

Care and Resource Utilisation Policies

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1. Introduction

This document is the policy of NHS South East Essex (hereafter referred to as “the PCT”) for ensuring that the PCT’s resources are utilised in a way that maximises the health gain for the population and represents best value for the taxpayer.

This document details the treatments which are not routinely funded by the PCT, or where there are clinical criteria or thresholds associated with certain treatments, and the clinical rationale behind these restrictions.

2. Purpose

This policy complies with the Directions to Primary Care Trusts and NHS Trusts concerning decisions about drugs and other treatments (2009), which requires PCTs to make explicit and publicly available information on the restrictions it places upon funding specific treatments and the mechanisms for local decision-making on individual funding requests.

NHS South East Essex must ensure that the resources invested in commissioned services achieve the best possible health benefit for the population.

This requires careful prioritisation of investments so that the PCT’s commissioning budget is focused as far as possible on treatments and interventions which :

- Are proven to be clinically effective
- Provide a demonstrable health benefit
- Are cost effective
- Fit with other PCT policies and procedures
- Have a sound ethical base

This policy ensures that the PCT meets specific rights contained within the NHS Constitution for England (2009). These include :

- The right to not be refused access to NHS services on unreasonable grounds
- Right to drugs and treatments that have been recommended by the National Institute of Health & Clinical Excellence (NICE) for use in the NHS, if your doctor says they are clinically appropriate for you
- The right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence and to receive an explanation if funding is denied

This policy should be read alongside the PCT’s Individual Funding Requests Policy which details the mechanisms for clinicians and patients to apply under the PCT’s special case review process for funding of an excluded or restricted treatment as an exceptional case.

3. Duties

Director of Public Health – is responsible for regularly reviewing the Care and Resource Utilisation Policies (CRUP) to ensure that the restrictions and clinical thresholds remain relevant and based on the highest quality evidence available. This postholder also has Executive level responsibility for the special case review process.

The Planned and Unplanned Clinical Programme Board – is responsible for advising the Director of Public Health on any revisions or additions required to the CRUP.

Director of Commissioning and Contracting – is responsible for liaising with and auditing providers to ensure that they are aware of and observe the restrictions and exclusions set out in the CRUP.

Head of Consumer Relations – is responsible for managing all individual funding requests received by the PCT, including the management of the special case review process.

Special Case Review Panel - The Special Case Review Panel (SCRCP) is responsible for considering IFRs which have been assessed through the PCT's screening process as falling outside approved policy and where no precedent can be established as a basis for approving funding.

The Special Case Review Panel does not make policy decisions for the PCT. Potential service gaps and commissioning issues that may arise through the work of the Panel will be raised with the Planned and Unplanned Clinical Programme Board as they arise.

East of England Specialist Commissioning Group – is responsible for commissioning certain specialist services on behalf of all PCTs in the East of England, including bariatric surgery for the morbidly obese, assisted conception and gender dysphoria services. The SCG develop policies for the services they commission which contain eligibility criteria.

National Institute for Health & Clinical Excellence (NICE) – is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. A key part of the role of NICE is to appraise the evidence behind new drugs, technologies and other treatments as they come onto the market and to make an evidence-based recommendation to the NHS on the clinical cost effectiveness of their use.

4. Definitions

Individual Funding Request - An IFR is a request to a PCT to fund healthcare for an individual who falls outside the range of services and treatments that the PCT has agreed to commission (NHS Confederation 2008).

Criteria – are clinical indications that a patient must meet in order to be eligible for their specific treatment to be funded by the PCT. The CRUP contain criteria for certain conditions and treatments.

Cosmetic surgery – is defined as “surgical intervention undertaken with the sole purpose of enhancing an individual’s appearance”

5. Main Policy

5.1. Drugs and treatments approved by the National Institute for Health & Clinical Excellence (NICE)

The NHS Constitution gives patients the right to any drugs and treatments that have been recommended for use in the NHS by NICE, provided that the treating clinician has deemed this treatment clinically appropriate to do so. A drug or treatment is considered to be “recommended” as the outcome of a NICE technology appraisal.

The PCT will fund drugs and treatments recommended by NICE technology appraisals from a date no later than three months from the publication of the appraisal.

5.2. Plastic Surgery

Whilst most of the work of plastic surgeons in the NHS concerns the restoration of appearance and function following trauma, cancer, degenerative conditions or congenital deformity, a number of referrals are made for conditions that are considered to be of lower priority or for treatments not usually available under the NHS.

Appendices A-F provide guidance on priorities for the commissioning and delivery of plastic surgery services. They advise on explicit criteria for referral and treatment inclusion thresholds and trigger points for referrals in respect of NHS South East Essex registered patients.

The care and resource utilisation policies related to plastic surgery have been developed with reference to the Modernisation Agency’s Action on Plastic Surgery (2005).

The guiding principle is that the PCT will not fund cosmetic surgery undertaken exclusively to improve appearance, in the absence of previous trauma, disease or congenital deformity.

A more detailed statement of the general principles underpinning the PCT’s policy towards commissioning plastic surgery can be found in Appendix A.

6. Review and Revision Arrangements including Version Control

The Care and Resource Utilisation Policies will be reviewed every year by the Director of Public Health, or more frequently if either the evidence-base underpinning the policies or the local commissioning priorities change.

If only minor revisions are made then the policy can be approved by the Planned and Unplanned Care Clinical Programme Board and the version number for the policy will be updated by “.1” e.g. from version 1.0 to 1.1.

If significant amendments need to be made then the policy will need to be approved by the PCT Board. In this case the version number would increase to the next whole number e.g. from version 1.1 to 2.

7. Process for Monitoring Compliance and Effectiveness

Responsibility for ensuring that the Care and Resource Utilisation Policies remain clinically relevant with a robust evidence-base rests with the Director of Public Health.

The Director of Commissioning and Contracting is responsible for developing and implementing a rolling audit programme and other mechanisms for ensuring that all providers commissioned by the PCT are aware of and comply with the Care and Resource Utilisation Policies.

8. Equality Impact Assessment

NHS South East Essex is committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any equality implications.

This policy has been assessed using the PCT's Equality Impact Assessment framework and identified as having the following impact/s upon equality and diversity issues:

Age	Disability	Gender	Race	Sexuality	Religion	Human Rights	Total Points	Impact
3	0	3	0	0	3	3	12	Medium

Points

Scoring

3 – This area has a high relevance to equalities
2 – This area has a medium relevance to equalities
1 – This area has a low relevance to equalities
0 – This area has no relevance to equalities

13-18 points – High Impact
7-12 points – Medium Impact
0-6 points – Low or No Impact

9. Appendices

Any supporting papers or documents that are required to expand or explain sections or details of the main policy.

General Principles of Plastic Surgery Commissioning

Authorisation Pathway (shown in Appendix B)

All referrals to plastics providers will be assessed by the PCT's appointed clinical assessment service (CAS) against the criteria set out in the Care & Resource Utilisation Policies regarding plastics (Appendices C to F). This is a paper-based review based upon the information contained within the referral, upon which the CAS will seek clarity from the referrer if necessary.

If the CAS consider that the patient appears to meet the criteria, they will send the referral on to the plastics provider and make a first outpatient appointment on the patient's behalf using the Choose and Book System.

Should the CAS consider that the patient does not meet the criteria, they will return the referral to the GP advising him or her of the decision.

When the patient is seen in the plastics outpatient clinic, the plastic surgery specialist will assess the patient with regard to whether he or she would benefit from plastic surgical intervention and if so, establish that the patient fully understands the risks and benefits of surgery.

The specialist is also responsible for assessing whether the patient meets the criteria within the Care & Resource Utilisation Policies during the consultation and examination in outpatients.

If the patient is assessed as meeting the criteria by the specialist, it is not necessary for the plastics provider to approach the PCT for funding following the outpatient appointment.

The specialist is then responsible either for placing the patient on the waiting list for surgery or, if he or she considers that the patient does not meet the criteria, for advising the referrer to this effect. In this case, the specialist will discharge the patient from clinic and will not place the patient on the waiting list for surgery.

Assessment of patients being considered for referral who have an underlying genetic, endocrine or psychosocial condition should have had this fully investigated by a relevant specialist prior to the plastics referral being made.

Cosmetic Surgery

Cosmetic surgery undertaken exclusively to improve appearance will not be funded in adults.

Revision Surgery

Revisions of plastic surgery procedures originally performed in the private sector will not usually be funded. Referring clinicians should re-refer to the practitioner who carried out the original treatment.

Where a patient has previously received NHS funded plastic surgery, procedures necessary for dealing with complications or an outcome that, because of complications or technical difficulties, has resulted in cosmetic or physical problems that, from a clinical point of view, are severe enough to oblige the NHS to fund corrective treatment, will be funded.

An undesirable outcome from an aesthetic perspective and the question of whether revision should be funded is an issue that the referrer should discuss with the patient prior to referring on to plastic surgery.

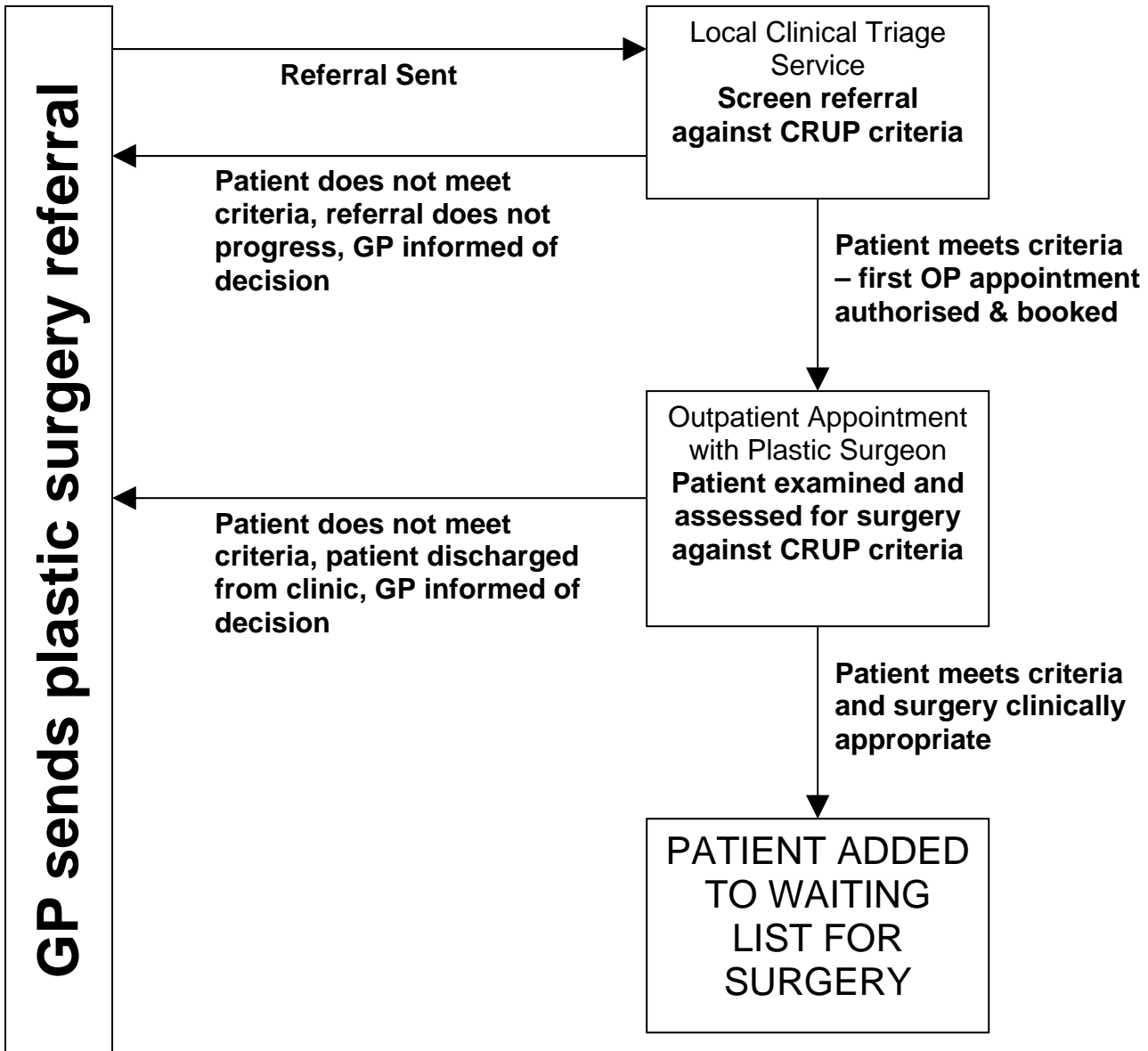
Plastic Surgery in Children

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services. DH October 2004), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again should be taken into consideration prior to referral.

Appeals Mechanism

The appeals mechanism should be activated for patients who are excluded from treatment to have a refusal decision independently reviewed in line with South East Essex PCT special case review process.

Plastics Authorisation Pathway



Plastic Surgery – Body Contouring Procedures

Abdominoplasty or Apronectomy

It is recognised that the consequences of morbid obesity will become an increasing problem for the NHS and that a robust restriction policy, needs to be developed to ensure that appropriate patients benefit from interventions that change the body contour.

Abdominoplasty and apronectomy may be offered to the following groups of patients who should have achieved a stable (for at least 2 years) BMI between 18 and 27 Kg/m² and be suffering from severe functional problems.

To receive PCT funded abdominoplasty or apronectomy, patients will need to be experiencing at least one of the following and also one of the severe functional problems listed, i.e., at least one from list A and at least one from list B

List A :

- Those with scarring following trauma or previous abdominal surgery
- Those who are undergoing treatment for morbid obesity and have excessive abdominal folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery
- Where previous post trauma or surgical scarring (usually midline vertical or multiple) leads to risk of infection.

List B:

Severe Functional problems include:

- Recurrent intertrigo beneath the skin fold
- Experiencing severe difficulties with daily living i.e. ambulatory restrictions. These patients will need full assessment by the appropriate professional e.g. Occupational Therapist prior to referral
- Problems associated with poorly fitting stoma bags

Rationale

Excessive abdominal skin folds may occur following weight loss in the previously obese patient and can cause significant functional difficulty. There are many patients who do not meet the definition of morbid obesity (BMI >40 Kg/m²) but whose weight loss is significant enough to create these difficulties. These types of procedures, which may be combined with limited liposuction, can be used to correct scarring and other abnormalities of the anterior abdominal wall and skin. It is important that patients undergoing such procedures have achieved and maintained a stable weight so that the risks of recurrent obesity are reduced. The availability of teams specialising in bariatric surgery is limited, but many patients achieving their weight loss outside such teams should not be disadvantaged in accessing body-contouring surgery if required.

Other skin excision for contour

Buttock lifts, thigh lifts and arm lifts (brachioplasty), procedures will only be funded in exceptional circumstances.

Rationale

Whilst the patient groups seeking such procedures are similar to those seeking abdominoplasty, the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance: in which case it should not be available on the NHS

Liposuction

Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy e.g. multiple lipomatosis, lipodystrophies. Liposuction is sometimes an adjunct to other surgical procedures. It will not be funded simply to correct the distribution of fat.

Plastic Surgery – Breast Procedures

Breast Reduction

Breast reduction surgery is an effective intervention that should be funded if all of the following criteria are met:

- The patient is suffering from neck ache or backache. Clinical evidence will need to be produced that this has been investigated to rule out any other medical/physical problems to cause these symptoms
- The wearing of a professionally fitted brassiere has not relieved the symptoms as documented by the GP
- Persistent intertrigo
- Serious functional impairment
- The patient has a BMI of less than 30 kg/m²

Patients should have an initial assessment by the referrer prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. Assessment of the thorax should be performed, including the use of x-ray, scan etc. The referrer and consultant will as part of their assessment consider the patient's breast size in relation to her BMI.

Rationale

Breast reduction places considerable demand on NHS resources due to the volume of cases and the length of surgery, and yet has been shown to be a highly effective health intervention. There is published evidence showing that most women seeking breast reduction are not wearing a bra of the correct size and that a well fitted bra can sometimes alleviate the symptoms that are troubling the patient.

The upper limit of normal BMI is 25 Kg/m². Patients seeking breast reduction have physical restrictions on their ability to exercise and additional weight in their excess breast tissue (sometimes 3-4Kg). Major complications for surgery in general and specifically related to breast reduction surgery have been shown to be greater if the BMI exceeds 30.

Breast Reconstruction/Augmentation

At present breast reconstruction competes with breast augmentation, which prevents the Plastic Surgeon Consultants being able to offer an appropriate, timely appointment for these patients. Therefore, augmentation will only be performed for reconstructive purposes following malignancy and will not be carried out for small but normal breasts or for breast tissue involution, including post partum changes.

Patients who have undergone gender reassignment and who request breast augmentation will need to fulfil the same criteria as born females, in the interests of equality, transparency and openness.

Funding will not be available for transwomen with small but normal breasts but where hormone therapy has produced no breast growth, the special case review panel will review the application along the same principle as born females with no breast growth.

Asymmetry

Funding will only be considered if there is gross disparity of breast cup sizes on initial consultation with the patients GP. This is defined for the purposes of this policy as two or more cup size difference between each breast.

Rationale

Demand for breast enlargement is rising in the UK. Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery, such as implant replacement, at some point in the future, is common. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

Revision of Breast Augmentation

Revisional surgery is carried out for implant failure, causing proven health problems. The decision to replace the implants rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the criteria for augmentation at the time of revision.

Replacement should not be funded if the original operation was done for cosmetic reasons in the private sector.

Rationale

Prior to the development of restriction/inclusion policies, a small number of patients underwent breast augmentation in the NHS for purely cosmetic reasons. There may however be clinical reasons why replacement of the implants remains an appropriate surgical intervention. For these reasons it is important that:

- Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from the current policy.
- Patients should also be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

Mastopexy (Breast Lift)

This is included as part of the treatment of breast asymmetry and reduction but not for purely cosmetic/aesthetic purposes such as post-lactational ptosis.

Rationale

Breast ptosis is normal with the passage of age and after pregnancy. Patients with breast asymmetry often have asymmetry of shape as well as volume and correction may require mastopexy as part of the treatment.

Nipple Inversion

Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires urgent referral and assessment.

Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

Rationale

Idiopathic nipple inversion can often (but not always) be corrected by the application of sustained suction. Commercially available devices may be obtained from major chemists or online without prescription for use at home by the patient. Greatest success is seen if it is used correctly for up to three months.

An underlying breast cancer may cause a previously normally everted nipple to become indrawn: this must be investigated urgently.

Gynaecomastia

Surgery to correct gynaecomastia should be allowed if the patient is:

- Post pubertal
- Stable BMI < 25 Kg/m² for at least two years

True gynaecomastia that is mainly caused by an excess of glandular breast tissue will be funded if the normal medical treatments have failed.

Pseudo-gynaecomastia, where the enlargement of the male breast is due to an excess of adipose tissue and the BMI is outside the range of a normal BMI, or where there is evidence that the problem relates to the use of drugs associated with body building, funding will not normally be agreed unless there is clear evidence that the problem has persisted in spite of rigorous dieting and weight loss.

Rationale

Commonly gynaecomastia is seen during puberty and may correct once the post-pubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely it may be caused by an underlying endocrine abnormality or a drug related cause including abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

Plastic Surgery - Facial Procedures

Face lifts and brow lifts (Rhytidectomy)

These procedures will be considered for treatment of:

- Congenital face abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery
- They will not be available to treat the natural processes of ageing.

Rationale

There are many changes to the face and brow as a result of ageing that may be considered normal, however there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.

Blepharoplasty (upper and lower lid)

➤ Upper Lid

This procedure will be funded to correct functional impairment (not purely for cosmetic reasons)

Indications:

- Impairment of visual fields in the relaxed, non-compensated state.
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow

Evidence will be required that eyelids impinge on visual fields, reducing field to 120 degrees laterally and 40 degrees vertically).

Rationale

Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

➤ Lower Lid

This will be funded for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale

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. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

Rhinoplasty

Rhinoplasty should be funded for:

- Problems caused by obstruction of the nasal airway
- Objective nasal deformity caused by trauma
- Part of reconstructive head and neck surgery
- Correction of complex congenital conditions e.g.cleft lip and palate

Patients with isolated airway problems, in the absence of visible nasal deformity, should be referred initially to an ENT consultant for assessment and treatment.

Pinnaplasty/Otoplasty

The following criteria should be met for funding to be made available:

- The patient must be between the ages of 5 and 14 years at the time of referral
- Patients seeking pinnaplasty should be seen by a plastic surgeon and following assessment, if there is any concern, assessed by a psychologist

Rationale

Prominent ears may lead to significant psychological dysfunction for children and impact on the education of young children as a result of teasing and truancy. Some patients are only able to seek correction once they are in control of their own healthcare decisions. Children under the age of 4 years are not deemed suitable clinically for this procedure, therefore surgery should only be offered from 5 years and upwards.

Repair of external ear lobes

This procedure will only be funded for the repair of totally split ear lobes as a result of direct trauma. Prior to surgical correction, patients should receive pre-operative advice to inform them of:

- Likely success rates
- The risk of keloid and hypertrophic scarring in this site
- The risks of further trauma with re-piercing of the ear lobe

Rationale

Many split earlobes follow the wearing of excessively heavy earrings with insufficient tissue to support them, such that the earring slowly 'cheese-wires' through the lobule. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

Aesthetic Facial Surgery

Funding should be considered for:

- Anatomical abnormalities in children <19 years, likely to cause impairment of normal emotional development
- Pathological abnormalities
- Correction of post traumatic bony and soft tissue deformity of the face

Alopecia

Funding will be available when it is a result of previous surgery or trauma including burns

Male pattern baldness

Is excluded from funding.

Rationale

So-called 'male pattern baldness' is a normal process for many men at whatever age it occurs.

Hair transplantation

Will not be funded, regardless of gender, other than in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

Hair depilation

Hair depilation will be funded for patients who:

- Have undergone reconstructive surgery leading to abnormally located hair-bearing skin
- Those with a proven underlying endocrine disturbance resulting in Hirsutism e.g. polycystic ovary syndrome
- Are undergoing treatment for pilonidal sinuses to reduce recurrence

Plastic Surgery – Skin and Subcutaneous Lesions

A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment.

Acne Vulgaris

The treatment of active acne vulgaris should be provided in primary care or through a dermatology service.

Patients with severe facial post-acne scarring can benefit from resurfacing and other surgical interventions, which may be available from the plastic surgery service. All resurfacing techniques, including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring, including post surgical and severe acne scarring once the active disease is controlled. This will need to be evaluated as being inactive by the referrer.

Lipomata

The NHS should consider lipomata of any size for treatment in the following circumstances:

- The lipoma is/are symptomatic
- There is a functional impairment
- The lipoma is rapidly growing or abnormally located e.g. sub-fascial, sub-muscular

Viral Warts

Most viral warts will clear spontaneously or following application of topical treatments.

Treatment for warts, including cryotherapy, should not be funded unless there are exceptional circumstances.

Cases of genital warts should be referred to the GUM clinic for screening.

Painful, persistent or extensive warts in the immuno-suppressed patient may need specialist assessment from a dermatologist.

In a small proportion of cases, surgical removal may be appropriate

Other Benign Skin Lesions

Clinically benign skin lesions should not be removed on purely cosmetic grounds. This will include, amongst other conditions, skin tags, seborrhoeic keratoses, benign pigmented moles and molluscum contagiosum

Patients with moderate to large lesions that cause actual facial disfigurement may benefit from surgical excision. The risk of scarring must be balanced against the appearance of the lesion.

Epidermoid or pilar cysts (sebaceous cysts) are always benign but some may become infected or be symptomatic. Some may require surgical excision particularly if located on the face or on a site where they are subjected to trauma.

Indications for intervention might include:

- Bleeding, recurrent trauma, site or size that interferes with normal day to day activity. E.g. a naevus on the bridge of the nose that interferes with the wearing of glasses.
- Uncertain diagnosis
- Sebaceous or inclusion cysts with a past history of repeated infection.

If a benign skin lesion of the eye obscures vision, or is causing a separate ocular problem then the patient can be referred to an ophthalmologist for removal.

Cysts on the scalp or other body parts should be managed in the context of the minor operations/general surgery. Funding will be considered for:

- Treatment of diabetic injection sites
- Pathological lipodystrophy

Multiple neurofibromatosis will be funded for plastic surgery.

Lesions on other sites, needing removal, should normally be managed in the context of dermatology or general surgery.

Rationale

The decision to remove benign skin lesions from conspicuous sites is a balance between the appearances of the original lesion against the likely appearance of the resulting scar. Potential patients should be fully counselled by the practitioner making the referral prior to the initial OPD appointment, to ensure the patient is fully aware of the surgical option being made and the consequences.

Vascular Skin Lesions

Port wine stains on the face will be funded for removal. Port wine stains on other parts of the body that are causing physical discomfort or are resulting in tissue hypertrophy should be funded.

The threshold for agreeing funding will be lower in patients under the age of 19 years.

Treatment should be considered for other haemangiomas or vascular lesions if:

- There are physical problems such as bleeding or ulceration
- The lesion is on the face and is unusually prominent and is getting bigger.

Funding will not be allowed for small benign, acquired vascular lesions such as thread veins and spider naevi.

Rhinophyma

The first-line treatment of the nasal skin condition is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment.

Xanthelasma

Patients with xanthelasma should always have their lipid profile checked before referral to plastic surgery.

Many xanthelasmata may be treated with topical trichloroacetic acid (TCA) or cryotherapy. Larger lesions or those that have not responded to these treatments may benefit from surgery if the lesion is disfiguring. Clinical evidence that previous treatment has been pursued before referral has been made will be required.

Rationale

Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for. They may be very unsightly and multiple and do not always respond to 'medical' treatments. Surgery can require blepharoplasty type operations and/or skin grafts.

Tattoo Removal

All requests for tattoo removal will need to be considered through the special case review process. The funding for removal of tattoos will be considered in the following circumstances :

- Funding should be considered for allergy to pigments
- Where the tattoo is the result of trauma, inflicted against the patient's will
- There is objective evidence that the individual was not Fraser (formally Gillick) competent, and therefore not responsible for their actions, at the time of the tattooing. This would need to be ascertained from contemporaneous medical or social care records
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial function). Psychiatric/psychological reports will need to be provided with the initial referral.

Rationale

Many patients seeking tattoo removal are from disadvantaged backgrounds that did not fully recognise the implications of a tattoo on subsequent employment and life opportunities.

Scar Revision

Scars that are resulting in physical disability due to contraction, tethering or recurrent breakdown will be funded.

Keloid scars, due to an over vigorous reaction in a scar, is more common in certain parts of the body and in certain racial groups.

Funding will be available for:

- Keloid scars that result in physical distress due to significant pain or pruritis
- Significant keloid scarring on the face
- Scars on the face that are ragged, over 2cm in length or can otherwise be regarded as particularly disfiguring

Funding will not be available for:

- Keloid scars on other parts of the body
- Keloid scars secondary to body piercing procedures
- Scars on the rest of the body. Scar revision for cosmetic purposes will not be funded. Cases will be judged on an individual basis through the special case review process.

Scars as a result of self-harm

- These are very difficult to treat and usually the only achievable outcome is to make the scars resemble trauma or burns rather than be obviously due to self-harm. Treatment will only be funded when there has been a minimum period of three years where there has been no self-harm and where there is a supporting report from a psychiatrist indicating that the behaviour would be unlikely to recur.

Other Policies Included in the Essex Health Policy Board Service Restriction Policy

Allergy Disorders

Only treatments for which there is evidence of clinical effectiveness should be funded. These include allergen avoidance, drugs and immunotherapy. Unconventional approaches to the management of allergy disorders should not be funded. These include clinical ecology, acupuncture, homeopathy, hypnosis, ionisation and herbal medicine.

Bobath Therapy

This policy specifies the criteria for referral of children with cerebral palsy to the Bobath Centre in London. Referrals are to be considered by the multidisciplinary team caring for the child, led by the Consultant Community Paediatrician. The policy advocates that children fulfilling the listed criteria should be considered for referral.

Children with cerebral palsy, requiring multidisciplinary therapeutic input, can be considered for referral for Bobath therapy. These would include :

- Severe, complex cerebral palsy
- Ataxic cerebral palsy
- Athetoid cerebral palsy
- Children with severe feeding difficulties
- Dystonic and hypertonic cerebral palsy

These children are to be assessed for the need for, and potential to benefit from Bobath therapy, prior to referral. The Consultant Community Paediatrician leading the child's care will be responsible for assessment and referral and also for informing the PCT of the decision.

Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME)

In common with all of the Essex PCTs, specialist services for people with chronic fatigue syndrome (CFS) are provided by the Essex CFS/ME Service which has been in operation since October 2006.

The Essex Team operate a multidisciplinary evidence-based approach to managing CFS/ME which complies with NICE guidance (issued in 2007).

The clinical pathway is reproduced overleaf.

Within the clinical pathway, CFS/ME is diagnosed by exclusion.

The process starts with the GP who will make the referral to the Essex CFS/ME Service if referral criteria are met.

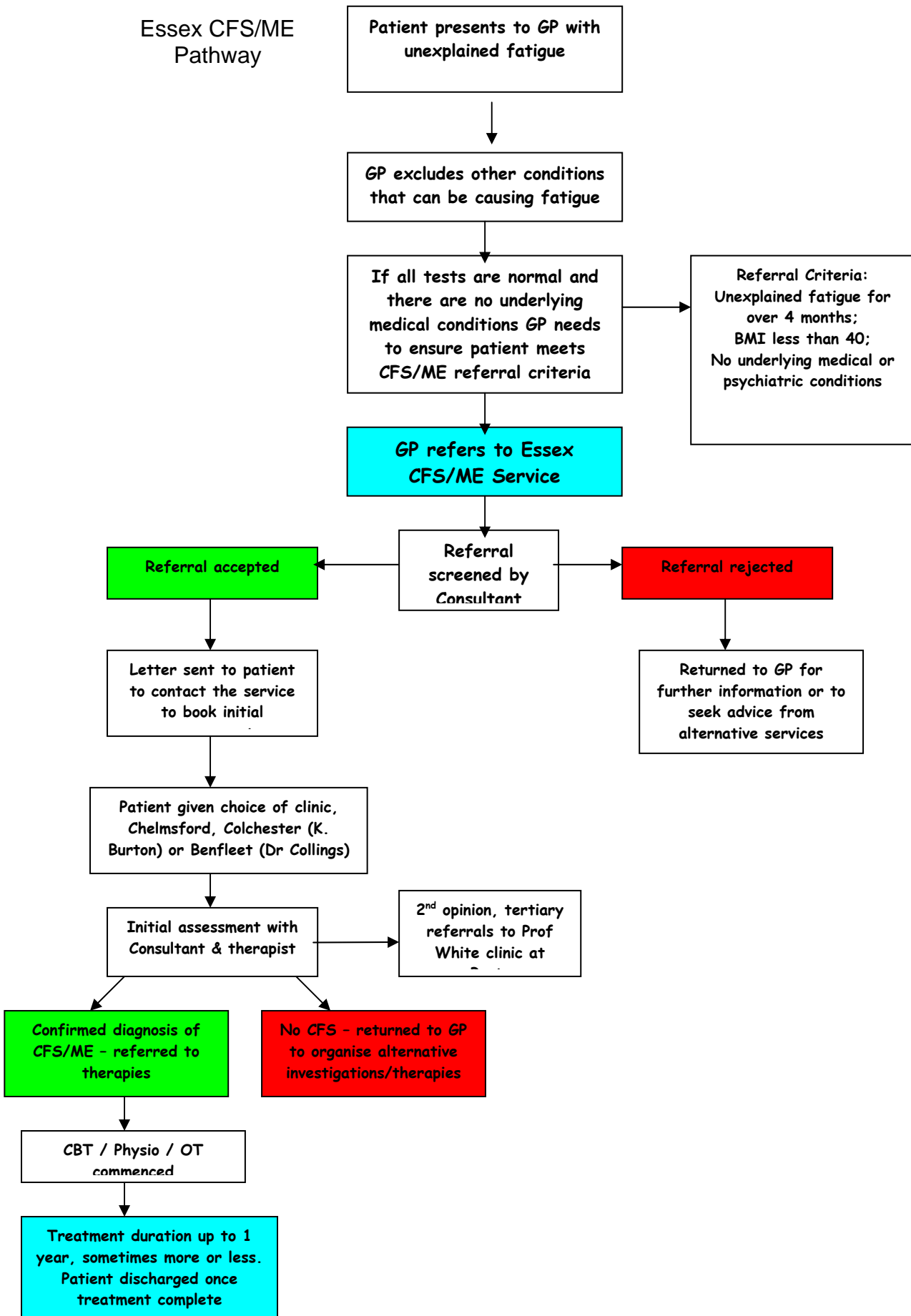
Once the referral is accepted by the service, patients will have an initial assessment at the centre nearest to their home.

Following diagnosis patients will be offered the therapy/therapies which meet their needs.

If a second opinion is required, the service will refer to Professor White's Clinic at Barts Hospital in London as part of the CNCC network

The PCT will only consider funding treatment for CFS/ME outside the Essex Pathway on an exceptional basis upon recommendation from the Essex Team if they consider that the individual's clinical needs cannot be met within the Service. Such referrals will only be funded by prior approval through the PCT's special case review process.

Essex CFS/ME Pathway



Complementary Therapies

Treatments or diagnostic procedures that are poorly supported by scientific theory and evidence of effectiveness, and are provided outside the mainstream of medical practice, will not be funded. Providers of services of unknown effectiveness will be asked to present evidence that would support funding.

Specific examples of services that would be commissioned only in exceptional circumstances (ascertained through the PCT's special case review process) are :

- Homeopathy
- Acupuncture – except for the relief of pain or nausea, as an adjunct to other treatments provided under the NHS
- Osteopathy and chiropractic services
- Other complementary therapies such as aromatherapy and massage

Treatment of People With Gender Dysphoria

Services for people with gender dysphoria are commissioned on behalf of NHS South East Essex by the East of England Specialist Commissioning Group (EOESCG).

The PCT will therefore apply the EOESCG Gender Dysphoria policy, the current version of which is accessible from www.eoescg.nhs.uk. As the policy changes, the PCT will automatically adopt the amended policy in its entirety.

Providers and other stakeholders should refer to the EOESCG policy in full to ensure full understanding of the eligibility criteria and other provisions in place. However for ease of reference, the key provisions contained in the policy are reproduced below.

The preferred providers are the Gender Identity Clinic (within West London Mental Health NHS Trust) for assessment and psychiatric support and either the Hammersmith Hospital or St Peter's Andrology Unit for surgical reassignment.

Patients presenting to their GP should be referred to a local psychiatrist for assessment. Referrals should be made by an approved local consultant psychiatrist. A written recommendation will be needed from the psychiatrist, confirming that the patient is not presenting with another affective psychiatric disorder or personality disorder. Referrals should not be accepted directly from GPs or other professionals.

The EOESCG Policy requires PCTs to approve all referrals for gender dysphoria treatment. Following assessment by the local psychiatrist, the letter of recommendation will be sent by the psychiatrist to the PCT (copied to the GP).

Provided that the letter from the psychiatrist is clear in its recommendation, the PCT's Individual Funding Requests (IFR) Service will confirm in writing that the patient may enter the pathway. There will be no need for the referral to be considered by a special case review panel. The PCT's approval letter will be sent to the psychiatrist (copied to the GP and EOESCG), requesting that the psychiatrist make the necessary referral.

In the event that the PCT does not receive a clear recommendation from a local psychiatrist, approval to enter the pathway will be declined by the IFR Service. In such instances the special case review panel will not consider the request as it will not, by definition, have the necessary clinical support.

Once approval is given to enter the pathway, this will be an agreement to commission the complete care pathway (if appropriate and medically supported by the specialist providers), including any referral that may eventually be made for gender reassignment surgery.

Patients will be required to undertake a "real life experience" of trial cross-gender living for at least two years. If the real-life experience is completed successfully, the suitability of the patient for gender reassignment surgery will then be assessed independently by two consultant clinicians as part of the assessment process, prior to their progression to surgery where appropriate.

Also for reasons of continuity of care, funding will normally be granted for further surgery if needed to correct the technical results of the initial reassignment surgery.

Patients who have undergone gender reassignment and who request breast augmentation will need to fulfil the same criteria as born females, in the interests of equality, transparency and openness. Such requests will be considered through the PCT's special case review process.

As such, funding will not ordinarily be available for transwomen with small but normal breasts but where hormone therapy has produced no breast growth, the special case review panel will review the application along the same principle as born females with no breast growth (see Appendix D).

Similarly funding for all other cosmetic procedures such as chondroplasty (larynx reshaping), crico-thyroid approximation surgery (to raise vocal pitch) and waist liposuction will only be funded in exceptional circumstances determined through the special case review process. Hair removal will only be funded where it is situated on donor sites to be used in surgery.

Infertility and Assisted Conception (including Reversal of Sterilisation)

Fertility services are commissioned on behalf of NHS South East Essex by the East of England Specialist Commissioning Group (EOESCG).

The PCT will therefore apply the EOESCG Fertility Services Commissioning Policy, the current version of which is dated August 2008 (accessible from www.eoescg.nhs.uk). As the policy changes, the PCT will automatically adopt the amended policy in its entirety.

Providers and other stakeholders should refer to the EOESCG policy in full to ensure full understanding of the eligibility criteria and other provisions in place. However for ease of reference, the key provisions contained in the policy are reproduced below.

Eligibility criteria for accessing fertility services

- Any treatment cycle will not be commenced before the female is 23 years of age but must be commenced before the female reaches her 40th birthday
- The woman must have a body mass index of between 19 and up to and including 30
- There should be no children from the couple's relationship. This would include adopted children
- Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted onto the IVF waiting list and should be non-smoking at the time of treatment
- Couples must have an identified cause for their fertility problems or have had infertility of at least three years duration
- Couples are ineligible if previous sterilisation has taken place (either partner), even if it has been reversed

Amount of treatment to be funded

- For couples requiring IVF or ICSI, this policy supports a maximum of 6 embryo transfers with a maximum of three fresh cycles
- IUI can be offered to couples for up to six cycles if clinically indicated
- In clinically appropriate cases and where investigations of the female partner are normal, including tubal patency, then six cycles of IUI with donor sperm should be offered before resorting to IVF treatment. If donor IUI fails, then 3 cycles of IVF using donor sperm would be funded

Clinical pathway

Couples who experience problems with their fertility will attend their GP practice to discuss their concerns and options. The patients will be assessed within the primary and secondary care setting.

A decision to refer a couple for IVF or other fertility services will be based on an assessment against the access criteria within the EOESCG policy which is based on the NICE guidelines and the HFEA recommendations as detailed in the clinical pathways.

Referral to one of the tertiary centres commissioned by EOESCG (listed below) will be via a Consultant Gynaecologist or a GP with Special Interest (GPwSI) in primary care.

Specialist Fertility Providers

As of May 2009, the EOESCG commissions fertility services from the following providers. Patients are able to choose any of these providers as they wish :

- Barts and the London Centre for Reproductive Medicines (London)
- Bourn Hall (Cambridge)
- IVF Hammersmith (London)
- Leicester Fertility Centre (Leicester)
- Oxford Fertility Unit (Oxford)

NB – this list may change from time to time.

Reversal of Sterilisation

Reversal of sterilisation (either gender) will not be funded.

Bariatric Surgery for Morbid Obesity

Obesity now affects more people world-wide than malnutrition. The prevalence of obesity (defined as body mass index (BMI) greater than 30 kg/m²) has now reached 21 per cent in both males and females in England (Health Survey for England 2000), and has almost trebled since 1980.

Obesity is associated with increased morbidity and mortality and the beneficial effects of weight loss are widely accepted.

Bariatric surgery refers to the various surgical procedures performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and/or absorption.

Bariatric surgery is commissioned on behalf of NHS South East Essex by the East of England Specialist Commissioning Group (EOESCG). The PCT will therefore apply the EOESCG bariatric surgery criteria set out below. As the criteria changes, the PCT will automatically adopt the amended criteria in their entirety.

Eligibility criteria for referral of morbidly obese patients for surgical assessment

Morbidly obese individuals (*BMI >40*) with type 2 diabetes and/or severe sleep apnoea, (*excludes hypertension*)

and

who are in the 18-60 years age group

and

have been receiving intensive obesity management for at least 6 months and have tried all appropriate and available non-surgical measures adequately but have not been able to maintain weight loss.

Approved centres

In the East of England, bariatric surgery is commissioned by the following two providers :

- Homerton University Hospital NHS Foundation Trust (Hackney, East London)
- Luton and Dunstable Hospital NHS Foundation Trust (Hertfordshire)

Eligible patients will have the choice of either of these two providers.

Surgical Thresholds - Ear, Nose and Throat Surgery

Grommets for otitis media with effusion

In addition, please note the Adenoidectomy Policy. It is envisaged that the decision to perform adenoidectomy at the time of grommet insertion, if appropriate, would be undertaken by the ENT surgical team.

Definition

A small bobbin-shaped tube used to keep open the incision made in the ear drum as a ventilation of secretory otitis media. It acts as a ventilation tube by allowing the Eustachian Tube to recover its normal function.

Eligibility criteria

Children with hearing impairment should have a period of at least 3 months of watchful waiting from the date of the first appointment with an audiologist or GP and the child is placed on a waiting list for the procedure at the end of this period.

The PCT will agree to fund treatment with grommets for children with otitis media with effusion (OME) where:

- there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP and the child is placed on a waiting list for the procedure at the end of this period;
- and
- A. OME persists after three months and the child (over three years of age) suffers from at least one of the following:
 - at least 5 recurrences of acute otitis media in a year;
 - evidenced delay in speech development;
 - educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss);
 - a second disability such as Down's syndrome or cleft palate;

or B. for children aged 2 years, the child has:

- OME with prolonged effusion (6 months or longer);
- AND measured hearing losses for 6 months or more;
- AND disability attributable to hearing loss (delay in speech development or other problems).

(There is some published evidence that suggests that prompt insertion of ventilation tubes in the under 3s does not significantly improve general and language developmental outcomes. However, most trials have not studied children under 3 years of age with periods of effusion longer than 6-9 months or those with moderate or severe hearing loss)

Funding will also be agreed if:

- OME is overlaying sensorineural deafness or is delaying diagnosis or treatment with aids or cochlear implants - this would be an indication for immediate grommets;

Regular audit of the indications for the surgical procedures carried out should be undertaken.

Rationale

Evidence of effectiveness is limited: **“surgery may resolve glue ear and improve hearing in the short term” compared with non-surgical treatment, but “there is less certainty about long-term outcomes and large variation in effect between children”.**

“There continues to be debate about how best to select children for surgery. The issue is complicated by the high rate of resolution of glue ear, particularly in younger children.”

“Timing of surgery may not be critical”. A 1999 trial compared 9 months 'watchful waiting' with immediate surgery and found outcomes to be similar by 18 months. However, by this time, 85% of children in the watchful waiting group had been treated with grommets.

“The benefits of surgery have to be balanced against possible harms”. About one third of children who have grommets have complications. Tympanosclerosis frequently occurs after grommet insertion, infection may occur, and there is a slightly increased incidence of chronic perforation.

The reduced risk of serious complications of anaesthesia and surgery must be balanced against the increased hearing loss and episodes of infection requiring antibiotic treatment and time off work, school or college.

Restricting access to grommets is not a new phenomenon. A 1995 survey revealed that 23 of the 129 then health authorities in England, Scotland and Wales had excluded grommets.

Conclusion of the Cochrane review

The benefits of grommets in children appear small compared with myringotomy or non-surgical treatment. **“The effect of grommets on hearing diminished during the first year”.** Adverse effects on the tympanic membrane are common after grommet insertion. **“Therefore, an initial period of watchful waiting seems to be an appropriate management strategy for most children with OME. As no evidence is yet available for the subgroups of children with speech or language delays, behavioural and learning problems or children with defined clinical syndromes (generally excluded from the primary studies included in this review), the clinician will need to make decisions regarding treatment for such children based on other evidence and indications of disability related to hearing impairment”.**

BMJ Clinical Evidence: Otitis media effusion. Williamson I - Summary

“One systematic review found that grommets improved hearing at up to 2 years, but not at 5 years compared with no grommets. The clinical significance of the improvement seen (<10dB) was unclear. The review found that grommets did not significantly improve cognition, language comprehension or expression compared with no grommets, although relatively insensitive outcomes may have been used. Grommets were associated

with an increased risk of tympanosclerosis at 1 year. One systematic review found that grommets plus adenoidectomy improved hearing at 6 months compared with no treatment, although the difference between the groups was reduced at 12 months. The review found no significant difference between the combined treatment and grommets alone at up to 12 months. Another review found that the combined treatment improved hearing more than adenoidectomy alone at up to 12 months, but found no significant difference between treatments at 2-5 years. The clinical significance of the improvements seen with surgery was unclear”.

SIGN guideline recommendation

A: Children under three years of age with persistent bilateral otitis media with effusion and hearing loss of ≤ 25 dB, but no speech and language, development or behavioural problems can be safely managed with watchful waiting. If watchful waiting is being considered, the child should undergo audiometry to exclude a more serious degree of hearing loss.

B: Children with persistent bilateral otitis media with effusion who are over three years of age or who have speech and language, developmental or behavioural problems should be referred to an otolaryngologist.

References

1. MRC Multicentre Otitis Media Study Group (2001). Surgery for persistent otitis media with effusion: generalizability of results from the UK trial (TARGET). *Clin. Otolaryngol* (26); 417-424
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9. SIGN guideline 66. Diagnosis and Management of Childhood Otitis Media in Primary Care (available online at <http://www.sign.ac.uk/pdf/sign66.pdf>).

Glossary

Adenoidectomy:	Surgical removal of the adenoids. Adenoids are an overgrowth of tissue at the back of the throat, into which the nose opens.
Down's Syndrome:	A genetic disorder in which the affected person usually carries an extra chromosome - 47 instead of the usual 46.
Glue Ear:	Another name for secretory otitis media (infection of the middle ear) - persistent sticky fluid in the middle ear.
Grommet:	A small bobbin-shaped tube used to keep open the incision made in the ear drum in the treatment of secretory otitis media. It acts as a ventilation tube by allowing the Eustachian tube to recover its normal function.
Myringotomy:	An operation to cut open the drum of the ear to provide drainage for an infection of the middle ear.
Otitis Media:	Infection of the middle ear.
Otolaryngologist:	A specialist in ear, nose and throat disorders.
Tympanosclerosis:	A pathological hardening or thickening of the ear drum.

Tonsillectomy

Definition

Surgical removal of tonsil or tonsils

Policy

Referrals for tonsillectomy will be funded if the criteria in the Surgical Threshold Checklist overleaf are met.

Evidence

- A Cochrane systemic review concluded that: "There is no evidence from randomised controlled trials to guide the clinician in formulating the indications for surgery in adults or children".
- The frequency of sore throat episodes and upper respiratory infections reduces with time whether Adenotonsillectomy has been performed or not.

Adenotonsillectomy probably "gives an additional, but small, reduction of sore throat episodes, days of sore throat associated school absence and upper respiratory infections compared to watchful waiting".

References

1. Management of sore throat and indications for tonsillectomy. A national clinical guideline. SIGN Publication Number 34.
2. Ryan, C.F. Sleep 9:An approach to treatment of obstructive sleep apnoea hypopnoea syndrome including upper airway surgery. *Thorax* 2005;60:595-604.
3. Cochrane Database of Systematic Reviews. Adenotonsillectomy for obstructive sleep apnoea in children.
<http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003136/abstract.html>
4. Cochrane Database of Systematic Reviews. Tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis (Review):
<http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001802/frame.html>.
5. Van Staaïj et al. Adenotonsillectomy for upper respiratory infections: evidence based? *Arch Dis Child* 2005;90:19–25.

PRIMARY CARE TONSILLECTOMY REFERRAL FORM
SURGICAL THRESHOLD CHECKLIST

Patient name: _____ NHS No.: _____

DOB: _____ Age: _____ Tel No.: _____

Address: _____

GP name/address: _____

Please tick all boxes that apply:

Group A

Two or more quinsies

Obstruction

Suspected malignancy

Group B

Intractable cough with a high level of streptococcal antibody

Severe halitosis which has been demonstrated to be due to tonsil crypt debris

Group C

Sore throats due to tonsillitis

Symptoms for at least a year

Episodes of sore throat are disabling and prevent normal functioning

Group D

Five or more episodes of tonsillitis per year

Three or more episodes per year requiring at least a week off school/work on each occasion

Criteria for funding

In line with the PCT's care and resource utilisation policy: if the patient is aged 12 or under, tonsillectomy will be funded IF:

- One box in group A is ticked, OR
- All boxes from group C AND at least one box from group D are ticked.

If the patient is aged 13 or over, tonsillectomy will be funded IF:

- One box from group A is ticked, OR
- One box from group B is ticked, OR
- All boxes from group C AND at least one box from group D are ticked.

Referrals not meeting the above criteria will be returned to the GP.

Declaration

The information given above is correct to the best of my knowledge.

Signed (GP): _____

Date: _____

Please send to hospital with or instead of a referral letter via electronic Choose & Book.

HOSPITAL USE ONLY
Date Referral Received:

Adenoidectomy

Policy summary

Adenoids are an overgrowth of glandular tissue at the back of the throat, into which the nose opens. Adenoidectomy combined with grommets may be considered in children who fulfil evidence-based eligibility criteria.

Adenoidectomy combined with grommets may be considered in children who fulfil the criteria for grommets as follows:

The PCT will agree to fund treatment with grommets for children with otitis media with effusion (OME) where:

- There has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP and the child is placed on a waiting list for the procedure at the end of this period,

and

- A. OME persists after three months and the child (over three years of age) suffers from at least one of the following:
- at least 5 recurrences of acute otitis media in a year;
 - evidenced delay in speech development;
 - educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss);
 - a second disability such as Down's syndrome or cleft palate.

or

- B. for children aged 2 years, the child has:
OME with prolonged effusion (6 months or longer);
- AND measured hearing loss;
 - AND disability attributable to hearing loss (delay in speech development or other problems).

[There is some published evidence that suggests that prompt insertion of ventilation tubes in the under 3s does not significantly improve general and language developmental outcomes. However, most trials have not studied children under 3 years of age with period of effusion longer than 6-9 months or those with moderate or severe hearing loss.]

or

- C. the child does not have OME but has had at least 5 occurrences of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensorineural deafness or cochlear implantation.

All referrals should be through an agreed pathway to optimise access to conservative treatment and advice. Regular audit of the indications for the surgical procedures carried out should be undertaken.

Other indications for adenoidectomy in conjunction with tonsillectomy that would require

referral to the PCT Special Cases Panel include:

Sleep apnoea (demonstrated by a sleep study or other accepted method of diagnosis) - a literature review by Ryan in 2005 was published in Thorax. This found that, in children, including those that are obese, "adenotonsillectomy was curative for 75-100%".

However, a Cochrane review (2006) noted that there is no randomised trial data relating to adenotonsillectomy for obstructive sleep apnoea in children and more research is needed.

Rationale

- Clinical Evidence, last updated in November 2005⁸, states that:
- ventilation tubes (grommets) and adenoidectomy represents a trade off between benefits and harms;
- adenoidectomy on its own is of unknown effectiveness.

- In a Cochrane review of grommets, the reviewers note some improvement in outcomes that look at adenoidectomy and grommet insertion compared to grommet insertion alone.

In 2005, in a randomised control trial (n=193) comparing watchful waiting with adenotonsillectomy for otitis media, Oomen et al found no significant difference in the occurrence of otitis media between the Adenotonsillectomy group and the watchful waiting group.

References

1. MRC Multicentre Otitis Media Study Group (2001). Surgery for persistent otitis media with effusion: generalisability of results from the UK trial (TARGET). Clin. Otolaryngol (26); 417-424.
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Glossary

Grommet: A small bobbin-shaped tube used to keep open the incision made in the ear drum in the treatment of secretory otitis media. It acts as a ventilation tube by allowing the Eustachian tube to recover its normal function.

Otitis Media: Infection of the middle ear.

Down's Syndrome: A genetic disorder in which the affected person usually carries an extra chromosome - 47 instead of the usual 46.

Cochlear implants

All referrals should be made by a consultant ENT surgeon, and that referrals should not be accepted directly from general practitioners or from voluntary agencies. Funding for cochlear implantation in children should be available on demand. The level of funding allocated for cochlear implantation in adults should be agreed by commissioners each year, dependent on other financial commitments.

Surgical Thresholds – General Surgery

Surgery for Carpal Tunnel Syndrome

Carpal Tunnel Syndrome is a condition characterised by attacks of pain and tingling in the first three or four fingers of one or both hands, which usually occurs at night. It is caused by pressure on the median nerve as it passes under the strong ligament that lies across the front of the wrist.

Policy

The PCT will fund Carpal Tunnel Surgery where:

- Symptoms persist after conservative therapy with either local corticosteroid injections and/or nocturnal splinting.
or
- There is neurological deficit, for example sensory blunting, muscle wasting or weakness or thenar abduction.
or
- Severe symptoms significantly interfering with daily activities.

Rationale

- Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients' symptoms may resolve for at least a year after conservative treatment. After corticosteroid injection, up to 50% of patients may report minor or no symptoms at one year.
- The benefits of conservative therapy are seen early after treatment and then decrease while the benefits of surgery take longer to be fully realised.
- Corticosteroid injections and nocturnal splinting are effective conservative therapies. Therefore patients would not normally be referred for carpal tunnel syndrome unless they have had a local steroid injection into the carpal tunnel together with the provision of night splints. Electro-diagnostic tests are not indicated in the diagnosis of classical carpal tunnel syndrome. These may be done where there is doubt about the diagnosis, which is uncommon.
- In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.

A trial of conservative therapy offers the opportunity to avoid surgery for some patients.

Evidence

- Local corticosteroid injection is effective in relieving symptoms, but effectiveness beyond one month is uncertain. Local injection is more effective than oral steroids (Cochrane Review, Search Date May 2002).
- Some studies suggest up to 80% effectiveness (no or minor symptoms) at one month which decreases to 50% at one year for corticosteroid injection (Dammers et al) compared with placebo.
- Non-surgical treatment, including oral steroids, splinting, ultrasound, yoga and carpal bone mobilisation show short-term benefit compared with placebo or other

non-surgical control interventions (Cochrane Review, Search Date March 2002).

- Surgery is better than splinting at relieving symptoms at three months and one year (Cochrane Review, Search Date October 2002).

Two recent randomised controlled trials compared surgery to injected steroids. One (n=50) showed greater symptomatic improvement with surgery at 20 weeks. The other (n=163) showed greater improvement in the steroid group for nocturnal paraesthesiae at three months but equivalence at six and twelve months. In the second study, most patients needed two steroid injections and referral to surgery was counted as treatment failure in the intention to treat analysis (Hui 2005, Ly-Pen 2005).

- One recent randomised controlled trial compared splinting to surgery. This study, included in the Cochrane review, showed improved outcomes with surgery at three months and 18 months (Gerritsen 2002). By 18 months, 41% of the splinting group had undergone surgery.
- Two randomised controlled trials have compared steroid injections with splinting. In one study in mild to moderate carpal tunnel syndrome, at one year, splinting was effective for both symptoms and nerve conduction when worn every night. Steroid injection was not effective at one year (Sevim 2004). The other study (Celiker 2002) compared non-steroidal anti-inflammatory agents and splinting to steroid injection. Both groups showed similar improvement at eight weeks.

Risk of nerve damage is low for most patients and the relationship between symptoms and nerve conduction study results is not good.

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2. J W H H Dammers, M M Veering, and M Vermeulen, Injection with methylprednisolone proximal to the carpal tunnel: randomised double blind trial *BMJ* 1999 319: 884-886.
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Glossary

Nocturnal splinting: A support worn on the hand at night.

Neurological: Conditions affecting the nervous system.

Placebo: Inactive substance - often used in clinical trials. Also has the ability to relieve a variety of symptoms.

Thenar: The thenar eminence is the body of [muscle](#) on the palm of the human [hand](#) just beneath the [thumb](#).

Paraesthesiae: Unusual feelings, apart from mere increase, or loss of sensation, experienced by a patient without any external cause.

Surgery for Varicose Veins

Surgical treatment will not normally be funded for those veins that present a largely cosmetic problem or that cause simple aching that could be adequately controlled by properly measured surgical support stockings.

Surgical referral of patients with varicose veins with the complications outlined below will continue to be funded :

- Venous ulceration
- Venous eczema refractory to short term steroid creams
- Recurrent superficial thrombophlebitis
- Bleeding associated with varicose veins
- Post phlebitic syndrome

Circumcision

Circumcision should only be funded for medical reasons. The medical indicators for circumcision are phimosis and recurrent balanitis. Circumcision will not be funded for social or cultural reasons.

Appendix Kiii**Surgical Thresholds - Gynaecology***D&C and Hysteroscopy for heavy menstrual bleeding***Definition**

A hysteroscopy is a test to look inside the womb using a narrow tube-like telescope. This test can help find out what is causing symptoms such as unusual vaginal bleeding.

Dilatation and Curettage (D&C) is a gynaecological procedure, during which the lining of the womb is scraped out.

Policy

Patients will receive hysteroscopy under prior approval in the investigation and management of heavy menstrual bleeding only when it is carried out:

- As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive, for example to determine the exact location of a fibroid or the exact nature of the abnormality;
- Where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device;
- Pre-procedure when undertaking endometrial ablation.

Patients will not receive D&C:

- As a diagnostic tool for heavy menstrual bleeding; or
- As a therapeutic treatment for heavy menstrual bleeding.

Rationale

Ultrasound should be considered the first line diagnostic tool for the identification of structural pathology in heavy menstrual bleeding.

Hysteroscopy with biopsy is an accurate method for identification of endometrial and submucosal pathology, but should be considered only where ultrasound outcomes are inconclusive.

Limited evidence is available on the use of therapeutic D&C for heavy menstrual bleeding. The one study that was identified by NICE showed that any effect was temporary.

Hysteroscopy for the majority of women can be performed as an outpatient procedure.

Evidence

NICE released guidelines on heavy menstrual bleeding in January 2007, and these form the basis of these proposals. NICE recommends that if the history suggest heavy menstrual bleeding without structural or histological abnormality, pharmaceutical treatment can be started without carrying out a physical examination or other investigations at initial consultation in primary care, unless the treatment chosen is levonorgestrel-releasing intrauterine system (LNG-IUS). A physical examination should be carried out before all LNG-IUS fittings. If the history suggests heavy menstrual bleeding with structural or histological abnormality, with symptoms such as intermenstrual or postcoital bleeding, pelvic pain and/or pressure symptoms, a physical examination and/or other investigation (such as ultrasound) should be performed.

Endometrial Ablation:	Destruction/removal of the lining of the womb
Hysteroscope:	A Hysteroscope is a thin, telescope-like instrument that is inserted into the uterus (womb) through the vagina and cervix (neck of womb).
Hysteroscopy:	Is an examination of the uterus and the surface of the endometrium (mucous membrane lining the interior of the womb) using a hysteroscope.
Ultrasound:	The use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to image an internal body structure, monitor a developing foetus, or generate localised deep heat the tissues.
Postcoital:	After intercourse.
Heavy menstrual bleeding:	Excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms.

References

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Labiaplasty, Vaginoplasty and Hymenorrhaphy

Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely funded. Requests for labiaplasty will be considered for the following indications :

- Where the labia are directly contributing to recurrent disease or infection
- Where repair of the labia is required after trauma

Non-reconstructive vaginoplasty or “vaginal rejuvenation” is used to restore vaginal tone and appearance and is not routinely funded. Requests for vaginoplasty will be considered for the following indications :

- Congenital absence or significant developmental / endocrine abnormalities of the vaginal canal
- Where repair of the vaginal canal is required after trauma

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded.

This policy does not apply to genital reconstruction for gender dysphoria which is covered by the EOESCG Gender Dysphoria Policy (see appendix H).

Appendix K iv

Surgical Thresholds - Ophthalmic Surgery*Clinical Threshold for Elective Cataract Surgery***Guidance**

Cataracts are a common condition of later life affecting the lens of the eye. If left untreated, they can cause a gradual loss of clarity of vision, which can have a large impact on the quality of life of many elderly people. Currently the only effective treatment is surgery. As the operation is relatively straightforward and safe there is no reason why cataract should be a blinding condition in a developed country.

Recommendations

The aims of cataract surgery are to improve visual acuity and to improve the vision related quality of the patient's life. Unfortunately, the sheer scale of the problem creates its own difficulties, and the real challenge is how best to provide high-quality eye care to all people affected by cataract. These guidelines set out referral criteria and treatment thresholds for cataract surgery which are evidenced based and agreed amongst local providers. This is in accordance with the DOH Commissioning Toolkit for Community Based Eye Care Services¹.

Guidance to Primary Care

These referral guidelines have been developed in consultation with local clinicians and are consistent with guidance from *Action on Cataracts*², which suggests that referrals to the ophthalmologists should be based on reduced visual acuity, plus impairment of lifestyle plus willingness to have surgery, if appropriate.

First ('worst' eye)

Referral of patients with cataracts to ophthalmologists should therefore be based upon consideration of all three following indications.

If the patient does not meet these criteria they will not be treated and will be sent back to the referring clinician.

1:	Reduced visual acuity documented to be at least 6/12 or worse in the affected (i.e. worst) eye (corrected), assessed by the clinician as being due to a rectifiable lenticular opacity;
----	--

AND:

2:	<p>Impairment of lifestyle such as; the patient is at significant risk of</p> <p style="text-align: center;">Falls</p> <p><u>OR</u> the patient's vision is affecting their ability to drive (it is expected that the threshold will not render the majority of people unable to drive as it applies to the worse eye only – exceptions will be considered for:</p> <ul style="list-style-type: none"> ○ patients who need to drive who experience significant glare which affects driving; ○ patients who, for occupational reasons, need to drive at night and who experience glare that is related to cataract; <p><u>OR</u> the patient's vision is substantially affecting their ability to work</p> <p><u>OR</u> patients with glaucoma who require cataract surgery to control ocular pressure</p> <p><u>OR</u> patients with diabetes who require clear views of their retina to screen for, and monitor any, retinopathy</p>
----	---

AND:

-
3. **Willingness to have cataract surgery**
- **The referring optometrist or GP has discussed the risks and benefits using an approved information leaflet (national or locally agreed) and ensured the patient understands and is willing to undergo surgery before referring**
 - **Exceptional cases that do not meet the above criteria can be considered at the PCT individual case panel, e.g. those with significant functional disability from cataract but minimal visual acuity loss.**
-

Second eye

Referral of patients with cataract in the 'second eye' (i.e. following surgery on the 'worst' affected eye) to ophthalmologists should therefore be based upon consideration of all three following indications.

If the patient does not meet these criteria they will not be treated and will be sent back to the referring clinician.

1:	<p>Visual acuity:</p> <ul style="list-style-type: none"> ○ Where the cataract procedure on the first (worst) eye has achieved a VA of 6/9 or better, and the VA for the second eye is better than 6/12, then the patient should be discharged, unless receiving treatment for any other eye condition. The patient should be advised to attend an optometrist for a sight test annually or earlier if they notice any deterioration of vision. ○ If the first eye does not achieve a VA of 6/9 or better, then the second eye should be dealt with on clinical merit, taking into account the factors below. ○ There are circumstances where, despite good acuities, there may still be a clinical need to operate on the second eye fairly speedily e.g. where there is resultant anisometropia (a large refractive difference between the two eyes) which would result in poor binocular vision or even diplopia. In these circumstances, the notes should clearly record this so that it can be identified during any future clinical audit.
----	--

AND:

2:	<p>Impairment of lifestyle such as; the patient is at significant risk of falls</p> <p><u>OR</u> the patient's vision is affecting their ability to drive; e.g.</p> <ul style="list-style-type: none"> ○ patients who need to drive who experience significant glare which affects driving; ○ patients who, for occupational reasons, need to drive at night and who experience glare that is related to cataract; <p><u>OR</u> the patient's vision is substantially affecting their ability to work</p> <p><u>OR</u> patients with glaucoma who require cataract surgery to control ocular pressure</p> <p><u>OR</u> patients with diabetes who require clear views of their retina to screen for, and monitor any, retinopathy</p>
----	---

AND:

3:	<p>Willingness to have cataract surgery</p> <ul style="list-style-type: none"> ○ The referring optometrist or GP has discussed the risks and benefits using an approved information leaflet (national or locally agreed) and ensured the patient understands and is willing to undergo surgery before referring ○ Exceptional cases that do not meet the above criteria can be considered at the PCT individual case panel, e.g. those with significant functional disability from cataract but minimal visual acuity loss.
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Post Cataract surgery follow-up

As indicated by *Action on Cataracts*¹, the majority of patients who undergo cataract surgery need not be routinely followed-up by the ophthalmologist. Thus it is recommended that most patients should be seen by their optometrists, with the possibility of further specialist referral if clinically indicated.

Existing pathways would suggest only a minority of patients will require formal ophthalmology follow-up at 4 to 5 weeks after surgery. These patients include:

- those patients who are at increased risk of complications from surgery, for example those with a history of glaucoma
- those patients who experienced complications from surgery
- those patients whose post-operative recovery is of concern to their optometrist

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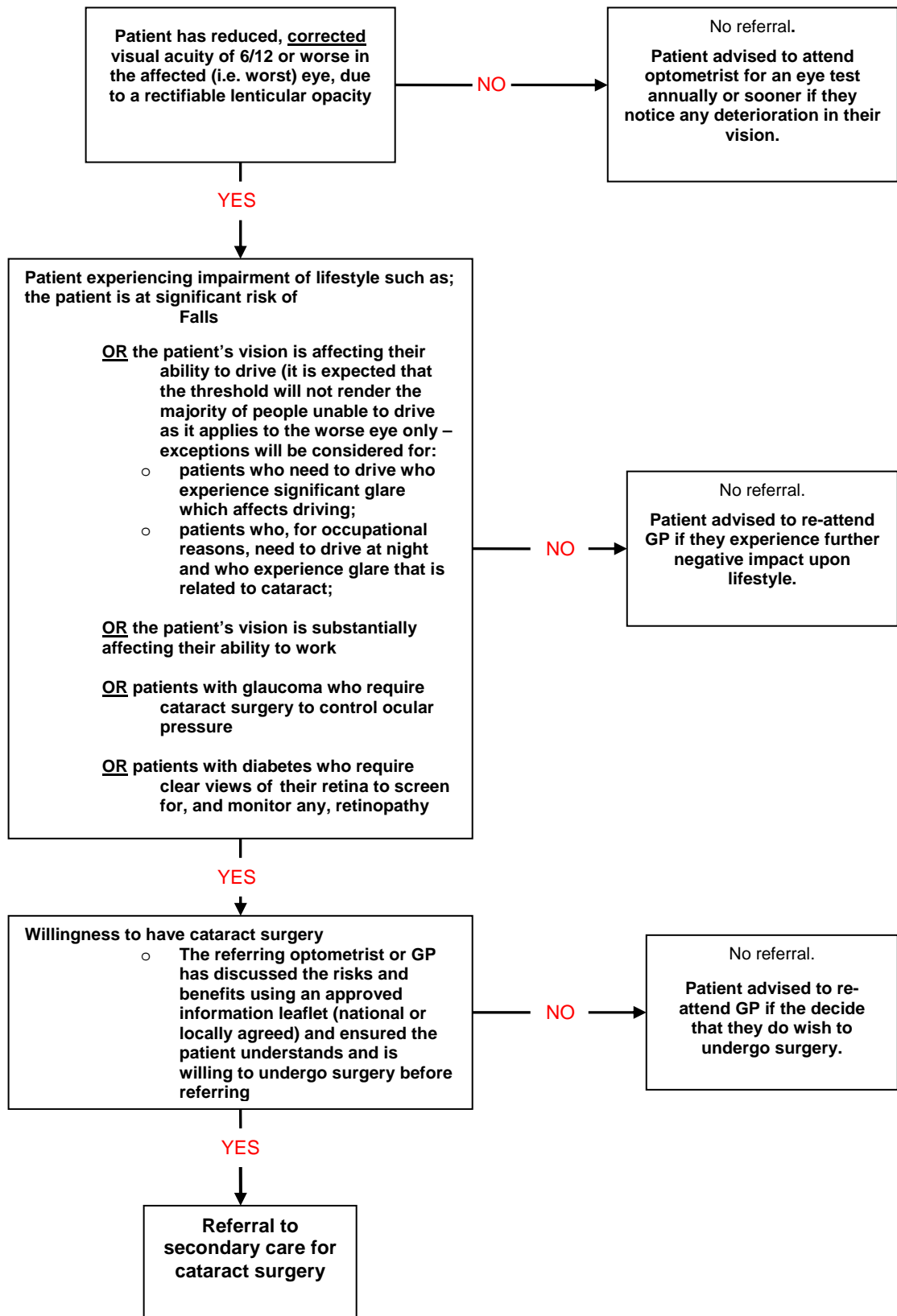
Glossary

Anisometropia: Inability to fuse images in the eyes adequately.

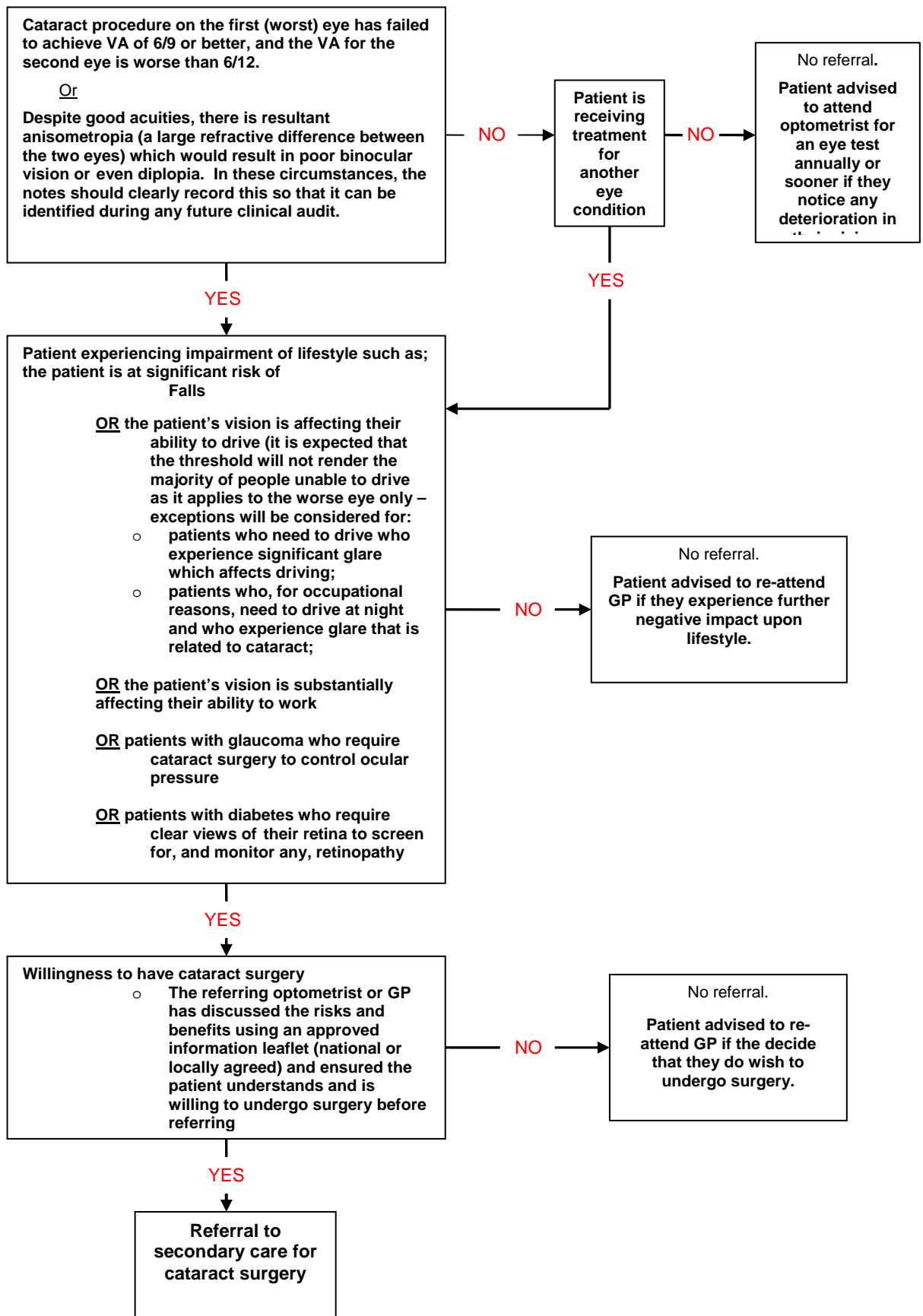
Anisekonia: Differences between the image in one eye and that in the other.

Myopia: Short sighted or near sighted

Hypermetropia: Long sightedness



NB: Exceptional cases that do not meet the above criteria can be considered at the PCT individual case panel, e.g. those with significant functional disability from cataract but minimal visual acuity loss.



NB: Exceptional cases that do not meet the above criteria can be considered at the PCT individual case panel, e.g. those with significant functional disability from cataract but minimal visual acuity loss.

Appendix K vi

KNEE ARTHROSCOPY

SURGICAL THRESHOLD

Knee arthroscopy can be undertaken where a competent clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective. The PCT is only able to fund knee arthroscopy for one of the following indications when sanctioned and approved by a Consultant Orthopaedic Surgeon:

Therapeutic Indications

(NB This list is an overview and is not intended to be exhaustive)

Soft tissue procedures

- Meniscal procedures (repair, debridement, excision)
- Synovial procedures (synovectomy, plica or adhesion division, lateral release)
- Stabilisation of patella (MPFJ reconstruction, Retinacular repair)
- ACL/PCL primary & revision reconstruction
- Infection

Osteochondral/bony procedures

- Removal of loose body
- Notchplasty, excision of osteophytes
- Repair of cartilage and osteochondral defects (primary repair, ACL, mosaicplasty, microfracture, drilling)
- Adjunctive procedure for ORIF or osteotomy
- Debridement of mechanical lesions in osteoarthritis

In some circumstances, intractable knee pain may benefit from arthroscopic washout and debridement where both conservative and non-invasive treatments have failed

Diagnostic Indications

(NB This list is not exhaustive. Diagnostic arthroscopy may be deemed necessary as an adjunct to other means of investigation, but must be sanctioned and approved by a Consultant Orthopaedic Surgeon.)

- Soft tissue knee disorders
- Knee ligament injuries
- Osteochondral/bony knee disorders
- Patellofemoral disorders
- Arthritides
- Suitability for reconstruction, eg osteotomy, arthroplasty
- Assessment of response to treatment, eg cartilage repair
- Biopsy

Rationale

In the majority of circumstances a clinical examination (history and examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination or if there are “red flag” symptoms/signs/ conditions then an MRI scan might be indicated¹.

Red flag symptoms or signs include

- recent trauma,
- constant progressive non-mechanical pain (particularly at night),
- previous history of cancer,
- long term oral steroid use,
- history of drug abuse or HIV,
- fever, being systematically unwell,
- recent unexplained weight loss,
- persistent severe restriction of joint movement,
- widespread neurological changes, and structural deformity.

Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis¹.

EVIDENCE

Knee arthroscopy for the treatment of Osteoarthritis

Evidence on the safety and efficacy of arthroscopic knee washout with debridement for the treatment of osteoarthritis is adequate to support the use of this procedure provided that normal arrangements are in place for consent, audit and clinical governance².

Diagnostic knee arthroscopy for investigation of abnormalities of the knee. Diagnostic arthroscopy is considered to have high diagnostic accuracy³. However, this invasive and expensive procedure might be more cost effectively replaced by greater use of magnetic resonance imaging (MRI). Case series data suggests that MRI might be an appropriate alternative to arthroscopy³.

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Appendix Kvi

**PRIMARY HIP REPLACEMENT SURGERY:
NON-ACUTE**Definition

The most common indication for elective primary total hip replacement (THR) is degenerative arthritis (osteoarthritis) of the joint, other indications include rheumatoid arthritis, injury, bone tumour and necrosis of the hip bone.

Relevant OPCS(s):

W37- Total prosthetic replacement of hip joint using cement.

W38- Total replacement of hip joint not using cement.

W39- Other total replacement of hip joint.

The aims of THR are relief of pain and improvement in function¹. THR can be very successful for the appropriate patients. More than 90% of people who undergo these operations will never require revision surgery.

The PCT will agree to fund referrals and surgery, under prior approval, where the patient meets the following criteria.

Policy

NHS South East Essex referral criteria for routine referral to orthopaedic services* (Refer to Table 1 for referral criteria definitions)

*Based on RAND appropriateness methodology developed by Jose Quintana and Colleagues⁹⁻¹⁰.

Candidates for elective THR should have:

- Moderate to severe persistent pain not adequately relieved by an extended course of non-surgical management.
- AND clinically significant functional limitations resulting in diminished quality of life.
- AND radiographic evidence of joint damage.

Guidance for secondary care on thresholds for hip replacement surgery.

Evidence suggests that the following patients would benefit from joint replacement surgery⁹⁻¹⁰.

When a patient complains of:

- Severe joint pain.
- AND has severe functional limitation irrespective of whether conservative management has been trailed.
- OR has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

Where the 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.
- AND is assessed to be low surgical risk.

Table 1: Referral Criteria Definitions¹².

Variables	Definitions
Pain Levels ¹	
Mild	Pain interferes minimally on an intermittent basis with usual daily activities. Not related to rest or sleep. Pain controlled by one or more of the following : NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol.
Moderate	Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be preformed. Not related to rest or sleep. Pain controlled with one or more of the following, NSAID's with no or tolerable side effects, aspirin at regular doses, paracetamol.
Severe	Pain is constant and interferes with most activities of daily living. Pain at rest or interferes with sleep. Pain not controlled even by narcotic analgesics.
Previous non-surgical treatments	
Correctly Done	NSAIDS, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done.
Incorrectly Done	NSAIDs, Paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief or no weight control treatment if overweight.
Functional Limitations ²	

Minor	Functional capacity adequate to conduct normal activities and self care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few or none of the normal activities and self care. Walking capacity of about one half hour. Aids such as a cane are needed.
Severe	Largely or wholly incapacitated. Walking capacity of less than half hour or unable to walk or bedridden. Aids such as a cane, a walker or a wheelchair are required.

Complications

A small number of patients experience complications following elective THR that can be devastating and for this reason patients should not be considered for joint replacement until their condition has become chronic and conservative methods have failed¹.

Guidance to Primary Care on the Treatment of Hip Pain due to Osteoarthritis

The Musculoskeletal Services Framework from the Department of Health (DH) and guidance from NICE, the GP Training Network and the National Institute of Health (NIH) Consensus Panel suggests that:

- Management of common musculo-skeletal problems, including hip pain, in primary care is ideal.
- Primary care practitioners need direct access to therapy, walking aids, dietetic and health promotion services.
- Primary care management should seek to maximise the benefits of surgery and minimise complications when surgery is necessary.

The initial non-surgical management of hip pain due to OA should provide a package of care that may include weight reduction, activity modification, adequate doses of non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics, introducing walking aids, other forms of physical therapies².

Contraindications

- There are few absolute contradictions for THR other than active local or systemic infections and other medical conditions that substantially increase the risk of serious peri-operative complications or deaths.
- Severe peripheral vascular disease and some neurological impairment are both relative contraindications to THR.
- Advanced age and obesity (BMI 30-39.9) are not contraindications to surgery.

Smoking

Patients who smoke should be encouraged to stop smoking at least eight weeks before surgery to reduce the risk of anaesthetic or operative complications 5,6.

Obesity

Evidence indicates that when other pre-existing medical conditions have been optimised and there is evidence of weight reduction to an appropriate weight, outcomes following hip replacement are improved³. Evidence also suggests that patients who are over weight (BMI 25-29.9) or obese (BMI 30>) should be supported to reduce their BMI below 25^{3,4,5}. There is limited evidence to show that if morbidly obese patients are to have their hip surgery delayed because of their weight, they should be referred into weight loss programme that meet their specific needs.

Hip Resurfacing

NICE guidance for metal on metal (MoM) hip-resurfacing⁸, states the following: MoM hip resurfacing arthroplasty is recommended as one option for people with advanced hip disease who would otherwise receive and are likely to outlive the conventional primary total hip replacement. In considering hip resurfacing arthroplasty, it is recommended that surgeons take into account activity levels of potential recipients and bear in mind that the current evidence for the clinical and cost-effectiveness of MoM hip resurfacing arthroplasty is principally in individuals less than 65 years of age. This guidance indicates that resurfacing is recommended for younger patients in order to avoid future revision surgery. However there is uncertainty over long-term reliability of hip resurfacing and RCT's were awaited⁸.

Number of people affected

Epidemiological background

The prevalence of all cause hip disease severe enough to require surgery has been estimated at 15.2 per 1000 per aged 35 to 85 years of age¹¹. It has been estimated, based on radiographic evidence, that between 10% and 25% of people over the age of 55 have osteoarthritis of the hip¹¹. Symptomatic hip osteoarthritis has been estimated to affect between 0.7% and 4.4% of adults¹¹. Hip osteoarthritis has a little association with obesity or gender and some association with race and particular occupations, for example farming, while congenital dysplasia of the hip is known precursor for hip osteoarthritis in a minority of people¹¹. Pain is usually the main presenting osteoarthritic problem for which patients seek relief often initially thought contracting their GP. Twelve percent of all total hip surgery in English NHS hospital during 1995-1996 consisted of revision operations, with a total of 33,320 primary total hip replacements¹¹

While the incidence of osteoarthritis increase with age there is evidence that is not a necessary consequence of ageing, nor is it necessarily a

progressive condition¹¹. There is some evidence that risk factors for the progression of osteoarthritis are different to those for initiation and that the worsening of symptoms may be associated with risk factors such as previous injury or obesity¹¹.

The success of hip replacement surgery depends crucially on the appropriate selection of patients and this is relevant to GP referral practices. A structured review of the outcomes of primary total hip replacement surgery concluded that with the poor quality of evidence overall it was not possible to recommend any particular prosthesis and the more expensive the prosthesis was the more difficult it was to provide any justification for its selection¹¹.

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pain due to osteoarthritis and clinical thresholds for elective primary hip replacement surgery, February 2007.

Glossary

Anaesthetic:	is used to temporarily reduce or take away sensation so that otherwise painful operations can be performed.
Analgesic:	is any member of the diverse group of drugs (more commonly known as a painkillers) used to relieve pain (achieve <i>analgesia</i>).
Arthritis:	is an inflammation of one or more joints in the body, though the term is used to describe almost all problems associated with the joints.
Body Mass Index (BMI):	is the common method of evaluating individual people to see if they are under or overweight. BMI compares body weight to height by dividing the weight measurement (in kilograms) by the square of the height (in meters).
Contraindication:	a condition or factor that increases the risks involved in using a particular drug, carrying out a medical procedure or engaging in a particular activity.
Dietetic:	relating to the diet.
Elective:	procedure or surgery/operation that is not essential, especially surgery to correct a condition that is not life threatening; surgery that is not required for survival.
Inflammatory	refers to those conditions of the joints that involve the immune system and Arthritis inflammation.
Morbid obesity:	is often referred to in the literature as a BMI over 40. The Department of Health website states that a BMI over 35 is known as morbid obesity and over 40 indicates extreme obesity.
Musculoskeletal:	relating to or involving the muscles and the skeleton.
Necrosis:	means death of tissue in the body.
Neurological impairments:	are a group of disorders that primarily relate to the central nervous system comprised of the brain and spinal cord.
NSAIDS:	Non-steroidal anti-inflammatory drugs, usually abbreviated to NSAIDs, are drugs with analgesic, antipyretic and anti-inflammatory effects - they reduce pain, fever and inflammation. The term "non-steroidal" is used to distinguish these drugs from steroids. As analgesics, NSAIDs are unusual in that they are non-narcotic.
Obesity:	is a heavy accumulation of fat in the body's fat cells to such a serious degree that it rapidly increases the risk of obesity-associated diseases and mortality. The fat may be equally distributed on the body, on the stomach (apple-shaped) or on the hips and thighs (pear-shaped). An excellent method to measure obesity and overweight is the Body Mass Index (BMI). A BMI of below 18.5 is underweight, between 18.5 and 25 is an indication of healthy weight, 25 to 30 is overweight, a BMI of over 30 is referred to as obese.

Operative:	of, relating to, or resulting from a surgical operation.
Orthopaedics:	is the branch of surgery concerned with acute, chronic, traumatic, and overuse injuries and other disorders of the musculoskeletal system.
Osteoarthritis:	of the hip and knee is the result of progressive degeneration of the cartilage of the joint surface.
Osteonecrosis:	is a disease resulting from the temporary or permanent loss of blood supply to the bones.
Peri-operative:	denotes prior to, during and after an operation or surgery.
Post-operative:	denotes after an operation or surgery.
Peripheral vascular disease:	this refers to diseases of blood vessels outside the heart and brain.
Prosthesis:	an artificial device used to replace a part of the body that is damaged, painful or not working properly.
Radiographics:	is the use of certain types of electromagnetic radiation - usually ionizing - to view objects.
Radiological features:	identified through the use of radiographics.
Referral:	to refer a patient is to transfer their care from one clinician to another.
Rheumatoid Arthritis:	is a chronic, progressive and disabling auto-immune disease, causing swelling and damaging cartilage and bone around the joints.
Symptoms:	a symptom is a sensation or change in health function experienced by a patient.
Symptomatology:	the combined symptoms of a disease.
Systemic infection:	the presence of pathogenic microorganisms or their toxins in tissues or in the blood



Primary Hip Replacement Surgery Surgical Threshold Checklist

Patient Details	
Name:	
Hospital Number:	NHS Number:
Date of Birth:	
Address: Postal Code:
Telephone Number:	
Clinician Details	
Name of Referring Clinician:	
Referrer's Address or Stamp: Postal Code:
Referrer's Telephone Number:	
Referrers Email Address:	
Name of Trust being Referred to:	
Criteria Checklist - patients should meet the following criteria: <i>tick boxes A or B</i>	
	<p>Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed.</p> <p>Please state the patients Body Mass Index at the time of going onto the waiting list for surgery)</p> <p>Please refer to the classification of pain levels and functional limitations in the table overleaf.</p>
AND either	
A	The patient complains of:

	Severe joint pain AND has severe functional limitation irrespective of whether conservative management has been tried.	
	OR	
	Severe joint pain AND minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAIDs analgesia, weight control treatments and physical therapies.	
	OR	

B	The patient complains of:	
	Mild to moderate pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAIDs analgesia, weight control treatments and physical therapies AND is assessed to be at low surgical risk.	

Form completed by : _____

Title: _____

Dated: _____

Classification of Pain Levels and Functional Limitations Table

Variable	Definition
Pain Level	
Mild	Pain interferes minimally on an intermittent basis with usual daily activities. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol.
Moderate	Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol.
Severe	Pain is constant and interferes with most activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.
Previous non-surgical treatments	
Correctly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done.
Incorrectly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight or no physical therapies done.
Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities and self care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few or none of the normal activities and self care. Walking capacity of about one half hour. Aids such as a cane are needed.

Severe	Largely or wholly incapacitated. Walking capacity of less than half hour or unable to walk or bedridden. Aids such as a cane, a walker or a wheelchair are required.
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Appendix vii

**PRIMARY KNEE REPLACEMENT SURGERY:
NON-ACUTE**Definition

Primary elective knee replacement (TKR) is most commonly performed for knee joint failure caused by osteoarthritis (OA); other indications include rheumatoid arthritis (RA), juvenile rheumatoid arthritis, osteonecrosis and other types of inflammatory arthritis¹. This threshold relates to adults.

Relevant OPCS(s)¹:

W40 – Total prosthetic replacement of knee joint using cement

W41 – Total replacement of knee joint not using cement

W42 – Other total replacement of knee joint

The aims of TKR are relief of pain and improvement in function¹. TRK can be very successful for the appropriate patients with over 90% of TKS still in place and functioning well at 10 to 15 years after surgery¹.

Policy

The PCT will agree to fund routine referrals and elective surgery under prior approval where patients meet the following criteria. Criteria for immediate/urgent referral are given for information.

Criteria for immediate/urgent referral to orthopaedic services. (Refer to table1 for referral criteria definitions)

*Based on RAND appropriateness methodology developed by Antonio Escobar and Colleagues¹²

- Evidence of infection in the knee joint.
- Symptoms indicating a rapid deterioration in the joint.
- Persistent symptoms that are causing severe disability.

Criteria for routine referral orthopaedic services:

- Moderate to severe persistent pain not adequately relieved by an extended course of non- surgical management.
- AND clinically significant functional limitation resulting in a diminished quality of life.
- AND radiographic evidence of joint damage.

Thresholds for Knee Replacement Surgery

The following patients would benefit from TKR:

Where the patient complains of:

- Intense or severe symptomatology.
- AND had radiological features of moderate disease.
- AND has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment

plus patello-femoral disease (bi-compartmental).

Where the patient complains of:

- Intense or severe symptomatology.
- AND has radiological features of moderate disease.
- AND is troubled by limited mobility or stability of the knee joint.

Where the patient complains of:

- Severe symptomatology
- AND has radiological features of slight disease.
- AND is troubled by limited mobility or stability of the knee joint.

Table 1 Referral criteria definitions¹

Variable	Definition
Mobility and Stability	
- Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range of movement from 0° to 90° Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint
- Limited mobility and/ or stable joint	Limited mobility is equivalent to a range of movement less than 0° to 90° unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint
Symptomatology	
- Slight	Sporadic pain Pain when climbing/ descending stairs Allows daily activities to be carried out (those requiring great physical activity may be limited) Medication; aspirin, paracetamol or NSAID to control pain with no side effects
- Moderate	Occasional pain Pain when walking on level surfaces (half an hour, or standing) Some limitation of daily activities Medication; aspirin, paracetamol or NSAID to control pain with no/ few side effects
- Intense	Pain of almost continuous nature Pain when walking short distances on level surfaces or standing for less than half an hour Daily activities significantly limited Continuous use of NSAIDs for treatment to take effect Requires the sporadic use of support systems (walking stick, crutches)
- Severe	Continuous pain Pain when resting Daily activities significantly limited constantly Continuous use of analgesics – narcotics/ NSAIDs with adverse effects or no response Requires more constant use of support systems (walking stick, crutches)
Radiology	
- Slight	Ahlback grade I
- Moderate	Ahlback grade II and III
- Severe	Ahlback grade IV and V
Localisation	
- Unicompartmental	Excluded patello-femoral isolated
- Bicompartamental	Unicompartmental plus patello-femoral
- Tricompartamental	Disease affecting all three compartments of the knee

Rationale

Complications

A small number of patients experience complications following elective total knee replacements that can be devastating and for this reason patients should not be considered for joint replacement until their condition has become chronic and conservative methods have failed 1,16,12.

Guidance to Primary Care on the Treatment of Knee Pain due to Osteoarthritis

The Musculoskeletal Service Framework from the Department of Health and guidance from NICE, the GP Training Network and the National Institute of Health (NIH) Consensus Panel suggests the 2-5.

- Management of common musculoskeletal problems, including knee pain, in primary care is ideal.
- Primary care practitioners need direct access to therapy, walking aids, dietetic and health promotion services.
- Primary care management should seek to maximise the benefit of surgery and minimise complications when surgery is necessary.

The initial non-surgical management of knee pain due to OA should provide a package of care that may include weight reduction, activity modification, patient specific exercise programme, adequate doses of NSAIDS and analgesics, joint injection, walking aids and other forms of physical therapies 2-6. Referral should be considered when other pre-existing medical conditions have been optimised and there is evidence of weight reduction to an appropriate weight 2-6.

Contraindication for TKH include:

- Local or systemic infection;
- Medical conditions that substantially increase the risk of serious peri-operative complications or death;
- Advanced age and obesity (BMI 30 to 39) are NOT a contraindication to TKR.

Smoking

Patients who smoke should be encouraged to stop smoking at least 8 weeks before surgery to reduce the risk of anaesthetic or operative complications.

Obesity

There is evidence that patients who are morbidly obese (BMI>40) have increased complications following knee surgery⁸. If morbidly obese patients are to have their knee surgery delayed because of their weight, they should be referred into weight loss programme that meet their specific needs 9-12.

Evidence indicated that knee disability in overweight or obese patients can be

effectively improved following weight reduction at a rate of 0.24% reduction per week or a total weight reduction in excess of 5%¹³. Evidence also suggest that patients who are overweight (BMI25-29.9) or obese (BMI>30) benefit from support through a community weight reduction programme to achieve clinical weight loss of at least 5% over 20 weeks before referral for knee replacement surgery¹¹⁻¹³.

Numbers of people affected

Epidemiological background

The prevalence of symptomatic knee osteoarthritis has been estimated at 6.1% of people aged over 30 years and 7.5% of people aged over 55¹⁴. It has been estimated, on radiographic evidence, that between 14% and 34% of the people over the age of 55 have osteoarthritis of the knee¹⁴. Knee osteoarthritis is strongly association with obesity and gender (chiefly affecting women) is related to types of work that involve frequent squatting¹⁴. Pain is usually the main presenting osteoarthritic problem for which patients seek relief. A limp is common with knee osteoarthritis, which is often disturbing to people, but an additional distressing feature is that the knee joint may feel unstable, as if it might give way. This sensation can reduce an individual's self-confidence and ultimately their functional independence¹⁴. There is some evidence that obesity is a risk factor for the progression of osteoarthritis¹⁴.

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Glossary

Anaesthetic:	is used to temporarily reduce or take away sensation so that otherwise painful operations can be performed.
Analgesic:	is any member of the diverse group of drugs (colloquially known as a painkillers) used to relieve pain (achieve <i>analgesia</i>).
Arthritis:	is an inflammation of one or more joints in the body, though the term is used to describe almost all problems associated with the joints.
Body Mass Index (BMI):	is the common method of evaluating individual people to see if they are under or overweight. BMI compares body weight to height by dividing the weight measurement (in kilograms) by the square of the height (in meters).
Contraindication:	a condition or factor that increases the risks involved in using a particular drug, carrying out a medical procedure or engaging in a particular activity.
Dietetic:	relating to the diet.
Elective:	procedure or surgery/operation that is not essential, especially surgery to correct a condition that is not life-threatening; surgery that is not required for survival.
Inflammatory Arthritis:	refers to those conditions of the joints that involve the immune system and inflammation.
Morbid obesity:	is often referred to in the literature as a BMI over 40. The Department of Health website states that a BMI over 35 is known as morbid obesity, and over 40 indicates

extreme obesity.
Musculoskeletal: relating to or involving the muscles and the skeleton.



Primary Knee Replacement Surgery Surgical Threshold Checklist

Patient Details			
Name:			
Hospital Number:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 40%;">NHS Number:</td> </tr> </table>		NHS Number:
	NHS Number:		
Date of Birth:			
Address:	<p>.....</p> <p>.....</p> <p>.....</p> <p>Postal Code:.....</p>		
Telephone Number:			
Clinician Details			
Name of Referring Clinician:			
Referrer's Address or Stamp:	<p>.....</p> <p>.....</p> <p>.....</p> <p>Postal Code:.....</p>		
Referrer's Telephone Number:			
Referrers Email Address:			
Name of Trust being Referred to:			
Criteria Checklist - patients should meet the following criteria: <i>tick boxes A or B or C</i>			

	<p>Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed. This will include weight reduction, NSAIDs and analgesics, changing activity, and introducing a walking aid.</p> <p>Where weight may restrict mobilisation post operatively or place pressure on the new joint, there should be evidence of weight reduction to an appropriate weight before referral.</p> <p>Please state the patients Body Mass Index at the time of going onto the waiting list for surgery)</p> <p>Please refer to the classification of pain levels and functional limitations in the table overleaf.</p>	
	AND either	
A	The patient complains of:	
	Intense or severe symptomatology AND has radiological features of severe disease AND has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental).	
B	OR	
	The patient complains of	
	Intense or severe symptomatology AND has radiologic features of moderate disease AND is troubled by limited mobility or stability of the knee joint.	
C	OR	
	The patient complains of	
	Severe symptomatology AND has radiological features of slight disease AND is troubled by limited mobility or stability of the knee joint.	

Classification of Mobility, Stability, Symptomatology, Radiology and Localisation Table

Variable	Definition
Mobility and Stability	
Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range of movement from 0° to 90°. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.
Limited mobility and/or stable joint	Limited mobility is equivalent to a range of movement less than 0° to 90° unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.
Symptomatology	
Slight	Sporadic pain. Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	occasional pain. Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.

Intense	<p>Pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems walking stick, crutches).</p>
Severe	<p>Continuous pain. Pain when resting. Daily activities significantly limited constantly. Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).</p>
Radiology	
Slight	Ahlback grade I.
Moderate	Ahlback grade II and III.
Severe	Ahlback grade IV and V.
Localisation	
Unicompartmental	Excluded patello-femoral isolated.
Bicompartmental	Unicompartmental plus patello-femoral.
Tricompartmental	Disease affecting all three compartments of the knee.

Form completed by : _____

Title: _____

Dated: _____

Appendix K viii

**ORAL AND MAXILLO-FACIAL SURGERY
REFERRAL GUIDELINES**

NON-THIRD MOLAR EXODONTIA

NHS Hospital Oral Surgery Departments generally do not provide a service for “routine” extractions in healthy patients. If a surgical approach is obviously necessary (e.g. retained roots) then referral should be made.

Indications for referral include:

- Associated pathology that needs to be submitted for histological examination (e.g. cysts).
- Extractions from abnormal or diseased bone (e.g. patients who have received therapeutic doses of irradiation to the jaws).
- Surgical complexity such that a general anaesthetic may be indicated.
- Difficult access due to opening restrictions.

If there is no surgical indication for general anaesthesia, it is more appropriate to manage anxious patients under local anaesthesia as a staged procedure in Primary Care. A previous history of a difficult extraction is a less reliable indicator of surgical difficulty than accurate clinical and radiographic examination. Most of these patients will have had a bad experience from poorly managed previous extractions.

It is rare for a patient’s medical history to complicate the extraction to such an extent that it needs to take place within the hospital setting.

Please ensure that relevant radiographs accompany all requests, so that we can help to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

If you are referring a patient because they request treatment under general anaesthesia, please ensure that the GDC guidelines with regard to risk counselling have been followed and that evidence of this is provided in your letter.

If a referral is made outside these guidelines, please give the reasons why treatment cannot be undertaken in primary dental care.

ORAL AND MAXILLO-FACIAL SURGERY

REFERRAL GUIDELINES

APICAL SURGERY

Prior to referral for apical surgery complete orthograde obturation of the root canal system must have taken place. Since there is good evidence to suggest that endodontic re-treatment has higher success rates than apical surgery, patients will be advised to pursue a non-operative route if obturation is radiographically incomplete or short of the root apex.

In order to prevent recontamination and failure of apical surgery, all patients should also have a satisfactory coronal seal.

The success rate of apical surgery on molar teeth is low and will not be routinely undertaken. Repeat apicectomy has a low success rate and will also not be routinely undertaken.

Referral may be appropriate in cases of peri-radicular disease in root filled teeth while orthograde endodontic therapy cannot be re-performed or has failed. Likewise patients may be offered surgery in cases of suspected root perforation, root fracture or where biopsy of peri-radicular tissue is required (e.g. cystic change suspected).

Please ensure that relevant radiographs accompany all requests so that we can help to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

ORAL AND MAXILLO-FACIAL SURGERY

REFERRAL GUIDELINES

THIRD MOLARS

The National Institute of Clinical Excellence (NICE) has published referral guidelines for third molars which are available at their website (www.nice.org.uk).

Patients will normally only be offered surgical removal of third molars at within an NHS Hospital Oral Surgery Department if they fulfill these guidelines. Indications include:

- Unrestorable caries
- Non-treatable pulpal and/or periapical pathology
- Cellulitis
- Abscess and osteomyelitis
- Internal/external resorption of the tooth or adjacent teeth
- Fracture of tooth
- Fractured tooth
- Disease of follicle including cyst/tumour
- Tooth/teeth impeding surgery or reconstructive jaw surgery
- Tooth involved in or within the field of tumour resection

Anterior crowding, if it occurs in the absence of any of the above, is not an indication for third molar removal.

All relevant radiographs should accompany all requests to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

If a patient is being referred because they request treatment under general anaesthesia please ensure that the General Dental Council guidelines with regard to risk counselling have been followed and that evidence of this is provided in your letter.

Adapted from NICE Guidance published March 2

Managing patients who are taking Warfarin and undergoing dental treatment

General guidelines

- If patients on Warfarin who require dental surgery have an International Normalised Ratio (INR) of below 4.0, they can usually receive their dental treatment in primary care without needing to stop their Warfarin or adjust their dose.
- The risk of thromboembolism after temporary withdrawal of Warfarin therapy outweighs the risk of oral bleeding following dental surgery.
- Patients on Warfarin may bleed more than normal, but bleeding is usually controlled with local measures.

Advice to be given to patients

Advice for patients is available in the patient leaflet, *Oral Anticoagulant Therapy: Important information for dental patients*.

Drug interactions

Amoxicillin

There have been anecdotal reports that amoxicillin interacts with Warfarin causing increased prothrombin time and/or bleeding, but documented cases are relatively rare. Patients requiring a course of amoxicillin should be advised to be vigilant for any signs of increased bleeding.

Clindamycin

Clindamycin is restricted to specialist use and should not be used routinely for dental infections due to its serious side effects. There is a single case report of an interaction between Warfarin and clindamycin.

Erythromycin and other macrolide antibiotics (for example, azithromycin) **Macrolide antibiotics interact with Warfarin unpredictably and only in certain individuals. Patients should be advised to be vigilant for any signs of increased bleeding.**

If increased bleeding occurs then the patient should be advised to contact the GP or anticoagulant clinic to arrange additional INR testing and dose review.

Metronidazole
Metronidazole interacts with Warfarin and should be avoided if possible. If it cannot be avoided, the Warfarin dose may need to be reduced by a third to a half, and re-adjusted again when the antibiotic is discontinued. Contact the GP or anticoagulant clinic to arrange additional INR testing and dose review.

Non-steroidal anti-inflammatory drugs
Drugs including ibuprofen, aspirin and diclofenac should not be used as analgesics in patients taking Warfarin.

Dental surgery covered by this advice includes:

Treatment where the INR *does not* need to be checked:

- Prosthodontics
- Conservation
- Endodontics

Treatment where the INR *does* need to be checked (follow flow diagram):

- Extractions
- Minor oral surgery
- Periodontal surgery
- Biopsies

