Planned Procedures with a Threshold

Version 3

April 2013

Help and advice

The IFR Service is available to provide help and answer any questions you might have. Further details and all related documentation to the IFR service can be found at www.northwestlondon.nhs.uk/ifr

Email: ppwtnw.london@nhs.net

Phone number for borough staff and clinical stakeholders: 020 3350 4242

Phone number for patients and carers: 0203 350 4123
Abdominoplasty / Apronectomy

NHS NWL CCGs will not routinely fund abdominoplasty or apronectomy surgery because they are considered to be cosmetic procedures. However, funding could be considered where the following criteria are met:

1) The patient is 18 or over at the time of application

AND

2) The patient has BMI of 18-27 kg/m² and stable for at least two years

OR

The patient has lost at least 50% of their original excess weight and maintained their weight for at least two years

AND

3) The patient is suffering from severe functional problems, e.g.
   - Difficulties with activities of daily living (e.g. walking & dressing)
   - Recurrent skin infection in the skin fold that recurs or fails to respond despite appropriate medical therapy for at least 6 months

Please provide supporting evidence for the above.

Where the criteria are not met, funding may be considered via the IFR route if there are any exceptional reasons.

This policy does not apply to belt lipectomy. Funding for this procedure is not routinely available and will be considered via IFR only. See the cosmetics policy.

This policy does not apply where the abdominoplasty/abdominal wall repair is required in conjunction with other medically necessary procedures such as complex hernia repair.

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Abdominoplasty or a "tummy tuck" is used to make the abdomen firm. The surgery involves the removal of excess skin and fat from the middle and lower abdomen in order to tighten the muscle and fascia of the abdominal wall. An Apronectomy or mini tummy tuck is less radical than the abdominoplasty.

This type of surgery is usually sought by patients with loose tissues after pregnancy or individuals with sagging after major weight loss particularly following bariatric surgery. Excessive abdominal skin folds may occur following weight loss in obese patients and these can cause significant functional difficulties for patients – difficulties walking, dressing, and problems with skin infections. Abdominoplasty is a beneficial procedure for these patients. It is important that patients undergoing abdominoplasty/apronectomy have achieved and maintained a stable weight so that the risks of obesity recurring are reduced.

### References

**Patient information leaflet:**

**References:**
Adenoidectomy in Children

Policy

Adenoidectomy is of limited clinical effectiveness when performed as a single procedure and will not be routinely funded.

Adenoidectomy will be funded together with grommets and tonsillecromy only where the relevant thresholds are met. See related PPwT policies.

Adenoidectomy for other indications will only be considered via the IFR route in exceptional cases.

Background

Adenoidectomy is an operation to remove the adenoids. Adenoids are removed in order to improve breathing in children especially while they sleep, and reduce frequency of attacks of acute otitis media with effusion (OME).

Evidence Base

The evidence for adenoidectomy supports surgery only if performed in conjunction with grommets insertion and the child meets the grommet referral criteria. This is because adenoidectomy on its own is of unknown effectiveness. NICE guidance does not recommend adjuvant adenoidectomy in the absence of persistent and/or frequent upper respiratory tract symptoms. Adenoidectomy does not reduce the incidence of otitis media.

Reference

4. NICE Clinical Guidance CG60 (February 2008)
Benign Lesions and lumps

<table>
<thead>
<tr>
<th>Within scope of policy - complete PPwT form (examples)</th>
<th>Not within scope (please refer via cancer pathway)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign pigmented moles</td>
<td>Malignant lesions</td>
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<tr>
<td>Comedones</td>
<td>Lesions with malignant potential e.g., actinic keratoses</td>
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<tr>
<td>Corn/callouses</td>
<td></td>
</tr>
<tr>
<td>Lipomata</td>
<td>Refer to related PPWT policies:</td>
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<tr>
<td>Milia</td>
<td>Chalazia</td>
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<tr>
<td>Molluscum contagiosum</td>
<td>Ganglion</td>
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<tr>
<td>Mucoïd cysts</td>
<td></td>
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<tr>
<td>Sebaceous cysts (epidermoid or pilar cysts)</td>
<td></td>
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<tr>
<td>Seborrhoeic keratoses (basal cell papillomata)</td>
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<tr>
<td>Skin tags including anal tags</td>
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<tr>
<td>Spider naevus</td>
<td></td>
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<tr>
<td>Warts</td>
<td></td>
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</tbody>
</table>

Benign lesions that are requested to be removed for cosmetic reasons only e.g. portwine stain or xanthelasma are not funded unless there are exceptional clinical circumstances.

Benign lesions
NHS NWL CCGs will fund the appropriate investigation and removal of any lesion or lump if any of the following criteria are met:

- causing obstruction of orifice or movement
- causing functional limitation e.g. lesion catching on clothing
- impairing vision, hearing or smell (but only if there has been no response to non-surgical treatments)
- subject to repeated infection or bleeding
- it is a sinus, fistula or fissure

Mucoïd cyst
- causing disturbance of nail growth
- tendency to discharge

Removal of warts
- Viral warts will only be eligible for removal if the following criteria are met: where painful, persistent or extensive warts (particularly in immuno-suppressed patients).

Lipomata
- lipoma(-ta) of any size causing symptoms or demonstrable functional impairment
- larger than 5 cm
- deep-seated
- the lump is rapidly growing or abnormally located (e.g. sub-fascial, submuscular, thigh)
- patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.

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Specific background comments for some of these benign skin conditions are given in the table below.

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Background and/or therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipomata</td>
<td>A population-based case series (n=428) comparing patients with lipoma to those with sarcoma, found that the solitary lipoma: sarcoma ratio decreased as size of mass increased. [Rydholm 1997]. Thigh and deep seated lipomas were also more likely to be sarcomas. Patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.</td>
</tr>
</tbody>
</table>
| Seborrheic keratoses (basal cell papillomata) | Medical Care  
Ammonium lactate and alpha hydroxy acids have been reported to reduce the height of seborrheic keratoses. Superficial lesions can be treated by carefully applying pure trichloroacetic acid and repeating if the full thickness is not removed on the first treatment. Topical treatment with tazarotene cream 0.1% applied twice daily for 16 weeks caused clinical improvement in seborrheic keratoses in 7 of 15 patients.  
Surgical Care  
A variety of techniques may be used to treat seborrheic keratoses. They include cryotherapy with carbon dioxide (dry ice) or liquid nitrogen, electrodesiccation, electrodesiccation and curettage, curettage alone, shave biopsy or excision using a scalpel, or a laser or dermabrasion surgery. Some of these techniques destroy the lesion without providing a specimen for histopathologic diagnosis.  
No consultations are needed, unless the sudden appearance of multiple pruritic seborrheic keratoses occurs (known as the Leser-Trélat sign). |
<table>
<thead>
<tr>
<th>Spider naevus (telangiectasia)</th>
<th>Management</th>
</tr>
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<tbody>
<tr>
<td>Usually no treatment is required and many will fade spontaneously or resolve as the underlying condition improves. Spider naevi may be treated with laser therapy or electrodessication if desired for cosmetic reasons.</td>
<td></td>
</tr>
<tr>
<td>Prognosis</td>
<td>This benign lesion tends to resolve spontaneously but may take a number of years to do so. If associated with liver disease, they may resolve if the liver disease improves.</td>
</tr>
<tr>
<td>eMedicine also has a chapter on spider nevus and they suggest electrodessication and laser treatment. They also highlight that treating the possible underlying cause should help.</td>
<td></td>
</tr>
</tbody>
</table>

| Viral warts | Viral warts are usually of aesthetic significance only and surgical removal is not routinely funded by the CCGs. Most viral warts will clear spontaneously or following application of topical treatments so should normally be treated in primary care.. Painful, persistent or extensive warts (particularly in immuno-suppressed patient) may need specialist assessment by a GPwSi or a Dermatologist. For a small proportion surgical removal (cryotherapy, cautery, laser or excision) may be appropriate. However, treatment of viral warts on the eyelid is problematic and these should be referred for consideration of treatment. There are no restrictions on treatment of genital warts. |

### Patient Information:
- [www.emedicine.com](http://www.emedicine.com)
- [www.dermnetnz.org](http://www.dermnetnz.org)
- [www.nhs.uk](http://www.nhs.uk) (NHS choices)
Breast Augmentation

Policy

NHS NWL CCGs will not fund breast augmentation surgery for cosmetic purposes. Funding could be considered via the IFR route in exceptional clinical circumstances.

This policy does not apply to post mastectomy or lumpectomy reconstruction, which is routinely funded.

Background

Breast augmentation, or augmentation mammoplasty, involves increasing the size or improving the shape of a woman's breasts (or breast) by inserting a breast implant. It is the most commonly performed cosmetic procedure performed on women in the UK. When this is done as a purely cosmetic procedure the aim is to reduce a woman’s dissatisfaction with the size, shape or appearance of her breasts. Breast augmentation may also be deemed medically necessary (rather than cosmetic) after a mastectomy or lumpectomy that results in significant deformity i.e.: mastectomy or lumpectomy for treatment of or prophylaxis for, breast cancer and mastectomy or lumpectomy performed for chronic severe fibrocystic breast disease, also known as cystic mastitis, unresponsive to medical therapy. Procedures include mastopexy (breast lift), insertion of breast prostheses, the use of tissue expanders, or reconstruction with transverse rectus abdominis myocutaneous flap, deep inferior epigastric perforator flap or similar procedure and associated nipple and areolar reconstruction and tattooing of the nipple area.

Breast augmentation commonly has a high rate of patient satisfaction (rates of 90% and more have been reported in the literature) with evidence of improvements in body-image and self-esteem. There is no evidence that health-related quality of life improves after breast augmentation.

Some patients will benefit from counselling and psychological therapies.

References

NHS NWL CCGs will fund breast implant removal where the following criteria are met:

**Indications for removal (any of the following)**

- Rupture of silicone-filled gel.
- Implants complicated by recurrent infections.
- Extrusion of implant through skin.
- Implants with Baker Class IV contracture*.

**And**

The patient is 18 or over at the time of application.

Removal of both implants where asymmetry is an issue will be funded.

Where the above criteria are met re-implantation with a new prosthesis will only be considered where original implants were funded by the NHS for non-cosmetic purposes. Additional cosmetic surgery (e.g. mastopexy or bigger implants) should **not** be done at the same time as the re-implantation and will not be funded.

If the patient does not meet policy but has exceptional circumstances to be considered an IFR form can be submitted.

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Background

Women who have undergone breast augmentation procedures can rarely go through their entire lives with the same prostheses (implants). The survival time of implants varies depending on individual circumstances but removal is often necessary at some point for various reasons. Some prostheses breakdown over time and complications may develop.

The US Food and Drug Administration (FDA) advise that ruptured silicone implants should be removed since the health risks of extruded silicone are not known. The FDA caution that asymptomatic rupture may be present in up to 4% of women with silicone implants, and recommend regular screening for asymptomatic ruptures.

Rupture of silicone implants can be subdivided into two categories, intra- and extra- capsular. After implantation, a reactive fibrous capsule is formed around the implant. If the extruded silicone is contained by this fibrous capsule the rupture is termed intracapsular. If the silicone gel is extruded beyond the capsule, the rupture is termed extracapsular. Extracapsular silicone can induce granulomatous reaction and can occasionally migrate to the axillary lymph nodes, producing a lymphadenopathy, which can mimic cancer. Clinically, extracapsular ruptures are often associated with a change in size and consistency of the breast. Extracapsular ruptures can usually be identified on mammography or other imaging studies. Research by the Department of Health concluded that there is no evidence of long term harm associated with the use of silicone gel implants. Nevertheless, an intracapsular rupture can evolve to an extracapsular rupture and the FDA indicated that ruptured implants, whether intracapsular or extracapsular, should be explanted.

*Baker’s Classification Grade

<table>
<thead>
<tr>
<th>Grade I (Absent)</th>
<th>Grade II (Minimal)</th>
<th>Grade III (Moderate)</th>
<th>Grade IV (Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The breast is soft with no palpable capsule and looks natural.</td>
<td>The breast is a little firm with a palpable capsule but looks normal.</td>
<td>The breast is firm with an easily palpated capsule and is visually abnormal.</td>
<td>The breast is hard, cold, painful, and markedly distorted.</td>
</tr>
</tbody>
</table>

References

Patient information leaflet
http://www.cks.nhs.uk/patient_information_leaflet/breast_implants

References

2. FDA News release, November 2006 FDA Approves Silicone Gel-Filled Breast Implants After In-Depth Evaluation.
NHS NWL CCGs will not routinely fund breast reduction for cosmetic purposes. However, funding will be considered for functional purposes where the following criteria are met:

1. Patients with breast hyperplasia/hypertrophy

2. The patient should be 18 or over at the time of application.

3. BMI equal to or below 30 for at least two years.

4. Patient is symptomatic – with at least two of the following for at least one year (and documented evidence of GP visits for these problems): evidence to be submitted
   - Pain in the neck
   - Pain in the upper back
   - Pain in the shoulders
   - Painful kyphosis documented by X-rays.
   - Pain / discomfort / ulceration from bra straps cutting into shoulders.

5. Pain symptoms persist as documented by the physician despite a 6-month trial of therapeutic measures including all of the following: with evidence submitted
   - Supportive devices (e.g., proper bra/support bra fitted by a trained bra fitter, wide bra straps).
   - Analgesic / non-steroidal anti-inflammatory drugs (NSAIDs) interventions.
   - Physical therapy / exercises / posturing manoeuvres.

Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless all of the above are met and the patient has failed to respond to 6 months of conservative treatment. Where criteria are not met funding will be considered via an IFR application.

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Female breast reduction, also known as reduction mammoplasty, is a surgical operation to reduce the weight and volume of the breasts. During the procedure, fat, glandular tissue and skin are removed from the breasts, which are then reshaped and the nipples repositioned. This is a commonly performed procedure with almost 4000 cases per year carried out by the NHS in England.

Breast size is determined by genes, hormones, body frame and weight. For most women, breast size is proportionate to the body, but for some, the breasts are particularly large. When breasts grow to be unusually large (gigantomastia) in young women at puberty, this is termed virginal hyperplasia or virginal hypertrophy. This condition is thought to be caused by a particular sensitivity to female sex hormones. Large breasts can cause physical symptoms such as discomfort, backache, neck pain or skin irritations. Large breasts can also cause psychological distress. Common complaints from women with large breasts include unwanted attention, not being able to wear fashionable clothes and finding it difficult to take part in active sports.

Breasts are particularly sensitive to the hormone oestrogen. They can grow particularly large during adolescence or later in life following the menopause or because of the use of hormone replacement therapy (HRT). Some women also develop a noticeable asymmetry (difference in size or shape) between their breasts. The goal of medically necessary breast reduction surgery is to relieve symptoms of pain and disability related to excessive breast weight.

References


Carpal Tunnel Syndrome Surgery

Policy

Referral for carpal tunnel surgery will be considered if the following criteria are met:

- Patient has acute, severe symptoms that persist after conservative therapy with either local corticosteroid injection and/or nocturnal splinting (with dates supplied)
- Mild to moderate symptoms persist for at least 4 months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks).
- There is neurological deficit e.g. sensory blunting, muscle wasting or weakness of thenar abduction.
- Severe symptoms significantly interfere with daily activities

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Background

Carpal tunnel syndrome causes pain, numbness and tingling in the hand and forearm. It is due to entrapment of the median nerve in the wrist.

Evidence Base

The benefits of conservative therapy are seen early after treatment and then decrease, while the benefits of surgery take longer to be fully realised. Local corticosteroid injection for carpal tunnel syndrome provides greater clinical improvement in symptoms one month after injection compared to placebo but significant symptom relief beyond one month has not been demonstrated.

Current evidence shows significant short-term benefit from oral steroids, splinting, ultrasound, yoga and carpal bone mobilisation. Other non-surgical treatments do not produce significant benefit.

Surgical treatment of carpal tunnel syndrome relieves symptoms significantly better than splinting both in the short and long term. Further research is needed to discover whether this conclusion applies to people with mild symptoms and whether surgical treatment is better than steroid injection.

There is no strong evidence supporting the need for replacement of standard open carpal tunnel release by existing alternative surgical procedures for the treatment of carpal tunnel syndrome. The pooled estimate indicated that a significant proportion of medically treated people required surgery while the risk of re-operation in the surgically treated people is low.
References

Cataracts are cloudy patches or areas in the eye lens that are very common in the elderly population and cataract surgery is a fast, safe and effective treatment. Referral depends on reduced visual acuity, impairment of activities of daily living and a willingness to have surgery. Impairment of activities of daily living may include the following:

- The patient is at significant risk of falls
- The patient’s vision is substantially affecting their ability to work
- The patient’s vision is substantially affecting their ability to undertake leisure activities such as reading, recognising faces or watching television

Although there is significant improvement in vision from mono- to binocular vision (35% of cataract operations are in the second eye), there is debate around whether second cataract surgery is cost effective. There is also debate around whether cataract surgery in both eyes should occur simultaneously. The risk of bilateral intraocular complications is generally perceived to be too important to warrant simultaneous treatment and if second surgery occurs it is usually delayed after the first operation.

As such, there is no agreed guidance for second eye cataract operations – is it cost-effective and should it be carried out simultaneously? This document summarises the risks, benefits and cost-effectiveness for first and second eye cataract surgery, including immediately sequential cataract surgery (ISCS), and offers guidelines for clinicians and commissioners.

NHS North West London CCGs will fund cataract surgery for either or both eyes if the following thresholds are met:

1. Cataract surgery to be considered for patients with a best corrected visual acuity of 6/9 (LogMAR 0.18) or worse in the affected eye(s).

   AND

2. Have impairment in lifestyle such as significant effect on activities of daily living, leisure activities, and risk of falls

   OR THRESHOLD 3 ALONE

3. Surgery is indicated for management of ocular comorbidities e.g., management of glaucoma OR in diabetes where the view of the retina is obscured in retina screening

Revision cataract surgery is not in scope of this policy.

Where the criteria are not met, funding may be considered via the IFR route if there are exceptional reasons.

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First Eye Cataract Surgery

First eye cataract surgery is recommended by NICE and the Department of Health. Surgery can involve either accommodating or non-accommodating intraocular lenses as they both improve visual acuity. Compared with monofocal lenses, multifocal lenses reduce dependence on spectacles (OR 0.17 – 0.12, 0.24) but do increase the risk of halos and glares (OR 3.55 – 2.11, 5.96). Key efficacy outcomes from surgery are spectacle independence, uncorrected near and distance vision, postoperative refractive error, contrast sensitivity and quality of life. Referral should not be based only on the presence of the cataract but also on the presence of reduced visual acuity, impairment of lifestyle and willingness to have surgery.

Second Eye Cataract Surgery

The Royal College of Ophthalmologists released guidance on cataract surgery in 2004 stating that second eye surgery is warranted given the significant gains in visual function and quality of life compared with single surgery alone. Multiple randomised studies have shown improved clinical and functional benefit from surgery in the second eye, in terms of visual acuity, contrast sensitivity, stereoaucuity, and visual disability however second surgery does not improve the risk of falling in the elderly.

At the population level, maximum utility is obtained from increasing access to first eye surgery in the first instance. However where first surgery rates are high then second-eye surgeries should be performed to maximise quality of life to as many as possible.

Cost-benefit of Second Cataract Surgery

Modelled cost-benefit analysis has shown that second eye surgery yields an additional 0.92 QALYs over a 12 year life expectancy, with each additional QALY gained costing between $2045 to $3649. Compared with first eye surgery ($2023 per QALY) this is only slightly less cost-efficient and represents good cost-effectiveness when compared with other procedures. However, these estimates may not be generalisable to the UK because they are based on US studies where healthcare costs and systems are different from the NHS.

Immediate Sequential Cataract Surgery (ISCS)

Simultaneous surgery in both eyes results in improved visual function compared to single eye surgery, however this is not a long-lasting effect and its value is mostly to avoid suboptimal vision while waiting for second-eye surgery. Simultaneous bilateral surgery minimises the use of local and general anaesthesia, ensures only one-step visual rehabilitation is required, leads to fewer hospital visits, and a more efficient use of hospital time, shorter waiting lists and less demand on hospital services. Including all surgical costs, delayed second-eye surgery is 14% more expensive than ISCS. ISCS leads to 15-30% greater efficiency in the numbers of eyes that can be operated on per day, given that the second operation adds only 12 minutes on average to the operating time, compared to delayed surgery.

Theoretically, there is no risk arising from ISCS additional to that from monocular cataract surgery itself. The perceived threat of binocular complications occurring simultaneously underpins the concern around simultaneous bilateral surgery. However, evidence suggests that the risk of bilateral complications in ISCS (which includes catastrophic and non-catastrophic complications) compares favourably to unilateral surgery complication rates Smith and Liu (2001). In general, the risk of a complication in the second eye is the same as in the first eye. The chance of complications occurring in both eyes is the same as in the unilateral operations of two consecutive patients. The principal exclusion criteria for ISCS should be for patients that have specific underlying co-morbidities or experiences with previous cataract surgery that indicate an increased risk of post-operative complications.
Patient information leaflet
http://www.nhs.uk/conditions/Cataract-surgery/Pages/Introduction.aspx

References

2. NICE 2007 Interventional Procedure Guidance: implantation of multifocal (non-accommodative) intra-ocular lenses during cataract surgery
6. Alonso J et al 2006 – In a randomised trial, cataract surgery in both eyes increased benefits compared to surgery in one eye only. Journal of Clinical Epidemiology 59(2):201-7
Surgical excision of chalazia will only be funded where the following criteria

1. Conservative treatment has been tried for at least six months
   
   **AND**
   
   2. Interferes with vision
   
   **OR**
   
   Is causing persistent inflammation and pain

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Chalazia (meibomian cysts) are benign lesions of the eye lid that will normally resolve within 6 months. Mainstay of treatment is regular (four times daily) application of heat compressions. Surgical treatment is rarely indicated.
Patients with CFS/ME should be referred to the North West London sector service provided at Hillingdon Hospital in line with NICE criteria (http://www.cnwl.nhs.uk/hillingdon_adult_CFSMEService.html)

In-patient treatment for CFS at other centres will not be routinely funded except in exceptional circumstances.

Chronic fatigue syndrome (CFS – often known as ME) is relatively common, with a population prevalence of 0.2 – 0.4%. It is characterised by debilitating fatigue that has persisted for four months in an adult and three months in a child or young person. Diagnoses are often difficult and by exclusion, with symptoms ranging from fatigue, malaise, sleep disturbance and headaches to difficulty with concentration and muscle pain. As a result, clinical management can be difficult and requires a patient-centred, multi-disciplinary approach.

NICE guidelines on management of CFS recommend that patients should be referred to specialist CFS/ME care based on their needs, the type, duration, complexity of their symptoms and the presence of co-morbidities. Referral should be offered within 6 months of presentation for people with mild CFS, within 3-4 months for those with moderate symptoms and immediately if symptoms are severe. Patients should be managed holistically with a combination of cognitive behavioural therapy and graded exercise +/- pharmacological therapy for symptom control.

Note: according to White et al activity management programmes such as adaptive pacing have been shown to be ineffective

References


Link to Patient information leaflet on CFS/ME
http://www.nhs.uk/conditions/Chronic-fatigue-syndrome/Pages/Introduction.aspx
Cosmetic Surgery Policy

NHS NWL CCGs will not fund procedures done for cosmetic reasons. Funding may be considered through the Individual Funding Request (IFR) route in exceptional clinical circumstances.

This policy covers all procedures done for cosmetic reasons. Examples include: (list is not exhaustive)

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### Skin procedures

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</tr>
<tr>
<td>Skin graft for Scars</td>
<td>IFR only</td>
</tr>
<tr>
<td>2 Skin Resurfacing, including for acne scarring</td>
<td>IFR only</td>
</tr>
<tr>
<td>3 Light or laser therapy for aesthetic reasons</td>
<td>IFR only</td>
</tr>
<tr>
<td>4 Procedures for tattoo removals</td>
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<tr>
<td>5 Procedures to correct rhinophyma</td>
<td>IFR only</td>
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<tr>
<td>6 Procedures for removal of benign skin lesions</td>
<td>Complete PPwT or IFR where thresholds are not met</td>
</tr>
<tr>
<td>7 Surgery for removal of chalazia</td>
<td>Complete PPwT or IFR where thresholds are not met</td>
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### Breast Procedures

<table>
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<th>Procedure</th>
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<tbody>
<tr>
<td>1 Breast Augmentation</td>
<td>IFR only</td>
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<td>2 Mastopexy</td>
<td>IFR only</td>
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<tr>
<td>3 Breast reduction</td>
<td>Complete PPwT or IFR where thresholds are not met</td>
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<tr>
<td>4 Surgical treatment for Gynaecomastia</td>
<td>IFR only</td>
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<tr>
<td>5 Nipple Inversion Procedures</td>
<td>IFR only</td>
</tr>
<tr>
<td>6 Breast Prosthesis Removal and Replacement</td>
<td>Complete PPwT or IFR where thresholds are not met</td>
</tr>
<tr>
<td>7 Revision Mammoplasty</td>
<td>IFR only</td>
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</table>
## General Cosmetic procedures

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<th>Funding Route</th>
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<tbody>
<tr>
<td>1 Face and brow lift</td>
<td>IFR only</td>
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<tr>
<td>2 Blepharoplasty</td>
<td>IFR only</td>
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<td>3 Rhinoplasty</td>
<td>IFR only</td>
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<td>4 Pinnaplasty</td>
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<td>5 Earlobe Repair</td>
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<td>6 Liposuction</td>
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<td>7 Body contouring including Thigh lift, buttock lift, arm lift</td>
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<td>8 Belt lipectomy</td>
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<td>9 Abdominoplasty</td>
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<td>10 Hair Grafting</td>
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<td>11 Hair depilation for hirsuitism</td>
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</tr>
<tr>
<td>14 Plastic operations on the umbilicus</td>
<td>IFR only</td>
</tr>
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</table>
Refashioning of Scars and Keloids

NHS NWL CCGs will not fund surgery to re-fashion scars because this is considered as a cosmetic procedure. However, funding could be considered through the Individual Funding Request (IFR) route in exceptional circumstances.

Policy

Background

A scar is a patch or line of tissue that remains after a wound has healed and may look or feel different from the area around it. Scars are a natural part of the healing process and can happen both inside and outside the body. Visible scars sometimes form after the skin has been broken. When a wound occurs and there is a break in some of the tissue in the body, collagen builds up at the place where the tissue is broken, eventually helping to close it. New collagen continues to form and then break down in the site of the wound for years afterwards. The scar gradually becomes smoother and softer. Scars on the skin can take up to two years to fade, but after this time it is unlikely that they will fade any more. Certain areas of the body are more likely to have scars than others. The knees and shoulders often have more visible scars, perhaps because they need to move and stretch a lot during the healing process. Darker skin is more likely to scar.

Sometimes abnormal scars develop, for example:

- A hypertrophic scar is a red, raised scar that may form when healing goes on for too long. When these scars cover a large area, they can restrict movement because scar tissue is not as flexible or sensitive as the original skin. Hypertrophic scarring is more common in fair skin and tends to follow surgery and burn injuries.

- A keloid scar is an overgrowth of tissue when too much collagen is produced at the site of the wound and the scar continues to grow after the wound has healed. This type of scar may push into the normal skin or hang off the skin in a saggy lump. Keloid scarring is more common in darker skin and occurs after trivial injuries such as insect bites, ear piercing and vaccination.

Scars occurring on some sites of the body, such as the lower face, neck and upper arms are more likely to develop abnormally. Scarring, particularly when it involves the face, can have a psychological effect. People with scars can become depressed because they feel that they are being stared at, and this may mean they do not want to go out or see a lot of people. Scars only need to be treated if a patient feels uncomfortable with the way they look, or if they are painful or restrict movement in someway. Scars cannot be removed completely, but in many cases it is possible to make them less visible.

The type of treatment recommended depends on the particular scar. Factors that will affect the type of treatment include the size, location and character of the scar, as well as the aim of the treatment (to reduce to appearance or to minimise a physical problem that the scar is causing). Severe acne scars are sometimes removed using laser resurfacing, when the top layer of the skin is gently removed using lasers.

Sometimes surgery is used to improve the appearance of scars. This is known as scar revision.

More conservative therapies for scars where surgery is not considered appropriate include:

- Make-up: Both men and women can use camouflage make-up to cover up scars, on the face or elsewhere.
- Vitamin E: Creams or supplements containing vitamin E may speed up the healing process, leaving less visible scars afterwards.
- Silicone gel sheets: Soft, self-adhesive silicon gel sheeting is designed to be used in reducing the visibility of existing scars by flattening and softening them, as well as for preventing formation of scars. However, a recent Cochrane review found insufficient evidence for whether silicon gel sheeting helps prevent scarring or is effective in treating existing hypertrophic and keloid scars.
- Medications: Drugs such as potassium aminobenzoate or steroid injections help to break down scar tissue. These are often used to treat conditions such as scleroderma that can cause extensive scarring and hardening of the skin.
- Massage and steroid injections
Skin Resurfacing Procedures (dermabrasion, dermaroller, chemical peels)

Policy

NHS NWL CCGs will not fund skin resurfacing procedures (including dermabrasion, microdermabrasion, dermaroller, chemical peels and laser) because they are cosmetic in nature.
Light or laser therapy for aesthetic reasons will not be funded. Funding may be considered for funding in exceptional circumstances via the IFR route.

References


Shakespeare Peter G., Hambleton Joan and Carruth John A. S. Skin surface temperatures during argon and tunable dye laser therapy of port wine stains Lasers in Medical Science. Volume 6, Number 1, 29 34, DOI: 10.1007/BF02042643
Rhinophyma

Background

Rhinophyma is a descriptive term for a large, bulbous, ruddy appearance of the nose caused by hypertrophy of the sebaceous glands and surrounding connective tissue. It is thought to be the end stage of chronic rosacea and affects predominately men. There is no known medical treatment but multiple surgical techniques have been used to improve the cosmetic appearance of the nose.

Modalities of surgical treatment include dermabrasion, freehand scalpel shave, cryosurgery, electrocautery, excision, closure with local flaps and laser resection.

Evidence Base

The outcomes for the different surgical techniques used for treatment of rhinophyma generally report a good cosmetic outcome. However complications like scarring and bleeding are also reported. The studies in this evidence have small numbers and are followed up for only short periods. For this reason, the results should be used cautiously because the studies are of low quality of evidence.

Policy

NHS NWL CCGs will not fund cosmetic correction of rhinophyma. Funding could be considered in individual patients with exceptional circumstances through the IFR route.

References

Lim SW, Lim SW, Bekhor P Rhinophyma: Carbon dioxide laser with computerized scanner is still an outstanding treatment. Australasian Journal of Dermatology, November 2009, vol./is. 50/4(289-93), 0004-8380;1440-0960 (2009 Nov)


NHS NWL CCGs will fund the appropriate investigation and removal of any lesion or lump if the criteria in the PPwT policy are met. Benign lesions that are requested to be removed for cosmetic reasons will only be considered via the IFR route if there are exceptional clinical circumstances.
Policy

NHS NWL CCGs will fund the appropriate removal of Chalazia if the criteria in the PPwT policy are met. (Please refer to Chalazia policy). Surgery for the removal of Chalazia for cosmetic reasons will only be considered via the IFR route if there are exceptional clinical circumstances.
NHS NWL CCGs will not routinely fund laser tattoo removal unless in exceptional circumstances via the individual funding request. The following situations might be considered exceptional:

- The tattoo was applied under duress, or traumatic circumstances

Before lasers became popular for tattoo removal starting in the late 1980s, removal involved the use of one or more of these often painful, often scar-inducing surgeries such as dermabrasion, cryosurgery or excision. Although the procedures above are still used in certain cases today, lasers have become the standard treatment for tattoo removal because they offer a bloodless, low risk, effective alternative with minimal side effects. Each procedure is done on an outpatient basis in a single or series of visits. Patients may or may not require topical or local anaesthesia.

The type of laser used to remove a tattoo depends on the tattoo's pigment colours. (Yellow and green are the hardest colours to remove; blue and black are the easiest.) The three lasers developed specifically for use in tattoo removal use a technique known as Q-switching, which refers to the laser's short, high-energy pulses. The Q-switched Nd: YAG is the newest system in this class of lasers and is particularly advanced in the removal of red, blue and black inks.

Evidence Base

There are no references to tattoo removal procedures from SIGN, Trip or Cochrane. Most dermatologic surgeons caution that complete tattoo removal is not possible. Tattoos are meant to be permanent, so removing them is difficult. Few surgeons guarantee complete removal. However, there are various methods of tattoo removal which have been shown to be effective.

References

- Beuchamp 2008 - Use of class 3b and class 4 lasers and intense pulsed light sources for cosmetic procedures in
  http://www.aetmis.gouv.qc.ca/site/download.php?id=735e2c6a01a8002f9b8da150e893e5b3&countonly=1
- http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?id=32008100095
- Ealing ITPP - Individual Treatment Panel Policy 2008
- NHS Plan - The NHS Plan: a plan for investment, a plan for reform.

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References Continued

- NICE Board Appendix - September 2000 Board Appendix B The National Plan.
- NICE TW2 - The Threshold and the Appraisal Committee- NICE Threshold Technical Workshop 20 April 2009.
Breast Augmentation

Policy

NHS NWL CCGs will not fund breast augmentation surgery for cosmetic purposes. Funding could be considered via the IFR route in exceptional clinical circumstances.

This policy does not apply to post mastectomy or lumpectomy reconstruction, which is routinely funded.

Background

Breast augmentation, or augmentation mammoplasty, involves increasing the size or improving the shape of a woman's breasts (or breast) by inserting a breast implant. It is the most commonly performed cosmetic procedure performed on women in the UK. When this is done as a purely cosmetic procedure the aim is to reduce a woman's dissatisfaction with the size, shape or appearance of her breasts. Breast augmentation may also be deemed medically necessary (rather than cosmetic) after a mastectomy or lumpectomy that results in significant deformity i.e.: mastectomy or lumpectomy for treatment of or prophylaxis for, breast cancer and mastectomy or lumpectomy performed for chronic severe fibrocystic breast disease, also known as cystic mastitis, unresponsive to medical therapy. Procedures include mastopexy (breast lift), insertion of breast prostheses, the use of tissue expanders, or reconstruction with transverse rectus abdominis myocutaneous flap, deep inferior epigastric perforator flap or similar procedure and associated nipple and areolar reconstruction and tattooing of the nipple area.

Breast augmentation commonly has a high rate of patient satisfaction (rates of 90% and more have been reported in the literature) with evidence of improvements in body-image and self-esteem. There is no evidence that health-related quality of life improves after breast augmentation.

Some patients will benefit from counselling and psychological therapies.

References

Breast Lift (Mastopexy)

Policy

NHS NWL CCGs will not fund mastopexy. Funding could be considered via the IFR route in exceptional clinical circumstances.

This policy does not apply to post mastectomy or lumpectomy reconstruction which is routinely funded.

Background

Breast ptosis is inevitable in most women due to a combination of maturity, gravity and pregnancy/lactation. Mastopexy, or a breast lift, involves the relocation of the nipple and shaping the breast. Breast uplift surgery involves removing skin from underneath the breast or from around the areola (the area of dark tissue surrounding the nipple). The skin and tissue of the breast is tightened and the nipple is moved to a higher position to give a more youthful and firm appearance. A breast enlargement or reduction procedure may be done at the same time.

References:

1. Lim SW, Lim SW, Bekhor P Rhinophyma: Carbon dioxide laser with computerized scanner is still an outstanding treatment. Australasian Journal of Dermatology, November 2009, vol./is. 50/4(289-93), 0004-8380;1440-0960 (2009 Nov)
NHS NWL CCGs will not fund breast reduction for cosmetic purposes. Funding is available for functional reasons if the criteria in the PPwT policy are met. Funding could be considered via the IFR route in exceptional clinical circumstances.
Gynaecomastia (Enlarged Male Breasts)

Policy

NHS NWL CCGs will not routinely fund gynaecomastia surgery because it is considered as a cosmetic procedure. Funding could be considered via the IFR route in exceptional clinical circumstances.

Background

Gynaecomastia is a benign condition of the male breast. In most cases a thorough history and physical examination, along with laboratory investigations, should help to exclude breast malignancy and any serious underlying endocrine or systemic disease, as well as to identify pseudogynaecomastia. Careful clinical observation may then be all that is necessary, because gynaecomastia often resolves spontaneously, especially in the case of adolescence, with regard to pubertal gynaecomastia.

There is a lack of consensus as to the non-surgical management of gynaecomastia. Because gynaecomastia is usually caused by an imbalance of androgenic and estrogenic effects on the breast, medical therapy may include anti-oestrogens, such as tamoxifen (unlicensed indication), androgens or aromatase inhibitors. However, although idiopathic gynaecomastia is highly prevalent, there is no proven medical therapy for this condition and the quality of the medical research for pharmaceutical agents is very poor.

Psychological support may be important in relation to reassurance, especially in view of the social pressure on young men around body image and so-called "man boobs".

Gynaecomastia may have an extrinsic cause in up to 39% of cases. Of the suspected idiopathic cases, some will be found to have an important aetiology, such as testicular carcinoma. Selected endocrinological investigation is therefore important to address such aetiology.

There are at least 69 drugs that are known to be associated with gynaecomastia. Patients who are on medication that may cause gynaecomastia may not always be able to have that medication stopped, for example: anti-androgens as a monotherapy for prostate cancer. Furthermore, withdrawal of the medication may not always be associated with resolution of the gynaecomastia.

References

Godwin Y Gynaecomastia: considerations and challenges in treating male patients with varying body
MacLean GM, Smith B, Umeh H. UK National survey of Gynaecomastia management. European Journal of Surgical Oncology 2012;38(5)434,
Correction of Inverted Nipple

Policy

Surgical correction of nipple inversion will not be funded it is considered as a cosmetic procedure. Funding could be considered via the IFR route in exceptional clinical circumstances.

Background

The term inverted nipple refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological disturbance. Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.
NHS NWL CCGs will fund breast prosthesis removal and replacement if the criteria in the PPwT policy are met. Requests that do not meet the policy will only be considered via the IFR route if there are exceptional clinical circumstances.
Revision Mammoplasty

Policy

NHS NWL CCGs will not fund revision mammoplasty as it is considered a cosmetic procedure. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.

Related policy: Breast Prosthesis Removal and Replacement

Background

The term mammoplasty refers to breast reduction or augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or as a result of problems with implants.
NHS NWL CCGs will not fund face or brow lift for cosmetic reasons. Requests for cosmetic reasons will only be considered via the IFR route if there are exceptional clinical circumstances.
NHS NWL CCGs will not fund blepharoplasty for cosmetic reasons. Requests for cosmetic reasons will only be considered via the IFR route if there are exceptional clinical circumstances.
Rhinoplasty

Policy

NHS NWL CCGs will not fund rhinoplasty procedures for cosmetic reasons. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.

This policy excludes manipulation of fractured nasal bones following trauma.

References


R J Honigman, K A Philips, D J Castle, Review of Psychosocial outcomes for Patients seeking cosmetic surgery, Centre for Reviews and Dissemination, 2009


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NHS NWL CCGs will fund pinnaplasty only in exceptional circumstances through the individual funding request (IFR) route for children less than 19 years with prominent ears where the child, rather than parents alone, expresses concern.

**Background**

**Otoplasty (pinnaplasty)** is a procedure designed to realign the normal anatomical features of the ear (pinna) into a more aesthetically pleasing form for people with prominent ears. There are different techniques available to effect this change.

**Evidence Base**

The evidence shows that different surgical techniques employed in pinnaplasty produce positive outcomes.

Pinnaplasty (otoplasty) is an effective procedure in alleviating psychosocial distress in the vast majority of children that undergo the operation on the NHS for children with prominent ears.

The NHS Modernization Agency instituted an ‘Action on Plastic Surgery’, guide which justifies the use of surgery for pinnaplasty because “prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy”.

**References**


Leclere FM, Petropoulos I, Mordon S. Laser-assisted cartilage reshaping (LACR) for treating ear protrusions: a clinical study in 24 patients. *Aesthetic Plastic Surgery*, April 2010, vol./is. 34/2(141-6), 0364-216X;1432-5241 (2010 Apr)


External ear lobe repairs

Policy

NHS NWL CCGs will not fund procedures to correct external ear lobe deformities for cosmetic reasons. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.

Background

NHS NWL CCGs will not fund procedures to correct external ear lobe deformities for cosmetic reasons. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.

Torn earlobes, or cleft ear lobes, may be classified as either a complete or partial cleft. Acquired clefts or splitting of the earlobes commonly occur from prolonged traction of heavy earrings. In rare cases, it can also occur from pressure necrosis from the clip-on earring, as well as from intentional and unintentional trauma. These clefts are most commonly incomplete; however, complete clefts are also common. Bleeding is minimal, and the defect edges heal with little scar formation except when keloids occur.

References

NHS NWL CCGs will not fund liposuction surgery for cosmetic reasons. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.

Related policy: Inpatient & surgical treatments for Lymphoedema and Lipoedema policy.

**Background**

Liposuction also known as liposculpture or suction-assisted lipectomy is a treatment to remove body fat. It is carried out for aesthetic reasons on areas of the body where deposits of fat tend to collect, such as the buttocks, hips, thighs and abdomen. Other popular areas for liposuction are under the chin, neck, upper arms, breasts, knees, calves or ankles.
NHS NWL CCGs will not fund body contouring procedures for cosmetic reasons. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.
Related policy: Abdominoplasty policy
NHS NWL CCGs will not fund Belt Lipectomy. Funding may be considered for funding in exceptional circumstances via the IFR route.
NHS NWL CCGs will not fund abdominoplasty or belt lipectomy for cosmetic purposes. Funding is available for abdominoplasty procedures where there are functional problems present. Please refer to the abdominoplasty PPwT policy. Funding could be considered via the IFR route in exceptional clinical circumstances where thresholds are not met.
NHS NWL CCGs will not fund hair grafting. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.
NHS NWL CCGs will not fund hair depilation for hirsutism for cosmetic purposes. Please refer to the PPWT policy for funding thresholds. Where thresholds are not met, funding could be considered via the IFR route in exceptional clinical circumstances.
NHS NWL CCGs will not fund labiaplasty procedures. Requests will only be considered via the IFR route if there are exceptional clinical circumstances. This policy does not relate to reversal of female genital mutilation which is routinely funded.

References

NHS NWL CCGs will not fund varicose vein procedures for cosmetic purposes. Funding is available for varicose vein procedures where there are functional problems present via the PPWT route. If the thresholds are not met funding will only be considered via the IFR route if there are exceptional clinical circumstances.
NHS NWL CCGs will not fund plastic operations on the umbilicus. Requests will only be considered via the IFR route if there are exceptional clinical circumstances.
Male Circumcision

This policy does not apply to

- Suspected penile malignancy. Use the 2 week cancer referral pathway (do not fill in a PPwT form)
- Traumatic foreskin injury where it cannot be salvaged.

Circumcision may only be funded for medical reasons.

- Balanitis xerotica obliterans
- Recurrent balanitis or balanoposthitis
- Adult phimosis or phimosis in children with spraying, ballooning and/or recurrent infection
- Paraphimosis
- Dermatological disorders unresponsive to treatment, such as lichen planus or eczema
- Painful intercourse
- Recurrent febrile UTI’s with an abnormal urinary tract.

Applications for other indications must proceed through the IFR route.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

Male circumcision is defined as the surgical removal of all or part of the foreskin of the penis. It may be done for medical reasons, but is often done for cultural or religious reasons. Male circumcision is generally assumed to be lawful provided that: “it is performed competently; it is believed to be in the child’s best interests; and there is valid consent.” [BMA, 2006] The General Medical Council advises that doctors must "have the necessary skills and experience both to perform the operation and use appropriate measures, including anaesthesia, to minimise pain and discomfort”.

Although circumcision for non-medical reasons is generally not thought to be of benefit, there is strong evidence that male circumcision reduces the acquisition of HIV by heterosexual men, in areas of high HIV prevalence. [Siegfried et al, 2009]

When performing a circumcision, adequate pain relief should be given. [Brady-Fryer et al, 2004] Common risks of surgical circumcision include bleeding (1.5%), local sepsis (8.5%), oozing (36%), discomfort > 7 days (26%), mental scabbing or stenosis, removal of too much or too little skin, urethral injury, amputation of the glans and inclusion cyst. [BAPS, 2007]. Furthermore, long-term psychological trauma and decreased sexual pleasure have also been reported.
Patient information
http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx

References


Complementary and Alternative Therapies

NHS NWL CCGs will fund the following complimentary / alternative therapies in exceptional circumstances only via the IFR route because of some evidence of clinical benefit in selected conditions:

**Acupuncture**
- For non-surgical management of joint pain as part of pathway which may lead to joint replacement.
- In non-acute lumbar pain not warranting surgical referral.
- In chronic pain conditions (and only when therapy is accompanied by continued symptomatic improvement i.e. not maintenance)
- In selected patients with migraine headache
- In selected cases of nausea of pregnancy
- In some cases with postoperative and chemotherapy-induced nausea and vomiting; or
- In selected cases of postoperative dental pain; or
- Temporomandibular disorders (TMD)
- Sub-acute and chronic low back pain of more than six weeks duration

**Osteopathy**
- Children with spastic cerebral palsy
- In the treatment of paediatric dysfunctional voiding
- Adults with Lumber or Cervical pain not warranting surgical referral being treated as part of an integrated MSK Package.
- Some adults with large joint pain as part of a care pathway that may lead to joint replacement.

**Biofeedback, for:**
- Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation)
- Irritable bowel syndrome
- Levator ani syndrome.
- Migraine and tension headaches (muscle, thermal or skin biofeedback);
- Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators)
- Raynaud's disease
- Refractory severe subjective tinnitus
- Temporomandibular joint (TMJ) syndrome
- Urinary incontinence

**Electrical stimulation**
- As an adjunct or as an alternative to the use of drugs either in the treatment of acute post-operative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as appropriate, physical therapy and pharmacotherapy.
- A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue.

**Selected use in palliative care**
- Mistletoe in cervical cancer
- Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95)

**Hypnotherapy**
- Severe chronic insomnia
- IBS

**Manipulation and Stretching**
- Selected cases of osteoarthritis of the hip as an adjunct to core treatment
- Sub-acute and chronic low back pain of more than six weeks duration
- Acute low back pain of less than six weeks
- Mobilisation of the neck

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NHS NWL CCGs will **NOT** routinely fund the following therapies because of lack of sufficient evidence of effectiveness:

- Homeopathy
- Aromatherapy
- Herbal remedies
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium Phenylbutyrate
- Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium Phenylbutyrate Apitherapy
- Applied kinesiology
- Art therapy
- Autogenous lymphocytic factor
- Auto urine therapy
- Bioenergetic therapy
- Biofield Cancell (Entele) cancer therapy
- Bioidentical hormones
- Brain integration therapy
- Carbon dioxide therapy
- Cellular therapy
- Chelation therapy for Atherosclerosis -- see CPB 234 - Chelation Therapy
- Chiropractic services
- Chung Moo Doe therapy
- Coley's toxin
- Colonic irrigation
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Conceptual mind-body techniques
- Craniosacral therapy
- Cupping
- Dance/Movement therapy
- Digital myography
- Ear Candling
- Egoscue method
- Electrodiagnosis according to Voll (EAV)
- Equestrian therapy -- see CPB 151 - Hippotherapy
- Essential Metabolics Analysis (EMA)
- Essiac
- Feldenkrais method of exercise therapy (also known as awareness through movement)
- Flower essence
- Fresh cell therapy
- Functional intracellular analysis (also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing).
- Gemstone therapy
- Gerson therapy
- Glyconutrients
- Graston technique
- Greek cancer cure
- Guided imagery
- Hair analysis - see CPB 300 - Hair Analysis
- Hako-Med machine (electromedical horizontal therapy)
- Hellerwork
• Hoxsey method
• Human placental tissue
• Hydrolysate injections
• Humor therapy
• Hydrazine sulfate
• Hypnosis
• Hyperoxygen therapy
• Immunooaugmentive therapy
• Infratonic Qi-Gong machine
• Insulin potentiation therapy
• Inversion therapy
• Iridology
• Iscador
• Juvent platform for dynamic motion therapy
• Kelley/Gonzales therapy
• Laetrile
• Live blood cell analysis
• Macrobiotic diet
• Magnet therapy
• MEDEK therapy
• Meditation/transcendental meditation
• Megavitamin therapy (also known as orthomolecular medicine)
• Meridian therapy
• Mesotherapy
• Moxibustion (except for fetal breech presentation) - see CPB 135 - Acupuncture
• MTH-68 vaccine
• Music therapy
• Myotherapy
• Neural therapy
• Ozone therapy
• Primmer deep muscle therapy
• Polarity therapy
• (Poon's) Chinese blood cleaning
• Primal therapy
• Psychodrama
• Purging
• Qigong longevity exercises
• Ream's testing
• Reflexology (zone therapy)
• Reflex Therapy
• Reiki
• Remedial massage
• Revici's guided chemotherapy
• Rife therapy/Rife machine
• Rolfing (structural integration)
• Rubenfeld synergy method (RSM)
• 714-X (for cancer)
• Sarapin injections
• Shark cartilage products
• Telomere testing
• Therapeutic Eurythmy-movement therapy
• Therapeutic touch
• Thought field therapy (TFT) (Callahan Techniques Training)
• Trager approach
• Visceral manipulation therapy
• Whitcomb technique
• Wurn technique/clear passage therapy

*Adapted from the AETNA Complementary and Alternative Medicine Policy

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Complimentary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and ‘natural’ approach to dealing with a variety of complaints. Attractors include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health. However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered ‘alternative’ or ‘complimentary’ therapies will be considered in the same way.

Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services. Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

Evidence Base

The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS. The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007 and more recent reviews by AETNA are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies.

There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends Acupuncture for up to ten sessions for the treatment of sub-acute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, sub-acute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck. Acupuncture, osteopathy and chiropractic may already be routinely provided within the NHS in North West London as part of an integrated pathway within musculoskeletal or chronic pain services as an adjunct to other treatments. Gut directed Biofeedback is routinely commissioned as a specialist service.
References

Dilatation and Curettage (D&C)

This should be read along with “Hysterectomy for Menorrhagia” & Hysteroscopy policy

Policy

**Recommendations**

The use of D & C in the non pregnant uterus will not be routinely funded.

D&C will not be specifically funded for the following indications.

- Investigation and/or treatment of menorrhagia (HMB) – NICE CG no.44
- Investigation of dysfunctional uterine bleeding (DUB) or post-menopausal bleeding (PMB)
- Treatment of irregular periods
- Treatment of endometrial hyperplasia
- Removing unwanted tissue, endometrial polyps or benign tumours from the womb

**Hysteroscopy and biopsy when indicated are now the procedures of choice. (Please see Hysteroscopy policy)**

ERPC and evacuation of molar pregnancies are routinely funded and not covered by this Policy.

**Funding for any other indication that does not meet the PPwT criteria should be applied for via the IFR route**

*These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is coordinated on behalf of the CCGs by North West London Commissioning Support Unit.*

Background

**Dilatation and curettage (D&C)** is a procedure performed under general anaesthetic in which the lining of the uterus (the endometrium) is blindly biopsied (diagnostic) or removed (therapeutic) by scraping with a sharp metal instrument (curette) in a systematic fashion.

**Diagnosis**

Historically, D&C was the traditional diagnostic technique for obtaining endometrial samples for pathological examination (detecting histological abnormalities), e.g. in investigation of menorrhagia/heavy menstrual bleeding (HMB), dysfunctional uterine bleeding (DUB), or post-menopausal bleeding (PMB). However, as the technique is ‘blind’, the operator cannot assess whether lesions have been missed. In several small case series, where patients had a D&C immediately prior to hysterectomy for PMB, endometrial lesions were overlooked in up to 10% of the instances in which D&C was the only procedure used. One study evaluating the completeness of endometrial sampling by D&C showed that in 60% of patients less than half the cavity was curetted.

Ultrasound is the recommended first-line investigation to detect structural abnormalities in investigation of HMB or PMB. Hysteroscopy (allows direct visualisation of the uterine cavity) should be used as a diagnostic tool only when ultrasound results are inconclusive. Neither saline infusion sonography nor MRI should be used as a first-line diagnostic tool. To detect histological abnormalities in HMB (i.e. to exclude endometrial cancer or atypical endometrial hyperplasia), endometrial sampling or hysteroscopy with directed biopsy (curettage) have superseded D&C for obtaining endometrial tissue. Indications for an endometrial biopsy/sampling in investigation of HMB include persistent inter-menstrual bleeding, and in women aged ≥45 years - treatment failure or ineffective treatment. D&C is no longer recommended as a diagnostic tool for HMB.

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Background (continued)

Treatment
D&C has also been used historically for treatment purposes, e.g., where first line (medical) therapy has been ineffective in management of menorrhagia/ heavy menstrual bleeding (HMB), irregular periods or endometrial hyperplasia; or for evacuation of retained products of conception, removal of molar pregnancy (gestational trophoblastic disease), removal of unwanted tissue, endometrial polyps or benign tumours from the womb.

Limited evidence is available on the use of therapeutic D&C for HMB, but the one study that was identified showed that any effect was temporary. Given the limited evidence, the NICE recommendation – that D&C should not be used as a therapeutic treatment for HMB – was based on clinical experience. While medical treatment options remain first-line, surgical treatment options for HMB and DUB include endometrial ablation methods that preserve the uterus but ‘ablate’ (remove) the lining (these have superseded D&C); and hysterectomy (the definitive treatment, which results in high satisfaction rates but with potential surgical morbidity). The first generation gold standard hysteroscopic ablative techniques include laser, transcervical resection of the endometrium and rollerball. Where dilatation is required for non-hysteroscopic (‘blind’) second generation ablative procedures, NICE recommend that hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device.

Evacuation of retained products of conception (ERPC) after incomplete miscarriage or delivery has been recommended treatment in order to reduce potential complications like blood loss and infection. Surgical evacuation has been considered the most effective method of ensuring complete evacuation, by D&C (sharp metal curettage) historically, or by vacuum aspiration/suction curettage. A 2001 Cochrane review of trials found that vacuum aspiration/suction curettage was safe, quick and easy to perform, and less painful than D&C, and in most developed countries vacuum aspiration has replaced D&C for surgical evacuation of the uterus in management of incomplete miscarriage. A 2006 Cochrane review, and the large randomized controlled MIST trial also suggest however, that non-surgical treatments including expectant (watchful waiting) and medical management are reasonable alternatives to routine surgical uterine evacuation depending on the clinical situation and the patient's desires.

Gestational trophoblastic disease encompasses a range of pregnancy-related disorders, consisting of the premalignant disorders of complete and partial hydatidiform mole, and the malignant disorders of invasive mole, choriocarcinoma, and the rare placental-site trophoblastic tumour. Suction/vacuum curettage (rather than sharp metal curettage/D&C) is the preferred method of evacuation irrespective of uterine size in patients with suspected hydatidiform mole who want to preserve fertility. Intraoperative ultrasonography can reduce the risk of uterine perforation. Hysterectomy is rarely recommended but might be considered for women who do not want further children or have life-threatening haemorrhage. Hysteroscopy and biopsy (curettage) is the preferred technique to detect polyps and other benign lesions, and allows targeted removal.

References

Patient information

Menorrhagia: http://www.nhs.uk/conditions/periods-heavy (NHS Choices)

References

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Dupuytren’s Disease/Contracture

**Policy**

NHS NWL CCGs will fund surgery for patients with

- Flexion deformity >30° at the MCPJoint or PIPJoint.

  OR

- Rapidly progressive disease

  OR

- Contracture interferes with lifestyle and/or occupation

Requests that do not fulfil the above criteria or requests for clostridial collagenase injections will be considered via the IFR route only

*These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.*

**Background**

Dupuytren’s Disease (DD) is characterised by skin changes in the palms of the hand (the development of pits, nodules and cords) due to thickening of the palmar fascia (tissue plane under the skin of the palm). This may progress to cause fixed flexion of the fingers.

DD can be classified into:

- **Mild** (no functional impairment, contractures < 30° at metacarpophalangeal joints (MCPJ, knuckles))
- **Moderate** (notable functional impairment and 30-60° fixed flexion at the MCPJ and <30° at the proximal interphalangeal joint (PIPJ, small finger joint))
- **Severe** (fixed flexion > 60° at the MCPJ and >30° at the PIPJ) (from British Society of Surgery of the Hand (BSSH) [http://www.bssh.ac.uk/education/referralguidelines/dupuytrens_disease.pdf](http://www.bssh.ac.uk/education/referralguidelines/dupuytrens_disease.pdf))

**Treatment**

Spontaneous resolution does not occur. Patients may be managed with observation if the contractures themselves are not functionally limiting. Nodules, in general, do not require treatment (BSSH).

**Conservative and “Non-operative” Treatment**

Direct injection of clostridial collagenase into nodules and cords has been shown to cause lysis and rupture of digital cords, releasing contractures (Badalamente 2000) Percutaneous needle fasciotomy (PNF) is used to relieve contracture in the elderly or frail or as a temporising measure. PNF may be performed on an outpatient basis by an appropriately trained specialist. In 2004, the NICE published guidance stating that percutaneous fasciotomy was safe and effective ([www.nice.org.uk/ip177overview](http://www.nice.org.uk/ip177overview)). However, this technique does carry the risk of adverse events and recurrence.
Operative/Surgical Treatment
Surgery remains the mainstay of treatment. Techniques include: limited fasciectomy (most widely used); radical fasciectomy (fallen out of favour); dermofasciectomy (use of skin grafts which may reduce disease recurrence but not its extension); amputation (in severe cases) and joint fusion. A recent retrospective audit undertaken by the BSSH (British Society for Surgery of the Hand) (Dias and Braybrook 2006) indicated that surgery for Dupuytren’s disease is successful in achieving full or almost full correction in 75% of cases. Complication rates, including early recurrence were high at 46%.

There is limited evidence on safety and efficacy for radiation therapy for the treatment of early DD, however a review of the evidence does not raise serious concerns. The 2010 NICE guidance (http://www.nice.org.uk/nicemedia/live/12353/51717/51717.pdf) suggested that radiation therapy can be used if special arrangements for clinical governance, consent and audit or research are made.

Indications for Surgery
Indications for surgery depend on the patient’s requirement for hand function, the patient’s age, the severity of the contracture, and the joint or joints involved.

BSSH recommendations for surgery (http://www.bssh.ac.uk/education/referralguidelines/dupuytrens_disease.pdf) are contractures > 30° at the MCPJ and any contracture at the PIPJ.

Reversal of Female Sterilisation

**Policy**

Reversal of female sterilisation will only be funded under exceptional individual circumstances such as:

- Death of only child (biological or adopted) from current relationship or any previous relationship

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**Background**

Female sterilisation is considered a permanent form of contraception. The operation involves cutting, sealing, or blocking, the fallopian tubes. This prevents the eggs from reaching the uterus (womb) where they could become fertilised, resulting in pregnancy. Female sterilisation can be reversed, but it is a very difficult process that involves removing the blocked part of the fallopian tube and re-joining the ends. There is no guarantee that the patient would become fertile again. The success rates of female sterilisation reversal depend on factors such as age, and the method that was used in the original operation. For example, if the tubes were clipped, rather than tied, a successful reversal is more likely. The current success rate of sterilisation reversal is between 50-60%. ¹. It is not normally available on the NHS.

The reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. The sterilisation procedure is available on NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

**References**

2. Prabha S; Burnett LC; Hill R. Reversal of sterilisation at Glasgow Royal Infirmary. *Journal of Family Planning and Reproductive Health Care* 2002; 29: 32–33

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NHS NWL CCG will fund functional electrical stimulation (FES) for drop foot of central neurological origin only. Patients should have been assessed by a multidisciplinary team specialising in rehabilitation prior to referral to FES.

NHS NWL CCG will not fund FES for upper limbs or foot drop due to lower motor neurone diseases (such as motor neurone disease, polio, Guillain–Barre syndrome, peripheral neuropathy, traumatic injury etc.).

There is a lack of evidence for FES for shoulder pain, shoulder subluxation or reaching or grasping and so FES will not be funded for these indications.

Patients who are already receiving treatment will only be considered for ongoing funding if the following criteria apply:

- Documented history of tripping, falling, or gait problems;
- Patient has a full range of ankle dorsal flexion/good calf tone/absence of severe spasticity and lower limb oedema.

All referrals for the indication above should be sent to the Ealing FES service, ENable Service Manager, Ealing and Harrow Community Services, Clayponds Hospital, W5 4RN, Tel: 020 8568 0679, Mobile: 07908 205483. Email: Contact k.walecki@nhs.net or nicolaking@nhs.net for further information regarding the FES service, or referrals may be sent to ehn-tr.ENable@nhs.net.

Referrals to any other centre for patients who meet the criteria will be for CCGs to consider as non-contracted activity and funding will be dependent on the CCG.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Functional electrical stimulation (FES) is the procedure by which electrical impulses (either through the skin or via implanted electrodes) are used to stimulate muscle contractions that mimic normal voluntary muscle contractions. FES is used where muscles have been paralysed by upper motor neurone lesions (UMN) (e.g. stroke, cerebral palsy, multiple sclerosis or spinal cord injury) with the aim of improving muscle function.

Current therapies for muscle weakness secondary to UMN include physiotherapy, orthosis, medical therapies such as muscle relaxants or botulinum toxin type A injections. Surgery is reserved for refractory cases. FES is not suitable for lower motor neurone conditions (such as Motor Neurone Disease, Polio, Guillain-Barre disease, peripheral neuropathy and traumatic injury) as it requires an intact peripheral nerve through which to conduct.

Evidence Base

Current evidence (NICE IPG 278, 2009) on the safety and efficacy (in terms of improving gait) of functional electrical stimulation (FES) for drop foot of central neurological origin appears adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit. There have been a number of trials and several recent systematic reviews into the effectiveness of FES in limb dysfunction. However, most of the available evidence come from small studies with short intervention period and substantial methodological weaknesses. The cost per QALY of FES for foot drop of central neurological origin is approximately £19,238 (with a cost per QALY in the first year of £52,337, and of £10,964 in subsequent years).
References

Ganglions

Policy

Surgery for ganglia will only be funded in adults for the following indication:

- The ganglion is very painful and restricts work and hobbies.

For mucoid cysts, please refer to the policy on Benign Lesions.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

A ganglion is a benign, mucin-filled cyst that forms around joints or tendons. They normally occur around the hands, wrists and fingers. Most are symptom free, but occasionally they can give pain, weakness, mobility disorders or pressure neuropathy. Untreated approximately 50% resolve in adults, while up to 79% resolve spontaneously in children.

Recurrence rates after surgery vary, but can be up to 30-40%. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness. Side effects of surgery are pain and discolouring of the skin.

References

Patient information:
http://www.nhs.uk/conditions/Excisionofganglion/Pages/Introduction.aspx

References:
NHS NWL CCG will fund grommets (with or without adenoidectomy) for children who meet the following criteria:

- Otitis media with effusion has persisted, following a period of watchful waiting, for three months from diagnosis in primary care;

AND

- The child suffers from at least one of the following:
  - at least 5 recurrences of acute otitis media in a year
  - evidence of delay in speech development, educational or behavioural problems attributable to persistent hearing impairment
  - with hearing loss of at least 25dB, particularly in the lower tones
  - a second, relevant health problem, e.g. Down’s syndrome, cleft palate

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Grommets are small tubes that are put inside children's ears to help drain away sticky fluid that is trapped there and to aid their hearing. Acute otitis media is one of the most common infectious diseases in childhood. Recurrent acute otitis media is defined for the purposes of this review as either three or more acute infections of the middle ear cleft in a six-month period, or at least five episodes in a year. Otitis media with effusion (OME) is common in children with a peak incidence from about 2 to 6 years of age. Most cases resolve spontaneously. Bilateral hearing loss (>=25 dB) is the major concern in children with persistent (>=3 months) OME.

**Evidence Base**

There is evidence that ventilation tube insertion reduces the frequency of episodes of recurrent acute otitis media and the proportion of children with symptoms of ear disease within the first six months after insertion. Ventilation tube insertion is also associated with an improvement in the mean hearing levels with both unilateral and bilateral tubes in the first 6 months of follow-up. However, this effect diminishes with time and the benefits of grommets in children in the long run appear small compared with myringotomy or non-surgical treatments. Grommets improved hearing at up to 2 years, but not at 5 years compared with no grommets. Grommets did not significantly improve cognition, language comprehension or expression compared with no grommets; although relatively insensitive outcomes may have been used.

Adverse effects on the tympanic membrane such as otorrhoea, focal atrophy or retraction of the tympanic membrane and tympanosclerosis are common after grommet insertion. Therefore, an initial period of watchful waiting seems to be an appropriate management strategy for most children with OME.
NICE clinical guidance recommends that healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant. Tube ventilation and hearing aids is also recommended in children with Down’s syndrome and cleft lip who have hearing loss. The Scottish Intercollegiate Guidelines Network (SIGN) recommends watchful waiting for children under three years of age with persistent bilateral otitis media with effusion and hearing loss of <=25 dB, but no speech and language, developmental or behavioural problems to be safely managed with watchful waiting. However, referral should be considered for 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.

There is some evidence that bilateral ventilation tube insertion plus adenoidectomy results in a reduction in the time spent with effusion, time spent with abnormal hearing, and in the number of surgical re-treatments at 2 years of follow-up. Combined grommets and adenoidectomy improves hearing more than adenoidectomy alone at up to 12 months, but there are no significant difference between treatments at 2-5 years.

References

- NICE Clinical Guidance 60, Surgical Management Of OME, by the Collaborating Centre for Women’s and Children’s Health
Gynaecomastia (Enlarged Male Breasts)

Policy

NHS NWL CCGs will not routinely fund gynaecomastia surgery because it is considered as a cosmetic procedure. Requests may be considered only in exceptional circumstances via the submission of an Individual Funding Request (IFR) form.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

Gynaecomastia is a benign condition of the male breast. In most cases a thorough history and physical examination, along with laboratory investigations, should help to exclude breast malignancy and any serious underlying endocrine or systemic disease, as well as to identify pseudogynaecomastia. Careful clinical observation may then be all that is necessary, because gynaecomastia often resolves spontaneously, especially in the case of adolescence, with regard to pubertal gynaecomastia.

There is a lack of consensus as to the non-surgical management of gynaecomastia. Because gynaecomastia is usually caused by an imbalance of androgenic and estrogenic effects on the breast, medical therapy may include anti-oestrogens, such as tamoxifen (unlicensed indication), androgens or aromatase inhibitors. However, although idiopathic gynaecomastia is highly prevalent, there is no proven medical therapy for this condition and the quality of the medical research for pharmaceutical agents is very poor.

Psychological support may be important in relation to reassurance, especially in view of the social pressure on young men around body image and so-called “man boobs”.

Gynaecomastia may have an extrinsic cause in up to 39% of cases. Of the suspected idiopathic cases, some will be found to have an important aetiology, such as testicular carcinoma. Selected endocrinological investigation is therefore important to address such aetiology.

There are at least 69 drugs that are known to be associated with gynaecomastia. Patients who are on medication that may cause gynaecomastia may not always be able to have that medication stopped, for example: anti-androgens as a monotherapy for prostate cancer. Furthermore, withdrawal of the medication may not always be associated with resolution of the gynaecomastia.
2. South East London Exceptional Treatments Commissioning Policy. March 2009
This policy does not apply to

- Referrals for suspected cancer and acute, profuse rectal bleeding

Haemorrhoidectomy will be funded for

- Patients with first or second degree haemorrhoids who do not respond to conservative treatment (e.g. lifestyle changes and pharmacological treatment) and other techniques (e.g. rubber band ligation, sclerotherapy, or infra-red photocoagulation)

- Patients with third or fourth-degree haemorrhoids that are either too large for other measures or have not responded to them.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is coordinated on behalf of the CCGs by North West London Commissioning Support Unit.
Background

Evidence Base

Haemorrhoids are common with estimates of between 4 and 25% of the UK population being affected. Haemorrhoids are a benign, mostly self-limiting condition that can cause bleeding, discomfort and pain. The aetiology is unknown but a number of risk factors are known, such as increasing age, pregnancy and childbirth, chronic constipation, chronic diarrhoea and a family history. The haemorrhoids are graded according to their size, location and protrusion from the anus. It is usually the Grade 4 haemorrhoids, which protrude from the anus, and remain outside that require treatment.

There are a number of treatments, both surgical and non-surgical. A “treatment ladder” is recommended whereby less invasive treatments are used first. The treatments are designed to relieve symptoms rather than altering the pathology. The non-surgical treatments include dietary changes, such as eating a high fibre diet, creams, ointments and suppositories. Cold compresses or sitting a bath of warm water can also help to ease the pain. The more invasive treatments include banding, sclerotherapy, infrared coagulation and surgical options such as haemorrhoidectomy and stapling. [Chand et al, 2008] [NICE TA, 2007]

Haemorrhoidectomy is necessary when clots repeatedly form in external haemorrhoids, ligation fails to treat internal haemorrhoids, the protruding haemorrhoid cannot be reduced, or there is persistent bleeding. [Brisinda G, 2000] A Cochrane systematic review confirms the long-term efficacy of excisional haemorrhoidectomy for patients who failed after repeated RBL or grade III haemorrhoids. Compared to rubber band ligation, excisional haemorrhoidectomy leads to increased pain, higher complications and more time off work, patient satisfaction appears to be similar. [Shanmugam V et al, 2005]

Classification of haemorrhoids [Goligher et al, 1984]

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal appearance. Bleeding but not prolapsing</td>
</tr>
<tr>
<td>2</td>
<td>Bleeding and prolapsing, but will reduce spontaneously</td>
</tr>
<tr>
<td>3</td>
<td>Bleeding and prolapsing, but requires manual reduction</td>
</tr>
<tr>
<td>4</td>
<td>Bleeding and permanently prolapsed</td>
</tr>
</tbody>
</table>

References

1. Brisinda G. How to treat haemorrhoids. BMJ. 2000; 321: 582-583
**Policy**

NHS NWL CCGs will fund facial hair depilation only when the following criteria are met:

**Facial**
- There is an existing endocrine medical condition and severe facial hirsutism
- Ferriman Gallwey Score of 3 or more per area requested
- Medical treatments such as hormone suppression therapy has been tried for at least one year and failed.
- Patients with a BMI>30 should be in a weight reduction programme and should have lost at least 5% of their body weight.

**Peri Anal**
- Removal of excess hairs in the peri anal area will only be funded as part of treatment for pilonidal sinuses.

**Other Area**
- Have undergone reconstructive surgery leading to abnormally located hair- bearing skin

Laser treatment for excess hair (hirsutism) will only be funded for 6 treatment sessions and only at NHS commissioned services.

Hair depilation for sites other than the above is not routinely funded and may be available via the IFR route under exceptional circumstances.

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**Background**

Hirsutism is excessive hair growth in women in areas of the body where only men tend to develop coarse hair, primarily on the face and neck area.¹ Unwanted and excessive hair growth is a common problem and considerable amounts of time and money are spent on hair removal. It affects about 5-10% of women, and is often quoted as a cause of emotional distress. Possible underlying causes include Polycystic Ovarian Syndrome (PCOS), (a condition of unknown cause characterised by reduced fertility, ovarian cysts and increased androgen production), other rare hormone disorders and some forms of medication. Traditional treatments include shaving, waxing and plucking. Most endocrine causes of hirsutism respond to hormone suppression therapy with a contraceptive pill containing an anti-androgen or an anti-androgen alone.² Hirsutism also improves with weight loss.³

Hair depilation (for the management of hypertrichosis – code L68) involves permanent removal/reduction of hair from face, neck, legs, armpits and other areas of body usually for cosmetic reasons. It is usually achieved by electrolysis or laser therapy. Although evidence on the use of laser in hirsutism is currently limited, it is advised that laser treatment should not be used by dark-skinned women and there is evidence that it is less effective with blond, red or white hair. Light-skinned women with dark hair get the best results from laser treatment and the benefits are greater for large areas of hair. Most types of laser hair removal are considered safe if performed properly, but recent studies suggest other skin structures can be adversely affected by laser irradiation and the long-term consequences of this are yet unknown. Hair re-growth is common, hence the need for repeated treatments.
The benefits of using laser treatment can include:

- Minimal pain experienced
- Improved appearance
- Improved satisfaction with results from patients

Common side effects include pigmentary changes, occasional blistering and rare scarring, along with other untoward effects were observed. These included: de-novo growth of hair outside the area treated by laser, potentiation of co-existing vellus hair in the treatment area, induction or aggravation of acne, rosacea-like rash, premature greyness of hair, tunnelling of hair under the skin, prolonged diffuse redness and oedema of the face, focal hypopigmentation of the lip, angular cheilitis, allergic reaction to the cooling gas, and inflammatory and pigmentary changes of pre-existing nevi.\(^1\) It has been noted that burning and sequelae, leukotrichia, paradoxical hypertrichosis and folliculitis are four major side effects of the use of Lumina IPL system and Vasculight-SR multi-functional laser and IPL system when used to treat hair removal in hirsute patients.\(^1\) In addition pain, skin redness, swelling, burned hairs and pigmentary changes were infrequently reported adverse effects.\(^1\)

The Steer report found no evidence to compare effects of different laser techniques. Case series evidence suggests that after laser depilation, hair growth is reduced for a period of weeks to months, but that multiple treatments may be required to achieve complete hair loss.

**Acceptable indications for Intervention**

For those patients who:

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

**Figure illustrating how to score severity of hirsutism using The Ferriman Gallwey score.**
References

**Hernias in Adults**

**Policy**

**NHS NWL CCG will fund surgery for hernia only in patients who meet the following criteria:**

- History of incarceration, or real difficulty in reducing the hernia
- Inguino-scrotal hernia
- Progressive increase in size of hernia (month-on-month)
- Pain or discomfort significantly interfering with activities of daily living
- Presence of Work related issues e.g. missed work/unable to work/on light duties due to hernia
- Patients with suspected femoral hernias (including all women presenting with a groin hernia)

**NHS NWL CCG will not fund surgery for the following:**

- Small, asymptomatic hernias
- Minimally symptomatic hernias
- Large, wide necked hernias unless there is demonstrable evidence that it is causing significant symptoms

*These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.*

**Background**

An asymptomatic inguinal hernia has been defined as an inguinal hernia without pain or discomfort for the patient, and a minimally symptomatic hernia as an inguinal hernia with complaints that do not interfere with normal daily activities. There is increasing evidence that not all symptomatic or minimally symptomatic hernias will progress to complication or a state that will require surgical intervention, and many clinicians now agree that watchful waiting is a treatment option. In a few cases the risk of surgery may outweigh the benefit.

**Evidence base**

The European Hernia Society (EHS)\(^1\) produced guidelines for the treatment of inguinal hernia in adult patients in 2009. Evidence from a good quality RCT in 2006 that compared elective surgery to watchful waiting supports a watchful waiting strategy.\(^2,3\) The EHS 2009 made the following recommendations:

- A watchful waiting strategy in minimally symptomatic or asymptomatic inguinal hernia in men
- Urgent surgery for strangulated hernias
- Routine surgery for symptomatic inguinal hernias
- Exclude a femoral hernia in women presenting with hernia in the groin

NHS NWL CCGs Planned Procedures with a Threshold Policy. Version 3 (April 2013)

Is this the latest version? Check here: [http://www.northwestlondon.nhs.uk](http://www.northwestlondon.nhs.uk)
Links to Patient Information Leaflets
http://www.cks.nhs.uk/patient_information_leaflet/hernia

References

4. Regional/PCT Funding Policies reviewed:
   a. Bedfordshire and Hertfordshire Priorities forum statement
   b. Thames Valley Priorities Committees (Oxfordshire PCTs)
   c. West Essex PCT
   d. Herfordshire PCT Derbyshire County PCT
   e. West Sussex PCT
   f. Outer North East London (ONEL)
Referral criteria for Total Hip Replacements (THR) should be based on the level of pain and functional impairment suffered by the patient. NHS NWL CCGs will fund THR for patients who fulfil the following criteria;

1. Patient complains of severe joint pain AND functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

Or

2. 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.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

Total hip replacement (THR) is a common intervention carried out in the NHS. The most frequent indication for this is degenerative osteoarthritis in adults. Osteoarthritis of the hip is common in the older age groups in the UK, with approximately 210,000 people thought to have moderate to severe osteoarthritis. The aim of a THR is to relieve pain and improve function. This operation can be very successful for the appropriate patients, with less than 10% of people who undergo these operations needing revision surgery.

Prior to referral for THR, non-surgical treatments, as specified in Figure 1, should be offered for all patients and the management of any underlying medical conditions should be optimised. This should include communication of the risks and benefits of all treatment options, taking into account the individual patient’s comorbidities. Where appropriate, patients should be encouraged to reduce their BMI to <30 prior to surgery. Referral decisions should not be made on the basis of hip radiography as this is thought to be unreliable.
Cemented vs Cementless procedures

Hip replacement techniques can broadly be split into those that use cement and those that do not. Traditionally cement has been used to fix the prosthesis in place, but cementless prostheses that allow the bone to grow into the implant, are becoming more popular. In 2004 cemented hip replacements made up approximately half of the total while cementless accounted for a fifth. Cementless hip replacements have increased from 22% of all replacements in 2005 to 41% total replacements in 2011 across England and Wales.

The 2010 National Hip Fracture database report showed that the proportion of cemented procedures being done in NWL acute trusts varies considerably, ranging from 30-92%. Clinically there are advantages and disadvantage to both techniques. A meta-analysis comparing both procedures has shown them to have equivalent revision rates, though analysis of the newer studies may indicate better survival in uncemented hip replacements.

At present it is not possible to make robust comparisons of outcomes for cemented vs cementless hip replacements.

NICE is due to update its guidance on prosthesis for hip replacements next year but its Technology Appraisal in 2000 recommended that cemented hip replacements should be performed over cementless. This is supported by SIGN 2009, and the recent 2010 National Hip Fracture Database analysis report. SIGN 2009 recommended that cementless procedures could be considered in patients with cardiorespiratory complications, particularly in frail older patients. The difference in cost of the procedures is mostly that of the prosthesis, with cementless prostheses being more expensive. The limited cost-effectiveness research has shown both procedures to have a similar cost-effectiveness due to differences in revision rates.

Figure 1: Targeting treatment: a summary of available treatments
### Background (continued)

#### Definitions of pain and functional limitation levels:

**Pain level**

<table>
<thead>
<tr>
<th>Pain level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>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.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Functional limitations**

<table>
<thead>
<tr>
<th>Functional limitations</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Functional capacity adequate to conduct normal activities and self care. Walking capacity of more than one hour. No aids needed.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

### References

Patient information leaflet:

5. National Joint Registry Annual report 2012
9. Guidance on the Selection of Prostheses for Primary Total Hip Replacement NICE 2000 TA
The funding criteria: The list below is based on the best available evidence of effectiveness from the report mentioned above.

HBOT will be funded for the following conditions:

1. Diabetic Lower Extremity Ulcers where the conditions listed below are met.
2. Radiation-induced Proctitis

HBOT for diabetic lower extremity ulcers will only be funded if the patient meets all of the following conditions:

- Type I or II diabetes mellitus
- Wounds/Ulcers classified as Wagner grade III only.
- History of failed standard wound therapy for at least 30 days for a Wagner Grade 3
- Wound/Ulcer i.e. failure of objective evidence of any improvement

The Wagner classification system of wounds is defined as follows:

Grade 0 - no open lesion;
Grade 1 - superficial ulcer without penetration to deeper layers; Grade 2=ulcer penetrates to tendon, bone or joint;
Grade 3 - lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths;
Grade 4 - wet or dry gangrene in the toes or forefoot;
Grade 5 - gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated.

Standard wound therapy protocols will include the use of all of the following:

- Objective evaluation of ischaemia
- Assessment and correction of vascular abnormalities Optimisation of nutritional status and glucose control
- Exclusion of the presence of osteomyelitis
- Performing sharp debridement
- Provision of moist wound healing
- Provision of essential offloading of the wound
- Regular follow-up assessment

For HBOT to continue at 30 day intervals, re-evaluation must show continued progression to healing.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.
Background

Hyperbaric Oxygen Therapy (HBOT) has been used for a number of years in the NHS for a variety of conditions, not all of which are supported by evidence of clinical effectiveness or of cost effectiveness. NHS Quality Scotland published a comprehensive review of the evidence for HBOT in April 2008 (http://www.nhshealthquality.org/nhsqis/4208.html). The only indication for which there was a body of cost-effective evidence was diabetic foot ulcer. There is sufficient evidence for the use of HBOT in radiation induced proctitis. HBOT use in decompression illness and carbon monoxide poisoning is supported by a good theoretical basis, long-standing use and clinical consensus, despite a lack of RCT evidence. It would be difficult to justify further trials in these treatment areas.

For many conditions there may be some evidence of effectiveness but this had been derived from case series or clinical trials that were poorly conducted or reported, and therefore cannot not be considered robust.

References

In accordance with the licensing, treatment with Botulinum Toxin A will only be funded for the management of severe (HDSS score of 3 or 4) axillary hyperhidrosis, provided first-line treatment (topical therapy) and/or iontophoresis have failed or are contraindicated.

*These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.*
Background

Hyperhidrosis (ICD-10 Code: R61) refers to excessive/enhanced sweating beyond that which is required to return body temperature to normal. It can be generalised or focal, primary or secondary. Primary focal hyperhidrosis is the most common type, is idiopathic, and develops in previously healthy people. It typically affects the axillae, palms, soles of feet (plantar) and face (craniofacial), areas principally involved in emotional sweating. It is thought to affect >2.5% of the population. It usually has its onset in childhood or adolescence, but can occur at any age. Palmar and plantar hyperhidrosis may be present at birth.

Secondary generalised hyperhidrosis involves the entire body, and is due to an underlying condition, most often an infectious, endocrine or neurological disorder; or may be simply drug-induced. It develops due to dysfunction of the central or peripheral nervous system. Secondary focal hyperhidrosis involves specific areas of the body, but is also caused by an underlying condition (e.g. neurological disorders, intrathoracic neoplasms, or compensatory hyperhidrosis).

The Hyperhidrosis Disease Severity Scale (HDSS) (http://www.sweathelp.org/pdf/HDSS.pdf) provides a qualitative measure of the severity of the patient’s condition, and allows tailoring of treatment. A score of 1 or 2 indicates mild or moderate hyperhidrosis. A score of 3 or 4 indicates severe hyperhidrosis. A one-point improvement in HDSS score post-treatment has been associated with a 50% reduction in sweat production and a 2-point improvement with an 80% reduction.

Recommended treatment approaches

<table>
<thead>
<tr>
<th>Type of hyperhidrosis</th>
<th>First-line therapy</th>
<th>Second-line therapy (options)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild axillary, palmar, and plantar hyperhidrosis (HDSS score of 2)</td>
<td>• Topical treatments - aluminium chloride-based (AC) &amp; other</td>
<td>• Iontophoresis</td>
<td>**unlicensed indication</td>
</tr>
<tr>
<td></td>
<td>• Consider treating any underlying anxiety, which may be an exacerbating factor</td>
<td>• Botulinum toxin A (BTX-A)**</td>
<td></td>
</tr>
<tr>
<td>Severe axillary, palmar, and plantar hyperhidrosis (HDSS score of 3 or 4)</td>
<td>• Topical treatments – AC &amp; other</td>
<td>• Iontophoresis^</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider treating any underlying anxiety, which may be an exacerbating factor</td>
<td>• BTX-A **^</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local surgery (axillary) and ETS should only be considered after failure of all other treatment options</td>
<td></td>
</tr>
<tr>
<td>Craniofacial hyperhidrosis</td>
<td>• Topical treatments – AC &amp; other</td>
<td>• Oral anti-cholinergic medications^</td>
<td>** licenses indication only for severe axillary hyperhidrosis, but evidence exists for benefit of treatment for palmar and plantar hyperhidrosis</td>
</tr>
<tr>
<td></td>
<td>• Consider treating any underlying anxiety, which may be an exacerbating factor</td>
<td>• BTX-A** ^</td>
<td>^Canadian expert statements suggest considering these first-line</td>
</tr>
<tr>
<td>Generalised hyperhidrosis</td>
<td>• Treatment of underlying condition</td>
<td>• Oral anti-cholinergic medications</td>
<td>BTX-A not indicated</td>
</tr>
</tbody>
</table>

§ based on Guidelines for the primary care treatment and referral of focal hyperhidrosis (9), an evidence-based review (22), US and Canadian expert consensus statements (6, 8), and internet-based guidelines (23)
Evidence base for treatment

Secondary hyperhidrosis

Management of secondary generalised or focal hyperhidrosis should be directed at looking for an underlying cause, and managing that appropriately. Oral anti-cholinergics may also be used.

Primary focal hyperhidrosis

Various medical, surgical and electrical therapies exist for primary focal hyperhidrosis. However, for many, the efficacy is short-term or they are associated with unacceptable side effects. A step-by-step approach is recommended for treatment. Local treatment options with few and minor side effects should be tried first.

First-line treatment (primary care)

- 20% aluminium chloride (AC) hexahydrate in alcohol solution e.g. aluminium salts in OTC anti-perspirants.
- Consider treating any underlying anxiety, which may be an exacerbating factor.
- If that fails – refer to dermatologist/secondary care.

Secondary care treatment options

- Modified topical therapy:
  - emollients, topical corticosteroids, different strengths of aluminium salts (up to 50%), and topical glutaraldehyde or formaldehyde
  - topical glycopyrrolate (an antimuscarinic agent) can be prepared by special order manufacturers, and may be useful for primary craniofacial hyperhidrosis
  - efficacy and tolerability vary widely.

- Lontophoresis
  - The sites of hyperhidrosis (hands, feet) are immersed in warm water (or a wet contact pad may be applied e.g. for the axillae) through which a weak electric current is passed
  - In more severe cases of hyperhidrosis affecting plantar and palmar areas, glycopyrronium bromide (an antimuscarinic agent) as a 0.05% solution can be added to the water, but adverse effects are common
  - Some people seem to gain considerable symptom relief. Most report an improvement after 6-10 sessions. Maintenance treatment is usually required at 1-4-week intervals.
Botulinum toxin A (BTX-A) (Botox®)

- BTX-A blocks neuromuscular transmission by binding to acceptor sites on motor or sympathetic nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. When injected intradermally, BTX-A produces temporary chemical denervation of the sweat gland resulting in local reduction in sweating.
- BTX-A is the best-studied treatment to date for focal hyperhidrosis, and local intradermal injections of BTX-A have been used since 1996 as a minimally invasive treatment for focal hyperhidrosis, with numerous studies documenting safety, efficacy, effectiveness, and extremely high levels of patient satisfaction, especially when other treatment options have proven ineffective.
- It is only licensed for the treatment of severe axillary hyperhidrosis that is inadequately managed by unresponsive to topical agents.

Effectiveness: BTX-A effectively treats axillary hyperhidrosis. In a 52-week, multicentre, double-blind study comparing BTX-A with placebo for treatment of severe primary axillary hyperhidrosis, published in 2007 (15), a 2-point improvement on the 4-point HDSS was reported in 75% of subjects in the 75- U and 50-U BTX-A groups and in 25% of the placebo group (p <0.001). In a single-centre, randomised, parallel, open-label, 12-week study which compared the efficacy and safety of BTX-A with 20% AC for the treatment of primary focal axillary hyperhidrosis, 92% of subjects in the BTX-A group (n=25) achieved treatment response at week 4, compared with 33% of the subjects in the AC group.

Duration of effectiveness: effectiveness is of limited duration, and repetitive treatments are necessary. In a 52-week, multicentre, double-blind study comparing BTX-A with placebo for treatment of severe primary axillary hyperhidrosis, published in 2007 (15), the median duration of effect was 197 days, 205 days, and 96 days in the 75-U BTX-A, 50-U BTX-A, and placebo groups, respectively. An audit by Moffat et al in 2008, which aimed to determine treatment durability by active follow-up of patients over 24 months, suggests that patients experience a gradual return of symptoms between 6 and 24 months. A minority do not require re-treatment at this time.

Other anatomic sites: while BTX-A is also used routinely off-label for other anatomic sites, the procedure may be more difficult and painful at these sites. It has been shown to be effective for treatment of primary palmar hyperhidrosis. It may also be helpful for gustatory sweating and plantar, and craniofacial hyperhidrosis. Other indications (forehead sweating, truncal sweating) are only anecdotally reported.

Paediatric patients: while the product information states that safety and effectiveness of BTX-A have not been established for the treatment of hyperhidrosis in paediatric patients under age 18, there is some evidence to suggest the efficacy of BTX-A in primary palmar hyperhidrosis in children, with a mean duration of effect of 7 months in one study of nine patients.

Safety: BTX-A is reported to be well-tolerated in children. The most frequently reported adverse events (3-10% of adult patients) following injection of Botox® in double-blind studies included injection site pain and haemorrhage, non-axillary sweating (compensatory sweating), infection, pharyngitis, flu syndrome, headache, fever, neck or back pain, pruritus, and anxiety.

Patient satisfaction: BTX-A is reported to produce high levels of patient satisfaction.

Cost-effectiveness: the cost-effectiveness of BTX-A compared to other treatments has yet to be established.

Surgery
- Local surgery (axillary: resection of sweat glands) and endoscopic thoracic sympathectomy (ETS) should only be considered if other treatment options have failed or have not been tolerated. Complications may be permanent and significant.
- ETS involves video-assisted laparoscopic division of the sympathetic chain over the neck of the ribs under general anaesthesia, usually by a vascular surgeon. It is mainly indicated as a last resort for severe palmar, axillary, and sometimes craniofacial hyperhidrosis. Lumbar sympathectomy is not used for plantar hyperhidrosis because of the risk of sexual dysfunction.

Oral medication
- Oral anti-muscarinics, such as glycopyrronium bromide (which needs to be importend and oxybutinin, may be used, but their use is limited by adverse effects; other options include: clonidine, diltiazem, benzodiazepines.
- Systemic therapies are mainly used in treatment of generalised hyperhidrosis.
Patient information


Referral for hysterectomy should be considered only if the following criteria are met:

There has been a prior unsuccessful trial with a levonorgestrel intrauterine system, unless medically contraindicated.

AND

At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the NICE guidelines:

- Non-steroidal anti-inflammatory agents
- Tranexamic acid
- Injected progesterones
- Combined oral contraceptives

AND

Endometrial ablation has been tried (unless patient has fibroids > 3cm or the uterus is bigger than a 10 week pregnancy)

Women who have contraindications or ethical reasons for not trying LNG-IUS must try two or more of the second line treatments and failed. These include:

- 3 cycles of traxanemic acid or NSAID treatment
- 3 cycles of alternative hormonal contraceptive treatment in line with NICE guidelines (NICE CG44)
- Endometrial ablation
- Uterine Artery Embolisation (for fibroids under 3cm)
- Myomectomy (for fibroids over 3cms)

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.
Menorrhagia, or heavy menstrual bleeding, can be defined as blood loss of greater than 80ml per menstrual cycle [Warner et al.] or excessive menstrual blood loss which interferes with a woman’s physical, social, emotional/material quality of life. [NICE 2007]

Hysterectomy is the most effective treatment for menorrhagia but compared to other treatments, it is not thought to produce a significantly improved quality of life. [Marjoribanks et al., Clarke] Hysterectomy should not be used as a first-line treatment solely for menorrhagia as it is a major surgical procedure with associated complications (the risk of serious complications is about 10% [Brown et al.]). It should only be considered when the fully informed patient requests the procedure, wishes for amenorrhea and to no longer retain her uterus and fertility. The risks and complications of the procedure should be explained. [NICE 2007]

Medical treatment options include oral medication and a hormone-releasing intrauterine system. An alternative surgical option is uterine resection or ablation, which both are effective and have high satisfaction rates. [Lethaby] In women with menorrhagia alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation is considered preferable to hysterectomy [NICE 2007].

References

- Clarke J. Treatment of heavy menstrual bleeding. BMJ 2010; 341: 353
- 2010/11 South West London Effective Commissioning Initiative. May 2010
Hysteroscopy for diagnostic purposes

Policy

NHS NWL CCG will fund Hysteroscopy for Diagnostic purposes where ultrasound scan has been insufficient to make a diagnosis.

This policy does not apply for hysteroscopy for suspected cancer (including PMB) or hysterosalpingograms for the diagnosis of subfertility or operative/therapeutic purposes.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

A hysteroscopy is a procedure used to examine the inside of the uterus (womb). It is done using a hysteroscope, a narrow tube with a telescope at the end. Images are sent to a computer to give a close-up of the womb. There are two types of hysteroscopy, and the procedure can be performed with or without a local anaesthetic. A diagnostic hysteroscopy is used to look for abnormalities in the womb and find the cause of any symptoms. These can include: heavy or irregular periods, pelvic pain, unusual vaginal discharge, repeated miscarriage and infertility. Operative hysteroscopy is when it involves an additional procedure such as a biopsy or treatment. The common types of operative hysteroscopy include the removal of polyps, division of uterine adhesions, scars and septum, endometrial resection, resection of sub mucous fibroids, and removal of missing IUCDs.

Evidence

There is strong evidence that hysteroscopy is safe and accurate in diagnosing endometrial cancer in women with abnormal uterine bleeding, but diagnostic accuracy for endometrial hyperplasia is only moderate (Clark et al, 2003). Sonohysterography, hysteroscopy and transvaginal ultrasonography TVUS are all effective in detecting submucous fibroids, but hysteroscopy is associated with unacceptable pain in 3.6% of women (Farquhar et al, 2005). Both sonohysterography and hysteroscopy are effective in the investigation of women with dysfunctional uterine bleeding (DUB), but Sonohysterography is more cost-effective (Evans, 2004). Transvaginal ultrasonography (TVUS) is an effective diagnostic tool for the identification of structural pathology in women with heavy menstrual bleeding (Farquhar et al. 2005).

Ultrasound is the recommended first-line investigation to detect structural abnormalities in investigation of HMB or PMB. Hysteroscopy (allows direct visualisation of the uterine cavity) should be used as a diagnostic tool only when ultrasound results are inconclusive. Neither saline infusion sonography nor MRI should be used as a first-line diagnostic tool. To detect histological abnormalities in HMB (i.e. to exclude endometrial cancer or atypical endometrial hyperplasia), endometrial sampling or hysteroscopy with directed biopsy (curettage) have superseded D&C for obtaining endometrial tissue. Indications for an endometrial biopsy/sampling in investigation of HMB include persistent inter-menstrual bleeding, and in women aged ≥45 years - treatment failure or ineffective treatment. D&C is no longer recommended as a diagnostic tool for HMB.

Limited evidence is available on the use of therapeutic D&C for HMB, but the one study that was identified showed that any effect was temporary. Given the limited evidence, the NICE recommendation – that D&C should not be used as a therapeutic treatment for HMB – was based on clinical experience. While medical treatment options remain first-line, surgical treatment options for HMB and DUB include endometrial ablation methods that preserve the uterus but ‘ablate’ (remove) the lining (these have superseded D&C); and hysterectomy (the definitive treatment, which results in high satisfaction rates but with potential surgical morbidity). The first generation gold standard hysteroscopic ablative techniques include laser, transcervical resection of the endometrium and rollerball. Where dilatation is required for non-hysteroscopic (‘blind’) (2nd generation) ablative procedures, NICE recommend that hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device.

Hysteroscopy and biopsy (curettage) is the preferred technique to detect polyps and other benign lesions, and allows targeted removal.
Patient Information Leaflet

http://www.patient.co.uk/health/Hysteroscopy.htm

References

<table>
<thead>
<tr>
<th>Funding Criteria</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guiding principles</td>
<td>• The welfare of the child&lt;br&gt;• Evidence in support of improved treatment outcome (higher chances of success)&lt;br&gt;• Equity of access to services and choice of provider for those meeting the eligibility criteria.&lt;br&gt;• The Constraints on NHS Resources. Clauses 226 to 230 of the NHS Act 2006 deal with the financial duties of Health Bodies. It is a duty to ensure that annual expenditure does not exceed annual allowance (as set out in accordance with the provisions of the NHS Act).</td>
</tr>
<tr>
<td>Definition of a treatment cycle</td>
<td>A cycle of IVF/ICSI includes ovarian stimulation, egg recovery, fertilisation and single fresh embryo transfer. This includes the provision for further transfer of one frozen embryo where the initial procedure does not result in a viable pregnancy and the subsequent storage of embryo. A frozen cycle is one which starts when a cryopreserved embryo is removed from storage in order to be thawed and then transferred.</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>Couples will <strong>only</strong> be referred for assisted conception if they meet the eligibility criteria below and when <strong>all</strong> appropriate tests and investigations have been successfully completed in primary and secondary care in line with NICE guidelines. See appendix for list of investigations.</td>
</tr>
<tr>
<td>1. Registration status</td>
<td>Must be registered with a GP on the medical list of one of the 8 CCGs in NW London or if not registered reside in a NWL borough.</td>
</tr>
<tr>
<td>2. Compliance criteria</td>
<td>The referring clinician must ensure that patients are aware of the implications of IVF or ICSI treatment and the commitments required before making a referral for assisted conception. Those where compliance to IVF treatment is deemed to be a problem must be referred for counselling in the first instance.</td>
</tr>
<tr>
<td>3. Duration of infertility</td>
<td>Couples who have not conceived after one year of unprotected sexual intercourse should be offered investigations in primary and secondary care as appropriate and referred for Assisted Conception if they meet other IVF access criteria and have been trying to conceive without success for at least 2 years. Investigation after 6 months may be indicated if maternal age is approaching the maternal age referral criterion.</td>
</tr>
<tr>
<td>4. Cause of infertility</td>
<td>Couples with diagnosed or known cause of infertility that precludes natural conception do not need to wait for one year before referral for AC. This includes couples who cannot achieve full sexual intercourse due to disability.&lt;br&gt;Couples in whom one or both partners have been voluntarily sterilised will not be eligible for IVF treatment under this policy.</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>5. Age of the female</strong></td>
<td>IVF treatment will be funded for couples where the female partner at least 23 years and not yet reached their 40th birthday by the time the treatment commences (defined as the start of the stimulating phase of the IVF cycle). It is the responsibility of service providers to ensure that eligible couples have commenced the woman’s frozen treatment before her 40th birthday.</td>
</tr>
<tr>
<td><strong>6. Welfare of the child</strong></td>
<td>The referrer/provider should ensure that the HFEA code of ethics is followed. Details can be found at <a href="http://www.hfea.gov.uk/index.html">http://www.hfea.gov.uk/index.html</a></td>
</tr>
<tr>
<td><strong>7. Children from previous relationship</strong></td>
<td>Neither partner should have any living children (including adopted children) from current or previous relationships.</td>
</tr>
<tr>
<td><strong>8. Life style factors</strong></td>
<td>The couple’s health and social circumstances should pose no significant risk to conception, pregnancy or the resultant child. Obesity and smoking reduce fertility and increase risks to mother and baby during pregnancy. The woman must have a body mass index (BMI) of between 19 and 30 at the commencement of treatment. Women who are overweight or underweight will be offered referral to dieticians in order to improve their BMI before referral to AC. Women with a BMI less than 19 and greater than 30 will not be funded. Couples who smoke must be referred to smoking cessation service to support their efforts in stopping smoking. NHS NWL CCG will not fund IVF treatment until both partners have stopped smoking for six months. This information should be included in the referral letter to the tertiary provider. Referral for smoking cessation prior to referral will be the responsibility of the GP/hospital consultant. NHS NWL CCG recommends that households are encouraged to be smoke free.</td>
</tr>
<tr>
<td><strong>9. Number of cycles to be funded</strong></td>
<td>NHS NWL CCG will fund 1 Full cycle of IVF or ICSI at the current accredited providers across NWL - Hammersmith, UCLH, Guys and St Thomas’ and Chelsea and Westminster. The Full IVF cycle will consist of one fresh cycle and one frozen embryo transfer cycle. One treatment cycle will ideally be followed by the other, but a successful fresh cycle (in terms of a live birth) would make the couple ineligible for a frozen cycle. Similarly a spontaneous conception while on the waiting list will make the couple ineligible for further IVF treatment. NHS NWL CCG will not fund IVF where a patient has received any previous Full IVF or ICSI treatment cycle funded by the NHS. NHS NWL CCG will not fund IVF treatment where a woman has a history of 3 or more previous privately funded fresh cycles. Where a woman has previously privately funded one or two cycles, NHS NWL CCG will still fund one full cycle or only one fresh cycle as appropriate under this policy, until a maximum of three fresh cycles has been completed after which the chance of success decreases substantially.</td>
</tr>
</tbody>
</table>
| 10. Frozen Embryos | NHS NWL CCG will fund the freezing and transfer of embryos or preferably embryos as part of its multiple births minimisation policy.  
Embryo freezing and storage will be funded for a maximum of 12 months for eligible women. (Or the female partner’s 40th birthday if this is sooner) so that couples have the option to use stored embryos at a later stage if they choose to do so. Couples who do not use up their frozen embryos by 12 months will be responsible for subsequent annual storage charges, but NHS NWL CCG will pay for the embryo transfer costs where eligible.  
Where a woman has frozen embryos or embryos from a previous cycle of IVF treatment, NHS NWL CCG will only fund one cycle of frozen embryo transfer per one fresh cycle. The transfer of frozen embryos in this situation is less invasive, less stressful and does not involve another risk of unnecessary ovarian stimulation. |
| 11. Frozen cycles | The transfer of frozen embryos will constitute a cycle for the purpose of establishing entitlement to NHS funding under this policy.  
If a couple has had frozen embryos transferred as part of earlier self-funded treatment the frozen cycles will not be counted as previous cycles when assessing eligibility for NHS funded IVF.  
Frozen embryos must be transferred before the patient reaches their 40th birthday.  
Where couples have previously self funded and frozen embryos exist, the couple must implant one or two of the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again. |
| 12. Abandoned cycles | Abandoned cycles following known clinical complications of assisted conception treatment will not constitute a cycle for the purpose of establishing entitlement to NHS funding. Providers may only charge for the cycle if it reached the stimulating stage when treatment is stopped. |
| 13. Number of embryos to be transferred | In order to comply with the HFEA’s multiple births minimisation strategy as outlined in the document ‘One Child at a Time’, NHS NWL CCG will require its IVF and assisted conception provider units to adhere with the following guidance;  
If female partner is less than 37 years and having first fresh cycle, provider units should transfer one embryo NHS NWL CCG will fund embryo transfers and freezing in order to support this single embryo transfer strategy.  
If the female partner is more than 37 years, provider units can transfer up to 2 embryos in the first fresh cycle.  
Where the female is undergoing a frozen cycle for all age groups, only one embryo (or 2 embryos where the quality of frozen embryos are judged to be poor) could be transferred. NHS NWL CCG will leave this judgement to clinicians. |
<p>| | |</p>
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</table>
| 14. Gamete and Embryo storage | The CCGs will fund sperm banking for post-pubertal males under the age of 55 years who have not yet completed their family, and are about to undergo treatment which is likely to result in long-term sub-fertility. In accordance with HFEA guidance, gametes can be stored for up to 50 years.  
NHS NWL CCG will fund gamete storage for the first 12 months but subsequent annual storage charges will be the responsibility of the individual patient.  
Subsequent assisted conception procedures using the sperm will not be funded unless the other IVF eligibility criteria set out in this policy are met. Ovarian stimulation and embryo cryopreservation will be made available to women who are about to undergo treatment likely to cause infertility, provided they are in a stable relationship and wish to pursue this option.  
Oocyte (egg) preservation and ovarian tissue preservation are still experimental treatments, and will not be funded. However, the evidence will be kept under review.  
The procedures recommended by the Royal College of Physicians and the Royal College of Radiologists should be followed before commencing chemotherapy or radiotherapy likely to affect fertility, or management of post-treatment fertility problems. Retrieval and storage of sperm, eggs or embryos should also be in accordance with HFEA guidelines. |
| 15. Intra Uterine Insemination (IUI) | Intra Uterine Insemination (IUI) for unexplained infertility is part of the care pathway leading to IVF/ICSI. Therefore previous treatment with IUI will not preclude access to NHS funded IVF treatment. |
| 16. Egg Donation | NHS NWL CCG will fund IVF using donated eggs from UK clinics licensed by the HFEA (but not from clinics abroad) for women with premature ovarian failure due to a pathological or iatrogenic cause or in order to avoid the transmission of inherited disorders to a child where the couple meet the relevant eligibility criteria. Egg donation outside of these criteria will not be funded. |
| 17. Sperm Donation | NHS NWL CCG will not fund donor sperm but will fund the associated IUI/IVF/ICSI treatment in line with the criteria in this policy providing the sperm meet the criteria laid down by the treating provider unit. Patients wishing to access donor sperm treatments must make their own arrangements but are advised to check with the treating provider unit to ensure compliance with HFEA guidelines before accessing donated sperm. |
| 18. Surgical sperm retrieval | Surgical sperm retrieval will be funded in appropriately selected patients, provided that the azoospermia is not the result of a sterilisation procedure. |
| 19. Surrogacy | IVF using a surrogate mother will not be funded by NHS NWL CCG. |
| 20. Sperm Washing | NHS NWL CCG will fund sperm washing for IUI/IVF/ICSI in infertile couples where the male partner is HIV positive and the female partner is HIV negative. Where there are no fertility problems, NHS NWL CCG will fund sperm washing and up to 3 cycles of IUI in couples where the male partner is HIV positive and the female partner is HIV negative, subject to other IVF clinical criteria being met, in order to prevent the transmission of HIV to an unborn child. The attending Consultant in Genito Urinary Medicine or Infectious Diseases will be required to provide written confirmation of the suitability of the couple for NHS funding. |
| 21. Same sex couples and women not in a partnership | The main aim of this policy is to assist couples with medical or physical limits to their fertility. Applying the infertility policy to same sex couples requires some flexibility from those seeking treatment and the clinical team referring or treating the couple to ensure that the over-arching aim of this policy is met. Women in same sex relationships and women not in a partnership should have access to professional experts in reproductive medicine to obtain advice on the options available to them. Same sex female couples will not have access to initial investigations for IVF without some medical evidence of six unsuccessful cycles of IUI or donor sperm use and no resultant pregnancy. Same sex male couples will not be able to access fertility treatment within their relationship but may be eligible for some assistance if there is a medical infertility issue as would be available for couples using a surrogate (e.g. women born without a uterus but have normal ovaries, premature menopause, Cancer of the ovaries, uterus etc.). Applications from women not in a partnership will be considered in line with HFEA Guidance and Code of Practice and the Human Rights of the individual. NHS NWL CCG will fund assisted conception treatment for same sex couples who demonstrate evidence of clinical infertility as would be required for couples in heterosexual relationships. (This is normally defined as failure to conceive after regular unprotected sexual intercourse for 2 years or where there is already known or established anatomic cause(s) of infertility, but for the purposes of this policy, couples could start investigations in primary care after 1 year of unexplained infertility). Same sex couples will be expected to have undertaken all necessary fertility tests to exclude possible causes of treatable infertility such as anovulation and tubal blockage in the first instance. Where fertility tests show no obvious cause of infertility, same sex couples will be required to provide evidence of failure to conceive after 6 cycles of self funded donor IUI before they become eligible for NHS funded IVF or other assisted conception treatment. In the case of women in same sex couples in which only one partner is sub fertile, clinicians should discuss the possibility of the other partner receiving treatment before proceeding to interventions involving the sub fertile partner. |
21 Continued

NHS NWL CCG will not fund donor sperm, so same sex couples have to fund this element themselves, for either IUI or IVF.

All couples will have to be in a stable relationship for at least 2 years before eligibility for NHS funded IVF or other assisted conception treatment.

22. Provider units

Because NHS NWL CCG is committed to improving choice for couples and commissions for better treatment outcomes, it will commission IVF and other tertiary assisted conception treatments from the current providers across NWL – Hammersmith, UCLH (NHS wing), Chelsea and Westminster and Guys and St Thomas’.

The IVF provider units are expected to meet nationally agreed waiting times for all fertility treatments and to comply with the NHS NWL CCG access criteria.

Where no existing arrangements are in place (such as IVF units outside London), the provider units must gain funding approval from NHS NWL CCG before accepting a referral.

All drug costs should be met by the tertiary unit as part of the commissioned service and must not be prescribed by a GP.

Providers are expected to use the most clinically and cost effective drugs available.

To avoid the clinical risks associated with multiple births, tertiary units must have a strategy in place to comply with the HFEA’s multiple births minimisation strategy as outlined in the document ‘One Child at a Time’ published by HFEA (www.oneatatime.org.uk/36.htm).

Where a consultant has assessed a patient and established that the likelihood of success is less than 10% (due to FSH levels or other valid clinical reasons such as previous poor response), the clinician may decide not to continue with IVF/ICSI treatment even if the patient meets the access criteria set out in this policy. In these cases, NHS NWL CCG will be guided by the clinician’s view.

23. Specific provider unit responsibilities

- Confirm that any referred patient is registered with a GP in NWL or respective CCG catchment area.
- Check that the couple meets the eligibility criteria stated in this policy.
- Have up to date patient information leaflets including information on treatment outcomes for patients.

- Develop their own clinical criteria for success and discuss implications with patients before starting treatment. For example a woman with an FSH level > 12 have a significantly reduced chance of success using her own eggs, and such patients should be counselled on the option of donor eggs in order to maximise their outcomes.
- Check that BMI and smoking status comply with CCG policy, in addition to excluding problem drinking or alcoholic addiction through usual enquiries with the patient’s GP.
- Provide NHS NWL CCG with timely monitoring and audit data as listed below.
- Ensure all information exchanges with NHS NWL CCG or the CCG comply with Caldecott standards for confidentiality and the requirements of the HFEA Act.
24. Monitoring and Audit

NHS NWL CCG will require assisted conception units to provide yearly returns on their activity levels with emphasis on the following:

- The number of couples treated
- Age profile of patients treated
- The conception rate per cycle

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG. Production of the polices and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.
### Appendix 1

**Investigations to be done**

<table>
<thead>
<tr>
<th>Question</th>
<th>Insert Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age of female partner less than 40 ? (Please be aware that the stimulation phase of IVF must start before the patient turns 40)</td>
<td>Insert Response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Menstrual history</th>
<th>LMP Cycle Menorrhagia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social history of both partners</td>
<td>Female Smoking status Female Alcohol intake Male Smoking Status Male Alcohol intake</td>
</tr>
<tr>
<td>Sexual history</td>
<td>Frequency Duration of trying Dyspareunia</td>
</tr>
<tr>
<td>Predisposing factors</td>
<td>PCOS PID/STIs Tubal Surgery Erectile Dysfunction History of scrotal lumps/surgery</td>
</tr>
<tr>
<td>BMI of female patient (≥ 30 will exclude from treatment)</td>
<td></td>
</tr>
<tr>
<td>Preconception investigations done in primary care</td>
<td>Smear result Rubella Status Chlamydia screening Mid luteal Progesterone Day 2-5 LH/FSH in irregular cycle FBC TFT Prolactin Semen Analysis</td>
</tr>
<tr>
<td>Hospital Investigations</td>
<td>HSG or hysteroscopy findings Direct access for GPs to be arranged Vaginal US Laparoscopy</td>
</tr>
</tbody>
</table>
Knee arthroscopy

Policy

Referral for knee arthroscopy should be considered only in the following situations:

- Removal of loose body
- A clear history of mechanical locking in a patient with osteoarthritis.
- Meniscal surgery (repair or resection)
- Ligament reconstruction/repair (including lateral release)
- Synovectomy or synovial biopsy
- Suspected chondral lesion

Use of knee arthroscopy as a diagnostic tool will only be funded in the following situations:

- Patients with medial knee pain where the Plica syndrome is suspected.
- When Chondromalacia patellae is suspected

Arthroscopy will not be funded for the following indications:

- As part of treatment for osteoarthritis.
- Use of knee arthroscopy as a primary diagnostic tool

Intractable knee pain which may benefit from arthroscopic treatment may be funded under exceptional circumstances.

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Background

Arthroscopy uses a fibreoptic telescope to perform washout and debridement of the knee joint. Washout removes debris in the joint, while debridement removes damaged cartilage or bone. Other than a small risk of infection and venous thromboembolism arthroscopy is thought to be a safe procedure.
Patient information leaflet:  
http://www.cks.nhs.uk/patient_information_leaflet/arthroscopy/introduction#460280000

References:
1. N.I.C.E. Interventional Procedure Guidance IPG230- Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis (August 2007)
2. NICE 2008 clinical guideline 59 Osteoarthritis: the care and management of osteoarthritis in adults
5. NHS West Essex Surgical Thresholds. November 2009
Funding for total or partial knee replacement surgery is available if the following criteria are met

1. Patients with BMI <40

AND

2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

AND

3. Has radiological features of severe disease;

OR

4. Has radiological features of moderate disease with limited mobility or instability of the knee joint

Patients not meeting the above criteria can be referred via the IFR route where there are exceptional circumstances present.

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Background

Total knee replacement can be performed for a number of conditions, but it is most often for osteoarthritis of the knee. Osteoarthritis of the knee presents with joint pain, deformity, stiffness, a reduced range of movement and sometimes giving way.

Complications for knee replacement can be severe for a small number so it should only be considered when other treatments have failed. Non-surgical management includes medications for pain and inflammation, weight reduction in patients who are obese with patient-specific exercise programmes, walking aids, cushion-soled footwear. Corticosteroids may also be injected into the knee joint to relieve inflammation. If these therapies are insufficient, a partial or total knee replacement may be necessary.1,2,3,4

The usual indications for a knee replacement are pain and disability with accompanying radiological changes. Occasionally knee replacements are done to manage a progressive deformity/instability. Any comorbidities, including obesity should be managed to their optimum level prior to referral.5 All treatment options with risks and benefits should be offered to the patient. Patients who meet the criteria below before having knee replacement surgery are thought to have greater quality of life improvements.6
Definitions of pain and functional limitation levels:

Pain level

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>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.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

Functional limitations

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Functional capacity adequate to conduct normal activities and self care. Walking capacity of more than one hour. No aids needed.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility and Stability</td>
<td>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.</td>
</tr>
<tr>
<td>Limited mobility and /or stable joint</td>
<td>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.</td>
</tr>
<tr>
<td>Radiology</td>
<td>Ahlback grade 1.</td>
</tr>
<tr>
<td>Slight</td>
<td>Ahlback grade II and III.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Ahlback grade IV and V.</td>
</tr>
</tbody>
</table>
References:
1. NICE Referral Advice. A guide to appropriate referral from general to specialist services. 2001
3. NICE 2008 clinical guideline 59 Osteoarthritis: the care and management of osteoarthritis in adults
4. NICE Mini-incision surgery for total knee replacement. May 2010
5. British Orthopaedic Association Total Knee Replacement; A Guide to Best Practice. 1999
NHS NWL CCGs will fund combined decongestion therapy and other conservative physical therapies for patients with severe lipoedema or lymphoedema. Obese patients with lipoedema should first be assessed in an appropriate service.

Inpatient treatment and other forms of treatment such as surgical intervention for patients with severe lipoedema or lymphoedema or treatment at centres not commissioned by the NHS will only be considered in exceptional circumstances through the IFR route.

*These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is coordinated on behalf of the CCGs by North West London Commissioning Support Unit.*
Lymphoedema is a medical condition in which excessive fluid (or 'lymph') is accumulated in the tissues as a result of impaired lymphatic drainage. Although it is not life-threatening it can be very distressing and can become a major physical and social problem. Lipoedema is the accumulation of adipose tissue in the lower limbs which is often bilateral, symmetrical and often develops in a “chaps-style” fashion, namely starting from the hips down to the ankles. It affects women more than men, with a prevalence of up to 11% in women. The aetiology is unknown and it can be progressive. At late stages it can present as oedematosus-fibrosclerotic panniculitis, elephantiasis and immobility. Management is generally as with lymphoedema.

There is no known cure for lymphoedema and lipoedema. Various treatment strategies have been suggested for the management of both conditions. These aim to reduce the volume of the affected limb, retain or restore function and provide cosmesis to improve an individual’s health outcomes and quality of life. Manual lymphatic decompression is often used but not recommended as first line treatment for obese patients with lipoedema.

NICE provides guidance for liposuction to treat lymphoedema. Lymphoedema is the abnormal accumulation of lymph fluid in body tissues that results from an impaired lymphatic system. It most commonly affects the arms and legs. It can limit mobility and cause recurrent infection, pain, disfigurement and distress. Secondary lymphoedema results from damage to the lymphatic system or removal of lymph nodes by surgery, radiation, infection or injury, while primary lymphoedema results from congenital inadequacy of the lymphatic system.

In the UK, the most common type of chronic lymphoedema is secondary lymphoedema of the arm following breast cancer. Liposuction for chronic lymphoedema involves the surgical removal of excess subcutaneous fat tissue through several small incisions. It can be performed under general or regional anaesthesia. Cannulas connected to a vacuum pump are inserted into small incisions and lymphoedematous fat tissue is removed by vacuum aspiration.

Evidence base

The NICE palliative care guidance recommends the provision of lymphoedema services as part of the range of rehabilitation services that should be available through cancer networks. Summary of literature evidence for current management strategies are given below:

- The long-term use of low-stretch elastic garments or compression bandaging is effective in reducing and/or controlling limb swelling and may be an essential component of combination physical therapies.
- Favourable outcomes have been described for complex physical therapy; however, some of the evidence is inconsistent and further trial evidence is required to define an optimal strategy.
- Current evidence regarding the use of drug therapy is inconclusive.
- Surgical procedures may be indicated in select patients with lipoedema or lymphoedema who have not responded to physical therapy.

References


NHS NWL CCGs Planned Procedures with a Threshold Policy. Version 3 (April 2013)

Is this the latest version? Check here: http://www.northwestlondon.nhs.uk
Magnetic Resonance guided Focused Ultrasound (MRgFUS) for uterine fibroids

Policy

NHS NWL CCGs will not fund magnetic resonance guided ultrasound (MRgFUS) treatment for uterine fibroids for the purposes of fertility preservation because of lack of evidence of effectiveness.

NHS NWL CCGs will not routinely fund MRgFUS treatment for symptomatic relief except in exceptional circumstances via the individual funding request (IFR) route.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

Uterine fibroids are benign tumours of smooth muscle cells and fibrous connective tissue that develop within the walls of the uterus. They occur in approximately one third of women. In many cases they are asymptomatic, but they can cause abnormal uterine bleeding, pressure on the bladder or bowel and a feeling of pelvic pressure or pain.

Treatment depends on whether the fibroids are symptomatic, and on the woman’s desire to become pregnant. Treatment will rarely be required after the menopause (because of natural shrinkage of the fibroid in response to hormonal changes). Asymptomatic fibroids (often discovered incidentally) require no treatment other than monitoring. Symptomatic fibroids can be removed surgically by either hysterectomy (which can be laparoscopic or abdominal and either total or partial) or myomectomy (open surgical removal of just the fibroid with conservation of the uterus). Uterine artery embolisation (a type of non-surgical treatment which blocks off the uterine arteries causing the fibroids to shrink) may also be a treatment option for some women.

Magnetic Resonance-guided Focused Ultrasound (MRgFUS) treatment is a minimally invasive technique designed to reduce the symptoms of fibroids. Low power ultrasound is used to target the fibroid. It is then heated with high power ultrasound which destroys the fibroid tissue.

Evidence base

The pivotal study ‘Clinical outcomes of focused ultrasound surgery for the treatment of uterine fibroids’ established the safety and efficacy of the procedure and resulted in MRgFUS receiving FDA approval in the United States. However, the evidence currently available is of single arm treatment trials with small patient groups and does not compare this treatment with other treatment options. There have not yet been any randomised controlled trials comparing this procedure with other existing procedures or treatments.
The 2007 NICE interventional procedure guidance (IPG) found that the evidence on safety is adequate to support use of this procedure provided that normal arrangements are in place for clinical governance and audit. NICE recommends that the procedure should only be carried out by clinicians with specific training in this technique and patient selection to be done by a multidisciplinary team including a gynaecologist and an appropriate imaging specialist. Patients should be informed that their symptoms may not be relieved or that they may return and further treatment may be needed. NICE also found that the evidence on efficacy for MRI-guided FUS was adequate for treatment of uterine fibroids in the short term, although further treatment may be required and there may be risks of skin burns. Effect on subsequent pregnancy is uncertain (evidence based on one non-randomised comparative study and case-series studies).

The BlueCross BlueShield Association Technology Evaluation Centre undertook a comprehensive review of the effectiveness of MRgFUS in 2005 and concluded that MRI-guided focused ultrasound for uterine fibroids did not meet the TEC criteria. The TEC assessment noted that durability of MRI-guided ultrasound is a major concern because a substantially greater proportion of women undergo other (or repeat) procedures after MRI-guided ultrasound compared to either UAE or myomectomy. The TEC assessment also found that available data suggest that fibroid volume reduction with MRI-guided ultrasound is much lower than with comparison procedures. Uterine artery embolization appears to produce a more profound improvement in symptom severity scores than MRI-guided ultrasound. For fertility preservation, myomectomy was considered as the treatment of choice (TEC BCBSA, 2005).

2. National Institute for Health and Clinical Excellence, Magnetic resonance image guided transcutaneous focused ultrasound for uterine fibroids 23 November 2011 - Publication type: Full Guidance,
Reversal of Male Sterilisation

Policy

Reversal of male sterilisation (vasectomy) will not be funded except in exceptional circumstances such as:

- Death of only child (biological or adopted) from current relationship or any previous relationship

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Background

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent. A vasectomy can be reversed, but reversals are not usually successful.

References


Link to Patient Information Leaflet
NHS NWL CCGs will fund Open MRI of greater than 0.5T as an alternative to conventional MRI in the following circumstances:

- Patients who suffer from claustrophobia where an oral, prescription sedative has not been effective (GPs are expected to support Extended Scope Practitioners (ESPs) in prescription of sedatives in this situation)
- In patients who are obese and therefore cannot fit comfortably in a conventional MRI

*These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.*
Background

MRI is a widely used diagnostic imaging technology and is particularly useful in detecting soft tissue damage and disease. The patient undergoing imaging is placed in a gradient magnetic field delivering radiofrequency pulses to the patient and processing the resulting electromagnetic signals emitted from the region being examined (CADTH)\(^1\). The standard (closed/high-field) method of MRI requires the patient to be in a supine or recumbent position. The orientation of standard MRI requires the patient to be horizontal and stationary. For most scanners, the patient examination table is positioned in a long, narrow tube. Some patients may experience claustrophobic reactions which might be effectively controlled by sedation or anaesthesia. Obese individuals may be unable to fit into the tube. Open MRIs in which patients lie, sit or stand between two plates overcome these difficulties. They are also used for intraoperative imaging or image-guided interventions where easy access to the patient is required\(^1\).

The technology

The quality of MRI images is partly dependent on the field strength of the magnet which is measured in Tesla (T). Above 1T is considered high field strength. Closed MRIs have magnet field strengths of ≥1.5 tesla whereas open MRIs have medium strength magnets of 0.5-1.0T. The lower field strength of open MRIs results in poorer quality images in comparison to closed MRIs, with lower signal-to-noise ratios and more motion artefacts. The length of time required to obtain an image is also longer.

Generally low field strength is below 0.5T, mid-field strength is 0.5 T, up to 0.9 T or 1 T; and high-field strength is at/and or above 1 T. High-field strength devices are usually closed-bore magnets due to the fact that the stronger magnetic fields (1–3 T) require more robust shielding and gradient structure to maintain field homogeneity. The open magnet's field strength usually varies from 0.2–1.0 T.

Evidence Base

MRI studies reported in the literature are generally based on intermediate or high-field MRI. There is insufficient evidence in the published peer-reviewed literature to support the use of low-field strength MRI for any diagnostic indication\(^2\). The Washington State Health Technology Assessment on standing, weight-bearing, positional, or upright MRI in 2006\(^3\) concluded that there is insufficient evidence for the diagnostic accuracy or diagnostic utility of standard MRI for these situations. Open MRI (i.e., extremity, upright, and positional) allows for imaging without the patient being placed within an enclosed space. Open-design MRI has become the standard of care when conventional design is contraindicated. Specifically, this includes patients with pulmonary and/or cerebrovascular disease as well as patients who would require sedation for a conventional MRI such as severely claustrophobic or paediatric patients.

A review on the impact of obesity on medical imaging\(^4\) suggested an industry weight and maximum aperture diameter for closed (cylindrical bore) MRI’s as:

\[
\text{Wt – 350 lb (159kg) and Aperture diameter of 60cm (minus 15-18cm for table thickness).}
\]

References

2. CIGNA. Magnetic Resonance Imaging- low field. CIGNA coverage policy 0444
3. Washington State Department of Labor and Industries, Office of the Medical Director. Standing, weight-bearing, positional or upright MRI. Health Technology Assessment. Olympia Washington State Department of Labor and Industries; May 31 2006
Pain Management Programmes

NHS NWL CCGs will fund outpatient pain management programmes (of at least 25-30 hours) for those meeting the following criteria (Grade B recommendation): **Inclusion criteria:**

1. Clinical staff from the pain management programme has assessed the patient and agreed that they would benefit from the programme;
2. The patient has chronic non-malignant pain of at least 3 months duration, which is causing significant disability and/or distress, and a negative impact on quality of life. Patients satisfying these criteria do not have to wait until other treatments have failed before referral to PMP.
3. The patient is able to communicate in the language in which the PMP is conducted (a trained independent interpreter may facilitate successful participation);

**Exclusion criteria**

1. The patient has a limited life expectancy or rapidly deteriorating disease or condition;
2. The patient has active psychological or psychiatric problems which require urgent attention, or which preclude the use of cognitive and behavioural methods in a group (including severe cognitive impairment); (3) The patient has current primary drug or alcohol problems;
3. The patient has severe disability or significant medical condition such that the basic requirements of attending treatment exceed the patient’s current capacity.

Background

Chronic pain is continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery (British Pain Society). There are several different treatments available for chronic pain, including pain management programmes.

A pain management programme (PMP) is a psychologically-based rehabilitative treatment for people with chronic pain which remains unresolved by other treatments currently available (British Pain Society). It is delivered in a group setting by a multidisciplinary team, either on an outpatient or inpatient basis.

There is good evidence that PMPs improve pain and function compared to non-multidisciplinary treatments (Flor 1992, Thomson 2002, Guzman 2002, British Pain Society). A systematic review of ten trials found strong evidence for improved function, good evidence for decreased pain, but contradictory evidence for improved return to work (Guzman 2002). There is some evidence for reduced demand on healthcare after participation in PMPs, including reduced use of analgesics, reduced consultations, and reduced surgical interventions (Flor 1992, Turk 2001, Gatchel 2006).

Although both outpatient programmes of at least 25-30 hours are effective, more intensive inpatient programmes produce better outcomes (Bendix 1995, Williams 1996, Guzman 2002, British Pain Society). This difference was maintained at one year in one randomised controlled trial (Williams 1996). Less intensive outpatient programmes did not improve pain, function or work readiness when compared with non-multidisciplinary outpatient therapy or usual care (Guzman 2002). However, inpatient programmes are four times as expensive as outpatient programmes (Bedfordshire & Hertfordshire policy).

National and regional guidelines recommend PMPs for lower back pain (NICE CG88, Airaksinen 2006). Clinical guidelines recommend assessment by one or more members of the PMP clinical staff before acceptance onto a PMP, in order to gauge potential benefit (British Pain Society). Common exclusion criteria include: a limited life expectancy or rapidly progressive disorder; active psychiatric problems or drug/alcohol misuse; inability to speak or write in the language used by the PMP; or severe disability which would preclude attendance in the PMP (British Pain Society, comparative policies).

NHS NW London CCGs Planned Procedures with a Threshold Policy. Version 3 (April 2013)

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Background

Summary

- Pain management programmes are effective in improving pain and function in chronic pain, and can lead to return to work (level 1a)
- Pain management programmes can reduce healthcare costs for these patients (level 1b)
- Inpatient programmes produce better outcomes than outpatient programmes, but are much more expensive (level 1b)
- Patients who meet certain criteria are more likely to benefit from these programmes (level 5)

Reference


Comparative policies

- Kent & Medway List of Low Priority Procedures policy
  - Residential Pain Management Programmes are not routinely funded
- NHS Berkshire Priorities Policy:
  - Funding for inpatient pain management programmes for chronic pain should be low priority on the basis of lack of evidence of clinical and cost effectiveness compared to other multi-disciplinary interventions
- Bedfordshire and Hertfordshire Priorities statement:
  - Inpatient programmes may support more significant improvement, but are four times as expensive as outpatient programmes
- Outer North East London Procedures of Limited Clinical Effectiveness (PoLCE) policy:
  - Inclusion & exclusion criteria
Penile Implants

Policy

NHS NWL CCG will not fund penile implants as first or second-line treatment for erectile dysfunction (Grade C recommendation).

Possible exceptions to this policy are patients with severe structural disease such as:

- Peyronie’s disease
- post-priapism
- complex penile malformations

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

This is a surgical intervention to improve male erectile dysfunction (ED). ED is the persistent inability to attain and maintain an erection sufficient to permit satisfactory sexual performance. ED is highly prevalent, and 5–20% of men have moderate to severe ED. First-line therapy is either oral phosphodiesterase inhibitors or vacuum erection devices combined with risk factor modifications. If these are not effective, second-line therapy includes intracavernous injections or intraurethral medication. Penile implants are usually third-line therapy for patients who fail to respond to or are unable to continue with medical therapy or vacuum devices.

Two types of penile implants (PI) exist: malleable and inflatable. The malleable version uses semi-rigid rods that keep the penis fairly rigid all the time, but allow it to be bent down when an erection isn’t needed. The other type is a hydraulic system comprising a fluid-filled reservoir in the abdomen, a pump placed in the scrotum and two inflatable cylinders. The prosthesis is activated by squeezing the pump which transfers fluid from the reservoir to the cylinders, causing the penis to become rigid. Patients must be medically fit for surgery and accept potential complications of infection and mechanical failure which may require re-operation.
Evidence Base

Although older devices have had technical problems, the latest generation of three-piece inflatable devices have low rates of complications and mechanical failure. A health technology assessment from Spain put prosthesis survival rate at five years at 78%-91% and the complication rate as 3%-8%. Several studies have also reported high patient satisfaction levels after penile implants, including with regard to intercourse ability and confidence, and device rigidity and function. However, no systematic reviews or randomised controlled trials were available.

PI has the highest initial cost of all the treatments for ED. First and second-line treatments are considerably cheaper and have proven efficacy. A Canadian cost-utility study assessed the cost of various ED treatments and their utilities in patients with spinal cord injury. The incremental cost-utility ratios for PI compared to sildenafil (a phosphodiesterase inhibitor) and vacuum erection devices were CAN $63,412 and CAN $178,626 per quality-adjusted life year, respectively. Therefore first and second-line treatments are more likely to be cost-effective in patients with ED than PI. Several guidelines including the British Society for Sexual Health concur that the management of ED should be staged, with PI as a last-stage treatment for those in which previous treatments have failed or those with severe structural disease, such as Peyronie’s disease, post-priapism or complex penile malformations.

Summary

- Low failure and complication rates (level 2b)
- High patient satisfaction outcomes (level 2b)
- Less cost-effective than first and second-line treatments (level 2b)

References:

8. Comparative policies (other NHS organisations):
   - NHS Kent & Medway: Not routinely funded
   - NHS Devon: Not routinely funded
   - NHS Western Cheshire: Not routinely funded
   - NHS North Lincolnshire: Treatment will not routinely be approved except for patients with impotence of organic cause, or for those who have failed to respond to or are unable to continue with medical treatment or external

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Polysomnography

Policy

Full polysomnography (with electroencephalogram EEG, electro-oculogram EOG and electromyogram EMG sleep staging) is NOT needed to diagnose the majority of cases of obstructive sleep apnoea/hypnoea syndrome (OSA/H). In those with high and moderate pretest probability respiratory polygraphy (a cardiorespiratory sleep study) is adequate. 1,2

Full polysomnography is reserved for those with:

a) suspected sleep disordered breathing (OSA/H) in whom a cardiorespiratory sleep study has not produced a clear diagnosis,

b) if an intrinsic sleep disorder is suspected e.g. narcolepsy, REM sleep behaviour disorder in which EEG/EOG/EMG sleep staging is required to make the diagnosis

c) to assess response to therapy/monitor progress in some conditions

d) to investigate failure to respond to therapies such as continuous positive airway pressure (CPAP) and non-invasive ventilation (NIV) providing adequate control of respiratory events and adherence to therapy has been confirmed.

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Background

Adults (>16 years) services

Full polysomnography is indicated:

- In patients with symptoms of obstructive sleep apnoea/hypnoea syndrome such as excessive daytime somnolence or nocturnal choking in whom a cardiorespiratory sleep study has not established a diagnosis.
- In patients with hypersomnolence and features associated with narcolepsy - e.g. cataplexy, sleep paralysis, hypnogogic hallucinations (combined with multiple sleep latency tests, MSLT).
- In patients with features of parasomnias such as REM sleep behavior disorder (e.g. acting out dreams, hitting partner/bedside objects)
- In patients with limb movement disorders in which a diagnosis cannot be made on a clinical history and cardiopulmonary sleep study alone.
- In the differential diagnosis of circadian sleep disorders such as delayed sleep phase syndrome and advanced sleep phase syndrome (usually together with actigraphy)
- In cases of persistent hypersomnolence (>3 months) or cyclical hypersomnolence which are not explained by other causes.

NHS NWL CCGs Planned Procedures with a Threshold Policy. Version 3 (Feb 2013)
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In nocturnal movement disorders, nocturnal fits or if repetitive stereotypic movements occur during sleep (full montage EEG monitoring and neurology opinion may be required).

In patients with confirmed obstructive sleep apnoea/hypopnoea syndrome who fail to respond to CPAP therapy despite evidence of control of apnoea and hypopnoeas, and evidence of adherence to treatment.

In patients receiving ventilatory support e.g. non-invasive ventilation (NIV) for nocturnal hypoventilation in whom symptom control is not achieved despite evidence of control of hypoventilation, adherence to therapy and use of information downloaded from device on leak, respiratory events mask fit etc. from device.

In suspected parasomnias such as sleep walking, sleep terrors in which diagnosis cannot be made of history alone.

In some cases of insomnia to exclude other diagnoses which may be contributing to poor sleep quality.

To assess response to medical therapeutic interventions such as use of: modafinil for narcolepsy, e.g. clonazepam for REM sleep behavior disorder, antiparkinsonian medication such as L-dopa or ropinirole for restless limb syndrome, melatonin for circadian disorder and use of antiepileptic therapy for simple or complex fit disorders.

Paediatric services

Full polysomnography is indicated:

- In children with symptoms of obstructive sleep apnoea/hypopnoea syndrome (symptoms and signs may include somnolence or hyperactivity, witnessed apnoeas, snoring and failure to thrive) in whom a cardiorespiratory sleep study (respiratory polygraphy) has not achieved a diagnosis. This includes children with adenotonsillar hypertrophy, or those with syndromes such as Prader Willi syndrome, Down syndrome, mucopolysaccharidoses or craniofacial disorders.
- If the diagnosis or narcolepsy is suspected.
- To confirm the diagnosis of congenital central hypoventilation syndromes (CO2 monitoring also required).
- To confirm central apneas and other complex sleep disorders in which occurrence in NREM or REM sleep is important to know for further management.
- In infants in who sleep disordered breathing is suspected or who have had an apparent life threatening episode (ALTE), and in whom diagnosis is not clear using a cardiorespiratory sleep study.
- In patients with cyclical or episodic hypersomnolence and features suggestive of Kleine Levin syndrome.
- As part of the diagnostic work-up of a child with a undiagnosed neurological/neuromuscular disorder in which it may clarify the component of central control of breathing disorder and peripheral weakness of respiratory muscles.
- Full polysomnography may be indicated to titrate device therapy e.g. CPAP or NIV in children with complex sleep disorders or in obstructive sleep apnoea/hypopnoea if symptomatic control cannot be achieved using cardiorespiratory titration, and information downloaded from device.
- Full polysomnography may be indicated to assess the response to medical therapy in children with narcolepsy, complex sleep disorders, nocturnal epilepsy, insomnia, circadian disorders.

References

NHS NWL CCGs will not fund Septorhinoplasty procedures for cosmetic reasons

Septorhinoplasty procedures will be funded for functional reasons where:

1. Patient has a deviated septum causing significant and persistent nasal blockage
2. A septoplasty alone will not improve functional impairment
3. Septorhinoplasty is not being performed for cosmetic reasons.

For all other indications – please apply via the IFR route etc.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Septorhinoplasty is a surgical procedure to correct a deformity of the nasal septum as well as the bony deformity of the pyramid of the nose.

References

   http://www.aetna.com/cpb/medical/data/1_99/0005.html
Laser Surgery for Short Sigh

Policy

NHS NWL CCGs will not fund laser eye surgery for the correction of Myopia, only in exceptional circumstances via the Individual Funding Request (IFR) route.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.

Background

Short sight or myopia (ICD-10 Code: H52.1) is a condition where distant objects appear blurred. Refractive errors are usually corrected by wearing spectacles or contact lenses, and these treatments are currently not available on the NHS. Both have limitations and contact lens wear is associated with an increased risk of sight-threatening corneal infection. Surgical treatments have been developed to permanently improve refraction by re-shaping the cornea. In laser (photorefractive) surgery, corneal re-shaping is achieved using excimer laser ablation. Excimer laser techniques include photorefractive keratectomy (PRK), laser epithelial keratomileusis (LASEK) and laser in situ keratomileusis (LASIK).

Evidence Base

Current evidence suggests that laser surgery for the correction of myopia is safe and efficacious for use in appropriately selected patients.\(^1\)\(^2\) Several reviews have concluded that the three techniques appear to be equally effective in achieving the predicted refractive outcome in myopia.\(^2\)\(^3\)\(^4\) There is some risk for permanent side effects associated with the surgical procedures, although these are rare.\(^2\)\(^4\)

Laser surgery is more effective at lower levels of myopia.\(^2\)\(^4\) An alternative technique for higher levels is phakic intraocular lenses (IOL). A Cochrane review suggested that phakic IOLs are safer than laser surgical correction for moderate to high myopia and preferred by patients.\(^5\)

The safety and efficacy of laser surgery should be considered against the more common methods of correction: spectacles and contact lenses. Unfortunately, there was no evidence directly comparing the risk profile and/or cost-effectiveness of surgery with spectacles and contact lenses.\(^6\)

Summary:

- There is strong evidence (level 1A) that laser surgery is safe and effective in selected patients with myopia.
- Phakic IOLs are safer than laser surgery in higher levels of myopia (level 1A).
- There is no evidence directly comparing the risk profile and/or cost-effectiveness of laser surgery to the alternatives of spectacles and/or contact lenses.
Patient information

http://www.nhs.uk/Conditions/Short-sightedness/Pages/Introduction.aspx

NHS NWL CCGs will not fund TMJ appliances unless in exceptional cases. For example, the following situations might be considered exceptional:

- Patient has unsuccessfully tried alternative, cheaper treatments including: analgesics, muscle relaxants, stress reduction and self-massage, soft diet

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**Background**

Malfunction of the temporomandibular joint (TMJ) which lies between the base of the skull and the lower jaw is an important oral health problem and reduces the quality of life of sufferers due to pain, muscle spasms and difficulties in moving the joint. In 2007 approximately 1 in 1000 people in England were diagnosed with TMJ by a GP, although more will present to a dentist. It is estimated that around 1 in 6 people suffer from some sort of TMJ disorder, onset is most common between 20 and 50 and approximately 2/3 of sufferers are women. The prognosis for TMJ is generally good as both groups in RCTs tend to improve with time, regardless of type of treatment received (analgesics, physical therapy, stress reduction, massage, occlusal splints) or placebo, however “no specific therapies have proven to be uniformly effective but conservative treatments provide at least as much symptomatic relief as invasive treatments, with less risk of harm”.

**Evidence base**

Occlusal splints, also known as the *Tanner appliance*, the *Fox appliance*, the *Michigan splint*, or the *centric relation appliance* are the subject of two systematic reviews. A Cochrane systematic review found weak evidence that hard stabilization splints (the most common type of occlusal splint) reduce pain severity in people with myofascial pain, but that they are no more effective than various other active treatments. Conversely, a subsequent systematic review found more convincing evidence that hard stabilization appliances (splints) reduce pain in people with temporomandibular disorders compared with a non-occluding appliance, but did not demonstrate that hard stabilization appliances reduce pain more than no treatment, possibly due to underpowered studies. No economic evaluations or cost benefit analysis of treatment have been found (NHS Evidence, NICE, Bandolier, EMBASE, HMIC, MEDLINE).
Patient information:
http://www.tmj.org/site/

References:

Link to further sources of evidence:
http://www.aadronline.org/i4a/pages/index.cfm?pageid=3465#TMD Accessed 19/10/10
Suspected or confirmed malignancy – this is an absolute indication to refer. Please use the two week cancer referral form.

Referral criteria
Referral for tonsillectomy should be considered for the following indications.

Tonsillectomy in Adults:

- Recurrent severe sore throat in adults where Group A Streptococcal infection is suspected.
- Two or more quinsys (peri-tonsillar abscesses)
- Co-existing complications such as neck abscess or tonsillar enlargement causing upper airway obstruction.

Tonsillectomy in Children:

- Recurrent acute sore throat in children where the following conditions are met:
  - sore throats are due to acute tonsillitis
  - the episodes of sore throat are disabling and prevent normal functioning
  - seven or more well documented, clinically significant, adequately treated sore throats in the preceding year
  - five or more such episodes in each of the preceding two years
  - three or more such episodes in each of the preceding three years
- Two or more quinsys (peri-tonsillar abscesses)
- Co-existing complications such as neck abscess or tonsillar enlargement causing upper airway obstruction.
- Failure to thrive where recurrent tonsillitis is considered a contributory factor.
- Sleep apnoea. Tonsillectomy will be considered where one or more of the following apply:
  - A positive sleep study
  - Demonstrable significant impact on quality of life
  - A strong clinical history suggestive of sleep apnoea

* Adapted from SIGN Guidelines 2010; ONEL, and Kent & Medway Policy Documents

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Background

Tonsillectomy is the surgical removal of the tonsils usually after recurrent episodes of tonsillitis.

Evidence Base

Tonsillectomy offers relatively small clinical-benefit. In the year after the operation the number of days not attending school is reduced by approximately 2.8 days. The mortality risk of tonsillectomy is between 1:8000 and 1:35 000 cases.

The quality of the evidence for tonsillectomy in children is poor, but it suggests that surgery may be beneficial in selected cases. In adults, evidence from a small randomized controlled trial with a short follow up time of only 3 months suggested that tonsillectomy may benefit people with recurrent infection. A six-month period of watchful waiting by an ENT surgeon is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of the operation. Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur. Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.

References

- Burton MJ, Glasziou PP. Tonsillectomy or adenotonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. Cochrane Database of Systematic Reviews 2009, Issue 1
Surgery for trigger finger will be funded in patients who have functional limitation affecting lifestyle or occupation and meet one of the following criteria:

- Failure to respond to conservative treatment, including at least 2 corticosteroid injections with dates.
- Who have a fixed flexion deformity that cannot be corrected
- Patients for whom corticosteroid treatment is not suitable such as multiple digits affected.

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**Trigger Finger / Tenosynovitis**

Trigger finger (stenosing tenosynovitis) is a disease of the tendons of the hand leading to triggering (locking) of affected fingers, dysfunction and pain. Trigger finger usually affects the thumb, middle or ring finger, and may develop on both hands. In most cases the underlying cause is unknown, but could be linked to diabetes or inflammatory conditions, e.g., rheumatoid arthritis.

The symptoms may include stiffness and clicking when the finger is moved, especially first thing in the morning; and a bump (nodule) or tenderness at the base of the affected finger in the palm. If the condition worsens, the finger may get stuck in a bent position, then suddenly pop straight. Eventually, it may not fully straighten and become ‘locked’.

In most cases, trigger finger is a nuisance rather than a serious condition. However, if left untreated, the finger or thumb may actually become closed in a bent position or, less likely, in a straightened position, which can cause difficulties in performing everyday tasks.
Background (continued)

Treatment:

Patients managed in primary care may benefit from advice and conservative treatment that includes: rest from activities that aggravate the condition (if that is an option for the patient) the use of ice packs to reduce swelling exercising/massaging the affected finger(s) to relieve pain placing the affected finger(s) in warm water for 5-10 minutes, especially in the morning NSAIDs to reduce pain and inflammation wearing a splint at night if finger(s) bend and lock during the night and are painful to straighten in the morning for appropriate patients, corticosteroid injection (with lidocaine) in the area of tendon sheath thickening

Spontaneous recovery may occur with time. (Schofield, 993).

Steroid injection is an effective therapy for trigger finger and thumb. Success rates for a single injection of steroid vary between 49-78% (Fleisch 2007, Peters-Veluthamaningal 2008). A second injection is often (50%) successful if the first has no, or only temporary, effect (Akhtar 2007, Ring 2008). Steroid injections have few complications (Baumgarten 2008, Peters-Veluthamaningal 2008) and are safely given in the primary care setting (Peters-Veluthamaningal 2008).

Surgical release is an effective treatment with a high success rate, low complication rate and short recovery period (3-4 weeks). It is usually done on a day case basis under local anaesthetic and provides a permanent “cure” when performed by appropriately trained surgeons.

Surgery (trigger finger release) is indicated:
- after failed conservative treatment
- for recurrent triggering after 1-2 injections of steroid
- if there are severe symptoms at presentation
- in populations who are unlikely to benefit from steroid injections (for example a diabetic with many digits affected and severe symptoms)

References:


Patient Information:
http://www.nhs.uk/conditions/Trigger-finger/Pages/Introduction.aspx

References:
NHS NWL CCGs will only fund surgical interventions for Uterovaginal Prolapse in the following circumstances:

1) In cases of mild to moderate symptomatic cystoceles where trial of a pessary has failed.

2) In cases of mild to moderate symptomatic rectoceles.

3) In severe cases of prolapse or procidentia

Initially, patients should be assessed and managed conservatively in primary care.

1. Watchful waiting, with observation for the development of new symptoms or complications
   - Appropriate if the prolapse is minimal (Stage I)\(^2\), or asymptomatic

2. Conservative treatment options
   2.1 Lifestyle modification
   - Treatment of conditions that increase intra-abdominal pressure: constipation, chronic cough, overweight/obesity; reduction of heavy lifting (while POP has been associated with these factors, the role of lifestyle modification in prevention/treatment has not been investigated)\(^3\).

2.2. Pelvic floor muscle exercises
   - Role in managing prolapse unclear; probably not useful if the prolapse extends to or beyond the vaginal introitus.
   - Cochrane review 2006: concluded evidence was insufficient (from 3 randomised trials) to judge the value of conservative management of POP, & that further trials were needed\(^4\).
   - The pilot study for the Pelvic Organ Prolapse Physiotherapy (POPPY) multi-centre trial suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic Stage I or II POP women in an outpatient setting may reduce the severity of prolapse\(^5\).

2.3. Local (vaginal) oestrogen creams
   - Cochrane review 2010: limited evidence from RCTs regarding use of oestrogens to reduce or prevent the symptoms of prolapse; need for rigorous RCTs with long-term follow-up to assess oestrogen preparations, particularly as an adjunctive treatment for women using pessaries, and before & after prolapse surgery\(^6\).
   - Use of local oestrogen in conjunction with pelvic floor muscle training before surgery may reduce the incidence of post-operative cystitis within 4 weeks after surgery\(^7\).
   - Oral raloxifene may reduce the need for POP surgery in women >60 years although this cannot be taken as an indication for practice\(^8\).

3. Vaginal pessary insertion
   - Cochrane review 2004: no RCTs of pessary use in women with prolapse\(^9\); there is no consensus on the use of different types of device, the indications, nor the patterns of replacement & follow-up care\(^10\); evidence for pessary selection and management is incomplete so trial and error, expert opinion, and experience remain the best guides for use and management of the pessary\(^11\).
   - Although not supported by definitive evidence, current opinion is that pessaries are effective\(^1\) & should be considered before surgery in women who have symptomatic prolapse\(^12\); they can be attempted in all POP cases irrespective of stage\(^13,14\):
     - for short-term relief before surgery, or in the long-term if surgery is not wanted or recommended\(^14\)
     - to predict surgical outcomes\(^14\) or unmask urodynamic stress incontinence before surgery, as part of the investigation of continent women with POP (so that the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored)
   - Risk factors for unsuccessful fitting include: short vaginal length <6 cm and wide introitus >4 fingerbreadths\(^15\); local oestrogens may play a role in successful fitting\(^17\).
   - Failure to retain the pessary has been associated with increasing parity and previous hysterectomy\(^18\); and discontinuation with history of hysterectomy or prolapse surgery, and stress incontinence\(^19\).
   - Follow-up: no clear consensus on how often to follow up\(^1\); after 3 months & then every 6 months, if there are no complications, has been suggested\(^1\).
   - Complications tend to occur in women who are not regularly followed up\(^1\); self-care of pessary is also important to minimise adverse events\(^20\); however, many patients find insertion & removal of most pessary types challenging\(^2\).
4. Surgery

- Assessed as effective, but with a close risk/benefit in mild cases; a combination of procedures may be required and reoperation is required in 29% of cases¹
- Types of repair surgery vary depending on type of POP & associated symptoms, whether the woman is sexually active & her fitness for surgery

4.1. Reconstructive surgery (abdominal or vaginal approach)

- 2010 Cochrane review of surgical management of POP: found 40 RCTs with a variety of types of POP⁵
  - There was not enough evidence on most types of common prolapse surgery, nor about the use of mesh or grafts in vaginal prolapse surgery
  - Impact of POP surgery on bowel, bladder & sexual function can be unpredictable & may make symptoms worse or result in new symptoms, such as leakage of urine (unmask occult SI) or problems with intercourse⁵
  - Uterine/vaginal vault prolapse: abdominal sacral colpopexy may be better than vaginal sacrospinous colpopexy – it was associated with a lower rate of recurrent vault prolapse and dyspareunia; these benefits must be balanced against a longer operating time, longer time to return to activities of daily living and increased cost of the abdominal approach⁵
  - Posterior vaginal wall prolapse/ rectocele: posterior vaginal wall repair may be better than transanal repair in terms of recurrence of prolapse (limited evidence)⁵
  - Value of the addition of a continence procedure to a prolapse repair operation in women who are dry before operation remains to be assessed⁵
  - Use of mesh/graft inlays (biological or synthetic):
  - 2010 Cochrane review⁶: use of mesh or grafts at the time of anterior vaginal wall repair reduces the risk of recurrent anterior wall prolapse on examination; however, evidence of benefit to the woman, including symptoms and quality of life improvement, is lacking for the use of grafts over native tissue repairs⁷
  - 2008 NICE guidance⁸: surgical repair of vaginal wall prolapse using mesh

4.2 Obliterative Surgery

- Corrects POP by moving the pelvic viscera back into the pelvis & closing off the vaginal canal; vaginal intercourse is no longer possible¹

<table>
<thead>
<tr>
<th>Clinical scenarios where surgery will not be routinely funded</th>
<th>Clinical scenarios where referral for specialist assessment is necessary to determine suitability for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic pelvic organ prolapse</td>
<td>Failure of pessary</td>
</tr>
<tr>
<td>Mild pelvic organ prolapse (unless combined with urinary/faecal incontinence)</td>
<td>Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence)</td>
</tr>
<tr>
<td>Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence</td>
<td>Women with moderate to severe prolapse who want definitive treatment</td>
</tr>
</tbody>
</table>

Recommendations

- Initially, patients should be assessed and managed conservatively in primary care
- All patients should have a trial of ring pessary, including suitable candidates for surgery, as part of the investigation of continent women with prolapse; the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored

Patient information

- [http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx](http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx)

These polices have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.
Pelvic organ prolapse (POP) (genitourinary prolapse) refers to abnormal descent/herniation of one or more of the pelvic organs as a result of failure of ligamentous and fascial supports, resulting in the protrusion of the organ beyond its normal anatomical confines. Prolapse can occur in the anterior (urethrocele, cystocele, cystourethrocele), middle/apical (uterine, vaginal vault (post-hysterectomy), enterocele), or posterior (rectocele) compartment of the pelvis. POP development is multifactorial, with vaginal child birth, advancing age, and increasing body mass index (BMI) the most consistent risk factors.

Diagnosis is usually clinical and based on history and pelvic (speculum) examination, to establish the compartments affected (classification of the prolapse) and define the extent of the prolapse (grading of severity/degree).

**Background**

**References**

NHS NWL CCGs will only fund invasive procedures for varicose vein surgery if at least one of the following criteria are met:

- History of bleeding from a varicosity and at risk of bleeding again
- Ulcer which is progressive and/or painful despite treatment
- Recurrent superficial thrombophlebitis.
- Progressive skin changes e.g. pigmentation, eczema, lipodermatosclerosis or atrophie blanche
- Venous skin problems
- If the patient's quality of life is severely affected for example, inability to stand for long periods of time, affecting life and/or occupation. **ALL** of the below must apply
  - There is evidence that symptoms severely affect quality of life with respect to physical functioning
  - There has been a documented unsuccessful 6 month trial of conservative management, for relief of the symptoms severely affecting quality of life
  - Symptoms are disease-specific and cannot be attributed to co-morbidities or other disease/disability affecting the lower limb(s) concerned,

**Patients who do not meet these criteria should be offered conservative therapy in primary care, which includes:**

- Compression stockings
- Exercise
- Daily elevation several times a day

This policy will be reviewed once final NICE guidance is published. Revised policy is expected to be in September 2013.

These policies have been approved by the eight Clinical Commissioning Groups in North West London (Brent CCG, Central London CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG and West London CCG). Production of the policies and management of appeals is co-ordinated on behalf of the CCGs by North West London Commissioning Support Unit.
Varicose veins (ICD-10 Code:183) are dilated superficial veins in the leg caused by incompetent venous valves. In the UK varicose veins occur in around 15–20% of adults. Although treatment for varicose veins is generally effective, recurrence is estimated at around 50% within five years. An evidence-based classification of varicose veins (CEAP, 2004) is given below to assist clinicians in assessing the severity of varicose veins. There is mixed evidence as to the relative effectiveness of sclerotherapy or surgery, therefore specific surgical options for individual patients should be left to clinical decision. Whilst symptom severity generally corresponds to disease severity, there is also evidence of severe limitations on quality of life in some patients with lower level disease.

<table>
<thead>
<tr>
<th>CEAP Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0</td>
<td>No visible or palpable signs of venous disease</td>
</tr>
<tr>
<td>C1</td>
<td>Telangiectasies or reticular veins</td>
</tr>
<tr>
<td>C2</td>
<td>Varicose veins; diameter &gt;3mm</td>
</tr>
<tr>
<td>C3</td>
<td>Oedema</td>
</tr>
<tr>
<td>C4</td>
<td>Changes in skin and subcutaneous tissue: pigmentation, eczema, lipodermatosclerosis or atrophie blanche</td>
</tr>
<tr>
<td>C5</td>
<td>Healed venous ulcer</td>
</tr>
<tr>
<td>C6</td>
<td>Active venous ulcer</td>
</tr>
</tbody>
</table>

**References**

- N.I.C.E. Referral Advice: a guide to appropriate referral from general practice to specialist services 2001
- N.I.C.E. Interventional Procedures guidance IPG8 (September 2003)
- N.I.C.E. Interventional Procedures guidance IPG52 (March 2004)
- Darvall KA, Bate GR, Adam, DJ Bradbury AW. Generic Health-related Quality of Life is Significantly Worse in Varicose Vein Patients with Lower Limb Symptoms Independent of Ceap Clinical Grade. European Journal of Vascular and Endovascular Surgery 2012; 44;) 341-344