

Greater Manchester EUR Policy Statement

Title/Topic: Surgical Revision of Scarring

Reference: GM066

Date: June 2015

Last Reviewed: August 2016



VERSION CONTROL

Version	Date	Details	Page number
0.1	02/09/2014	Initial draft	N/A
0.2	25/09/2014 17/09/2014	<p>Amendments made following discussion by the Greater Manchester EUR Steering Group on 17/09/2014:</p> <p>The mandatory criteria under section 4 amended to include a minimum period of time that the scar should have been present of 18 months.</p> <p>The second bullet point under the mandatory criteria was also amended to include the word 'objectively', i.e. 'where the scar is objectively considered.....'</p> <p>Policy approved for consultation by Greater Manchester EUR Steering Group, subject to agreed amendments.</p>	7
0.3	01/10/2014	Branding changed following the creation of the North West CSU on 01/10/2014.	All
0.4	21/11/2014 21/11/2014	<p>Amendments made following discussion of the Consultation feedback by the Greater Manchester EUR Steering Group on 19/11/2014:</p> <p>Mandatory criteria under section 4 amended to only commission for scars that have been present for a minimum of 18 months post injury/surgery, and where the scar is causing a functional problem that is likely to be resolved with surgery.</p> <p>Standard set of information added if clinician applying on grounds of individual clinical exceptional circumstances.</p> <p>Definition re-formatted and an extra paragraph added around non-surgical treatment.</p> <p>Sentence added under section 6 that keloid scars are best managed by non-surgical treatments as they are very likely to recur after surgical revision.</p>	7/8 7/8 7 8
1.0	21/01/2015	Policy approved by GM EUR Steering Group	N/A
1.1	29/06/2015	<p>Variance column removed and funding mechanism column added to table.</p> <p>Format of funding mechanism changed.</p>	3 9
1.2	06/04/2016	<p>List of diagnostic and procedure codes in relation to this policy added as Appendix 2.</p> <p>Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services.</p>	14 N/A

		Wording for date of review amended to read <i>“One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)”</i> on ‘Policy Statement’ and section ‘13. Date of Review’.	4 & 10
2.0	05/08/2016	Evidence reviewed June 2016 - no new studies or reviews were found. GM EUR Steering Group agreed: No changes to policy other than the “Date of Review” on “Policy Statement” and in body of report changed to “Three years from the date of last review unless new evidence warrants earlier review.” Review date added to cover page and ‘Policy Statement’.	4&10 1&4

POLICY STATEMENT

Title/Topic:	Surgical revision of scarring
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Issue Date:	June 2015
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Reviewed:	August 2016
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Commissioning Recommendation:	<p>Scar revision is considered to be mostly cosmetic and is therefore a procedure of low clinical value and not routinely commissioned.</p> <p>Surgical revision of scarring is only commissioned for scars that have been present for a minimum of 18 months post injury/surgery, and where the scar is causing a functional problem that is likely to be resolved with surgery.</p> <p>See Section 4: Criteria for Commissioning</p>
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Date of Review:	Three years from the date of last review unless new evidence warrants earlier review.
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Prepared By:	Greater Manchester Shared Services Effective Use of Resources Policy Team
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Approved By	Date Approved	Funding Mechanism
Greater Manchester Effective Use of Resources Steering Group	19/11/2014	GM EUR Steering Group recommended funding mechanism: Funding will be made available on an individual patient basis. Individual Funding Requests may be made in line with the procedures described in the Greater Manchester EUR Operational Policy.
Greater Manchester Chief Finance Officers / Greater Manchester Heads of Commissioning	May 2015	N/A
Greater Manchester Association Governing Group	02/06/2015	N/A
Bury Clinical Commissioning Group	01/07/2015	Recommended mechanism above
Bolton Clinical Commissioning Group	26/06/2015	Recommended mechanism above
Heywood, Middleton & Rochdale Clinical Commissioning Group	17/07/2015	Recommended mechanism above
Central Manchester Clinical Commissioning Group	30/07/2015	Recommended mechanism above

North Manchester Clinical Commissioning Group	08/07/2015	Recommended mechanism above
Oldham Clinical Commissioning Group	02/06/2015	Recommended mechanism above
Salford Clinical Commissioning Group	02/06/2015	Recommended mechanism above
South Manchester Clinical Commissioning Group	24/06/2015	Recommended mechanism above
Stockport Clinical Commissioning Group	24/06/2015	Recommended mechanism above
Tameside & Glossop Clinical Commissioning Group	22/07/2015	Recommended mechanism above
Trafford Clinical Commissioning Group	21/07/2015	Recommended mechanism above
Wigan Borough Clinical Commissioning Group	30/06/2015	Recommended mechanism above

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Policy Statement

The Greater Manchester Shared Services (GMSS) has developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission surgical revision of scarring in accordance with the criteria outlined in this document.

In creating this policy the GMSS has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

Equality & Equity Statement

The GMSS/CCG has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. The GMSS/CCG is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, the GMSS/CCG will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMSS Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMSS evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis was carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Association Governing Group (AGG) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the Greater Manchester EUR Operational Policy.

1. Introduction

This commissioning policy has been produced in order to provide and ensure equity, consistency and clarity in the commissioning of the surgical revision of scarring services by Clinical Commissioning Groups in Greater Manchester. When this policy is reviewed all available additional data on outcomes will be included in the review and the policy updated accordingly.

Surgical revision of scarring is rarely indicated for clinical reasons unless part of the pathway of care following the initial injury /operation. Most procedures are carried out for aesthetic reasons and are not curative. In the case of Keloid scars these may recur and in some cases be worse than before the

revision. This policy has been developed to target resources to cases where there will be the most benefit.

2. Definition

Every time the skin is cut or damaged through its full thickness it will heal with a scar. Scars which lie in the lines of skin tension tend to heal better than ones that run across them. Surgeons will try and choose a good site and direction, but if the scar is due to an injury, there is no choice. Scar revision will not “cure” scarring; however, a better scar can be achieved.

Time is the best healer as eventually normal scars and hypertrophic scars will mature and become pale.

Non-surgical treatment of scarring involves the use of pressure bandages, silicone sheets and steroid injections.

There is a whole range of scars but at the poor end there is the hypertrophic scar which occurs when the wound heals to become red, raised and itchy for a few months but will then resolve to become flat and pale.

A keloid scar is similar but the scar continues to grow encroaching upon normal tissue and may need specific treatment. In a true keloid scar there is a high likelihood of recurrence and a strictly adhered to post-operative regimen is necessary for the best result.

3. Aims and Objectives

Aim

This policy document aims to specify the conditions under which surgical revision of scarring will be routinely commissioned by Clinical Commissioning Groups in Greater Manchester.

Objectives

- To reduce the variation in access to surgical revision of scarring.
- To ensure that surgical revision of scarring is commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- To reduce unacceptable variation in the commissioning of surgical revision of scarring across Greater Manchester.
- To promote the cost-effective use of healthcare resources.

4. Criteria for Commissioning

Mandatory Criteria

Surgical revision of scarring is only commissioned where the scar is causing a demonstrable functional problem that is likely to be resolved with surgery e.g. difficulty closing their eyes or inability to close the mouth properly when eating, and has been present for a minimum of 18 months post injury/surgery.

Requests made by clinicians will be considered under clinical exceptionality. Where exceptionality is claimed the following standard set of information will need to be provided in addition to the individual clinical exceptional circumstances:

- Date of the original injury
- Exact anatomical location of the scar
- A detailed description of the functional impairment caused to the patient

- A list of all treatments used to minimise the scarring, including:
 - Date each treatment used
 - Details of whether or not there was any improvement
- Expectations of the outcome of the revision (e.g. full restoration of functionality or the degree of improvement expected)
- Non-identifiable photographs, if possible showing the functional issues and preferably medical illustrations if available, will be requested, to support the decision making process, but will not form the sole basis of the decision. It is not mandatory for photographs to be provided by a patient.

Policy Exclusions

Treatment of burn scars and surgical revision of scars post operatively for clinical reasons are not covered by this policy.

Clinicians can submit an Individual Funding Request (IFR) if they feel there is a good case for exceptionality.

Exceptionality means ‘a person to which the general rule is not applicable’. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is:

- Significantly different to the general population of patients with the condition in question.

and as a result of that difference

- They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

5. Description of Epidemiology and Need

Individuals of all ethnic backgrounds can form keloids and hypertrophic scars. Keloids are seen with greater frequency in those ethnic groups with more highly pigmented skin – in these groups it can be as high as 16% of scars, and a familial predisposition is believed to exist. Keloid formation is approximately 15 times greater in the more highly pigmented ethnic groups than white Caucasians.

6. Evidence Summary

Most scarring will improve over time with raised red scars becoming flat and pale. There are a number of non-surgical and surgical interventions for scarring but none are curative and all are aimed at improving the appearance of the scar. Keloid scars are best managed by non-surgical treatments as they are very likely to recur after surgical revision.

Full details of the Evidence Review are contained with Appendix 1

7. Rationale behind the Policy Statement

Scar revision is usually carried out for aesthetic reasons and is therefore considered a procedure of low clinical value. This type of surgery is only commissioned where function, e.g. movement of a joint, is restricted by the scar.

8. Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

9. Mechanism for Funding

Clinical Commissioning Group	Funding Mechanism
Bolton Bury Heywood, Middleton & Rochdale Manchester Central Manchester North Manchester South Oldham Salford Stockport Tameside & Glossop Trafford Wigan	Funding will be made available on an individual patient basis. Individual Funding Requests may be made in line with the procedures described in the Greater Manchester EUR Operational Policy.

10. Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

11. Documents which have informed this Policy

- The British Association of Aesthetic and Plastic Surgeons website: Scars and Keloids information sheet.
- Greater Manchester Effective Use of Resources Operational Policy.

12. Links to other Policies

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

13. Date of Review

Three years from the date of last review unless new evidence warrants earlier review.

14. Glossary

Term	Meaning
Fibrous tissue	Tissue consisting of or containing fibers (threads or filaments from which a tissue is formed).
Hypertrophic	Enlargement or overgrowth of an organ or part of the body due to increased size of the constituent cells.
Keloid	A keloid is the formation of a type of scar which, depending on its maturity, is composed mainly of either type III or type I collagen. It is a result of an

	overgrowth of granulation tissue at the site of a healed skin injury which is then slowly replaced by collagen type 1.
Pressure bandages	A thick pad of gauze or other material placed over a wound and attached firmly so that it will exert pressure.
Scar/Scarring	A mark left on the skin or within body tissue where a wound, burn, or sore has not healed completely and fibrous connective tissue has developed.
Silicone sheets	Silicone scar sheets are a type of treatment used to prevent the formation of new scars and to reduce the appearance of existing scars. The scar sheet is lined on one side with silicone gel.
Steroid injections	Injections that may help relieve pain and inflammation in a specific area of the body.

References

1. Scars and Keloids information sheet, The British Association of Aesthetic and Plastic Surgeons: http://baaps.org.uk/docs/procedures/Scars_and_Keloids.pdf [accessed 31/08/2014]

Appendix 1 – Evidence Review

Title/Topic: Scar Revision Surgery
Ref: GM066

Search Strategy

Database	Result
NICE	Nil found
NHS Evidence and NICE CKS	Cochrane review (see below)
SIGN	Nil found
Cochrane	2 reviews in development
York	Nil found – Cochrane reviews referenced
BMJ Clinical Evidence	<ul style="list-style-type: none"> • Treatment of Keloids and Hypertrophic Scars A Meta-analysis and Review of the Literature Douglas Leventhal, MD; Maxwell Furr, BS; David Reiter, MD, DMD <i>Arch Facial Plast Surg.</i> 2006;8(6):362-368. • Management of Keloids and Hypertrophic Scars GREGORY JUCKETT, MD, MPH, and HOLLY HARTMAN-ADAMS, MD, West Virginia University, Morgantown, West Virginia <i>Am Fam Physician.</i> 2009 Aug 1;80(3):253-260.
BMJ Best Practice	Nil found
General Search (Google)	Provider websites
Medline / Open Athens	Not done
Other	Royal College websites searched: <ul style="list-style-type: none"> • The British Association of Aesthetic and Plastic Surgeons website: Scars and Keloids information sheet

Summary of the evidence

Most scarring will improve over time with raised red scars becoming flat and pale. There are a number of non-surgical and surgical interventions for scarring but none are curative and all are aimed at improving the appearance of the scar.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series

Level 5	Expert opinion
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1. LEVEL 5: EXPERT OPINION

The British Association of Aesthetic and Plastic Surgeons website: Scars and Keloids information sheet

The treatment of active scars

Time is the best healer as eventually normal scars and hypertrophic scars will mature and become pale. We tend however, to try and treat the severer hypertrophic scars and keloids.

We use:

- **Pressure** which can be from a bandage or a pressure garment which would be made of some sort of stretchy material such as Lycra or Tubigrip. This pressure should be applied day and night for many months or even years.
- **The application of silicone.** Usually in sheet form directly to the wound is thought by many to speed up maturation of the scar.
- **Steroids.** The simplest is the application of a steroid containing tape (Haelan tape) which is worn day and night for extended periods. Strong steroids such as Triamcinalone can be injected into the scar itself. It is usually given

Scar revisions

These are usually done under local anaesthesia when it is felt that a scar can be improved because of particular circumstances or complications of healing in the first instance, or because the procedure is likely to be carried out in a better manner. The old scar is removed by one of several plastic surgery techniques and is repaired. Post-operative pain is usually minimal. Sutures are usually removed in 4 to 6 days from the face and 7 to 10 days from other parts of the body. However, dissolving sutures are frequently used on the trunk and limbs to avoid stitch marks. Stitch marks are much less likely to appear on the face as the stitches are removed early. All new scars will initially be red. Fading occurs within 6 to 24 months depending on the scar's location and the patient's skin type.

Additional procedures

A Z-plasty is used to reduce the tightness or contracture of the scar making it more comfortable and less conspicuous. It may also be used to change the position of a scar and by reducing tightness improve healing. A Z-plasty is performed by raising two adjacent skin flaps and transposing the flaps (putting each flap where the other one was). Dermabrasion and laser surgery can also be used to blur the edges of the scar and minimise surface irregularities.

2. LEVEL 1: SYSTEMATIC REVIEW

Treatment of Keloids and Hypertrophic Scars A Meta-analysis and Review of the Literature

Douglas Leventhal, MD; Maxwell Furr, BS; David Reiter, MD, DMD

Arch Facial Plast Surg. 2006;8(6):362-368.

Management of hypertrophic scars and keloids has advanced from crude, invasive methods such as gross excision and radiation to intralesional or topical agents that act on a cellular level. There is no universally accepted treatment regimen and no evidence-based literature to guide management. Our objectives are to present a list of available treatment regimens, their proposed mechanisms of action, and supporting evidence and to perform a meta-analysis of clinical trials to identify treatments with a better-than-even likelihood of improvement. We conducted a PubMed search through October 2005, identifying clinical studies of various treatments for hypertrophic scars and keloids. We graded the

quality of each study, delineated the results into favorable vs non-favorable, and calculated the statistical significance of the findings. The meta-analysis of 70 treatment series for various clinical measures showed a 70% chance of improvement with treatment; however, the mean amount of improvement to be expected was around 60%. There was no statistically significant difference between treatments. Most treatments for keloidal and hypertrophic scarring offer minimal likelihood of improvement. The magnitude of likely permanent improvement in any sign or symptom may be clinically meaningful but far short of cure. Novel therapies deserve further investigation but remain without proven benefit to date.

3. LEVEL 5: EXPERT OPINION

Management of Keloids and Hypertrophic Scars

GREGORY JUCKETT, MD, MPH, and HOLLY HARTMAN-ADAMS, MD, West Virginia University, Morgantown, West Virginia

Am Fam Physician. 2009 Aug 1;80(3):253-260.

Keloids and hypertrophic scars represent an exuberant healing response that poses a challenge for physicians. Patients at high risk of keloids are usually younger than 30 years and have darker skin. Sternal skin, shoulders and upper arms, earlobes, and cheeks are most susceptible to developing keloids and hypertrophic scars. High-risk trauma includes burns, ear piercing, and any factor that prolongs wound healing. Keloid formation often can be prevented if anticipated with immediate silicone elastomer sheeting, taping to reduce skin tension, or corticosteroid injections. Once established, however, keloids are difficult to treat, with a high recurrence rate regardless of therapy. Evidence supports silicone sheeting, pressure dressings, and corticosteroid injections as first-line treatments. Cryotherapy may be useful, but should be reserved for smaller lesions. Surgical removal of keloids poses a high recurrence risk unless combined with one or several of these standard therapies. Alternative postsurgical options for refractory scars include pulsed dye laser, radiation, and possibly imiquimod cream. Intralesional verapamil, fluorouracil, bleomycin, and interferon alfa-2b injections appear to be beneficial for treatment of established keloids. Despite the popularity of over-the-counter herb-based creams, the evidence for their use is mixed, and there is little evidence that vitamin E is helpful.

Appendix 2 – Diagnostic and Procedure Codes

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM066 - Surgical Revision of Scarring Policy	
Shave excision of lesion of skin of head or neck	S06.3
Shave excision of lesion of skin NEC	S06.4
Excision of lesion of skin of head or neck NEC	S06.5
Curettage and cauterisation of lesion of skin of head or neck	S08.1
Curettage and cauterisation of lesion of skin NEC	S08.2
Laser destruction of lesion of skin of head or neck	S09.1
Laser destruction of lesion of skin NEC	S09.2
Cauterisation of lesion of skin of head or neck NEC	S10.1
Cryotherapy to lesion of skin of head or neck	S10.2
Other specified other destruction of lesion of skin of head or neck	S10.8
Unspecified other destruction of lesion of skin of head or neck	S10.9
Cauterisation of lesion of skin NEC	S11.1
Cryotherapy to lesion of skin NEC	S11.2
Other specified other destruction of lesion of skin of other site	S11.8
Unspecified other destruction of lesion of skin of other site	S11.9
Refashioning of scar NEC	S60.4
Excision of scar tissue NOC	Y06.4
<i>With the following ICD-10 diagnosis code(s) (nothing to show demonstrable functional problem, as per policy):</i>	
Scar conditions and fibrosis of skin	L90.5
Hypertrophic scar	L91.0
Exceptions (ICD-10); the following in a secondary diagnostic position to either L90.5 or L91.0:	
Sequelae of burn, corrosion and frostbite of head and neck	T95.0
Sequelae of burn, corrosion and frostbite of trunk	T95.1
Sequelae of burn, corrosion and frostbite of upper limb	T95.2
Sequelae of burn, corrosion and frostbite of lower limb	T95.3
Sequelae of burn and corrosion classifiable only according to extent of body surface involved	T95.4
Sequelae of other specified burn, corrosion and frostbite	T95.8
Sequelae of unspecified burn, corrosion and frostbite	T95.9