorrhage. It involves the use of heat generated by an electric current to ablate or liquefy adenoid tissue, which is then removed using suction.
- 2.2.2 The procedure is performed with the patient under general anaesthesia. Direct (using a mirror) or endoscopic visualisation is used. A suction diathermy probe (coagulator) is passed into the mouth and applied to the adenoid tissue in the nasopharynx, to liquefy and remove it. The procedure is considered to be complete when the choanae are clearly visible and the nasopharynx has a smooth contour.
- 2.2.3 Several different devices are available for this procedure, which may require different diathermy settings to minimise the risk of heat damage.

## 2.3 Efficacy

Sections 2.3 and 2.4 describe efficacy and safety outcomes from the published literature that the Committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the [overview](#).

- 2.3.1 A meta-analysis of 2,252 patients reported a subjective success rate (definition varied for each study) for 1,812 patients treated by suction diathermy across 6 studies of 95% (1,721 out of 1,812; 95% confidence interval [CI] 92.7 to 97.3;  $p<0.001$ ).
- 2.3.2 A randomised controlled trial of 100 patients treated by suction diathermy or by curettage reported that suction diathermy-treated patients had significantly fewer Wormald and Prescott grade 3 remnant adenoids than patients treated by curettage at 6-month follow-up ( $p=0.0184$ ; scale ranges from grade 1 [less than one third of the posterior choanae are obstructed] to grade 3 [more than two thirds of the posterior choanae are obstructed]).
- 2.3.3 A prospective audit of 126 patients treated by suction diathermy or by curettage used a scale from 0 (best) to 6 (worst) to measure nasal obstruction, loudness and frequency of snoring, duration of coloured rhinorrhoea and presence of irregular sleep patterns. It reported significantly lower mean postoperative symptom scores after both treatments (0.4 and 0.7, respectively) compared with mean preoperative scores (3.3 and 3.0, respectively;  $p<0.001$  for both groups). No significant difference in mean symptom score change from baseline was reported between the 2 treatment groups (absolute figures not stated;  $p=0.07$ ).
- 2.3.4 The Specialist Advisers listed key efficacy outcomes as reduced blood loss (especially important in small children), completeness of adenoidectomy and relief of symptoms (for example, infection and obstructive sleep apnoea).

## 2.4 Safety

- 2.4.1 In the meta-analysis of 2,522 patients treated by suction diathermy or curettage, mean intraoperative blood loss was 4.31 ml (95% CI 0.4 to 8.2;  $p=0.03$ ; 5 studies,  $n=359$ ) and 24.00 ml (95% CI 0 to 48.3;  $p=0.052$ ; 3 studies,  $n=139$ ), respectively.

2.4.2 A non-randomised controlled trial of 149 patients reported no (0 out of 77) postoperative bleeding episodes in patients treated by suction diathermy compared with 10% (7 out of 72) in those treated by curettage ( $p<0.001$ ). In the prospective audit of 126 patients, secondary bleeds (defined in the paper as pink-stained nasal discharge) were reported in 4% (3 out of 68) of patients treated by suction diathermy and in 2% (1 out of 58) of those treated by curettage (no intervention required).

2.4.3 Postoperative neck stiffness was reported in a non-randomised controlled trial of 276 patients treated by suction diathermy, curettage, or microdebrider adenoidectomy to have occurred in 9% (8 out of 93), 10% (8 out of 84) and 17% (17 out of 99) of patients, respectively ( $p=0.08$ , not stated if 'overall' or pair-wise comparison).

2.4.4 Grisel's syndrome was reported in 1 patient in the retrospective study of 1,206 patients and 1 patient in a case report. One of these patients had torticollis and type I atlantoaxial subluxation which resolved in 3 weeks and the other patient had a reduced range of neck movement at 9-month follow-up. Retropharyngeal fluid collection resulting in neck stiffness and low-grade fever was reported in 1 patient in the retrospective study of 1,206 patients.

2.4.5 Cervical osteomyelitis was reported in 1 patient after suction electrocautery, in a case report: this resolved completely after 4 weeks of medical therapy.

2.4.6 Velopharyngeal insufficiency (improper closing of the soft palate against the posterior pharyngeal wall during speech and swallowing) was reported in 16 patients in the case series of 1,206 patients: this resolved within 6 months in all but 1 patient, in whom it persisted for more than 2 years. The prospective audit reported that 4% (3 out of 68) of patients treated by suction diathermy had transient velopharyngeal insufficiency compared with 7% (4 out of 58) of patients treated by curettage: it resolved in all 7 patients within 2 to 4 weeks.

2.4.7 The Specialist Advisers considered theoretical adverse events to include Grisel's syndrome, thermal damage or burns to the nasopharynx and surrounding structures from diathermy, scarring and infection.

# Update information

## Minor changes since publication

**January 2026:** Interventional procedures guidance 328 has been migrated to HealthTech guidance 209. The recommendations and accompanying content remain unchanged.

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## Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.