**Criteria Based Clinical Treatments**

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| --- | --- |
| **Provided by:** | NHS Halton CCG  NHS Liverpool CCG  NHS Southport and Formby CCG  NHS South Sefton CCG  NHS St Helens CCG  NHS Warrington CCG |

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# 

# INTRODUCTION

**Purpose and Scope**

CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed. This document is intended to be a statement of such arrangements made by the CCGs and will act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which CCGs will commission the service.

This policy describes the eligibility criteria under which the CCGs listed below will commission treatments or interventions classified as ‘Criteria Based Clinical Treatments’ (CBCT). The term Criteria Based Clinical Treatments refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP).

In making these arrangements, the CCGs have given regard to relevant legislation and NHS guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012, Equality legislation – duties discharged under the Public Sector Equality Duty 2011, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, the Joint Strategic Needs Assessment, relevant guidance issued by NHS England and the NHS Constitution.

**Context**

CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of their population.

It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. Therefore, it will not be possible for CCGs to commission all the healthcare needs of the population they serve. As a result, CCGs need to prioritise their commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.

The CCGs intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.

Using the CBCT policies as presented in this document, the CCGs can prioritise their resources using evidence-based information that determines what is clinically effective and therefore cost effective and likely to provide the greatest proven health gain for the whole of the CCG’s population.

The main objective for having CBCT policies is to ensure that:

* Patients receive appropriate health treatments in the right place and at the right time;
* Treatments with no or a very limited clinical evidence base are not routinely undertaken; and
* Treatments with minimal health gain are restricted.

This also means that certain procedures will not be commissioned by CCGs unless patients meet all the criteria set out in relation to a procedure or treatment; or exceptional clinical circumstances can be demonstrated.

CCGs recognise there may be exceptional clinical circumstances where it may be clinically effective to fund any of the procedures listed in this policy for individual patients. Either where:

* The clinical threshold criteria as specified by this policy is not met; or
* The procedure is not routinely commissioned;

In accordance with each CCG’s Individual Funding Request (IFR) process, the patient’s circumstances as clinically evidenced in an application made by the patient’s clinician will be considered on a case-by-case basis. This position is supported by each CCG’s Ethical Framework which can be found on the respective CCG website.

**Background**

The following CCGs have worked collaboratively to develop this harmonised core set of commissioning criteria:

* Halton CCG;
* Knowsley CCG;
* Liverpool CCG;
* St Helens CCG;
* South Sefton CCG;
* Southport and Formby CCG;
* Warrington CCG;

This policy aims to improve consistency by bringing together one common set of criteria for treatments and procedures across the Merseyside and Warrington CCG footprints. This will help to reduce variation of access to NHS services in different areas (which is sometimes called ‘postcode lottery’ in the media) and allow fair and equitable treatment for all local patients.

**Principles**

Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out as follows:

* CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
* CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
* The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
* CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
* CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community;
* CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
* Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered;
* Commissioning decisions will give ‘due regard’ to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

**Core eligibility criteria**

However, there are a number of circumstances where a patient may meet a ‘core eligibility criterion’ which means they are eligible to be referred for the procedures and treatments listed within this policy, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

* Any patient who needs ‘urgent’ treatment will always be treated.
* All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment;
* In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2 week rule;

NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England;

* Reconstructive surgery post cancer or trauma including burns;
* Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures;
* Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis;
* For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

**Policy Categories**

Each procedure/treatment is categorised as either ‘not routinely funded’ or ‘restricted’ and these are defined as follows:

* Not routinely funded (NRF) – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an IFR application in line with the CCG’s IFR process, demonstrates clinical exceptionality;
* Restricted – This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG’s IFR process, demonstrates clinical exceptionality;

**Diagnostic Procedures**

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

**Psychological factors**

Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress.  In these cases, ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient’s psychological wellbeing, their duration and impact.  The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image, but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

**Lifestyle and surgery**

Lifestyle factors can have an impact on the functional results of some elective surgery. In particular, smoking is well known to affect the outcomes of some foot and ankle procedures. In addition, many studies have shown that the rates of postoperative complications and length of stay are higher in patients who are overweight or who smoke. Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to secondary care, should be able to access CCG and Local Authority Public Health commissioned smoking cessation and weight reduction management services prior to surgery.

Patient engagement with these “preventive services” may influence the immediate outcome of surgery. While failure to quit smoking or lose weight will not be a contraindication for surgery, GPs and Surgeons should ensure patients are fully informed of the risks associated with the procedure in the context of their lifestyle.

**CBCT Referral/Treatment Listing Processes**

**Primary Care**

Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.

If in doubt over the local process, the referring clinician should contact the relevant CCG, IFR Team or Referral Management Team for guidance. Failure to comply with the local process may delay a decision being made.

Any referral letter should include specific information regarding the patient’s potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.

In cases where there may be an element of doubt the General Practitioner/Optometrist/Dentist should discuss the case with the IFR Team in the first instance.

**Secondary Care**

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not. The consultant may also request additional information before seeing the patient.

If a secondary care consultant considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the consultant should follow the listing process for treatment. NB. For some CCGs this will involve following a process of prior approval. If in doubt over the CCG requirements, the consultant should contact the relevant CCG or the IFR Team for guidance. Failure to comply with the CCGs’ processes may delay a patient’s treatment and/or release of funding resources.

Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient’s notes should clearly reflect exactly how the criteria were fulfilled including prior approval authorisation where relevant. This will allow for case note audit to support contract management.

Should the patient not meet the eligibility criteria this should be recorded in the patient’s notes and the consultant should return the referral back to the General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

**IFR Applications/Clinical Exceptionality**

Exceptionality is where a patient does not meet all of the criteria outlined for a specific procedure or treatment or, the procedure or treatment is not routinely commissioned.

In this scenario, should a patient not fulfil the clinical criteria, but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Panel for consideration. The person who fills in the IFR can be a consultant or a GP.

In dealing with clinically exceptional requests for an intervention that is considered to be a poor use of NHS resources, the Merseyside CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

* The patient has a clinical picture that is significantly different to the general population of patients with that condition; and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

The CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS, namely that people with equal need should be treated equally. Therefore, non-clinical factors will not be considered except where this policy explicitly provides otherwise.

The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

Individual Funding Requests should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form; can be found on the CCGs websites.

IFR contact information follows, however please refer to the CCG IFR policy for more information:

Individual Funding Request Case Manager   
Midlands and Lancashire Commissioning Support Unit (MLCSU)  
1829 Building

Countess of Chester Health Park

Liverpool Road

Chester

CH2 1HJ

Telephone: 01244 650 305

Email addresses for Individual Funding Request teams at CCGs:

|  |  |
| --- | --- |
| **CCG** | **Email Address** |
| Halton CCG | [IFR.manager@nhs.net](mailto:Ifr.manager@nhs.net) |
| Liverpool CCG |
| South Sefton CCG |
| Southport & Formby CCG |
| St Helens CCG |
| Warrington CCG | [Warringtonccg.IFR@nhs.net](mailto:Warringtonccg.IFR@nhs.net) |

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**Medicines**

Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

* Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG;
* Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication;
* Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1;
* Any drug used out with NICE Guidance (where guidance is in existence);
* Any proposed new drug/new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG;
* Any medicines that are classed by the CCG as being of limited clinical value;
* Any medicines that will be supplied via a homecare company agreement;

**Clinical Trials**

The CCGs do not expect to provide funding for patients to continue treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

**Photographic evidence**

Photographic evidence may be required in cases which are being considered for clinical exceptionality in line with the IFR processes. However, photographic evidence will not be accepted for consideration unless it is impossible to make the case in any other way.

The decision to submit photographic evidence remains with the patient and responsible clinician and must meet the CCGs criteria for submission as outlined by the CCGs IFR Policy.

If photographs are accepted for consideration in accordance with the CCGs criteria, they will be examined by clinical members of the IFR team. In the course of the work for the case the applicant should be aware that other members of the IFR Panel, IFR Process Reviews Panel or IFR team who prepare the papers may need to handle or see the photographs.

**Personal data**

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

Clearly label the envelope to a named individual i.e. first name & surname, and job title.

Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Costs incurred will be the responsibility of the referrer, this includes photographic evidence.

**Copies of this policy**

Electronic copies of this policy can be found on the websites of the respective CCGs. Alternatively; you may contact the CCG and ask for a copy of the Criteria Based Clinical Treatments 2019-20 policy document.

**Monitoring and review**

This policy will be subject to continued monitoring using a mix of the following approaches:

* Prior approval process;
* Post activity monitoring through routine data;
* Post activity monitoring through case note audits;

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

**Evidence**

At the time of publication the evidence presented per procedure/treatment was the most current available. Where reference is made to older publications these still represents the most up to date view.

| GLOSSARY**Term** | **Meaning** |
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| **Analgesics** | Painkillers. |
| **Asymptomatic** | Without symptoms. |
| **Augmentation** | Increasing in size, for example breast augmentation. |
| **Benign** | Does not invade surrounding tissue or spread to other parts of the body; it is not a cancer. |
| **Binocular vision** | Vision in both eyes. |
| **Body Mass Index (BMI)** | Body Mass Index - a measure that adults can use to see if they are a healthy weight for their height. |
| **CCG** | Clinical Commissioning Group. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. |
| **Chronic** | Persistent |
| **Co-morbidities** | Other risk factors alongside the primary problem. |
| **Congenital** | Present from birth |
| **Conservative treatment** | The management and care of a patient by less invasive means; these are usually non-surgical |
| **DOH** | Department of Health |
| **Eligibility/Threshold** | Whether someone qualifies. In this case, the minimum criteria to access a procedure. |
| **Exceptional clinical circumstances** | A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient. |
| **Functional health problem/difficulty/impairment** | Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living. |
| **GP** | General Practitioner. |
| **Histology** | The structure of cells or tissue under a microscope. |
| **Individual Funding Request (IFR)** | A request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment. |
| **Irreducible** | Unable to be reduced. |
| **Malignant/malignancy** | Harmful. |
| **Monocular vision** | Vision in one eye only. |
| **Multi-disciplinary** | Involving several professional specialisms for example in a Multi-disciplinary team (MDT). |
| **NICE guidance** | The guidance published by the National Institute for Health and Care Excellence. |
| **Not routinely funded (a procedure)** | This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **NSAIDS** | Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation. |
| **Paediatric(ian)** | Medical care concerning infants, children and adolescents usually under 18. |
| **Pathology/pathological** | The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing. |
| **PCT** | Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups). |
| **PLCP** | Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances. |
| **Precipitates** | Brings about/triggers. |
| **Primary care** | a patient’s first point of interaction with NHS services e.g. a GP surgery. |
| **Rationale** | Explanation of the reason why. |
| **Restricted (a procedure)** | This means CCG will fund the treatment if the patient meets the stated clinical threshold for care. |
| **Secondary care** | Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services. |
| **Stakeholders** | Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc. |
| **Symptomatic** | Something causing or exhibiting symptoms. |

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# *PART A: 2019/20 REVISED POLICY POSITIONS*

## A2. Dermatology

### A2.2 Removal of benign skin lesions

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| Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined below. Risks from the procedure can include bleeding, pain, infection, and scarring. | |
| **Intervention** | **Removal of benign skin lesions** |
| **Policy Statement** | Removal of benign skin lesions means treating asymptomatic lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a small risk of infection, bleeding or scarring and is not usually offered by the NHS if it is just to improve appearance. In certain cases, treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to pre- malignant lesions and other lesions with potential to cause harm. |
| **Minimum eligibility criteria** | This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:   * benign moles (excluding large congenital naevi) * solar comedones * corn/callous * dermatofibroma * lipomas * milia * molluscum contagiosum (non-genital) * epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) * seborrhoeic keratoses (basal cell papillomata) * skin tags (fibroepithelial polyps) including anal tags * spider naevi (telangiectasia) * non-genital viral warts in immunocompetent patients * xanthelasmata * neurofibromata   The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:   * The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year * There is repeated infection requiring 2 or more antibiotics per year * The lesion bleeds in the course of normal everyday activity * The lesion causes regular pain * The lesion is obstructing an orifice or impairing field vision * The lesion significantly impacts on function e.g. restricts joint movement * The lesion causes pressure symptoms e.g. on nerve or tissue * If left untreated, more invasive intervention would be required for removal * Facial viral warts * Facial spider naevi in children causing significant psychological impact * Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.   The following are outside the scope of this policy recommendation:   * Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines. * Any lesion where there is diagnostic uncertainty, pre-malignant * lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care. * Removal of lesions other than those listed above.   Referral to appropriate speciality service (e.g. dermatology or plastic surgery):   * The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria. * This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.   For further information, please see:   * https://[www.nice.org.uk/guidance/csg8](http://www.nice.org.uk/guidance/csg8) * https://[www.nice.org.uk/guidance/ng12](http://www.nice.org.uk/guidance/ng12) |
| **Rationale** | Number of CCG interventions in 2017/18 – 116,255  There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning. |
| **Evidence for inclusion and threshold** | References   1. Higgins JC, Maher MH, Douglas MS. Diagnosing Common Benign Skin Tumors. Am Fam Physician. 2015 Oct 1;92(7):601-7. PubMed PMID: 26447443. 2. Tan E, Levell NJ, Garioch JJ. The effect of a dermatology restricted-referral list upon the volume of referrals. Clin Exp Dermatol. 2007 Jan;32(1):114-5. PubMed PMID: 17305918. |

## A4. ENT

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| A4.1 Policy for Adenoidectomy | |
| An adenoidectomy is an operation to remove the adenoids – small lumps of tissue at the back of the nose, behind the palate.  Adenoids are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoids are only present in children. They start to grow from birth and are biggest when your child is approximately three to five years old.  But by age seven to eight they start to shrink and by the late teens, are barely visible. By adulthood, the adenoids will have disappeared completely.  The adenoids disappear because – although they may be helpful in young children – they are not an essential part of an adult's immune system.  A good summary of adenoids and adenoidectomy is provided by NHS Choices.  Weblink:  <http://www.nhs.uk/conditions/Adenoids-and-adenoidectomy/Pages/Introduction.aspx> | |
| **Intervention** | **Adenoidectomy** |
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Adenoidectomy will only be funded if Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis (see weblink below), with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.    Or  Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.  This means (for patients who do not require tonsillectomy and/or grommets) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons Commissioning Guide for Rhinosinusitis (2013): The Royal College of Surgeons of England and ENT UK (2013). Commissioning guide: Rhinosinusitis, Available from:  <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/rhinosinusitis-commissioning-guide/>  This guide has been prepared for commissioners by the Royal College of Surgeons following a review of the latest research evidence.  Robb PJ et al (2009), Tonsillectomy and adenoidectomy in children with sleep-related breathing disorders: consensus statement of a UK multidisciplinary working party, Annals of the Royal College of Surgeons of England, 91, 371-373. Available from: <http://europepmc.org/articles/PMC2758429;jsessionid=MVfPN7W1Ky1PN4EiKikL.52>  <https://www.nice.org.uk/guidance/cg60>  *Adenoidectomy is not recommended*  “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.”  Scottish Intercollegiate Guidelines Network, NHS Quality Improvement Scotland. *Management of sore throat and indications for tonsillectomy 117.* April 2010. <http://www.sign.ac.uk/pdf/qrg117.pdf> |

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| A4.2 Policy for Pinnaplasty | |
| Ear correction surgery is cosmetic surgery to alter the size or shape of the ears, or pin them back if they stick out.  Pinning back the ears is known as an otoplasty, or pinnaplasty. It's usually carried out on children and young teenagers, although adults may wish to have it done, too.  An otoplasty isn't suitable for children younger than five as their ears will still be growing and developing.  Most people are happy with the results of an otoplasty, and generally it's a safe procedure. But it can be expensive and there are still risks to consider.  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx> and <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Pinnaplasty** |
| **Policy Statement** | Not routinely commissioned |
| **Minimum eligibility criteria** | Pinnaplasty is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons and British Association of Plastic, Reconstructive and Aesthetic Surgeons – Pinnaplasty Commissioning Guide (2013)  Weblink:  <http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty/at_download/file> |

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| A4.3 Grommets for Glue Ear in Children Evidence suggests that grommets only offer a short-term hearing improvement in children with glue ear who have no other serious medical problems or disabilities. They should be offered in cases that have a history of persistent (at least 3 months) bilateral, hearing loss as defined by the NICE guidance. Hearing aids can also be offered as an alternative to surgery <https://www.nice.org.uk/Guidance/CG60> | |
| **Intervention** | **Grommets for Glue Ear in Children** |
| **Policy Statement** | This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build-up (glue ear) when it is affecting hearing in children.  Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing.  Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems.  Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include:   * Recurrent acute otitis media * Atrophic tympanic membranes * Access to middle ear for transtympanic instillation of medication Investigation of unilateral glue ear in adults |
| **Minimum eligibility criteria** | The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met:   * All children must have had specialist audiology and ENT assessment. * Persistent bilateral otitis media with effusion over a period of 3 months. * Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, * & 4kHz * Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant. * Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant. * The guidance is different for children with Down’s Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance. * It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.   For further information, please see https://[www.nice.org.uk/Guidance/CG60.](http://www.nice.org.uk/Guidance/CG60)  The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age). |
| **Rationale** | Number of CCG interventions in 2017/18 – 8,669  In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.  The NHS should only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit. |
| **Evidence for inclusion and threshold** | References  NICE guidance: <https://www.nice.org.uk/Guidance/CG60>  Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3 |

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| A4.4 Tonsillectomy for Recurrent Tonsillitis Recurrent sore throats are a very common condition that present a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met. | |
| **Intervention** | **Tonsillectomy for recurrent Tonsillitis** |
| **Policy Statement** | This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children.  Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person’s ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms. |
| **Minimum eligibility criteria** | The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance:   * Sore throats are due to acute tonsillitis AND * The episodes are disabling and prevent normal functioning AND * Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year OR * Five or more such episodes in each of the preceding two years OR * Three or more such episodes in each of the preceding three years.   There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:   * Acute and chronic renal disease resulting from acute bacterial tonsillitis. * As part of the treatment of severe guttate psoriasis. * Metabolic disorders where periods of reduced oral intake could be dangerous to health. * PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis) * Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous   Further information on the Scottish Intercollegiate Guidelines Network guidance can be found here: <http://www.sign.ac.uk/assets/sign117.pdf>  Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:   * Obstructive Sleep Apnoea / Sleep disordered breathing in Children * Suspected Cancer (e.g. asymmetry of tonsils) * Recurrent Quinsy (abscess next to tonsil) * Emergency Presentations (e.g. treatment of parapharyngeal abscess)   It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future. |
| **Rationale** | Number of CCG interventions in 2017/18 – 32,238  Recurrent sore throats are a very common condition that presents a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met.  The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267, 159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. The Getting it Right First Time ENT report is due late 2018 and will present updated figures on readmission rates in relation to tonsillectomy.  There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation. |
| **Evidence for inclusion and threshold** | References   1. Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun 6;16:263. <https://www.ncbi.nlm.nih.gov/pubmed/26047934> 2. <http://www.sign.ac.uk/assets/sign117.pdf> 3. Osbourne MS, Clark MPA. The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018. May (100) 5: 406-408 |

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| A4.7 Policy for Rhinoplasty |
| Rhinoplasty, commonly known as a ‘nose job’, is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty. |

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| **Intervention** | **Rhinoplasty** |
| **Policy Statement** | **Restricted**  a) Rhinoplasty is not routinely commissioned for cosmetic reasons.  b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. a septoplasty. |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:   * Documented medical breathing problems caused by obstruction of the nasal airway **OR** * Correction of complex congenital conditions e.g. Cleft lip and palate   This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Rhinoplasty Guide  Weblink:  <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/> |

## A7. General Surgery

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| A7.1 Haemorrhoid Surgery Numerous interventions exist for the management of haemorrhoids (piles). The evidence recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less severe haemorrhoids. |
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| **Intervention** | **Haemorrhoid surgery** |
| **Policy Statement** | **Restricted** |
| **Minimum eligibility criteria** | This procedure involves surgery for haemorrhoids (piles).  Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.  Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically:   * Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or * Irreducible and large external haemorrhoids   In cases where there is significant rectal bleeding the patient should be examined internally by a specialist. |
| **Rationale** | Surgery should be performed, according to patient choice and only in cases of persistent grade 1 (rare) or 2 haemorrhoids that have not improved with dietary changes, banding or perhaps in certain cases injection, and recurrent grade 3 and 4 haemorrhoids and those with a symptomatic external component.  Haemorrhoid surgery can lead to complications. Pain and bleeding are common and pain may persist for several weeks. Urinary retention can occasionally occur and may require catheter insertion. Infection, iatrogenic fissuring (tear or cut in the anus), stenosis and incontinence (lack of control over bowel motions) occur more infrequently. |
| **Evidence for inclusion and threshold** | Number of CCG interventions in 2017/18 – 8,474  References   1. Watson AJM, Bruhn H, MacLeod K, et al. A pragmatic, multicentre, randomised controlled trial comparing stapled haemorrhoidopexy to traditional excisional surgery for haemorrhoidal disease (eTHoS): study protocol for a randomised controlled trial. Trials. 2014;15:439. doi:10.1186/1745-6215-15-439. 2. Watson AJM, Hudson J, Wood J, et al. Comparison of stapled haemorrhoidopexy with traditional excisional surgery for haemorrhoidal disease (eTHoS): a pragmatic, multicentre, randomised controlled trial. Lancet (London, England). 2016;388(10058):2375-2385. doi:10.1016/S0140-6736(16)31803-7. 3. Brown SR. Haemorrhoids: an update on management. Therapeutic Advances in Chronic Disease. 2017;8(10):141-147. doi:10.1177/2040622317713957. 4. NHS website: <https://www.nhs.uk/conditions/piles-haemorrhoids>/ 5. Royal College of Surgeons: https://[www.rcseng.ac.uk/-](http://www.rcseng.ac.uk/-)/media/files/rcs/standards-and- research/commissioning/rcsacpgbirectalbleeding2017documentfinal\_jan18.pdf 6. Health Technol Assess. 2016 Nov;20(88):1-150. The HubBLe Trial: haemorrhoidal artery ligation (HAL) versus rubber band ligation (RBL) for symptomatic second- and third-degree haemorrhoids: a multicentre randomised controlled trial and health-economic evaluation. Brown S et al. |

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| A7.2 Policy for Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti | |
| A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall.  A hernia usually develops between your chest and hips. In many cases, it causes no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin.  The lump can often be pushed back in or disappears when you lie down. Coughing or straining may make the lump appear.  A good summary about treating hernias is provided by NHS Choices:  Weblink:  <http://www.nhs.uk/conditions/hernia/Pages/Introduction.aspx>  A good summary about Disatasis Recti is provided by NHS Choices:  Weblink:  <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/your-body-after-childbirth.aspx?tabname=pregnancy#separated> | |
| **Intervention** | **Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti** |
| **Minimum eligibility criteria** | **Not routinely commissioned**  This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because these procedures highly specialised and techniques for treatment are not well developed making treatment complicated. |
| **Evidence for inclusion and threshold** | [A systematic review on the outcomes of correction of diastasis of the recti](http://link.springer.com/article/10.1007/s10029-011-0839-4/fulltext.html)  Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al. |

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| A7.3 Surgery for Asymptomatic Gallstones | |
| Gallstones are small stones, usually made of cholesterol, that form in the gallbladder. In most cases they don't cause any symptoms and don't need to be treated.  However, if a gallstone becomes trapped in an opening (duct) inside the gallbladder, it can trigger a sudden, intense abdominal pain that usually lasts between one and five hours. This type of abdominal pain is known as biliary colic.  Some people with gallstones can also develop complications, such as inflammation of the gallbladder (cholecystitis), which can cause:   * persistent pain * jaundice * a fever   When gallstones cause symptoms or complications, it's known as gallstone disease or cholelithiasis.  A Good summary of Gallstones is provided by NHS Choices:  Weblink:  <http://www.nhs.uk/conditions/gallstones/Pages/Introduction.aspx> | |
| **Intervention** | **Surgery for Asymptomatic Gallstones** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Rationale** | This is because the majority of people with gallbladder stones remain asymptomatic and require no treatment. |
| **Evidence for inclusion and threshold** | <https://www.rcseng.ac.uk/-/media/files/rcs/.../gallstones--commissioning-guide.pdf>  Royal College of Surgeons (2016). |

## A8. Gynaecology

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| A8.1 Hysterectomy for heavy menstrual bleeding NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding (HMB) see <https://www.nice.org.uk/guidance/ng88>  Heavy periods can be reduced by using medicines or intrauterine systems (IUS) or losing weight (if necessary). | | |
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| **Intervention** | **Hysterectomy for Heavy Menstrual Bleeding** |
| Policy Statement | Hysterectomy is the surgical removal of the uterus. |
| Minimum eligibility criteria | Based on NICE guidelines [Heavymenstrualbleeding:assessmentand management[NG88]Publisheddate:March2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.  It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.  Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.  1.13.1.1.1 NICE guideline NG88 1.5 Management of HMB  1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.  1.13.1.1.2 Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis  Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.  If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.  Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.  If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy.  1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.  1.13.1.1.3 Treatments for women with fibroids of 3 cm or more in diameter  Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.  If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.  Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.  For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.  Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.  Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]  Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.  If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation 1.5.10.  Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.  For further information, please see:  https://[www.nice.org.uk/guidance/ng88.](http://www.nice.org.uk/guidance/ng88)  https://[www.nhs.uk/conditions/heavy-periods/#Causes](http://www.nhs.uk/conditions/heavy-periods/#Causes) |
| Rationale | Number of CCG interventions in 2017/18 – 27,660  NICE’s Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for women with heavy menstrual bleeding.  Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur. |
| **Evidence for inclusion and threshold** | References   1. NICE guidance: <https://www.nice.org.uk/guidance/ng88>. 2. NHS website: <https://www.nhs.uk/conditions/heavy-periods/#Causes> 3. Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63. 4. Learman LA, Summitt Jr RL, Varner RE, et al. Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. Obstetrics and Gynecology 2004;103(5 I):824–33. 5. Zupi E, Zullo F, Marconi D, et al. Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. American Journal of Obstetrics and Gynecology 2003;188(1):7–12. 6. Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284. 7. Hehenkamp WJ, Volkers NA, Donderwinkel PF, et al. Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri- and postprocedural results from a randomized controlled trial. American Journal of Obstetrics and Gynecology 2005;193(5):1618–29. 8. Pinto I, Chimeno P, Romo A, et al. Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical trial. Radiology 2003;226(2):425–31. |

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| A8.2 Dilatation and Curettage (D&C) for heavy menstrual bleeding in women | |
| NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods\*.  Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), can be used to investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) can treat heavy periods.  \* <https://www.nice.org.uk/guidance/ng88>and <https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy>  Summary of intervention  Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).  Recommendation  D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.  UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods.  Medication and intrauterine systems (IUS) can be used to treat heavy periods. For further information, please see:  https://[www.nice.org.uk/guidance/ng88](http://www.nice.org.uk/guidance/ng88)  https://[www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy](http://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy) | |
| **Intervention** | **Dilatation and Curettage (D&C) for heavy menstrual bleeding in women** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned |
| **Rationale** | Number of CCG interventions in 2017/18 - 236  NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix. |
| **Evidence for inclusion and threshold** | References   1. NICE guidance: https://[www.nice.org.uk/guidance/ng88](http://www.nice.org.uk/guidance/ng88) 2. NHS advice: https://[www.nhs.uk/conditions/hysteroscopy/#alternatives-to-](http://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-) hysteroscopy 3. MacKenzie IZ, Bibby JG. Critical assessment of dilatation and curettage in 1029 women. Lancet 1978;2(8089):566–8. 4. Ben-Baruch G, Seidman DS, Schiff E, et al. Outpatient endometrial sampling with the Pipelle curette. Gynecologic and Obstetric Investigation 1994;37(4):260–2. 5. Gimpelson RJ, Rappold HO. A comparative study between panoramic hysteroscopy with directed biopsies and dilatation and curettage. A review of 276 cases. American Journal of Obstetrics and Gynecology 1988;158(3 Pt 1):489–92. 6. Haynes PJ, Hodgson H, Anderson AB, et al. Measurement of menstrual blood loss in patients complaining of menorrhagia. British Journal of Obstetrics and Gynaecology 1977;84(10):763–8. |

## A9. Mental Health

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| A9.4 Policy for Private Mental Health Care | |
| Private Mental Health Care is not routinely commissioned because most mental health conditions can be managed in the community with input from Community Mental Health teams.  NHS England Specialist Commissioning provides NHS specialist services for various conditions including PTSD, eating disorders and severe OCD.  There is also a specialist NHS Mental Health service provided for affective disorders. | |
| **Intervention** | **Policy for Private Mental Health Care** |
| **Policy Statement** | Not Routinely Commissioned |

## A11. Ophthalmology

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| A11.5 Policy for Cataract Surgery |
| A cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).  The Royal College of Ophthalmologists’ National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to:   * 6/6 Snellen (3% of cataract surgery patients) * 6/9 Snellen (5% of cataract surgery patients) * 6/12 Snellen (36% of cataract surgery patients)     So eyes with visual acuities of 6/9 or better, accounted for only about 10% of cataract surgery. |

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| **Intervention** | **Cataract Surgery** |
| **Policy Statement** | The presence of a cataract in itself does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risks and benefits of surgery. This assessment will usually be undertaken by an accredited community optometrist prior to referral.  Where both eyes are affected by cataract, the first eye referred for cataract surgery is usually expected to be the eye where cataract has caused the greatest reduction in visual acuity.  This policy does not extend to cataract removal incidental to the management of other eye conditions. |
| **Minimum eligibility criteria** | Referral of patients to ophthalmologists for cataract surgery should be based on the following indications:   1. The patient has sufficient cataract to account for visual symptoms.   It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient’s quality of life is significantly impaired.  A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any of the following factors, although this is not an exhaustive list:  a. the patient is at significant risk of falls  b. the impact of the visual symptoms is affecting the patient’s ability to access their chosen mode of transport including driving  c. the impact of symptoms is compromising the patient’s independence  d. the impact of the visual symptoms is affecting the patient’s ability to continue their employment or undertake caring responsibilities  e. the impact of the visual symptoms is substantially affecting the patient’s ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces.  f. the patient is experiencing disabling glare.  **AND**  2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. <http://sdm.rightcare.nhs.uk/pda/cataracts/>  3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery  **Guidance for second eye surgery in patients with bilateral cataracts**  **The second eye criteria is**  As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient’s quality of life despite one eye having been operated upon |
| **Guidance/evidence**  Atlas of Variation *Tacking Unwarranted Variation in Healthcare* *across the NHS* Public Health England, NHS Right Care and NHS England September 2015  *Evidence Review Cataract Surgery* –ChaMPs May 2014  Royal College of Ophthalmologists *Commissioning Guide for Cataract Surgery* February 2015  NHS Choices  NHS Patient Decision Aids – Cataract | |

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| A11.8 Chalazia Removal The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery. |
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| **Intervention** | **Chalazia Removal** |
| **Policy Statement** | This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage. |
| **Minimum eligibility criteria** | Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:   * Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks * Interferes significantly with vision * Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy * Is a source of infection that has required medical attention twice or more within a six month time frame * Is a source of infection causing an abscess which requires drainage * If malignancy (cancer) is suspected eg. Madarosis/ recurrence/ other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions |
| **Evidence for Inclusion and threshold** | Number of CCG interventions in 2017/18 – 6,026  NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used.  Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does  carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.  Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm however there are a small number which are persistent, very large, or can cause other problems such as distortion of vision.  In these cases surgery can remove the contents from a chalazion. However all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back. The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding.  Some trials comparing the two treatments suggest that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction but less pain and patient inconvenience. However this is controversial and other studies show that steroid injection is less effective than surgery. Therefore both options can be considered for suitable patients.  References   1. NICE clinical knowledge summaries, <https://cks.nice.org.uk/meibomian-cyst>- chalazion 2. Moorfield’s Eye Hospital Patient Information,   <https://www.moorfields.nhs.uk/sites/default/files/chalazion-adult.pdf>   1. Wu AY, Gervasio KA, Gergoudis KN, Wei C, Oestreicher JH, Harvey JT. Conservative therapy for chalazia: is it really effective? Acta Ophthalmol. 2018 Jan 16. doi: 10.1111/aos.13675. [Epub ahead of print] PubMed PMID: 29338124. 2. Goawalla A, Lee V. A prospective randomized treatment study comparing three treatment options for chalazia: triamcinolone acetonide injections, incision and curettage and treatment with hot compresses. Clin Exp Ophthalmol. 2007 Nov;35(8):706-12. PubMed PMID: 17997772. 3. Watson P, Austin DJ. Treatment of chalazions with injection of a steroid Suspension. British Journal of Ophthalmology, 1984, 68, 833-835. 4. Ben Simon, G.J., Huang, L., Nakra, T. et al. Intralesional triamcinolone acetonide injection for primary and recurrent chalazia (is it really effective?) . Ophthalmology. 2005; 112: 913–917. 5. Papalkar D, Francis IC. Injections for Chalazia? Ophthalmology 2006; 113:355–356. Incision and curettage vs steroid injection for the treatment of chalazia: a metaanalysis. Aycinena A, Achrion A et al. Ophthalmic Plastic and reconstructive surgery. 2016;32:220-224. 6. McStay. Stye and Chalazion. BMJ Best Practice 7. <https://bestpractice.bmj.com/topics/en-gb/214>(accessed 18/10/18) |

## A14. Plastic Surgery

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| A14.1 Breast Reduction The evidence highlights that breast reduction is only successful in specific circumstances and the procedure can lead to complications - for example not being able to breast feed permanently. However in some cases breast reduction surgery is necessary where large breasts impact on day to day life, for example ability to drive a car. Therefore, breast reduction should only be undertaken under specific criteria. Wearing a professionally fitted bra, losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts.  Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life. | |
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| **Intervention** | **Breast Reduction** |
| **Minimum eligibility criteria** | The NHS will only provide breast reduction for women if all the following criteria are met:   * The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. * In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided * Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). * Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes. * Body mass index (BMI) is <27 and stable for at least twelve months. * Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. * Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. * Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.   Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months.  Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.  This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.  Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer. |
| **Evidence for inclusion and threshold** | Number of CCG interventions in 2017/18 – 2,388  One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.  Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are  severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).  References   1. An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010). Pages 13 & 14 2. Royal College of Surgeons – https://[www.rcseng.ac.uk/-](http://www.rcseng.ac.uk/-) 3. /media/files/rcs/library-and-publications/non-journal-publications/breast- reduction--commissioning-guide.pdf 4. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. British Journal of Plastic Surgery, 56(3), 230–236. 5. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. Chiropractic & Osteopathy, 16(1), 1-7. 6. Singh KA, Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. Plast Reconstr Surg. 2012 Mar;129(3):562-70. PubMed: PM22090252 7. Strong B, Hall-Findlay EJ. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammaplasty Patients? Ann Plast Surg. 2014 Apr 10. PubMed: PM24727444 8. Valtonen JP, Setala LP, Mustonen PK, Blom M. Can the efficacy of reduction mammoplasty be predicted? The applicability and predictive value of breast-related symptoms questionnaire in measuring breast-related symptoms pre- and postoperatively. J Plast Reconstr Aesthet Surg. 2014 May;67(5):676-81. PubMed: PM24508223 9. Foreman KB, Dibble LE, Droge J, Carson R, Rockwell WB. The impact of breast reduction surgery on low-back compressive forces and function in individuals with macromastia. Plast Reconstr Surg. 2009 Nov;124(5):1393-9. PubMed: PM20009823 10. Shah R, Al-Ajam Y, Stott D, Kang N. Obesity in mammaplasty: a study of complications following breast reduction. J Plast Reconstr Aesthet Surg. 2011 Apr;64(4):508-14. doi: 10.1016/j.bjps.2010.07.001. Epub 2010 Aug 3. PubMed PMID: 20682461. 11. Oo M, Wang Z, Sakakibara T, Kasai Y. Relationship Between Brassiere Cup Size and Shoulder-Neck Pain in Women. The Open Orthopaedics Journal. 2012;6:140-142. doi:10.2174/1874325001206010140. 12. <https://www.nhs.uk/conditions/breast-reduction-on-the-nhs>/ 13. Plast Reconstr Surg. 2011 Nov;128(5):395e-402e. doi:10.1097/PRS.0b013e3182284c05.The impact of obesity on breast surgery complications.Chen CL(1), Shore AD, Johns R, Clark JM, Manahan M, Makary MA |

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| A14.2 Augmentation Mammoplasty - Breast Enlargement | |
| **Breast Enlargement**  Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Augmentation Mammoplasty - Breast Enlargement** |
| **Minimum eligibility criteria** | Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria:   * There is congenital absence of breast tissue unilaterally ***(affecting one breast only)*** of three or more cup size difference as measured by a specialist.   AND   * The patient’s BMI is under 25 and has been stable for at least 12 months   AND   * Aged over 18 years old. |
| **Evidence for inclusion and threshold** | NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).  Weblink:  <https://www.nice.org.uk/guidance/cg80>    NICE Quality Standard 12 – Breast Cancer (2016)  Weblink:  <https://www.nice.org.uk/guidance/qs12>    British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)  Weblink:  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0>    Breast Cancer Care – Breast Reconstruction  Weblink:  <https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction>  Dixon, J, et al, 1994, [ABC of breast diseases: congenital problems and aberrations of normal breast development and involution](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541002/), Br Med J, 309, 24 September, 797-800  Freitas, R, et al, 2007, [Poland’s Syndrome: different clinical presentations and surgical reconstructions in 18 cases](http://www.ncbi.nlm.nih.gov/pubmed/?term=Poland%E2%80%99s+Syndrome%3A+different+clinical+presentations+and+surgical+reconstructions+in+18+cases), Aesthet Plast Surg, 31, 140-46.  Heimberg, D, et al, 1996, [The tuberous breast deformity: classification and treatment](http://www.ncbi.nlm.nih.gov/pubmed/8881778), Br J Plast Surg, 49, 339-45.  Pacifico, M, et al, 2007, [The tuberous breast revisited](http://www.jprasurg.com/article/S1748-6815%2807%2900017-4/abstract), J Plast Reconstruct Aesthet Surg, 60, 455-64.  North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures”, 5-7.moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf  Sadove, C, et al, 2005, [Congenital and acquired pediatric breast anomalies: a review of 20 years experience](http://www.ncbi.nlm.nih.gov/pubmed/?term=Congenital+and+acquired+pediatric+breast+anomalies%3A+a+review+of+20+years+experience), Plast Reconstruct Surg, April, 115(4), 1039-1050.  [*Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service*](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.3 Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation | |
| **COSMETIC SURGERY**  Cosmetic surgery is often carried out to change a person’s appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner.  1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.  2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment  3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.  4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment  5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community  6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance  7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.  A good summary of Cosmetic Surgery is provided by NHS Choices.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation** |
| **Minimum eligibility criteria** | Removal and/or replacement of silicone implants is not routinely commissioned.  The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:  Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only but will **not** replace them. |
| **Evidence for inclusion and threshold** | [Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214975/dh_134657.pdf)  Department of Health (June 2012).  NHS Choices: PIP breast implants  <http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx>  NHS Choices: Breast Enlargement  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.4 Mastopexy - Breast Lift | |
| Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> | |
| **Intervention** | **Mastopexy - Breast Lift** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | NICE Quality Standard 12 – Breast Cancer (2016)  Weblink:  <https://www.nice.org.uk/guidance/qs12>    British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)  Weblink:  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0>    Breast Cancer Care – Breast Reconstruction  Weblink:  <https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction>  NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).  Weblink:  <https://www.nice.org.uk/guidance/cg80>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.5 Surgical Correction of Nipple Inversion | |
| Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> | |
| **Intervention** | **Surgical Correction of Nipple Inversion** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.6 Male Breast Reduction Surgery for Gynaecomastia | |
| **Gynaecomastia**  Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of >2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological.  Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter.  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and  <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Male Breast Reduction Surgery for Gynaecomastia** |
| **Minimum eligibility criteria** | See breast reduction policy. |

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| A14.7 Policy for Hair Removal Treatments | |
| Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.  Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or Middle-Eastern descent.  A range of treatment options are available:   * Patients can self-fund options such as shaving, waxing, depilatories (hair removal creams) and bleaching creams. They can also self-fund the physical treatments listed below. * Co-cyprindiol tablets (anti-androgen) may be prescribed. It should be noted however that eflornithine cream has Black status on the Pan Mersey formulary and is not recommended for prescribing. | |
| **Intervention** | **Policy for Policy for Hair Removal Treatments** |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:   * Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** * Is undergoing treatment for pilonidal sinuses to reduce recurrence   This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - hirsuitism patient information leaflet  Weblink:  <http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document>  NHS Choices – Laser Hair Removal  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx>  Pan Mersey APC Guidance for Eflornithine:  <http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=30670635620161221111329> |

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| A14.8 Surgical Treatment for Pigeon Chest - Pectus Anomaly | |
| Pectus anomaly describes a deformity with the sternum (breastbone). The condition is the most common congenital wall deformity.  There are two main types of anomaly:   * **Pectus excavatum** (also known as “funnel chest”/”sunken chest”) in which the sternum is sunken inwards and the chest looks hollow * **Pectus carinatum** (also known as “pigeon chest”) in which the sternum is raised and the chest pushed out. There may sometimes be a depression (dip) on one side and a protrusion (bulge) on the other.   There is also a rare third type of anomaly called **pectus arcuatum**. This is where there is a ridge high across the upper part of the sternum and so the rest of the chest falls away to a flatter shape.  Pectus anomalies occur in around four people in every 1,000 and are more common in men. Anomalies vary from mild to very marked.  Pectus anomalies are thought to be caused by poorly co-ordinated and possibly excessive growth of the costal (rib) cartilages. The anomaly occurs between the ribs and sternum (breast bone) before a child is born and can be excessive.  As the cartilagea grow longer, they “buckle” and push the sternum either inwards (pectus excavatum) or outwards (pectus carinatum).  Certain conditions are associated with pectus anomaly, such as:   * scoliosis – where the spine curves and becomes deformed * Marfan’s syndrome – an inherited disorder of the connective tissue * Poland’s syndrome – a rare inherited condition which involves the absence or underdevelopment of the chest muscles on one side of the body   A pectus anomaly is often seen at birth but usually becomes more obvious during early adolescence when growth is rapid. Once growth is complete the anomaly remains the same.  A good summary of Pectus deformities can be found here:  <http://www.pectus.org/livingwith.htm> | |
| **Intervention** | **Surgical Treatment for Pigeon Chest - Pectus Anomaly** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned |
| **Evidence for inclusion and threshold** | [nice.org.uk/guidance/IPG310](http://www.nice.org.uk/guidance/IPG310)  NICE (2009). |

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| A14.9 Surgical Revision of Scars | |
| The different types of scars include:   * **Flat, pale scars** – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or dark and raised after the wound has healed, but will become paler and flatter naturally over time. This can take up to two years. * **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years. * **Keloid scars** – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed. * **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance. * **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.   **Treating scars**  Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include:   * pressure dressings * corticosteroid injections * cosmetic camouflage (make-up) * surgery   It is often the case that a combination of treatments can be used. | |
| **Intervention** | **Surgical Revision of Scars** |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:   * For severe post burn cases or severe traumatic scarring   **OR**   * Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function   This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf)  NHS Choices – Scars - Treatment  <http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx> |

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| A14.10 Laser Tattoo Removal | |
| Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks.  The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all.  A good summary of Cosmetic Surgery is provided by NHS Choices.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and  <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Laser Tattoo Removal** |
| **Minimum eligibility criteria** | Removal of Tattoos is not routinely commissioned. |
| **Evidence for inclusion and threshold** | [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf)  Modernisation Agency’s Action on Plastic Surgery 2005.  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2>    NHS Choices – The NHS Guide to cosmetic procedures  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx> |

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| A14.11 Abdominoplasty/Apronectomy (sometimes called ‘tummy tuck’) | |
| Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.  A good summary of Cosmetic Surgery is provided by NHS Choices.  Weblink: <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx>  and <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Abdominoplasty/Apronectomy (sometimes called ‘tummy tuck’)** |
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | [A systematic review of outcomes of abdominoplasty](http://informahealthcare.com/doi/abs/10.3109/2000656X.2012.683794). Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).  Royal College of Surgeons - Cosmetic Surgery Categorisation  Weblink:  <https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file>    Royal College of Surgeons – Abdominplasty Guide  Weblink:  <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/>  NHS Choices: Tummy Tuck (abdominoplasty  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.12 Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat | |
| Thigh Lift, Buttock Lift and Arm Lift (Brachioplasty), Excision of Redundant Skin or Fat are surgical procedures performed to remove loose skin or excess fat to reshape body contours  A good summary of Cosmetic Surgery is provided by NHS Choices.  Weblink:  <http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and  <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat** |
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons (2013).  <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/massive-weight-loss/>  BAPRAS Commissioning Guide: Massive weight loss body contouring:  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/body-contouring-surgery-commissioning-guide-published.pdf?sfvrsn=0>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.13 Surgical Treatments for hair Loss |
| **Alopecia**  Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.  In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour. Some people go on to develop a more severe form of hair loss, such as:  • Alopecia totalis (no scalp hair)  • Alopecia universalis (no hair on scalp or body)  Alopecia areata is caused by a problem with the immune system (the body’s natural defence against infection and illness). It’s more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down’s syndrome.  It’s also believed some people’s genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.  Alopecia areata can occur at any age, although it’s more common in people aged 15-29. It affects one or two people in every 1,000 in the UK.  Further information can be found at following link:  <http://www.alopeciaonline.org.uk/treatments-and-wigs.asp>  **Hair transplantation**  A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. ,It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant isn't normally available on the NHS, as it is regarded as cosmetic surgery.  **Male Pattern Baldness**  Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties.  It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon.  Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone |

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| **Intervention** | **Surgical Treatments for hair Loss** |
| **Minimum eligibility criteria** | Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned.  The NHS has a policy for Wigs which may be an alternative option for patients: <http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx>  The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - alopecia areata patient information leaflet  Weblink:  <http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document>  [Interventions for alopecia areata](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004413.pub2/abstract) – Cochrane Library 2008.  <http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf>  Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment.  [No evidence of effective treatments for alopecia](http://www.cochraneprimarycare.org/sites/cochraneprimarycare.org/files/uploads/93_no%20evidence%20treatment%20alopecia.pdf) – Cochrane Pearls 2008.  NICE Clinical Knowledge Summaries 2014.  <https://cks.nice.org.uk/alopecia-areata>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf)  Modernisation Agency’s Action on Plastic Surgery 2005.  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2>  NHS Choices – Guide to Hair Loss Treatment  Weblink:  <http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx>  **Hair transplantation**  [*A trial on subcutaneous pedicle island flap for eyebrow reconstruction*](http://www.burnsjournal.com/article/S0305-4179%2809%2900398-2/abstract) – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697.  Modernisation Agency’s Action on Plastic Surgery 2005.  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2> |

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| A14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy | |
| **Labiaplasty**  A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening.    **Vaginoplasty**  Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex.  **Hyenorrhaphy**  hymenorrhaphy or hymen reconstruction surgery, is a cosmetic procedure.  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx> | |
| **Intervention** | **Labiaplasty, Vaginoplasty and Hymenorrhaphy** |
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | [rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf](https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf)  (RCOG Statement 6).  <http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf>  NHS Choices – Guide to Labiaplasty  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx>  [Clinical characteristics of well women seeking labial reduction surgery: a prospective study.](http://www.ncbi.nlm.nih.gov/pubmed/21883873) BJOG; 2011 Nov;118(12):1507-10.  Liao, L-M; Michala, L; Creighton, SM. (2010). [Labial Surgery for Well Women; a review of the literature.](http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2009.02426.x/abstract)  Goodman, M. P. (2009). [Female Cosmetic Genital Surgery.](http://www.ncbi.nlm.nih.gov/pubmed/19104372) *Obstetrics and Gynaecology; 113: 154-159*  Bramwell R, Morland C, Garden A. (2007). [Expectations and experience of labial reduction: a qualitative study](http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01509.x/abstract). *BJOG* 2007; 114:1493-1499.  Department for Education and Skills. (2004). [*Local Authority Social Services Letter*](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Localauthoritysocialservicesletters/AllLASSLs/DH_4074779)*. LASSAL (2004)4,* London, DfES. |

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| A14.17 Liposuction | |
| Liposuction (also known as liposculpture) is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.  A good summary of Cosmetic Surgery is provided by NHS Choices.  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx> | |
| **Intervention** | **Liposuction** |
| **Minimum eligibility criteria** | Liposuction is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Liposuction: Weblink  <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/>  NHS Choices: Liposuction  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx>  [Liposuction for chronic lymphoedema](http://guidance.nice.org.uk/IPG251)  NICE 2008.  Modernisation Agency’s Action on Plastic Surgery 2005.  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2>  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf) |

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| A14.18 Rhytidectomy - Face or Brow Lift | |
| A facelift (rhytidectomy) is cosmetic surgery to lift up and pull back the skin to make the face tighter and smoother. The procedure is designed to reduce flabby or sagging skin around the lower half of the face (mainly the jowls) and neck. If you're thinking of going ahead, be absolutely sure about your reasons for wanting a facelift and don't rush into it. The procedure can be expensive, the results can't be guaranteed, and there are risks to consider  Weblink:  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx> and <http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx> | |
| **Intervention** | **Face Lift or Brow Lift (Rhytidectomy)** |
| **Minimum eligibility criteria** | Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.  Recognised diagnosis of Congenital (present from birth) facial abnormalities  **OR**  Facial palsy (congenital or acquired paralysis)  **OR**  As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis |
| **Evidence for inclusion and threshold** | Modernisation Agency’s Action on Plastic Surgery 2005.  <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2>  Royal College of Surgeons – Rhytidectomy Weblink  <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/facelift/>    NHS Choices: Facelift (Rhytidectomy)  <http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx> |

## A15. Respiratory

### A15.1 Adult Snoring Surgery (in the absence of OSA)

In two systematic reviews of 72 primary research studies, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has up to 16% risk of severe complications (bleeding, airway compromise, death). Therefore, it is no longer commissioned. A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion.

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person’s partner.

This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment of the OSA.

It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

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| **Intervention** | **Adult Snoring (in the absence of OSA)** |
| **Minimum eligibility criteria** | It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.  Alternative Treatments  There are a number of alternatives to surgery that can improve the symptom of snoring. These include:   * Weight loss * Stopping smoking * Reducing alcohol intake * Medical treatment of nasal congestion (rhinitis) * Mouth splints (to move jaw forward when sleeping) |
| **Evidence for inclusion and threshold** | Number of CCG interventions in 2017/18 – 812  In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent  side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.  References   1. Franklin KA, Anttila H, Axelsson S, Gislason T, Maasilta P, Myhre KI, Rehnqvist N. Effects and side-effects of surgery for snoring and obstructive sleep apnoea- a systematic review. Sleep. 2009 Jan. 32(1):27-36 2. Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs. Health Technol Assess 2009;13(3). https://[www.ncbi.nlm.nih.gov/pubmed/19091167](http://www.ncbi.nlm.nih.gov/pubmed/19091167) 3. Jones TM, Earis JE, Calverley PM, De S, Swift AC. Snoring surgery: A retrospective review. Laryngoscope. 2005 Nov 115(11): 2015-20. https://[www.ncbi.nlm.nih.gov/pubmed/16319615](http://www.ncbi.nlm.nih.gov/pubmed/16319615) |

## A16. Trauma and Orthopaedics

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| A16.1 Policy for non-invasive interventions for low Back pain and sciatica | |
| Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer.  Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur. Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities.  For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that’s the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery.  If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help.  You should seek early advice from your GP if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor. | |
| **Intervention** | **Policy for non-invasive interventions for low Back pain and sciatica** |
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | **Acupuncture**  Acupuncture for low back pain and sciatica is **not routinely commissioned**  **Manual Therapy**  The following procedures are **not routinely commissioned**:   * Lumbar traction * Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) * Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation.   Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.  **Orthotics**  The following are **not routinely commissioned**:   * Foot orthotics * Rocker shoes * Belts and corsets   **Electrotherapy**  The following are **not routinely commissioned:**   * Transcutaneous electrical nerve stimulation (TENS) * Percutaneous electrical nerve stimulation (PENS) * Ultrasound * Interferential * Laser therapy   **Pharmacological interventions**  The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain:   * Paracetamol used alone * Selective serotonin re-uptake inhibitors (**SSRIs**) * Serotonin– norepinephrine reuptake inhibitors * Tricyclic antidepressants * Anti-convulsants * Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)   Patients with neuropathic pain should be managed in line with NICE CG 173:   * Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)   1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.  1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).  1.1.11 Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.  ***Treatments that should not be used***  1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:   * cannabis sativa extract * capsaicin patch * lacosamide * lamotrigine * levetiracetam * morphine * oxcarbazepine * topiramate * tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) * venlafaxine. |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)  <https://www.nice.org.uk/guidance/ng59>  National Low Back and Radicular Pain Pathway 2017  <http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf>  Osteoarthritis: the care and management of osteoarthritis in adults  <https://www.nice.org.uk/guidance/cg59>  The effect of TAMARS treatments on chronic back pain, disability  and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012)  <http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf>  Final\_TAMARS\_report[1].pdf |

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| A16.2 Imaging for patients presenting with low back pain | |
| Imaging does not often change the initial management and outcomes of someone with back pain. This is because the reported imaging findings are usually common and not necessarily related to the person's symptoms. Many of the imaging findings (for example, disc and joint degeneration) are frequently found in asymptomatic people. Requests for imaging by non-specialist clinicians, where there is no suspicion of serious underlying pathology, can cause unnecessary distress and lead to further referrals for findings that are not clinically relevant. | |
| **Intervention** | **Imaging for patients presenting with low back pain.** |
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings.  For patients with non-urgent presentations consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery.  Imaging is only commissioned where patients present with red flags(see below) or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management.  Emergency Spinal Referral   * Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms) * Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit) * Major motor radiculopathy * Suspected Spinal Infection   Priority Spine imaging (Protocol led MRI whole spine unless contraindicated)   * Past history of cancer \*(new onset spinal pain) * Recent unexplained weight loss * Objectively unwell with spinal pain * Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice) * Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids). * Prolonged steroid use \* * Known osteoporosis, with new severe spinal pain   Age <15, or >60 years new onset axial back pain  \*Statistically significant red flags. Although the others listed may not be |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)  <https://www.nice.org.uk/guidance/ng59>  Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging  <https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referrals-for-imaging>  National Low Back and Radicular Pain Pathway 2017  <http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf>  NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) <https://www.nice.org.uk/guidance/cg173> |

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| A16.3 Injections for nonspecific low back pain without sciatica | |
| NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work - <https://www.nice.org.uk/guidance/ng59> | |
| **Intervention** | **Injections for nonspecific low back pain without sciatica** |
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.  Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.  For people with non-specific low back pain the following injections should not be offered:   * facet joint injections * therapeutic medial branch blocks * intradiscal therapy * prolotherapy * Trigger point injections with any agent, including botulinum toxin * Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis * Any other spinal injections not specifically covered above   Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.  Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.  Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.  For further information, please see:  https://[www.nice.org.uk/guidance/ng59](http://www.nice.org.uk/guidance/ng59)  NICE guidelines recommend that spinal injections should not be offered for non- specific low back pain.  Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.  Exclusion criteria for the NICE (NG59) include: Conditions of a non-mechanical nature, including;   * Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera) * Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse) * Neurological disorders (including cauda equina syndrome or mononeuritis) Adolescent scoliosis   Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease) Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.  NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s  Spinal injections  1.3.1 Do not offer spinal injections for managing nonspecific low back pain.  Radiofrequency denervation  1.3.2 Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when:  non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.  1.3.3 Only perform radiofrequency denervation in people with non-specific low back pain after a positive response to a diagnostic medial branch block.  1.3.4 Do not offer imaging for people with non-specific low back pain with specific facet join pain as a prerequisite for radiofrequency denervation. |
| **Evidence for inclusion and threshold** | References   1. NICE guidance: https://[www.nice.org.uk/guidance/ng59,](http://www.nice.org.uk/guidance/ng59) 2. United Kingdom Spine Societies Board: https://[www.ukssb.com/improving-](http://www.ukssb.com/improving-) spinal-care-project 3. Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al.The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul- Aug;15(4):E363-404 4. Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53. 5. Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May- Jun;38(3):175-200. 6. Royal College of Anaesthetists: <https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk> |

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| A16.4 Spinal Fusion | |
| Spinal fusion is used to join two or more vertebrae together by placing an additional section of bone in the space between them.  This helps to prevent excessive movements between two adjacent vertebrae, lowering the risk of further irritation or compression of the nearby nerves and reducing pain and related symptoms.  The additional section of bone can be taken from somewhere else in your body (usually the hip) or from a donated bone. More recently, synthetic (man-made) bone substitutes have been used.  To improve the chance of fusion being successful, some surgeons may use screws and connecting rods to secure the bones.  Afterwards, the surgeon will close the incision with stitches or surgical staples.  <http://www.nhs.uk/Conditions/Lumbardecompressivesurgery/Pages/surgery.aspx> | |
| **Intervention** | **Spinal Fusion** |
| **Minimum eligibility criteria** | The following procedures are not routinely commissioned:   * Fusion * Non-rigid stabilisation techniques * Lateral body fusion in the lumbar spine * Transaxial interbody lumbrosacral fusion * Anterior lumbar interbody fusion (ALIF) * Posterior lumbar interbody fusion (PLIF) * Or any other combination of approach where surgical fixation is performed |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)  <https://www.nice.org.uk/guidance/ng59>  National Low Back and Radicular Pain Pathway 2017  <http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf>  NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) <https://www.nice.org.uk/guidance/cg173>  IPG 387: <https://www.nice.org.uk/guidance/ipg387>  Transaxial interbody lumbosacral fusion |

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| A16.5 Disc and Decompression procedures | |
| **Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.**    It's only recommended when non-surgical treatments haven't helped.  The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.  Lumbar decompression surgery is often used to treat:  •spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside  •a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve  •spinal injuries – such as a fracture or the swelling of tissue  •metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves | |
| **Intervention** | **Disc and Decompression procedures** |
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:   * Patient presents with severe and acute sciatica   AND   * have failed to respond to conservative intervention   AND   * have imaging findings concordant with clinical presentation   Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network.  The following procedures are NOT routinely commissioned:   * Endoscopic Laser Foraminoplasty * Endoscopic Lumbar Decompression * Percutaneous Disc Decompression using Coblation for Lower Back Pain * Percutaneous Intradiscal Laser Ablation in the Lumbar Spine * Automated Percutaneous Mechanical Lumbar Discectomy * Prosthetic Intervertebral Disc Replacement in the Lumbar Spine * Intradiscal Electro Thermal Annuloplasty (IDET) * Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)  <https://www.nice.org.uk/guidance/ng59>  National Low Back and Radicular Pain Pathway 2017  <http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf>  NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) <https://www.nice.org.uk/guidance/cg173>  [IPG31 Endoscopic laser foraminoplasty: guidance](http://www.nice.org.uk/nicemedia/live/11028/30622/30622.pdf)  NICE 2003 (confirmed 2009)  Reviewed October 2011 – Decision taken that this policy does not require update.  IPG570: <https://www.nice.org.uk/guidance/ipg570> Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016)  IPG543: <https://www.nice.org.uk/guidance/ipg543>  Percutaneous coblation of the intervertebral disc for low back pain and sciatica  IPG:357 <https://www.nice.org.uk/guidance/ipg357>  Percutaneous intradiscal laser ablation in the lumbar spine  IPG141: <https://www.nice.org.uk/guidance/ipg141>  Automated percutaneous mechanical lumbar discectomy  IPG 306: [Prosthetic intervertebral disc replacement in the lumbar spine](http://publications.nice.org.uk/prosthetic-intervertebral-disc-replacement-in-the-lumbar-spine-ipg306)  NICE 2009. |

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| A16.6 Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain | |
| The lower back is commonly defined as the area between the bottom of the rib cage and the buttock creases. Chronic low back pain is tension, soreness and/or stiffness often worsened by movement lasting more than six weeks in the lower back region. Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Peripheral nerve-field stimulation involves implanting electrodes in the back, connected to a neurostimulator under the skin. The aim is to mask the back pain by modulating the transmission of pain signals to the brain. The patient uses a remote control to deliver low voltage electrical stimulation to the subcutaneous tissue layers of the lower back. The stimulation causes a tingling sensation (paraesthesia) in the area of the body associated with the pain, easing the discomfort.  <https://www.nice.org.uk/guidance/ipg451> | |
| **Intervention** | **Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) <https://www.nice.org.uk/guidance/cg173>  IPG 451: [Peripheral nerve-field stimulation (PNFS) for chronic low back pain](http://publications.nice.org.uk/peripheral-nerve-field-stimulation-for-chronic-low-back-pain-ipg451) NICE 2013.  Current evidence on the efficacy of peripheral nerve-field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device |

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| A16.7 Therapeutic endoscopic Division of epidural adhesions | |
| Endoscopic epidural procedures are used to treat lower back pain, particularly when radiculopathy is present. The epidural space is examined with an endoscope and further interventions may then be performed, such as mobilising spinal adhesions or administering drugs to inflamed tissue. | |
| **Intervention** | **Therapeutic Endoscopic Division of Epidural Adhesions** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | IPG333: <https://www.nice.org.uk/guidance/ipg333>  Therapeutic endoscopic division of epidural adhesions  NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) <https://www.nice.org.uk/guidance/cg173>  Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. |

### A16.18 Trigger Finger Release in Adults

Trigger finger often resolves over time and is often a nuisance rather than a serious problem. If treatment is necessary steroid injection can be considered. Surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs.

Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to “lock” in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

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| **Intervention** | **Trigger Finger Release in Adults** |
| **Minimum eligibility criteria** | Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.  Cases interfering with activities or causing pain should first be treated with:   1. one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics;   or   1. splinting of the affected finger for 3-12 weeks (weak evidence).   Surgery should be considered if:   1. the triggering persists or recurs after one of the above measures (particularly steroid injections);   or   1. the finger is permanently locked in the palm;   or   1. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods;   or   1. diabetics.   Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release). |
| **Rationale** | Number of CCG interventions in 2017/18 - 7,789  Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%). |
| **Evidence for inclusion and threshold** | References   1. <https://www.nhs.uk/conditions/trigger-finger/treatment>/ 2. Amirfeyz R, McNinch R, Watts A, Rodrigues J, Davis TRC, Glassey N, Bullock J. Evidence-basedmanagementofadulttriggerdigits. J Hand Surg Eur Vol. 2017 Jun;42(5):473-480. doi: 10.1177/1753193416682917. Epub 2016 Dec 21. 3. British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST).   <http://www.bssh.ac.uk/_userfiles/pages/files/professionals/BEST%20Guidelines/BEST%20trigger%20finger%20PUBLISHED(1).pdf>   1. Chang CJ, Chang SP, Kao LT, Tai TW, Jou IM. A meta-analysis of corticosteroid injection for trigger digits among patients with diabetes. Orthopedics. 2018, 41: e8-e14. 2. Everding NG, Bishop GB, Belyea CM, Soong MC. Risk factors for complications of open trigger finger release. Hand (N Y). 2015, 10: 297-300. 3. Fiorini HJ, Tamaoki MJ, Lenza M, Gomes Dos Santos JB, Faloppa F, Belloti JC. Surgery for trigger finger. Cochrane Database Syst Rev. 2018 Feb 20;2:CD009860. doi: 10.1002/14651858.CD009860.pub2. Review. 4. Hansen RL, Sondergaard M, Lange J. Open Surgery Versus Ultrasound- Guided Corticosteroid Injection for Trigger Finger: A Randomized Controlled Trial With 1-Year Follow-up. J Hand Surg Am. 2017;42(5):359-66. 5. Lunsford D, Valdes K, Hengy S. Conservative management of trigger finger: A systematic review. J Hand Ther. 2017. 6. Peters-Veluthamaningal C, Winters JC, Groenier KH, Jong BM. Corticosteroid injections effective for trigger finger in adults in general practice: a double-blinded randomised placebo controlled trial. Ann Rheum Dis. 2008 Sep;67(9):1262-6. Epub 2008 Jan 7. |

### A16.19 Hyaluronic Acid and Derivatives Injections for Peripheral joint pain

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| **Intervention** | **Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain** |
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Rationale** | Hyaluronic Acid and Derivatives Injections are not commissioned for joint injections.  **Do not offer intra-articular hyaluronan injections for the management of osteoarthritis** |
| **Evidence for inclusion and threshold** | **Do Not Do Recommendation**  <https://www.nice.org.uk/donotdo/do-not-offer-intraarticular-hyaluronan-injections-for-the-management-of-osteoarthritis> |

### A16.21 Dupuytren’s Contracture Release in Adults

NICE recommends no treatment is necessary for people with Dupuytren’s disease who do not have contracture. Referral to hand surgery should be made for people with Dupuytren’s contractures according to the criteria listed below.

Dupuytren’s contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient’s life. However, none cure the condition which can recur after any intervention so that further interventions are required.

Splinting and radiotherapy have not been shown be effective treatments of established Dupuytren’s contractures.

Several treatments are available: collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others. The need for, and choice of, intervention should be made on an individual basis and should be a shared decision between the patient and a practitioner with expertise in the various treatments of Dupuytren’s contractures.

No-one knows which interventions are best for restoring and maintaining hand function throughout the rest of the patient’s life, and which are the cheapest and most cost-effective in the long term. Ongoing and planned National Institute for Health Research studies aim to address these questions.

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| **Intervention** | **Dupuytren’s Contracture Release in Adults** |
| **Minimum eligibility criteria** | Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.  An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermo-fasciectomy) should be considered for:   1. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.   or   1. severe thumb contractures which interfere with function   NICE concluded that collagenase should only be used for:   1. Participants in the ongoing clinical trial (HTA-15/102/04)   or   1. Adult patients with a palpable cord if:   i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints;  and  ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon |
| **Rationale** | Number of CCG interventions in 2017/18 – 14,376  Contractures left untreated usually progress and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.  Common complications after collagenase injection are normally transient and include skin breaks and localised pain. Tendon injury is possible but very rare. Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness. |
| **Evidence for inclusion and threshold** | References   1. <http://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/dupuytrens_disease_leaflet_2016.pdf> 2. <https://cks.nice.org.uk/dupuytrens-disease> 3. Crean SM, Gerber RA, Le Graverand MP, Boyd DM, Cappelleri JC. The efficacy and safety of fasciectomy and fasciotomy for Dupuytren's contracture in European patients: a structured review of published studies. J Hand Surg Eur Vol. 2011;36(5):396-407. 4. Krefter C, Marks M, Hensler S, Herren DB, Calcagni M. Complications after treating dupuytren's disease. A systematic literature review. Hand surgery & rehabilitation. 2017, 36: 322-9. 5. NICE 2004. Needle fasciotomy for Dupuytren's contracture. https://[www.nice.org.uk/guidance/ipg43](http://www.nice.org.uk/guidance/ipg43) 6. NICE, 2017. Collagenase clostridium histolyticum for treating Dupuytren's contracture: https://[www.nice.org.uk/guidance/ta459,](http://www.nice.org.uk/guidance/ta459) 7. Rodrigues JN, Becker GW, Ball C, Zhang W, Giele H, Hobby J, et al. Surgery for Dupuytren's contracture of the fingers. Cochrane Database Syst Rev. 2015(12):CD010143. 8. Scherman P, Jenmalm P, Dahlin LB. Three-year recurrence of Dupuytren's contracture after needle fasciotomy and collagenase injection: a two-centre randomized controlled trial. J Hand Surg Eur Vol. 2018;43(8):836-40. 9. Skov ST, Bisgaard T, Sondergaard P, Lange J. Injectable Collagenase Versus Percutaneous Needle Fasciotomy for Dupuytren Contracture in Proximal Interphalangeal Joints: A Randomized Controlled Trial. J Hand Surg Am. 2017;42(5):321-8 e3. 10. Stromberg J, Ibsen Sorensen A, Friden J. Percutaneous Needle Fasciotomy Versus Collagenase Treatment for Dupuytren Contracture: A Randomized Controlled Trial with a Two-Year Follow-up. J Bone Joint Surg Am. 2018;100(13):1079-86. 11. van Rijssen AL, Gerbrandy FS, Ter Linden H, Klip H, Werker PM. A comparison of the direct outcomes of percutaneous needle fasciotomy and limited fasciectomy for Dupuytren's disease: A 6-week follow-up study. J Hand Surg Am. 2006, 31: 717-25. 12. van Rijssen AL, ter Linden H, Werker PM. Five-year results of a randomized clinical trial on treatment in Dupuytren's disease: Percutaneous needle fasciotomy versus limited fasciectomy. Plast Reconstr Surg. 2012, 129: 469-77. |

### A16.23a Hip Replacement Surgery

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| A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.  The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.  Some common reasons why a hip joint can become damaged include:   * osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other * rheumatoid arthritis – this is caused by the immune system (the body’s defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness * hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it   Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.  The purpose of a new hip joint is to:   * relieve pain * improve the function of your hip * improve your ability to move around * improve your quality of life   Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms-   * Pain * Stiffness * reduced function   Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time. | |
| **Intervention** | **Hip Replacement Surgery** |
| Minimum eligibility criteria | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.  **Referral criteria for Total Hip Replacements (THR)** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria;   1. Patient complains of severe joint pain.   AND   1. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.   OR   1. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.   The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44). |
| **Guidance/evidence**  Royal College of Surgeons – Painful Hip Commissioning Guide  <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/>  NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)  Weblink:  <https://www.nice.org.uk/guidance/cg177>    NHS Choices – Hip replacement  Weblink:  <http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx> | |

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| A16.23b Policy for Knee Replacement Surgery | |
| Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old.  For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain.  There are two main types of surgery, depending on the condition of the knee:   * total knee replacement (TKR) – both sides of your knee joint are replaced * partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period   The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:   * rheumatoid arthritis * haemophilia * gout * knee injury   A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven't helped reduce pain or improve mobility.  You may be offered knee replacement surgery if:   * You have severe pain, swelling and stiffness in your knee joint and your mobility is reduced * your knee pain is so severe that it interferes with your quality of life and sleep * everyday tasks, such as shopping or getting out of the bath, are difficult or impossible * you cannot work or have a normal social life   Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms;   * Pain * Stiffness * Reduced function | |
| **Intervention** | **Knee Replacement Surgery** |
| Minimum eligibility criteria | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.  **Funding for total or partial knee replacement surgery is available if the following criteria are met**   1. Patients with BMI <40.   AND   1. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.   AND   1. Has radiological features of severe disease.   OR   1. Has radiological features of moderate disease with limited mobility or instability of the knee joint. |
| **Guidance/evidence**  Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017)  Weblink:  <https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en>  NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)  Weblink:  <https://www.nice.org.uk/guidance/cg177>    Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review  Saif Salih\* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25)  Weblink:  (<http://www.biomedcentral.com/2052-1847/5/25>)  NHS Choices – Knee replacement  Weblink:  <http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx> | |

### A16.25 Knee arthroscopy for patients with osteoarthritis

NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis, unless the knee locks (in which case it may be considered). More effective treatments include physiotherapy, exercise programmes like ESCAPEpain, losing weight (if necessary) and pain management.

If symptoms do not resolve, knee replacement or osteotomy are effective procedures that should be considered.

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| **Intervention** | **Knee Arthroscopy for Patients with Osteoarthritis** |
| **Minimum eligibility criteria** | Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.  Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.  More effective treatment includes exercise programmes (e.g. ESCAPEpain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non- operative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.  For further information, please see:  https://[www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-](http://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-) 492463117  https://[www.nice.org.uk/guidance/ipg230/chapter/1-Guidance](http://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance)  https://[www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-](http://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-) debridement-should-not-be-offered-as-part-of-treatment-for- osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear- history-of-mechanical-locking-not  <http://www.escape-pain.org/> |
| **Evidence for inclusion and threshold** | Number of CCG interventions in 2017/18 – 3,437  NICE has reviewed the evidence for how well knee washout works for people with osteoarthritis. Seven clinical trials and three case studies have shown that knee wash out for people with osteoarthritis did not reduce pain nor improve how well their knees worked. There was a small increased risk of bleeding inside the knee joint (haemarthrosis) (2%) or blood clot in the leg (deep vein thrombosis) (0.5%).  References   1. NICE guidance: <https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf>- 492463117 2. NICE guidance: <https://www.nice.org.uk/guidance/ipg230/chapter/1>- Guidance 3. NICE guidance: <https://www.nice.org.uk/donotdo/referral-for>- arthroscopic-lavage-and-debridement-should-not-be-offered-as-part- of-treatment-for-osteoarthritis-unless-the-person-has-knee- osteoarthritis-with-a-clear-history-of-mechanical-locking-not 4. British Orthopaedic Association and the Royal College of Surgeons: <https://www.rcseng.ac.uk/-/media/files/rcs/standards-and>- research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf 5. Siemieniuk Reed A C, Harris Ian A, Agoritsas Thomas, Poolman Rudolf W, Brignardello-Petersen Romina, Van de Velde Stijn et al. Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline BMJ 2017; 357 :j1982 6. Brignardello-Petersen R, Guyatt GH, Buchbinder R, et al Knee arthroscopy versus conservative management in patients with degenerative knee disease: a systematic review BMJ Open 2017;7:e016114. doi: 10.1136/bmjopen-2017-016114` 7. Moseley JB, O’Malley K, Petersen NJ et al. (2002) A controlled trial of arthroscopic surgery for osteoarthritis of the knee. The New England Journal of Medicine 347: 81–8. 8. Hubbard MJS. (1996) Articular debridement versus washout for degeneration of the medial femoral condyle. Journal of Bone and Joint Surgery (British) 78-B: 217–19. 9. Kalunian KC, Moreland LW, Klashman DJ et al. (2000) Visually- guided irrigation in patients with early knee osteoarthritis: a multicentre randomized controlled trial. Osteoarthritis and Cartilage 8: 412–18. 10. Chang RW, Falconer J, Stulberg SD et al. (1993) A randomized, controlled trial of arthroscopic surgery versus closed-needle joint lavage for patients with osteoarthritis of the knee. Arthritis & Rheumatism 36: 289–96. 11. Forster MC, Straw R. (2003) A prospective randomised trial comparing intra-articular Hyalgan injection and arthroscopic washout for knee osteoarthritis. The Knee 10: 291–3. 12. Jackson RW, Dieterichs C. (2003) The results of arthroscopic lavage and debridement of osteoarthritic knees based on the severity of degeneration: a 4- to 6-year symptomatic follow-up. Arthroscopy: The Journal of Arthroscopic and Related Surgery 19: 13–20. 13. Bernard J, Lemon M, Patterson MH. (2004) Arthroscopic washout of the knee – a 5-year survival analysis. The Knee 11: 233–5. 14. Harwin SF. (1999) Arthroscopic debridement for osteoarthritis of the knee: predictors of patient satisfaction. Arthroscopy: The Journal of Arthroscopic and Related Surgery 15: 142–6. |

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| A16.28 Carpal Tunnel Syndrome Release | |
| Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time. Splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. Surgical treatment of carpal tunnel should only be offered under the criteria included below.  Open or endoscopic surgical procedure to release median nerve from carpal tunnel. | |
| **Intervention** | **Carpal Tunnel Syndrome Release** |
| **Minimum eligibility criteria** | Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.  Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:   1. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)   or   1. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)   Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:   1. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks;   or   1. There is either: 2. a permanent (ever-present) reduction in sensation in the median nerve distribution;   or  ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).  Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain. |
| **Evidence for inclusion and threshold** | Number of CCG interventions in 2017/18 – 44,497  Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.  In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical effectiveness and long term benefit) should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.  The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.  References   1. Atroshi I, Flondell M, Hofer M, Ranstam J. Methylprednisolone injections for the carpal tunnel syndrome: a randomized, placebo-controlled trial. Annals of internal medicine. 2013;159(5):309-17. 2. Chesterton LS, Blagojevic-Bucknall M, Burton C et al. The clinical and cost- effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (instincts trial): An open-label, parallel group, randomised controlled trial. Lancet. 2018, 392: 1423-33. 3. Gerritsen AA, de Vet HC, Scholten RJ, Bertelsmann FW, de Krom MC, Bouter LM. Splinting vs surgery in the treatment of carpal tunnel syndrome: A randomized controlled trial. JAMA. 2002, 288: 1245-51. 4. Korthals-de Bos IB, Gerritsen AA, van Tulder MW et al. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: Results of an economic evaluation alongside a randomized controlled trial. BMC Musculoskelet Disord. 2006, 7: 86. 5. Louie D , Earp B & Philip Blazar P Long-term outcomes of carpal tunnel release: a critical review of the literature HAND (2012) 7:242–246 6. Marshall S, Tardif G, Ashworth N. Local corticosteroid injection for carpal tunnel syndrome. Cochrane Database Syst Rev. 2007(2):CD001554. 7. Page MJ, Massy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel syndrome. Cochrane Database Syst Rev. 2012(7):CD010003. 8. Shi Q, MacDermid JC. Is surgical intervention more effective than non- surgical treatment for carpal tunnel syndrome? A systematic review. J Orthop Surg Res. 2011;6:17. 9. Stark H, Amirfeyz R. Cochrane corner: local corticosteroid injection for carpal tunnel syndrome. J Hand Surg Eur Vol. 2013;38(8):911-4. 10. Royal College of Surgeons: <https://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2017.28> 11. Verdugo RJ, Salinas RA, Castillo JL, Cea JG. Surgical versus non-surgical treatment for carpal tunnel syndrome. Cochrane Database Syst Rev. 2008(4):CD001552. |

### A16.30 Ganglion excision

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| Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can be unnecessary, can cause complications, and recurrence is common following surgery. The complications may be similar to or worse than the original problem. Ganglion excision should only be offered under the criteria outlined below. | |
| **Intervention** | **Ganglion excision** |
| **Policy Statement** | Ganglia are cystic swellings containing jelly-like fluid which form around the wrists or in the hand. In most cases wrist ganglia cause only mild symptoms which do not restrict function, and many resolve without treatment within a year. Wrist ganglion rarely press on a nerve or other structure, causing pain and reduced hand function.  Ganglia in the palm of the hand (seed ganglia) can cause pain when carrying objects.  Ganglia which form just below the nail (mucous cysts) can deform the nail bed and discharge fluid, but occasionally become infected and can result in septic arthritis of the distal finger joint.  Wrist ganglia   * no treatment unless causing pain or tingling/numbness or concern (worried it is a cancer); * aspiration if causing pain, tingling/numbness or concern * surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.   Seed ganglia that are painful   * puncture/aspirate the ganglion using a hypodermic needle * surgical excision only considered if ganglion persists or recurs after puncture/aspiration.   Mucous cysts   * no surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity. |
| **Rationale** | Number of CCG interventions in 2017/18 – 6,219  Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation. Aspiration of wrist ganglia may relieve pain and restore hand function, and “cure” a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly.  Complication and recurrence are rare after aspiration and surgery for seed ganglia |
| **Evidence for inclusion and threshold** | Reference   1. Head L, Gencarelli JR, Allen M, Boyd KU. Wrist ganglion treatment: Systematic review and meta-analysis. J Hand Surg Am. 2015, 40: 546-53 e8. 2. Naam NH, Carr SB, Massoud AH. Intraneural Ganglions of the Hand and Wrist. J Hand Surg Am. 2015 Aug;40(8):1625-30. doi: 10.1016/j.jhsa.2015.05.025. PubMed PMID: 26213199. 3. <http://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/ganglion_cyst_leaflet-2016.pdf> |

### A16.36 Arthroscopic shoulder decompression for subacromial shoulder pain

Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases.

Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery.

Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. <https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf>

In order to facilitate non-operative treatment in primary and intermediate care, BESS and Getting It Right First Time programme have produced patient exercise rehab videos and booklets for GPs and patients to use. <http://www.bess.org.uk/index.php/public-area/shpi-videos>

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| **Intervention** | **Arthroscopic shoulder decompression for subacromial shoulder pain** |
| **Policy Statement** | Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically. |
| **Minimum eligibility criteria** | Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, ‘pure subacromial shoulder impingement’ means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.  For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention |
| **Rationale** | Number of CCG interventions in 2017/18 – 13,930  Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function1. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.  On the other hand, a more recent prospective randomised trial comparing the long-term outcome (10 year follow up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment.3  Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails.4,5 There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.6  A review of the literature identified one further systematic review that looked at the effectiveness of surgery.2 The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.  Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.7  Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic. |
| **Evidence for inclusion and threshold** | References   1. Beard DJ, Rees JL, Cook JA, Rombach I, Cooper C, Merritt N, Shirkey BA, Donovan JL, Gwilym S, Savulescu J, Moser J, Gray A, Jepson M, Tracey I, Judge A, Wartolowska K, Carr AJ; CSAW Study Group. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial. Lancet. 2018 Jan 27;391(10118):329-338. doi: 10.1016/S0140-6736(17)32457-1. Epub 2017 Nov 20. PubMed PMID: 29169668; PubMed Central PMCID: PMC5803129. 2. Dorrestijn O, Stevens M, Winters JC, van der Meer K, Diercks RL. Conservative or surgical treatment for subacromial impingement syndrome? A systematic review. J Shoulder Elbow Surg 2009; 18: 652–60. 3. Farfaras S, Sernert N, Rostgard Christensen L, Hallström EK, Kartus JT. Subacromial Decompression Yields a Better Clinical Outcome Than Therapy Alone: A Prospective Randomized Study of Patients With a Minimum 10-Year Follow-up. Am J Sports Med. 2018 May;46(6):1397-1407 4. Holmgren T, Björnsson Hallgren H, Öberg B, Adolfsson L, Johansson K. Effect of specific exercise strategy on need for surgery in patients with subacromial impingement syndrome: randomised controlled study. BMJ. 2012 Feb 20;344:e787. doi: 10.1136/bmj.e787 5. Magaji SA, Singh HP, Pandey RK. Arthroscopic subacromial decompression is effective in selected patients with shoulder impingement syndrome. J Bone Joint Surg Br. 2012 Aug;94(8):1086-9 6. Jacobsen JR, Jensen CM, Deutch SR. Acromioplasty in patients selected for operation by national guidelines. J Shoulder Elbow Surg. 2017 Oct;26(10):1854-1861. 7. <https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf> |

## A17. Urology

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| A17.1 Policy for Circumcision for medical reasons only | |
| Male circumcision is the surgical removal of the foreskin.  The foreskin is the retractable fold of skin that covers the end of the penis. It’s a continuation of the skin that covers the whole penis.  Further information can be found at:  <http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx> | |
| **Intervention** | **Circumcision for medical reasons only** |
| **Minimum eligibility criteria** | **Circumcision will be funded in the following medical circumstances**:   * Balantis xerotica obliterans. * Traumatic foreskin injury/scarring where it cannot be salvaged. * 3 or more episodes of balanitis/balanoposthitis. * Pathological phimosis. * Irreducible paraphimosis. * Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. * Tight foreskin causing pain on arousal/ interfering with sexual function   This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk.  This procedure is not offered for social, cultural or religious reasons. |
| **Evidence for inclusion and threshold** | [2008 UK National Guideline on the Management of Balanoposthitis](http://www.bashh.org/documents/2062.pdf) –  Clinical Effectiveness Group British Association for Sexual Health and HIV (2008).  [Balanitis](http://cks.nice.org.uk/balanitis)  NICE Clinical Knowledge Summaries 2015  [I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes](http://sti.bmj.com/content/88/Suppl_1/A55.4.abstract)  Sexually Transmitted Infections 2012;88:A55-A56.  [Balanitis](http://www.patient.co.uk/doctor/balanitis-pro)  Patient.co.uk.  <https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions--commissioning-guide.pdf>  Foreskin Conditions: Royal College of Surgeons guidance (2013).  NHS Choices – Circumcision  Weblink:  <http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx>  Male Circumcision: Guidance for Healthcare Practitioners  Royal College of Surgeons, 2000  <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/> |

## A18. Vascular Surgery

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| A18.3 Varicose vein interventions NICE has published detailed guidance on what treatment should be considered for varicose veins and when interventions for varicose veins (endothermal ablation, sclerotherapy or surgery) should be offered. Surgery is a traditional treatment that involves removal of the vein, patients can get recurrence of symptoms which may need further treatment. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy are less invasive than surgery and have replaced surgery in the management of most patients. However surgery is the most appropriate in some cases. Patients with symptomatic varicose veins should be offered treatment of their varicose veins. Compression hosiery is not recommended if an interventional treatment is possible.  <https://www.nice.org.uk/guidance/qs67> | |
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| **Intervention** | **Varicose vein interventions** |
| **Minimum eligibility criteria** | There are various interventional procedures for treating varicose veins. These include endothermal ablation, ultrasound guided foam sclerotherapy and traditional surgery (this is a surgical procedure that involves ligation and stripping of varicose veins) all of which have been shown to be clinically and cost effective compared to no treatment or treatment with compression hosiery. Varicose veins are common and can markedly affect patients quality of life, can be associated with complications such as eczema, skin changes, thrombophlebitis, bleeding, leg ulceration, deep vein thrombosis and pulmonary embolism that can be life threatening.   * 1. Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.   2. Refer people to a vascular service if they have any of the following;-      1. Symptomatic \* primary or recurrent varicose veins.      2. Lower‑limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.      3. Superficial vein thrombophlebitis (characterised by the appearance of hard,   painful veins) and suspected venous incompetence.   * + 1. A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).     2. A healed venous leg ulcer.   \*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).”  For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment   * 1. Refer people with bleeding varicose veins to a vascular service immediately.   Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable. |
| **Rationale** | Number of CCG interventions in 2017/18 – 28,846  International guidelines, NICE guidance and NICE Quality standards provide clear evidence of the clinical and cost-effectiveness that patients with symptomatic varicose veins should be referred to a vascular service for assessment including duplex ultrasound.  Open surgery is a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein), this is still a valuable technique, it is still a clinically and cost-effective treatment technique for some patients but has been mainly superseded by endothermal ablation and ultrasound guided foam sclerotherapy.  Recurrence of symptoms can occur due to the development of further venous disease, that will benefit from further intervention (see above). NICE guidance states that a review of the data from the trials of interventional procedures indicates that the rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%.  For people with confirmed varicose veins and truncal reflux NICE recommends:   * Offer endothermal ablation of the truncal vein. * If endothermal ablation is unsuitable, offer ultrasound‑guided foam sclerotherapy. * If ultrasound‑guided foam sclerotherapy is unsuitable, offer surgery. * Consider treatment of tributaries at the same time * Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.   Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. Complications of non-intervention include decreasing quality of life for patients, increased symptomatology, disease progression potentially to skin changes and eventual leg ulceration, deep vein thrombosis and pulmonary embolism. |
| **Evidence for inclusion and threshold** | References   * + 1. NICE Guidance: https://[www.guidelinesinpractice.co.uk/nice-referral-advice-](http://www.guidelinesinpractice.co.uk/nice-referral-advice-) 11-varicose-veins/300594.article     2. NICE Guidance: https://[www.nice.org.uk/guidance/cg168](http://www.nice.org.uk/guidance/cg168)     3. NICE Quality Standard: https://[www.nice.org.uk/guidance/qs67](http://www.nice.org.uk/guidance/qs67)     4. Editor's Choice - Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). Wittens C, Davies AH, Bækgaard N, Broholm R, Cavezzi A, Chastanet S, de Wolf M, Eggen C, Giannoukas A, Gohel M, Kakkos S, Lawson J, Noppeney T, Onida S, Pittaluga P, Thomis S, Toonder I, Vuylsteke M, Esvs Guidelines Committee, Kolh P, de Borst GJ, Chakfé N, Debus S, Hinchliffe R, Koncar I, Lindholt J, de Ceniga MV, Vermassen F, Verzini F, Document Reviewers, De Maeseneer MG, Blomgren L, Hartung O, Kalodiki E, Korten E, Lugli M, Naylor R, Nicolini P, Rosales A Eur J Vasc Endovasc Surg. 2015 Jun;49(6):678-737. doi: 10.1016/j.ejvs.2015.02.007. Epub 2015 Apr 25.     5. The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. Gloviczki P1, Comerota AJ, Dalsing MC, Eklof BG, Gillespie DL, Gloviczki ML, Lohr JM, McLafferty RB, Meissner MH, Murad MH, Padberg FT, Pappas PJ, Passman MA, Raffetto JD, Vasquez MA, Wakefield TW; Society for Vascular Surgery; American Venous Forum. J Vasc Surg. 2011 May;53(5 Suppl):2S-48S. doi: 10.1016/j.jvs.2011.01.079..     6. A Randomized Trial of Early Endovenous Ablation in Venous Ulceration.Gohel MS1, Heatley F1, Liu X1, Bradbury A1, Bulbulia R1, Cullum N1, Epstein DM1, Nyamekye I1, Poskitt KR1, Renton S1, Warwick J1, Davies AH1; EVRA Trial Investigators. N Engl J Med. 2018 May 31;378(22):2105-2114. doi: 10.1056/NEJMoa1801214. Epub 2018 Apr 24 |

# *PART B: 2014/15 COMMISSIONING POLICY POSITIONS STILL IN PLACE*

| B1. **Complementary Therapies** |
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| B1.1 Complementary Therapies | Not routinely commissioned unless recommended by NICE guidance. | [*Complementary and alternative medicine*](http://www.nhs.uk/LiveWell/complementary-alternative-medicine/Pages/complementary-and-alternative-medicine.aspx) – NHS Choices 2012.  <http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/> | Individual CCG addendums apply. |

| B2. Dermatology |
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| B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels) | Only be commissioned in the following circumstances:  Severe scarring following:  Acne once the active disease is controlled.  Chicken pox.  OR  Trauma (including post-surgical).  Procedures will only be performed on the head and neck area.  Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.  Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | Modernisation Agency’s Action on Plastic Surgery 2005.  Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78.  Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT.  [www.evidence.nhs.uk](http://www.evidence.nhs.uk/)  Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.  [NHS England interim protocol](http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf)  NHS England (2013)  Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. |  |

| B2.4 Treatments for Skin Pigment Disorders | NHS Cosmetic Camouflage is commissioned.  This is provided by Changing Faces formerly the Red Cross.\*  Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.  Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | <http://www.changingfaces.org.uk/Skin-Camouflage>  Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.  [NHS England interim protocol](http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf)  NHS England (2013).  Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. | Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only.  Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.  \*Access available for Wirral patients via Dermatology Department. |
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| B2.5 Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers | Will be commissioned in any of the following circumstances:  Severe pain substantially interfering with functional abilities.  Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.  Extensive warts (particularly in the immune-suppressed patient).  Facial warts.  Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist. | Modernisation Agency’s Action on Plastic Surgery 2005.  [Nongenital warts: recommended approaches to management](http://onlinelibrary.wiley.com/doi/10.1002/psb.28/abstract) Prescriber 2007 18(4) p33-44.  [Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf)  [patient.co.uk/doctor/viral-warts-excluding-verrucae](http://www.patient.co.uk/doctor/viral-warts-excluding-verrucae)  <http://www.patient.co.uk/doctor/verrucae> | Most viral warts will clear spontaneously or following application of topical treatments.  65% are likely to disappear spontaneously within 2 years.  There are numerous OTC preparations available.  Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care. |
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| B3. Diabetes |
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| B3.1 Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus | Not routinely commissioned and only considered if ALL of the following criteria are met;  Type I diabetes.  AND  Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151.  AND  HbA1c which is equal to or greater than 69 (8.5%) mmol/OR experiencing severe hypoglycaemic attacks which require intervention by a carer.  AND  Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value.  AND  Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum).  AND  Motivated to comply with the requirements.  The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months.  All cases will be subject to individual approval by the IFR Team. | [Continuous glucose monitoring systems for type 1 diabetes mellitus](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008101.pub2/abstract) – Cochrane Database of Systematic Reviews, 2012.  [Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials.](http://eje-online.org/content/166/4/567.long) – European Journal of Endocrinology. 2012 Apr; 166(4):567-74.  [Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3131116/) - BMJ. 2011; 343: d3805.  [Continuous Glucose Monitoring for Patients with Diabetes](http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/ontario-health-technology-assessment-series/continuous-glucose-monitoring-for-patients-with-diabetes) – Ontario: Health Quality Ontario, 2011.  [Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care](http://www.bsped.org.uk/clinical/docs/ContinuousGlucoseMonitoring.pdf)  - British Society for Paediatric Endocrinology and Diabetes, 2009.  For further references please refer to Public Health Continuous Glucose Monitors Paper. |  |
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| B4. ENT | | | |
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| B4.3b Insertion of Grommets for Glue Ear (otitis media with effusion) - ADULTS | ADULTS  Grommets in adults with OME will be funded only in the following circumstances:   * Significant negative middle ear pressure measured on two sequential appointments.   AND   * Significant ongoing associated pain.   OR   * Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy. | <http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome>  Royal College of Surgeons (2013).  <http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf> |  |

| B4.5 Surgical Remodelling of External Ear Lobe | This is not routinely commissioned. | Modernisation Agency’s Action on Plastic Surgery 2005. | Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. |
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| B4.6 Use of Sinus X-ray | X-rays of sinuses are not routinely commissioned. | [BSACI guidelines for the management of rhinosinusitis and nasal polyposis](http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2222.2007.02889.x/pdf)  Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007.  NHS Choices [Sinusitis](http://www.nhs.uk/Conditions/Sinusitis/Pages/Introduction.aspx)  <http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitus>  Royal College of Surgeons (2013). |  |
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| B4.8 Surgery of Laser Treatment of Rhinophyma | Not routinely commissioned. | [Nuances in the management of rhinophyma](http://www.ncbi.nlm.nih.gov/pubmed/22562574?dopt=Abstract)  Facial Plastic Surgery, 2012 Apr;28(2):231-7.  <http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm>  <http://www.nhs.uk/Conditions/Rosacea/Pages/Treatment.aspx> | The first-line treatment of this condition of the nasal skin is medical. However response is poor.  Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances. |
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| B5. Equipment |
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| B5.1 Use of Lycra Suits | Lycra Suits are not normally commissioned for postural management of cerebral palsy.  Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. | What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy?  Health Improvement Scotland, May 2013.  For further references please refer to Public Health Lycra Suits Paper. | Any application for exceptional funding should include a comprehensive assessment of the child’s postural management needs with clear outcome goals and time frames.  Public Health Recommendation:    Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.  Lycra suit orthoses for cerebral palsy should be assigned low priority.  Individual CCG addendums apply. |
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| B6. Fertility |
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| B6.1 Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation | See Cheshire & Merseyside Infertility Policy. | [CG156 Fertility: Assessment and treatment for people with fertility problems](http://publications.nice.org.uk/fertility-cg156) – NICE 2013.  Contraception – sterilization – NICE Clinical Knowledge Summaries 2012  [http://cks.nice.org.uk/contraception-sterilization#!scenario](http://cks.nice.org.uk/contraception-sterilization%23!scenario) | Individual CCG addendums apply. |
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| B7. General Surgery |
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| B7.4 Lithotripsy for Gallstones | Lithotripsy not routinely commissioned. |  | Lithotripsy rarely performed as rate recurrence high. |
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| B9. Mental Health |
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| B9.1 Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) | Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned.  If inpatient treatment is recommended an IFR referral will be required. | [*Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children*](http://www.nice.org.uk/nicemedia/live/11824/36193/36193.pdf)– NICE 2007, CG53.  [*Cognitive behaviour therapy for chronic fatigue syndrome in adults*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001027.pub2/abstract;jsessionid=C8899971BA41F1236FDEAB7EBAA06F6D.f04t01) - Cochrane Depression, Anxiety and Neurosis Group 2008.  [*Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis*](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411573/pdf/pone.0040808.pdf) - . PLoS ONE 7(8): e40808. doi:10.137.  [*Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care*](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3480915/pdf/1472-6963-12-264.pdf) *-* BMC Health Services Research 2012, 12:264. | Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.  NICE section 1.915 states:  Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital. |
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| B9.3 Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services) | This is not routinely commissioned. | [Interventions to reduce substance misuse among vulnerable young people](http://www.nice.org.uk/nicemedia/live/11379/31939/31939.pdf) –  NICE Public Health Guidance 4 (2007)  [Drug misuse: psychosocial interventions](http://www.nice.org.uk/nicemedia/live/11812/35973/35973.pdf) – NICE Clinical Guideline 51 (2007).  [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](http://www.nice.org.uk/nicemedia/live/13337/53191/53191.pdf) –  NICE Clinical Guideline 115 (2011). |  |
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| B10. Neurology |
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| B10.1 Bobath Therapy | Bobath Therapy is not routinely commissioned by the NHS.  The evidence base is poor for both children and adults. | [The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence?](http://stroke.ahajournals.org/content/40/4/e89.full.pdf+html) Stroke, 2009; 40:e89-e97.  [Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme](http://onlinelibrary.wiley.com/doi/10.1002/pri.474/abstract)  Physiotherapy Research International  Volume 16, Issue 2, pages 69–80, June 2011.  [Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial](http://www.ncbi.nlm.nih.gov/pubmed/22257503)  Clinical Rehabilitation, 2012 Aug;26(8):705-15.  <http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf> Cambridge CCG (2013).  [A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy](http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/($all)/ffc6935bce6f97b4802576d200548fa9/$file/bobath%20therapy%20for%20children%20with%20cerebral%20palsyv2b.doc)  National Public Health Service for Wales (2008). |  |
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| B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy | Not routinely commissioned. | [Physical therapy for Bell's palsy (idiopathic facial paralysis).](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006283.pub3/abstract)  Cochrane Database of Systematic Reviews. Issue 12 (2011). |  |
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| B10.3 Functional Electrical Stimulation (FES) | Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury.  It is not routinely commissioned for lower motor neurone lesions.  It is under review by NICE for dysphagia and muscle recovery chronic disease.  Patients must have receptive cognitive abilities.  Exclusion Criteria:   * Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. * Chronic oedema at site of stimulation. * Diagnosis of deep vein thrombosis. * Receptive dysphasia (unable to understand instructions). * Complete peripheral nerve damage. * Pacemaker in situ. * Pregnancy or intention to become pregnant. * Active cancer. * Uncontrolled epilepsy. * Metal in region of stimulation e.g.: pin and plate. * Ataxic and polio patients are generally poor responders although there are exceptions. | [Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness](http://www.cadth.ca/media/pdf/htis/april-2011/L0257_FES_ChildrenCerebralPalsy_final.pdf) –  CADTH Rapid Response Service, 2011.  [Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation](http://www.ncbi.nlm.nih.gov/pubmed/20685722). Clinical Rehabilitation. 2010 Nov; 24(11):963-78.  [Interventions for dysphagia and nutritional support in acute and subacute stroke](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000323.pub2/abstract) Cochrane Database of Systematic Reviews 2012, Issue 10.    [Functional electrical stimulation for drop foot of central neurological origin](http://www.nice.org.uk/nicemedia/pdf/IPG278Guidance.pdf)  NICE, 2009.  [Functional electrical stimulation for rehabilitation following spinal cord injury](http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=32012000186#.UneGHUp8Vsk) Centre for Reviews and Dissemination, NIHR, 2011. |  |
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| B11. Ophthalmology |
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| B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid | Only commissioned in the following circumstances:   * Eyelid function interferes with visual field. | [Eyelid Surgery](http://baaps.org.uk/procedures/eyelid-surgery)  *The British Association of Aesthetic Plastic Surgeons 2011.*  Modernisation Agency’s Action on Plastic Surgery 2005.  [Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base](http://www.lho.org.uk/Download/Public/16352/1/Consolidation%20of%20evidence%20base%20FINAL%20_2_.pdf)  London Health Observatory 2010. | Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.  Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment.  Impairment to visual field to be documented. |
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| B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid. | Only commissioned in any of the following circumstances:   * Correction of ectropion or entropion which threatens the health of the affected eye. * Removal of lesions of eyelid skin or lid margin. * Rehabilitative surgery for patients with thyroid eye disease. | [*Eyelid Surgery*](http://www.baaps.org.uk/procedures/eyelid-surgery)  The British Association of Aesthetic Plastic Surgeons 2011.  Local PCT consensus – review conducted 2007.  Modernisation Agency’s Action on Plastic Surgery 2005.  [Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base](http://www.lho.org.uk/Download/Public/16352/1/Consolidation%20of%20evidence%20base%20FINAL%20_2_.pdf)  - London Health Observatory 2010. | Excessive skin in the lower lid may cause “eye bags” but does not affect function of the eyelid or vision and therefore does not need correction. |
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| B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) | Only commissioned for:   * Larger legions which satisfy all of the following: * Not responded to treatment for underlying familial lipoprotein lipase deficiency. * Failed topical treatment. * Causing significant disfigurement. * Causing functional impairment. * Topical treatments may be available in a primary care or community setting. | Local PCT consensus – review conducted 2007.  [DermNet NZ information resources](http://www.dermnetnz.org/dermal-infiltrative/xanthoma.html)  updated Jan 2013.  [Commissioning Criteria – Plastic Surgery](http://wales.gov.uk/dhss/publications/healthcommission/policies/plasticsurgery/plasticsurgerye.pdf?lang=en)  Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service  Health Commission Wales (2008).  <http://www.patient.co.uk/doctor/xanthelasma> | The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy.  Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.  Lesions are harmless. |
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| B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia) | Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned. |  |  |
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| B11.6 Coloured (irlens) Filters for Treatment of Dyslexia | There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence. | [Coloured filters for reading disability:A systematic review WMHTAC 2008](http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/WMHTAC/REPreports/2008/ColouredfiltersforreadingdisabilityFINALVERSION.pdf) |  |
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| B11.7 Intra Ocular Telescope for Advanced Age-Related Macular Degeneration | This is not routinely commissioned as there is limited published evidence of effectiveness. | [Implantation of miniature lens systems for advanced age-related macular degeneration](http://www.nice.org.uk/nicemedia/pdf/IPG272Guidance.pdf) NICE, 2008.  [Intraocular telescope by Vision Care ™ for age-related macular degeneration](http://www.netag.nhs.uk/files/appraisal-reports/Intraocular%20miniature%20telescope%20for%20AMD%20-%20NETAG%20appraisal%20report%20-%20Oct%202012.pdf)  North East Treatment Advisory Group (2012). |  |
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| B12. Oral Surgery |
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| B12.1 Surgical Replacement of the Temporo-Mandibular Joint, Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement | Only commissioned in the following circumstances:  Any or a combination of the following symptoms are present:   * Restricted mouth opening <35mm). * Dietary score of< 5/10 (liquid scores 0, full diet scores 10). * Occlusal collapse (anterior open bite or retrusion). * Excessive condylar resorption and loss of height of vertical ramus. * Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). * Other significant quality of life issues.   AND   * Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms. | Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.    [Total prosthetic replacement of the Temporomandibular joint (IPG329)](http://guidance.nice.org.uk/IPG329)  NICE 2009  <http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes> |  |
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| B13. Paediatrics |
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| B13.1 Cranial Banding for Positional Plagiocephaly | Not routinely commissioned. | [Nonsurgical treatment of deformational plagiocephaly: a systematic review](http://www.ncbi.nlm.nih.gov/pubmed/18678803)  Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27.  [What is the role of helmet therapy in positional plagiocephaly?](http://www.bestbets.org/bets/bet.php?id=1702)  BestBETS 2008. | Most childrens head shapes will improve naturally in their own time. |
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| B16. Trauma & Orthopaedics |
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| B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha | Dibotermin alfa is commissioned in the following situation:   * The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. * Eptotermin alfa is commissioned in line with its licensed indication: * Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible. | [Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review](http://www.hta.ac.uk/fullmono/mon1130.pdf)  Health Technology Assessment NHS R&D HTA Programme, 2007.  [Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI](http://www.ncbi.nlm.nih.gov/pubmed/17669279)  [Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data](http://annals.org/article.aspx?articleid=1696645)  June 2013  [BMPs: Options, indications, and effectiveness](http://www.ncbi.nlm.nih.gov/pubmed/20182245) – [Journal of Orthopaedic Trauma.](http://www.ncbi.nlm.nih.gov/pubmed/20182245) 2010 Mar;24 Suppl 1:S9-16. |  |
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| B16.20 Secondary Care Administered Steroid Joint Injections | Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre. | [Ultrasound-guided injections of joints of the extremities](http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=32012000575#.UnDhTEp8Vsk) –  University of York Centre for Research and Dissemination 2012. |  |
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| B16.24 Diagnostic Arthroscopy for Arthritis of the Knee | Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate.  However it is not routinely commissioned for any of the following indications:   * Investigation of knee pain. * Treatment of Osteo-Arthritis including Arthroscopic washout. * If there is diagnostic uncertainty despite a competent examination or if there are ‘’red flag’’ symptoms then a Magnetic resonance imaging (MRI) scan may be indicated.   If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered. | [CG59 Osteoarthritis. Section 3.1](http://publications.nice.org.uk/osteoarthritis-cg59)  NICE 2008  [Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis](http://publications.nice.org.uk/arthroscopic-knee-washout-with-or-without-debridement-for-the-treatment-of-osteoarthritis-ipg230)  NICE 2007.  [Knee replacement: A guide to good practice](http://www.boa.ac.uk/Publications/Documents/tkr_good_practice.pdf) British Orthopaedic Association, 2000.  Commissioning Guide: [Painful osteoarthritis of the knee](http://www.rcseng.ac.uk/providers-commissioners/docs/Painfulosteoarthritisoftheknee.pdf)  Royal College of Surgeons (2013).  <http://guidance.nice.org.uk/CG177>  CG177Osteoarthritis  (NICE 2014) |  |
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| B16.26 Patient Specific Unicompartmental Knee Replacement | This is not commissioned. | [IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance](http://www.nice.org.uk/nicemedia/live/12079/45466/45466.pdf)  NICE, 2009 | Referral should be made to specialist centres only. |
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| B16.27 Patient Specific Total Knee Replacement | This is not commissioned. | [EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates](https://www.ecri.org/Documents/Sample_Reports/Emerging_Technology_Report.pdf)  ECRI Institute (2012)  [IPG 345: Mini-incision surgery for total knee replacement](http://publications.nice.org.uk/mini-incision-surgery-for-total-knee-replacement-ipg345)  NICE 2010 |  |
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| B16.29 Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) | Only commissioned for mucoid cysts under the following circumstance:   * Failure of conservative treatments including watchful waiting.   AND any of the following:   * Nail growth disturbed. * Discharging, ulcerated or infected. * Size interferes with normal hand function. | [Digital Mucous Cyst](http://emedicine.medscape.com/article/1056917-overview)  Overview of condition – Medscape. |  |
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| B16.31 Hip Arthroscopy for Femoro–Acetabular Impingement | CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria:   * A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. * An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. * The patient has had severe FAI symptoms (restriction of movement, pain and ‘clicking’) or significantly compromised functioning for at least 6 months. * The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy. | [IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance](http://www.nice.org.uk/nicemedia/live/11328/56416/56416.pdf) – NICE, 2011.  <http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf>  NHS Hull Clinical Commissioning Group 2012.  Vijay D Shetty, Richard N Villar. [Hip arthroscopy: current concepts and review of literature.](http://bjsm.bmj.com/content/41/2/64.full) British Journal of Sports Medicine, 2007;41:64–68.    Macfarlane RJ, Haddad FS [The diagnosis and management of femoro-acetabular impingement.](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180305/pdf/rcse9205-) Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).  Ng V Y et al.. [Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review](http://www.ncbi.nlm.nih.gov/pubmed/20489213). American Journal of Sports Medicine, November 2010,38 2337-2345.  Commissioning Guide: [Painful osteoarthritis of the hip](http://www.rcseng.ac.uk/providers-commissioners/docs/Painarisingfromthehipinadults.pdf)  Royal College of Surgeons (2013).  [IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance](http://www.nice.org.uk/nicemedia/live/11328/56416/56416.pdf)  NICE, 2011 | Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term.  With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes. |

| B16.32 Surgical Removal of Bunions/Surgery for Lesser Toe Deformity | Requests for the removal of bunions will only be considered where:   * Conservative methods of management\* have failed.   AND   * The patient suffers significant functional impairment\*\* as a result of the bunions.   AND   * Radiographic evidence of joint damage (at point of referral).   \*Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non-surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate.  \*\*Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.  Treatment will not be commissioned for cosmetic appearance only. | [Bunions](http://cks.nice.org.uk/#azTab)  NICE Clinical Knowledge Summaries (2012)  IPG 332: [Surgical correction of hallux valgus using minimal access techniques](http://publications.nice.org.uk/surgical-correction-of-hallux-valgus-using-minimal-access-techniques-ipg332)  NICE (2010)  Commissioning Guide: [Painful deformed great toe in adults](http://www.rcseng.ac.uk/providers-commissioners/docs/Painfuldeformedgreattoeinadults.pdf)  Royal College of Surgeons (2013) |  |
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| B16.33 Surgical Treatment of Morton’s Neuroma | Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway.  The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads.  Been referred to an orthotist or podiatrist for an assessment.  Had a trial of local corticosteroid injection. | [Therapeutic massage provides pain relief to a client with Morton’s Neuroma: A case report](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3390214/pdf/ijtmb-5-2-12.pdf) - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012.  [Clinical Inquiry. What is the best way to treat Morton's neuroma?](http://www.jfponline.com/index.php?id=22143&tx_ttnews%5btt_news%5d=175848) - Journal of Family Practice 2011 v.60(3), p157-9.  [Morton's neuroma](http://cks.nice.org.uk/mortons-neuroma)  NICE Clinical Knowledge Summaries (2010). |  |
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| B16.34 Surgical Treatment of Plantar Fasciitis | Surgical Treatment is not routinely commissioned unless the following pathway has been followed:   * Patient has documented evidence that they are not responding to conservative treatments * Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following: * Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss * Been referred to a podiatrist or physiotherapist * Not responded to corticosteroid injections | [Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association](http://www.jospt.org/doi/pdf/10.2519/jospt.2008.0302) - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.  [Plantar fasciitis](http://cks.nice.org.uk/plantar-fasciitis)  NICE Clinical Knowledge Summaries (2009).  [Plantar fasciitis](http://www.bmj.com/content/345/bmj.e6603)  BMJ 2012;345:e6603. |  |
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| B16.35 Treatment of Tendinopathies (Extracorporeal Shock Wave Therapy; Autologous Blood or Platelet Injection) | These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow. | IPG 311: [Extracorporeal shockwave therapy for refractory plantar fasciitis](http://publications.nice.org.uk/extracorporeal-shockwave-therapy-for-refractory-plantar-fasciitis-ipg311)  NICE 2009.  IPG 312: [Extracorporeal shockwave therapy for refractory Achilles](http://publications.nice.org.uk/extracorporeal-shockwave-therapy-for-refractory-achilles-tendinopathy-ipg312)  NICE 2009.  IPG 313: [Extracorporeal shockwave therapy for refractory tennis elbow](http://publications.nice.org.uk/extracorporeal-shockwave-therapy-for-refractory-tennis-elbow-ipg313)  NICE 2009.  IPG 437: [Autologous blood injection for plantar fasciitis](http://publications.nice.org.uk/autologous-blood-injection-for-plantar-fasciitis-ipg437)  NICE 2013.  IPG 438: [Autologous blood injection for tendinopathy](http://publications.nice.org.uk/autologous-blood-injection-for-tendinopathy-ipg438)  NICE 2013. |  |
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| B17. Urology |
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| B17.3 Reversal of Male Sterilisation | The NHS does not commission this service.  Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child. | [CG156 Fertility: Assessment and treatment for people with fertility problems](http://publications.nice.org.uk/fertility-cg156) – NICE 2013.  Contraception – sterilization – NICE Clinical Knowledge Summaries 2012  [http://cks.nice.org.uk/contraception-sterilization#!scenario](http://cks.nice.org.uk/contraception-sterilization%23!scenario) |  |
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| B17.4 ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome | This is not commissioned as there is limited clinical evidence of effectiveness. | [Guidelines on chronic pelvic pain](http://www.uroweb.org/gls/pdf/24_Chronic_Pelvic_Pain_LR%20March%2023th.pdf)  European Association of Urology (2012). |  |
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| B17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome | This is not commissioned as there is limited evidence of effectiveness. | [Guidelines on chronic pelvic pain](http://www.uroweb.org/gls/pdf/24_Chronic_Pelvic_Pain_LR%20March%2023th.pdf)  European Association of Urology (2012).  <https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf> |  |
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| B17.6 Surgery for Prostatism | Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances:   * International prostate symptom score >7; dysuria; * Post voided residual volume >150ml; * Recurrent proven Urinary Tract Infections (UTI); * Deranged renal function; * Prostate-specific antigen (PSA) > age adjusted normal values. | CG97: [Lower urinary tract symptoms: The management of lower urinary tract symptoms in men](http://www.nice.org.uk/nicemedia/live/12984/48557/48557.pdf)  NICE 2010.  [LUTS in men, age-related (prostatism)](http://cks.nice.org.uk/luts-in-men-age-related-prostatism)  NICE Clinical Knowledge Summaries (2010).  <http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts>  Royal College of Surgeons (2013). | No references to treatment thresholds found. |
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| B18. Vascular |
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| B18.1 Surgery for Extreme Sweating (Hyperhydrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy) | Treatment is medical.  Treatment of hyperhidrosis with surgery is not routinely commissioned.  Risk of compensatory hyperhidrosis elsewhere is very high. | [Hyperhidrosis](http://cks.nice.org.uk/hyperhidrosis) –  NICE Clinical Knowledge Summaries (2013).  [Hyperhidrosis](http://www.patient.co.uk/doctor/Hyperhidrosis.htm)  Patient.co.uk. |  |
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| B18.2 Chelation Therapy for Vascular Occlusions | This is not commissioned. | [Diagnosis and management of Peripheral arterial disease: A national clinical guideline](http://www.sign.ac.uk/pdf/sign89.pdf) -SIGN, 2006.  [Effect of Disodium EDTA Chelation Regimenon Cardiovascular Events in Patients With Previous Myocardial Infarction](http://jama.jamanetwork.com/article.aspx?articleid=1672238&resultClick=3" \l "Abstract)  [The TACT Randomized Trial](http://jama.jamanetwork.com/article.aspx?articleid=1672238&resultClick=3" \l "Abstract)  JAMA. 2013;309(12):1241-1250. | A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI. |
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| B19. Other |
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| B19.1 Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane. | The use of botulinum toxin type A is commissioned in the following indications:   * Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. * Blepharospasm and hemifacial spasm. * Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8 * Focal dystonia, where other measures are inappropriate or ineffective. * Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. * Idiopathic cervical dystonia (spasmodic torticollis). * Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260 * Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. * Sialorrhoea (excessive salivary drooling), when all other treatments have failed. | NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A  <http://guidance.nice.org.uk/TA260>  Idiopathic detrusor instability  - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women <http://guidance.nice.org.uk/CG171> and only one course of injections.  [Diagnosis and management of hyperhidrosis](http://www.bmj.com/content/347/bmj.f6800) British Medical Journal. |  |

|  | Botulinum toxin type A is not routinely commissioned in the following indications:   * Canthal lines (crow’s feet) and glabellar (frown) lines. * Hyperhidrosis. * Any other indication that is not listed above   The use of Botulinum Type B is not routinely commissioned.  Where the use of botulinum toxin is used to treat an indication outside of the manufacturer’s marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications.  For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG’s defined processes.  If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated. |  |  |
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