NHS
Vale of York
Clinical Commissioning Group

# PROCEDURES OF LIMITED CLINICAL VALUE (Last updated Feb 2012)

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**Appendices**



For further information or queries on the clinical guidance contained in this guide please contact Gill Fox, Policy and Implementation Manager – Email: gill.fox@nhs.net **or** Elaine Farthing, Individual Funding Request manager elainefarthing@nhs.net who will then ensure that your queries is dealt with by the appropriate clinician or member of staff within the Commissioning Support Unit.

## INTRODUCTION

The primary purpose of this guide is to provide Primary Care practitioners with a clinical framework which supports the commissioning of services for the residents of North Yorkshire. Our aim is to provide a consistent and equitable service, and these guidelines are applicable to all patients wherever they may be seeking secondary care interventions.

The guide draws together evidence-based guidance on a range of clinical pathways with criteria for referral to Secondary Care, and describes the PCT's intentions to commission services primarily in the community. Where necessary, it outlines commissioning thresholds which should be applied to all patients other than where exceptional circumstances can be identified.

The evidence supporting the clinical guidance and pathways is, where possible, high level primary care evidence from sources such as the National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), Prodigy and Royal Colleges. Where such evidence is not available, the guidance provided reflects the "usual care" that the PCT expects to commission, with guidance obtained from local consensus or expert opinion, and information sources such as GP notebook.

Some of the clinical thresholds (tonsillectomy, hernia, cholecystectomy, cystoscopy and osteoarthritis of the hip/knee) were initiated by the Yorkshire and the Humber SHA in consultation with clinicians and commissioners across the region, and have been adapted locally within NHSNYY following consultation with local clinicians.

The guide will highlight new services as they become available in different localities. Where local pathways do not yet exist to enable services to be provided in the community, traditional referral to Secondary Care Services should continue. The North Yorkshire and York PCT, in conjunction with Practice Based Commissioning Groups, will continue to undertake further work required at locality level, in order for a consistent service framework to be delivered across the PCT.

Health professionals are expected to take the guidance fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. It is assumed that the guidance will be followed in primary care prior to a referral being made to Secondary Care Services. Where an exceptional clinical need has been identified, which falls outside the scope of these guidelines, the PCT will consider funding for each request on a case-by-case basis via the PCT Individual Funding Request Panel.

As the commissioning of services develops to reflect best practice models, new clinical evidence, initiatives such as 18 weeks, and our local population's needs, revisions to this guidance will be necessary. It is anticipated that the guide will be updated on a regular basis, and notification will be given to all relevant stakeholders as and when this occurs.

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## Otitus Media – with Effusion (OME) / Insertion of Grommets

Referral to secondary care for children should only be made if there are any of the following circumstances: Tick those that apply:

- Hearing loss of greater than 25 decibels
- Persistence of otitis media with effusion for longer than 3 months
- Proven persistent hearing loss, detected on 2 occasions separated by 3 months or more (results of formal testing should be included in the referral letter)
- Suspected language or developmental delay
- Signs or symptoms that may make diagnosis difficult, or are a cause for concern

Reference

www.mapofmedicine.com

## Sore throat and tonsillitis

Referral to Secondary Care Services

The following referral criteria are for patients with recurrent sore throat due to tonsillitis:

When in doubt as to whether tonsillectomy would be beneficial, a six month period of watchful waiting is recommended prior to consideration of tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of an operation.

The PCT will only agree to fund elective surgery for recurring sore throat when:

- Sore throats are due to acute tonsillitis. This should be assessed by evidence of a history of pyrexia, tender anterior cervical lymph nodes and/or tonsillar exudates

AND

- Episodes of sore throat are disabling and result in prevention of normal functioning (for example time off work or school) resulting in a significantly diminished quality of life

AND

- 7 or more clinically significant sore throats in the preceding year
  OR
- 5 or more such episodes in each of the preceding 2 years
  OR
- 3 or more such episodes in each of the preceding three years

Attention should be taken of whether frequency is increasing or decreasing.

Other indications for tonsillectomy may include:

Marked tonsillar asymmetry, which there is clinical suspicion of sinister pathology

- Obstructive sleep apnoea
- Halitosis thought to be caused by the tonsils but ONLY where there is clear evidence of tonsillar debris

GP referral letter should contain:

- A clear indication if the referral is for surgery
- Info re: referral due to recurrent documented acute tonsillitis not recurrent sore throat
- any known factors affecting the patients fitness for day surgery

Source

Yorkshire and the Humber SHA clinical threshold 2011, adapted via local consensus for use in North Yorkshire

**Fertility**

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## Assisted Conception Treatment (Updated March 2011)

This includes all assisted conception treatments commissioned from a specialist tertiary centre, i.e. In Vitro Fertilisation (IVF), Intra Cytoplasmic Sperm Injection (ICSI), Intra Uterine Insemination (IUI), Egg Donation (ED), Donor Sperm Insemination (DSI) and IVF component of surrogacy.

With effect from 1 November 2010, and for the financial year 2011/12, the PCT will **not routinely commission** assisted conception services. Consideration of exceptional circumstances will be via the PCT's Individual Funding Request Panel

Patients may still have clinical investigations up to the point of referral to a Reproductive Medicine Unit.

## Reversal of Sterilisation (male and female)

The PCT will not commission male or female reversal of sterilisation.

The PCT expects that the majority of treatments will be under local anaesthetic, and will be performed in primary care clinics, Marie Stopes or, in CHARD locality, at the vasectomy clinic, Harrogate District Foundation Trust.

## Vasectomy

The PCT does not routinely commission vasectomy under a general anaesthetic. Referrals to secondary care (other than the Harrogate vasectomy service) will need prior authorisation by the PCT's Individual Funding Request Panel

**General Surgery**

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## Anal Fissure

Referral to Secondary Care Services

- Anal fissures that are multiple, off the midline, large, or irregular (atypical fissures) should be referred, as these may be the manifestation of underlying disease (e.g. Crohn's disease, ulcerative colitis, anal herpes, syphilis, Chlamydia, gonorrhoea, AIDS, tuberculosis, or neoplasm).
- Chronic fissures that have not healed after 8 weeks of treatment with topical GTN or Diltiazem 2% ointment
- Suspicion of underlying cancer. For detailed advice on cancer referral see NICE Clinical Guideline 27 www.nice.org.uk/nicemedia/pdf/Referraladvice.pdf

Reference

Clinical Knowledge Summary: Anal Fissure
cks.nhs.uk/anal_fissure

## Anal Skin Tags

Will not be routinely commissioned.

Where exceptional clinical indications exist (e.g. intractable pruritus ani), then referral to the PCT Individual Funding Request Panel is advised.

This does not restrict referral to secondary care for a surgical opinion where there is diagnostic uncertainty.

## Bariatric Surgery

Bariatric surgery will be commissioned on a prior approval basis via the PCT Individual Funding Request Panel.

Referral to Secondary Care Services

NB: NHS North Yorkshire and York do not routinely commission body contouring surgery following substantial weight loss, and that this can only be considered in cases of exceptional clinical need.

Bariatric surgery will be commissioned on a prior approval basis via the PCT Individual Funding Request Panel. For criteria for determining exceptional cases see PCT Individual Funding Request Panel Referral Information

Currently, the North Yorkshire and York PCT will consider funding for surgery for patients with:

- BMI of 50 or over
- BMI of 45-50 with co-morbidities such as diabetes, ischaemic heart disease, sleep apnoea, hypertension and musculoskeletal problems.

Each case is considered on the basis of whether conservative treatment options have been exhausted and whether there has been adequate input earlier in the pathway of psychology, dietetic and specialist nurse interventions.

Because we will prioritise the above patients, consideration will be given to the funding of surgery for patients with a BMI of 40-45 only in very exceptional circumstances.

Revisional/re-do surgery

Revisional/re-do surgery will not be routinely commissioned unless there is deemed to be a clinical 'urgent' reason ie causing significant pain/discomfort and/or the patient is unable to tolerate solid foods. Patients must be advised this is part of the informed consent process. The need for revisional/re-do surgery will be determined by the specialist surgical services MDT.

Non designated providers or private funding

Specialist post operative and locality MDT weight management support will not be routinely funded for patients who have chosen to receive their bariatric surgery from a provider who is not a designated Y & H provider of morbid obesity surgical services or where surgery has been privately funded.

## **Cholecystectomy**

Elective referral threshold into secondary care

1. Symptomatic gallstones
2. Dilated common bile duct on ultrasound
3. Asymptomatic gallstones with abnormal liver function test results
4. Asymptomatic gall bladder polyp(s) reported on ultrasound
5. Symptomatic gall bladder 'sludge' reported on ultrasound.

The GP referral letter should as a minimum contain:

- a clear indication of the grounds for referral against the threshold criteria
- any relevant medical history and current medication
- any known factors affecting the patients fitness for day surgery
- A recent ultrasound report conducted prior to referral
- A recent liver function test report conducted within 1 month at point of referral.

Surgical threshold for elective Cholecystectomy

1. Symptomatic gallstones
2. Gall bladder polyps larger than 8mm or growing rapidly
3. Common bile duct stones.
4. Acute pancreatitis

Source

Yorkshire and the Humber SHA clinical threshold 2011

**Haemorrhoids**

Referral to secondary care should only be made if there are any of the following circumstances:

- First or second degree haemorrhoids that have failed to respond to conservative management
- First or second degree haemorrhoids with severe symptoms
- Third or fourth Degree haemorrhoids
- Symptoms suggestive of systemic disease, e.g. Inflammatory bowel disease

Reference

www.mapofmedicine.com

**Hernia repair**

Elective referral threshold into secondary care:

1. Ventral Hernia

a. Para-umbilical & Epigastric

- Symptomatic - Patient complaining of pain and / or atrophic skin changes – refer to secondary care.
- Asymptomatic – reassure and watchful wait, counsel patient on lifestyle changes weight reduction / smoking cessation.

b. Incisional Hernia

- Symptomatic – refer to secondary care
- Asymptomatic but increasing in size – refer to secondary care
- Asymptomatic – watchful wait

2. Groin Hernia

a. Female groin hernia – refer to secondary care

b. Male femoral hernia – refer to secondary care

c. Inguinal hernia (male)

- Visible hernia on clinical examination (asymmetry on visual clinical examination whilst patient standing / coughing) and symptomatic (pain, nuisance, affecting activities of daily living or work) - refer to secondary care
- Visible hernia on clinical examination but no symptoms - Refer to secondary care if patient opts for repair or watchful wait if patient does not want surgical intervention. If patient opts for surgery, the GP will need to ensure the patient is fully aware of the risk/benefit of undertaking surgery for an asymptomatic hernia, which may in itself result in chronic groin pain or numbness.
- Large inguinal / inguinal scrotal – refer for opinion even if asymptomatic.
- No hernia seen on clinical examination but other symptoms (pain) – consider referral to physiotherapy and treatment with anti-inflammatories - if symptoms persist refer to secondary care. Ultrasound scanning is not an appropriate investigation to detect or exclude the possibility of a clinically significant hernia.

Source

Yorkshire and the Humber SHA clinical threshold 2011

**Varicose Veins**

Referral to Secondary Care Services

Patients with bleeding or objective evidence of skin changes occurring as a result of venous hypertension (e.g. eczema, Lipodermosclerosis, ulceration, or severe or recurrent bleeding) should continue to be referred to vascular surgery for an opinion.

Surgery for patients whose varicose veins are complicated by recurrent phlebitis, pain or discomfort is no longer routinely commissioned. Exceptional cases can be referred to the PCT Individual Funding Request Panel for prior approval.

Reference

Gpnotebook:
www.gpnotebook.co.uk/simplepage.cfm?ID=1886060567&linkID=35080&cook=yes

Local North Yorkshire consensus

**MUSCULOSKELETAL SERVICES**

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## Foot Problems (Adult)

### Hallux Valgus (Bunion)

Referral to Secondary Care Services

Refer to orthopaedic or podiatric surgery for consultation if:

- Self care advice and analgesia have been tried and symptoms are not improving
- Person suffers with pain this must be the primary indication for surgery
- Recurrent infection
- Recurrent ulcers
- Difficulty in obtaining suitable shoes

NB: All patients to be referred to local podiatry services prior to referral to secondary care.

**Reference**

Clinical Knowledge Summaries: bunions

http://www.cks.nhs.uk/bunions

## Foot Problems (Paediatric)

### Curly Toes

Referral to Secondary Care Services

- If the deformity is severe, as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe.
- When there is significant history of pain

NB: All patients to be referred to local podiatry services prior to referral to secondary care.

Reference

GP training
http://www.gp-training.net/protocol/paediatrics/orthopaedic_problems.htm#Curly

Patient plus
http://www.patient.co.uk/showdoc/40024675/#ref7

### Metatarsus Varus (Metatarsus Adductus)

Referral to Secondary Care Services

- If after the child reaches the age of 5 years the intoeing is still evident then surgical intervention may be necessary

NB: All patients to be referred to local podiatry services prior to referral to secondary care.

**Osteoarthritis of the hip and knee**

Patients; may be referred for surgical opinion if they meet the following criteria:

**Hip**

- Patient is experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living - washing, dressing, lifestyle and sleep.

*AND*

- Is troubled by clinically significant functional limitation resulting in diminished quality of life.

*AND*

- The patient is fit for surgery with a BMI ≤35. Patients with a BMI >35 should be advised and given appropriate support to address lifestyle factors that would improve their fitness for surgery

*AND*

- A simple x-ray to confirm diagnosis has been carried out within the past 6 months.

*AND*

- The GP referral letter needs to contains evidence that:
    - the recommended hierarchy of management has been followed (or reasons why a treatment is not appropriate): non-pharmacological treatments first, then drugs, and then if necessary, surgery;
    - a confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery;
    - patients fitness for surgery has been properly assessed and this is evidenced; Oxford hip pain scoring has taken place and the score is recorded

**Knee**

- Patient is experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living - washing, dressing, lifestyle and sleep.

*AND*

- Is troubled by clinically significant functional limitation resulting in diminished quality of life.

*AND*

- The patient is fit for surgery with a BMI ≤35. Patients with a BMI >35 should be advised and given appropriate support to address lifestyle factors that would improve their fitness for surgery

*AND*

- A simple x-ray to confirm diagnosis has been carried out within the past 6 months.

*AND*

- The GP referral letter contains evidence that:
    - the recommended hierarchy of management has been followed (or reasons why a treatment is not appropriate): non-pharmacological treatments first, then drugs, and then if necessary, surgery;
    - a confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery;
    - patients fitness for surgery has been properly assessed and this is evidenced; Oxford knee pain scoring has taken place and the score is recorded
    -

Source

Yorkshire and the Humber SHA clinical threshold 2011, adapted via local consensus for use in North Yorkshire

## UPPER LIMB

### Carpal Tunnel Syndrome

Referral to Secondary Care Services

Referral to secondary care should only be made if there are any of the following circumstances (tick those that apply):

- Symptoms persist after 6 months despite conservative measures (splinting, steroid injection / NSAID)
- Evidence of Neurological deficit, i.e. – sensory blunting or weakness of thenar abduction

Reference

www.mapofmedicine.com

For routine carpal decompression surgery, patients should be referred to one of the community GPwSI performing carpal tunnel decompression, where these are available, or to Clifton Park Treatment Centre. If this is not appropriate, traditional referral to Secondary Care Services should be made.

## Referral For Nerve Conduction Studies

Evidence has shown that where the clinical presentation is strongly suggestive of Carpal Tunnel Syndrome, neurophysiology confirmation is not beneficial. Therefore the PCT will only commission nerve conduction studies where there is diagnostic uncertainty of Carpal Tunnel Syndrome.

References


Bady, B. and Vial, C. (1996) Critical study of electrophysiologic techniques for exploration of carpal tunnel syndrome Neurophysiol Clin. 1996;26(4):183-201. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=8975109&query_hl=27&itool=pubmed_DocSum

Carter, T, Jordan, R and Cummins, C (2000) Electrodiagnostic techniques in the pre-surgical assessment of patients with carpal tunnel syndrome. West Midlands Development and Evaluation Service Report. http://rep.bham.ac.uk/pdfs/2000/electrodiag.pdf

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Jarvik, Jeffrey G.; Yuen, Eric and Kliet, Michael (2004) Diagnosis of carpal tunnel syndrome: electrodiagnostic and MR imaging evaluation. Neuroimaging Clin N Am. 2004 Feb;14(1):93-102, viii. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15177259&query_hl=27&itool=pubmed_DocSum

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Diagnosing carpal tunnel syndrome--clinical criteria and ancillary tests. Nat Clin Pract Neurol. 2006 Jul;2(7):366-74.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16932587&query_hl=27&itool=pubmed_DocSum

www.gp-training.net - on right hand side 'Doctors' click 'protocols' then 'orthopaedics' then 'orthopaedic referral guidelines'

NHS Scotland National Patient Pathways 2005: Orthopaedics; Hand conditions.
http://www.pathways.scot.nhs.uk/Orthopaedics/Orthopaedics hand 23Sep05.htm

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

## Dupuytrens Disease

Referral to Secondary Care Services

Referral to secondary care should only be made if there are any of the following circumstances (tick those that apply):

- Contracture has developed
- Early onset diathesis is suspected
- Tender palm pits or Garrods pads
- 30 degree extension deficit at metacarpophalangeal (MCP) Joints

Reference

www.mapofmedicine.com

## Ganglion

Referral to Secondary Care Services

The PCT does not routinely commission surgical removal of ganglion. If a patient's condition is felt to be exceptional, referral should be made to the PCT's Individual Funding Request Panel.

Referral for soft tissue ultrasound can be made, where there is diagnostic uncertainty. Where access to soft tissue ultrasound is not available, referral for a surgical opinion can be made to provide diagnostic support. However in these situations, where a diagnosis of a ganglion is confirmed clinically, excision will not be commissioned unless deemed an exceptional circumstance by the Individual Funding Request Panel.

NB: Few indications for surgery: Scar is often symptomatic. Up to 30% of ganglia recur. High dissatisfaction rate.

References

www.gp-training.net - on right hand side 'Doctors' click 'protocols' then 'orthopaedics' then 'orthopaedic referral guidelines'

NHS Scotland National Patient Pathways 2005: Orthopaedics; Hand conditions. http://www.pathways.scot.nhs.uk/Orthopaedics/Orthopaedics hand 23Sep05.htm

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

## Trigger Finger

Referral to Secondary Care Services

Referral to secondary care should only be made if there are any of the following circumstances (tick those that apply):

- Symptoms have not resolved or recur after 2-3 cortico-steroid injections
- Co-existing inflammatory or degenerative disorders of the hand
- Co-existing nerve entrapment syndromes or Dupuytrens disease
- Chronic or worsening symptoms
- Intermittent locking

Reference

www.mapofmedicine.com

## Spinal Pain

Lumbar Spine X-ray

Plain lumbar spine X-rays are appropriate to exclude either traumatic or osteoporotic fracture, but they are clinically ineffective as a routine investigation for acute or chronic non-specific low back pain, when X-rays are associated with an inappropriate exposure to radiation.

The PCT will only commission lumbar spine X-rays for other indications (eg low back pain) where requests from GPs have been discussed with and agreed by a Consultant Radiologist prior to referral**.**

## Epidural / Facet Joint Injections – Acute spinal pain

At the discretion of the MSK, CATS or Acute Physiotherapy Back Pain services, one spinal injection including either a transforaminal epidural or nerve root injection will be commissioned for acute or acute on chronic spinal pain of up to twelve weeks duration, as part of the physical management plan. This will be with the intention of facilitating management within the MSK, CATS or Acute Physiotherapy Back Pain service. There is poor evidence for the long-term effectiveness of epidural injections, and the PCT does not routinely commission serial epidural injections for pain management.

Facet joint injections will not be commissioned for acute or acute on chronic spinal due to poor evidence base.

See Spinal Pain Decision Tree (Appendix 1)

**Epidural / Facet Joint Injections / Rhizolysis – Chronic spinal pain**

The evidence base for epidural and facet joint injections for chronic spinal pain is poor.

As from 1 November 2009, the PCT no longer routinely commissions facet joint, epidural injections or rhizolysis for chronic spinal pain of more than 12 weeks' duration without prior approval.

We will continue to fund these treatments in exceptional circumstances.

The PCT will consider exceptionality on the basis of:

- Conservative management by MSK, CATS or Acute Physiotherapy Back Pain service has not been effective as evidenced through a formal Physiotherapy report

AND

- Exceptional response to treatment (eg achieving a more than 12 month benefit from a spinal injection)

OR

- Significant co-morbidities (eg infirmity or illness that make a patient unsuitable for other treatments that we commission in preference to spinal injections)

OR

- Aetiology of pain (eg patients with cancer-related pain)

**Spinal Surgery**

In the absence of red flag symptoms, patients should be referred for a surgical opinion only after conservative measures have been exhausted following assessment and management by the MSK, CATS or Acute Physiotherapy Back Pain service.

Referral should be in accordance with Yorkshire and the Humber Specialist Commissioning Group referral guidelines (Appendix 2).

Source

Yorkshire and the Humber Specialist Commissioning Group

## Facet Joint Injections for Diagnostic Purposes

For patients with complex multi-level disease requiring assessment for surgical intervention (specialist MSK service; orthopaedic or neurosurgical services) the PCT will commission a maximum of two facet joint injections for diagnostic purposes to help define surgical management. These should be performed no more than six weeks apart.

## Spinal Fusion

Consider referral for an opinion on spinal fusion for people who:

- have completed an optimal package of care, including a combined physical and psychological treatment programme

and

- still have severe non-specific low back pain for which they would consider surgery.

Patients with psychological distress should be offered appropriate treatment for the psychological impact of their illness, prior to referral for an opinion on spinal fusion.

Referral to a specialist spinal surgical service for consideration of spinal fusion should be following a multi-disciplinary MSK / orthopaedic assessment.

## Summary of Commissioning Position re: Epidural/Facet Joint/Transforaminal Injections for Spinal Pain

See Spinal Pain Decision Tree (Appendix 1)

References

Back Pain Europe: see European Back Pain Guidelines

Bandolier
http://www.jr2.ox.ac.uk/bandolier/booth/painpag/wisdom/C13.html#RTFToC41

Benzon, H.T. (1986). Epidural steroid injections for low back pain and lumbosacral radiculopathy. Pain , 24 , 277-295

Chou et al (2007) Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society, Annals of Internal Medicine, 2 October 2007, Volume 147 Issue 7 Pages 478-491
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Clinical Evidence
www.clinicalevidence.com/ceweb/conditions/msd/1116/1116.jsp
www.clinicalevidence.com/ceweb/conditions/msd/1102/1102.jsp

European Pain Guidelines 2004 (Acute non-specific low back pain guideline and Chronic non-specific low back pain guideline)
www.backpaineurope.org

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www.nice.org.uk/nicemedia/pdf/CG88NICEGuideline.pdf
Quick reference guide:
www.nice.org.uk/nicemedia/pdf/CG88QuickRefGuide.pdf

NICE Referral Advice. A guide to appropriate referral from general to specialist services. NICE, December 2001).
www.nice.org.uk/nicemedia/pdf/Referraladvice.pdf

Price C, Arden N, Coglan L, Rogers P. Cost-effectiveness and safety of epidural steroids in the management of sciatica. Health Technology Assessment Vol.9: No.33, 2005:88.

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www.prodigy.nhs.uk/back_pain_lower

Royal College of Radiologists Referral Guidelines for the Lumbar Spine 1998

Rozenberg S, Dubourg G, Khalifa P, Paolozzi L, Maheu E, Ravaud P. Efficacy of epidural steroids in low back pain and sciatica: a critical appraisal by a French Task

Force of randomized trials. Revue Du Rhumatisme. English edition. 1999;66(2):79-85.

Van denBosch MAAJ et al, Evidence against the use of lumbar spine radiography for low back pain, Clinical Radiology, 2004; 59: 69-76

Watts, R.W. and Silagy, C.A. (1995). A meta-analysis on the efficacy of epidural corticosteroids in the treatment of sciatica. Anaesthesia and Intensive Care , 23 , 564-569

## OPHTHALMOLOGY

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### Benign Lid Lesions

Cyst of Moll

Surgery for cyst of moll will not be routinely commissioned. Referral to Ophthalmology may be made where there is diagnostic uncertainty.

Cyst of Zeis

Surgery for cyst of zeis is not routinely commissioned. Referral to Ophthalmology may be made where there is diagnostic uncertainty.

Eyelid Papillomas and Skin Tags

Surgery for eyelid papillomas and skin tags will not be routinely commissioned. Referral to Ophthalmology may be made where there is diagnostic uncertainty.

Pingueculum

Surgery for pingueculum will not be routinely commissioned. Referral to Ophthalmology may be made where there is diagnostic uncertainty.

### Blepharitis

Referral to Secondary Care Services

- Admit urgently if orbital cellulitis is suspected (person is systemically unwell, tender sinuses, restriction of eye movements).
- Refer in the following instances:

- To exclude malignancy if there is:
  - Persistent localized disease or resistance to treatment
  - Marked eyelid asymmetry
- If there is evidence of corneal disease
- If vision deteriorates
- If there is moderate or severe pain
- If the diagnosis is uncertain
- Associated disease, for example Sjögren's syndrome or eyelid deformities, requires specialist management.

References

CKS (Prodigy guidance): Blepharitis
http://www.cks.library.nhs.uk/blepharitis/in_depth/management_issues

Quick reference guides:

Blepharitis: non infected
http://www.cks.library.nhs.uk/qrg/blepharitis_non_infected.pdf

Blepharitis: infected
http://www.cks.library.nhs.uk/qrg/blepharitis_infected.pdf

## Cataract

Adults

The PCT will only agree to fund elective surgery for cataract extractions when:

1. Patients have sufficient cataract

   - Objective loss of visual performance which may be acuity, reading speed or accuracy and / or contrast sensitivity;
   - Subjective loss of visual performance, where the patient experiences dim vision, glare, difficulty in reading or accomplishing everyday tasks, or in recognising faces or viewing the television;
   - Increased anisometropia causing asthenopic symptoms;
   - Rapid decrease in visual acuity.

2. Patient's lifestyle and/or quality of life is significantly affected.

   - See lifestyle questions on Cataract Scoring Tool (Appendix 3) – with threshold score of 7 for referral.
   - Could be exacerbated by immobility, deafness, living alone or the need to care for a dependant. A further consideration will be whether the patient is monocular.

3. Risks/ benefits of surgery are discussed and patient indicates willingness to have surgery

- Optometrists to provide generic literature to inform the patient regarding the risks and benefits of surgery.
- Optometrists to ensure patients are happy to be referred for surgery before referral is made.

4. Patients who do not meet all the criteria but in clinical opinion might significantly benefit from surgery (eg patients with significant co-morbidity who may benefit from cataract extraction)

Decisions by optometrists on behalf of patients should be communicated to the GP

Referral to Secondary Care Services

Simple cataracts (ie prime [sole] pathology)

All referrals by Optometrists should be made via the Choice Office following assessment and completion of the Cataract Scoring Tool (see Direct Cataract Referral Form, Appendix 3). The threshold for referral is a score of 7 and above.

The referral form should be forwarded to:

- NHS North Yorkshire and York, Choice Office, The Hamlet, Hornbeam Park, Harrogate, HG2 8RE.

The Choice Office will ensure the referral meets the threshold and will forward the referral to secondary care within 24 hours. This process will ensure consistency of referrals, enable clinical audit and ensure that, in line with the choice agenda, a choice of secondary provider will be offered to the patient.

Patients who do not meet the threshold should be referred to the PCT's Individual Funding Request (IFR) panel for consideration of exceptional circumstances.

Complex Cataracts (ie Significant Co-Morbidities)

Where the referral threshold is met, referral should be made by the Optometrist directly to secondary care via Choose and Book, or via the patient's GP.

Where the referral threshold is not met, referral may be made by the patient's GP to secondary care. Patients seen by Optometrists should be referred to the GP with a recommendation to refer to secondary care.

Second Eye Surgery

Second eye surgery will be decided in the ophthalmology clinic either at the first appointment (the patient will then be booked for sequenced surgery) or at follow up after first eye surgery. Medical indications for second eye surgery (eg glaucoma, diabetes, anisometropia) should be recorded in the patient letter in case evidence is required for validation purposes. In other cases second eye surgery will be allowed if the patient is symptomatic and there is visually significant cataract.

## Meibomian Cyst / Chalazion

Referral to Secondary Care Services

Referral of patients with meibomian cysts or chalazia which are symptomatic (eg, infection resistant to treatment, astigmatism, rosacea or sebaceous dysfunction), or which have not resolved spontaneously within two years, may be made to the PCT's Individual Funding Request panel.

References

Emedicine
http://www.emedicine.com/oph/topic243.htm

GP notebook
http://www.gpnotebook.co.uk/simplepage.cfm?ID=-234487777

## Oculoplastic Eye Problems (Watery Eyes, Ptosis, Ectropion And Entropion)

Surgery for watery eyes is not routinely commissioned.

## Eyelid Ptosis (Droopy Eye) and Dermatochalasis (Droopy Upper Eyelid Skin)

Surgery for eyelid ptosis or dermatochalasis, where the symptoms are purely cosmetic, will not be commissioned.

Patients with objective demonstration of visual field restriction within 20 degrees of fixation on visual field testing, as measured by an optometrist, may be referred to the PCT's Individual Funding Request Panel.

Referral to secondary care

Referral may be made directly to secondary care where a diagnostic ophthalmology opinion is required (eg to exclude underlying causes such as thyroid-related orbitiopathy, orbital tumours, iatrogenic Horners syndrome, basal cell carcinoma and myasthenia gravis).

## Eyelid Ectropion

Referral to Secondary Care

Surgery for eyelid ectropion is not routinely commissioned. Referral to the PCT's Individual Finding Request panel may be made where patients are experiencing recurrent infection or inflammation.

## Eyelid Entropion

Referral to Secondary Care

Referral should be made to secondary care when the condition is symptomatic and risks causing trauma to the cornea. While awaiting an operation a lubricating eye ointment may be prescribed to help protect the cornea.

References

Royal College of Ophthalmologists Guidelines which are available at www.microphth.com/focus1/Management%20of%20Epiphora.htm

Interventional Procedure Guidance Number 113 (2005) re Endoscopic Dacryocystorhinostomy available at: www.nice.org.uk

Information for patients on the conditions described here is available at www.patient.co.uk/showdoc/40024627 and www.nice.org.uk

Boboridis Kostas G, Bunce Catey (2002) Interventions for involutional lower lid entropion: A Systematic Review. Cochrane accessed via http://www.library.nhs.uk/EYES/ViewResource.aspx?resID=237571&tabID=289

**PLASTICS/COSMETIC SURGERY**
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## Plastics/Cosmetic Surgery

North Yorkshire and York PCT has a responsibility to commission the services necessary to meet the health needs of the whole PCT population within the resources available. Given the huge demands on these resources, difficult decisions regarding prioritisation of funding have had to be made.

When commissioning plastic surgery the PCT has to ensure that there is appropriate access to services for patients who are undergoing treatment for:

- Trauma and surgery; acute repair and acute reconstruction
- Cancer surgery and reconstruction
- Burns; acute care and reconstruction

The PCT will routinely commission plastic surgery in these circumstances and patients may be referred directly to secondary care.

Cosmetic surgical procedures for the correction of changes associated with age, pregnancy, weight or because of unhappiness with body image are of low priority. These will not be routinely commissioned from or performed by secondary/tertiary services in Plastic Surgery, Dermatology, General Surgery, Ophthalmology, or any other specialty, or from primary care based Minor Surgery Services, unless exceptional clinical need can be demonstrated and prior approval given by the PCT's Individual Funding Request Panel

A patient may be considered to be exceptional to the general policy if both the following apply:

- He/she is different to the general population of patients who would normally be refused the healthcare intervention, and
- There are good grounds to believe that the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

Only evidence of clinical need will be considered. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood will not be considered.

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## Circumcision

Referral to Secondary Care Services

No religious circumcisions will be commissioned

Children

See *Foreskin Problems in Children* (below)

Adults

This procedure is not commissioned unless there is evidence of any of the following clinical indications (these criteria are based on North Yorkshire consensus):

Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin).

- Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin).
- Balanoposthis (recurrent bacterial infection of the prepuce).
- Pain on intercourse

Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty.

## Foreskin Problems in Children

No religious circumcisions will be commissioned

Referral to Secondary Care Services

Indications for referral:

- Distal scarring of the preputial orifice. A short course of topical corticosteroids might help with mild scarring.
- BXO
- Painful erections secondary to a tight foreskin

- Recurrent bouts of infection (balanitis/balanoposthitis)
- Recurrent urinary tract infections with a phimotic foreskin.

References

British Association of Paediatric Surgeons (BAPS) (2001) Religious Circumcision of Male Children Standards of Care. www.baps.org.uk/documents/RELCIRC.htm

British Medical Association (BMA) (2003) The Law and Ethics of Male Circumcision – Guidance for Doctors. www.bma.org.uk/ap.nsf/Content/malecircumcision2003

Huntley JS, Bourne MC, Munro FD, Wilson-Storey D (2003) Troubles with the Foreskin: One Hundred Consecutive Referrals to Paediatric Surgeons. J R Soc Medicine, 96, 449 – 451

McGregor TB, Pike JG, Leonard MP (2007) Pathologic and Physiologic Phimosis: Approach to the Phimotic Foreskin. Can. Fam. Physician, 53:445 – 448.

Royal College of Surgeons of England (2002) Male Circumcision: Guidance for Healthcare Practitioners. www.rcseng.ac.uk

Yardley IE, Cosgrove C, Lambert AW (2007) Paediatric Preputial Pathology: Are We Circumcising Enough? Ann R Coll Surg Engl 89, 62-65.

## Dilatation And Curettage (D&C)

The evidence base for D&C is poor. As from 1 November 2009, all requests for D&C must be made via the PCT Individual Funding Request Panel.

## Menorrhagia

Referral to Secondary Care Services

Hysterectomy for heavy menstrual bleeding will only be commissioned when any clinically appropriate conservative treatment has failed or is contra-indicated. For the avoidance of doubt this means that ‘patient choice’ to opt for Hysterectomy without any form of prior conservative treatment is not routinely commissioned.

Treatments/investigations to be undertaken in primary care: Haemoglobin  Value and Pelvic Ultrasound .

Evidence is required that conservative management has been undertaken in Primary Care including:

First line treatment:

- Levonorgestrel-releasing intrauterine system (LNG-IUS

Second line treatment:

- Tranexemic acid

- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Combined oral contraceptives

Third line treatment:
- Oral progestogen (norethisterone)
- Injected progestogen

Reference

www.mapofmedicine.com

National Institute for Health and Clinical Excellence Guideline Clinical 44: Heavy menstrual bleeding (2007)

## Urinary Incontinence (female)

Local pathways for the management of urinary incontinence should be followed where applicable. Where local pathways do not yet exist to enable services to be provided in primary care, traditional referral to Secondary Care Services should continue.

Referral to Secondary Care Services

All female patients experiencing bladder and bowel symptoms should be referred in the first instance for a continence assessment by Continence Advisory Team or, if housebound, District Nurse.

Surgery for Female Urinary Incontinence

Prior to referral

1. Routine secondary care referrals should be made only after patients have undergone a full Continence Assessment and appropriate management advice within primary care following referral to Continence Advisory Team (or District Nurse) The following assessment to been undertaken in primary care prior to referral:
    - UTI excluded or treated
    - Initial assessment and categorisation of incontinence
    - Voiding dysfunction excluded (refer to secondary care if this is confirmed/suspected)

In addition patients should have been given advice on:

- Advice on weight loss if BMI over 30
- Advice on fluid intake including effect of caffeine/alcohol

2. First-line conservative management has been undertaken in primary care as follows:
    - A trial of supervised pelvic floor muscle training for at least 3 months (stress/mixed incontinence)

    AND/OR
    - Bladder retraining lasting for a minimum of 6 weeks +/- antimuscarinic (urge/mixed incontinence)

    In addition, if appropriate: topical vaginal oestrogens in
    - post-menopausal women with urogenital atrophy

<u>Reference</u>

www.mapofmedicine.com

National Institute for Health and Clinical Excellence Guideline Clinical 40: Urinary incontinence (women) (2006

**DENTAL**

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## Apical Surgery

Primary Care Dental Practitioners

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

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

Referral to Secondary Care Services

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

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

Referral in other cases is appropriate only where the patient has significant medical co-morbidities or risk factors that would pose a clinical risk if surgery were to be conducted in primary care.

## Non-third Molar Exodontia

The PCT will not commission in Secondary Care "routine" extractions in healthy patients, anxious patients, or those with a history of difficult extractions. A previous history of a difficult extraction is a less reliable indicator of surgical difficulty than accurate clinical and radiographic examination. Most of these patients will have had a bad experience from poorly managed previous extractions.

Referral to Secondary Care Services

Indications for referral:

- If a surgical approach is obviously necessary (e.g. buried retained roots)
- Associated pathology that needs to be submitted for histological examination (e.g. cysts).
- Extractions from abnormal or diseased bone (e.g. patients who have received therapeutic doses of irradiation to the jaws).
- Surgical complexity such that a general anaesthetic may be indicated.

If there is no surgical indication for general anaesthetic it is more appropriate to manage anxious patients under local anaesthesia as a staged procedure in primary care.

Treatment will not normally be provided under general anaesthesia because of patient choice unless there are clear clinical reasons which are fully compliant with General Dental Council guidance.

It is rare for a patient's medical history to complicate the extraction to such an extent that it needs to take place within the hospital setting. Referral in other cases is appropriate only where the patient has significant medical co-morbidities or risk factors that would pose a clinical risk if surgery were to be conducted in primary care.

## Orthodontic Treatment

Primary Care Dental Practitioners

In primary care, orthodontic treatment provided under the NHS contract will be consistent with the IOTN scale (Index of Orthodontic Treatment Need) at a level of 3 (with an aesthetic component of 6) or above.

Referral to Secondary Care Services

Orthodontic conditions with an IOTN within the grades of 4 or 5 will be commissioned **from acute care providers.**

## Routine Exodontia in Warfarinised Patients

Primary Care Dental Practitioners

There has been recent guidance issued related to the removal of teeth in dental practice for patients who are on warfarin (Appendix 4).

Patients should be managed according to these guidelines and not referred to hospital for “routine” extractions. The guidelines stipulate that extractions can safely be carried out in primary care in the following circumstances:

- Where the INR is less than 4.0.

- If the socket is packed and sutured.

Warfarin should not be stopped but the INR must be checked within 24 hours of the planned extraction (patients can usually co-ordinate this themselves with either their doctor or anti-coagulant clinic).

Referral to Secondary Care Services

Patients should be referred if other coagulopathies co-exist, if there is a need for intravenous antibiotic cover or if the INR is maintained at over 4 (the latter will be recorded in the patient's anticoagulant book).

Extractions should be timed appropriately and ideally should take place at the beginning of the week (such that delayed re-bleeding problems can be managed during the working week) and in the morning (such that immediate re-bleeding problems can be managed during the working day).

Reference

North West Medicines Information Centre (2007):
Surgical management if the primary care dental patient on warfarin
http://www.dundee.ac.uk/tuith/Static/info/warfarin.pdf

**Removal of 3rd molars (wisdom Teeth)**

In the management of wisdom teeth the PCT will commission surgery in line with NICE guidelines hence surgical removal of impacted third molars will only be considered in either of the following cases:

1. There is evidence of pathology such as: unrestorable caries, non-treatable pulpal and / or periapical pathology, cellulitis, abscess and osteomyelitis, internal / external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst / tumour, tooth / teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection.

2. There has been a severe first episode, or second/subsequent episode(s), of pericoronitis.

Referral to Secondary Care Services

Referral in other cases is appropriate only where the patient has significant medical co-morbidities or risk factors that would pose a clinical risk if surgery were to be conducted in primary care. See section below titled "Referral to secondary care for dental surgery where the patient has significant medical co-morbidities or risk factors
Reference

NICE Clinical Guideline 1, May 2000:
http://www.nice.org.uk/page.aspx?o=ta001&c=dental

http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/

SIGN guidance: http://www.sign.ac.uk/guidelines/published/index.html#Dentistry

**Referral to secondary care for dental surgery where the patient has significant medical co-morbidities or risk factors**

The PCT will commission such referrals in any of the following circumstances:

- The patient has a bleeding disorder eg haemophilia or von willebrand
- The patient's recorded INR levels are above 4 and/or unstable
- The patient is severely compromised/breathless/prescribed long-term oxygen due to pre-existing condition such as COPD
- The patient has known cancer and is receiving chemotherapy, has bone metastasis or has an upper aero digestive cancer under treatment
- The patient is diagnosed to have unstable angina
- The patient is taking IV bisphosphonates and requires essential extraction(s) (extractions should be avoided wherever possible)
- The patient has had radical radiotherapy affecting the mandible and/or maxilla

References

British Dental Association Guidance http://www.bda.org

www.bda.org/Images/bisphosphonates_fact_file.pdf

www.rcseng.ac.uk/...

Local Consensus Guidance

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