

# Value based commissioning of MSK Procedures: An appraisal of the evidence for the proposed policies

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## Background

The project team have conducted an independent appraisal of the evidence underpinning 14 proposed policies for musculo-skeletal (MSK) procedures.

Northumberland CCG had developed an MSK resource pack to ensure that procedures are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness. The CCG will only support the commissioning and payments of the 16 listed procedures in this policy when a patient meets the inclusion criteria. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their clinician believes exceptional circumstances exist that warrant deviation from this policy.

In September 2014, Northumberland CCG presented the MSK resource pack to the Value Based Clinical Policy Implementation Group. Northumberland indicated that, if agreed by other CCGs, these procedures would be incorporated into the regional Value Based Commissioning policy.

As part of this process we were asked to undertake an independent appraisal of the evidence underpinning the proposed policies for MSK procedures. Two of the 16 proposed policies included in the MSK resource pack were already included in the regional Value Based Commissioning Policy and required an approved individual funding request. This briefing summarises our appraisals of the evidence for the remaining 14 policies. A summary of our methods are presented in Appendix 1.

Summary Table 1 was presented and discussed at the Value Based Clinical Policy Implementation Group Meeting on the 8th October 2014.

## Summary table 1

### Value Based Commissioning of MSK Procedures

#### Summary of York evidence appraisals for proposed policies

October 2014

	Procedure	Policy evidence informed?
1	Autologous cartilage transplantation in knee joints	√
2	Autologous blood injection for tendinopathy	√
3	Bunions <sup>1</sup>	√
4	Surgery for carpal tunnel syndrome <sup>2</sup>	√
5	Discectomy for lumbar disc prolapse	√
6	Dupuytren's contracture	√
7	Epidural injections for lumbar back pain	√
8	Exogen Ultrasound Bone Healing	√
9	Facet joint injections for back pain	√
10	Ganglia <sup>4</sup>	√
11	Hip resurfacing <sup>3</sup>	√
12	Knee arthroscopy and irrigation <sup>1</sup>	√
13	Non-specific low back pain	√
14	Trigger finger <sup>4</sup>	√

Notes:

<sup>1</sup>Wording of policy deviates slightly from national guidance

<sup>2</sup>Already included in the VBCP

<sup>3</sup>Policy should refer to updated NICE guidance

<sup>4</sup>Unable to access national guidance

	Supported by national guidance and or good quality evidence from systematic reviews
	No national guidance but reflective of current evidence (low or moderate quality evidence)
	Contradicts national guidance and or is not supported by evidence from systematic reviews

#### Disclaimer

This summary has been produced by Paul Wilson, Liz Bickerdike and Alison Booth as part of an NIHR HS&DR funded project evaluating whether access to an evidence briefing service can enhance research evidence use by NHS commissioners ([www.nets.nihr.ac.uk/projects/hsdr/12500218](http://www.nets.nihr.ac.uk/projects/hsdr/12500218)). The content of this summary are judged to be up to date as of October 2014. The views expressed in this summary are those of the authors alone. For more information, contact [paul.wilson@mbs.ac.uk](mailto:paul.wilson@mbs.ac.uk) or [liz.bickerdike@york.ac.uk](mailto:liz.bickerdike@york.ac.uk).

# 1. Autologous cartilage transplantation in knee joints

## Proposed policy:

Autologous cartilage transplantation in knee joints will not be funded by the CCG in line with NICE Technology Appraisal 89 unless agreed via the Individual Funded Request process. <http://www.nice.org.uk/Guidance/TA89>

## Summary of current evidence:

A number of good quality reviews have been published since NICE guidance [TA89] was issued in 2005. The reviews provide no evidence that autologous cartilage implantation (ACI) or matrix-induced chondrocyte implantation (MACI) lead to better outcomes in the treatment of osteochondral lesions than any of the alternatives. The current evidence is consistent and supports the existing NICE guidance.

The current evidence supports the proposed commissioning policy.

## Current evidence:

The Australian Medical Services Advisory Committee (MSAC) does not support public funding for MACI or ACI for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes.<sup>1</sup>

Although the evidence informing the MSAC assessment included 10 systematic reviews, 18 comparative studies, and 39 case series, the overall quality of the evidence was poor.<sup>1</sup>

The clinical effectiveness evidence relying on functional outcome measures suggested that MACI and ACI are no better than microfracture or mosaicplasty in the short term, and imaging results up to five years post-procedure suggest no changes indicative of longer term incremental benefits. Neither MACI or ACI nor the comparator procedures have been reliably shown to be superior to non-surgical treatments.<sup>1</sup>

An appraisal undertaken to inform Austrian guidelines included nine comparative studies and six systematic reviews. They found no evidence that ACI or MACI

leads to better outcomes than any of the alternative treatments and concluded that ACI is not superior but at best equal, at much higher cost. The findings of this report matches the reimbursement policies of many other European countries including England and Scotland.<sup>2</sup>

A Cochrane review including six trials (442 participants) found insufficient evidence to draw conclusions on the use of ACI for treating full thickness articular cartilage defects in the knee.<sup>3</sup>

Another review published in 2010 included thirteen studies (917 participants). Microfracture, ACI, and osteochondral autograft were all found to provide short-term success. There are patient-specific and defect-specific factors that influenced clinical outcomes.<sup>4</sup>

In 2013 a systematic review including seven RCTs and two cohort studies (399 patients) was published. Meta-analyses combining either all ACI modifications or solely second and third generations of ACI showed no clinically relevant superiority of ACI over microfracture at 5-year follow up.<sup>5</sup>

## References:

1. Australian Government: Department of Health: Medical Services Advisory Committee (MSAC) 1140 - Matrix-induced Autologous Chondrocyte Implantation (MACI) and Autologous Chondrocyte Implantation (ACI) 2nd December 2010: <http://www.msac.gov.au/internet/msac/publishing.nsf/Content/app1140-1>
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4. Harris JD, Siston RA, Pan X, Flanigan DC. Autologous chondrocyte implantation: a systematic review. Journal of Bone and Joint Surgery. American volume 2010; 92(12): 2220-2233 <http://dx.doi.org/10.2106/JBJS.J.00049>
5. Negrin LL, Vecsei V. Do meta-analyses reveal time-dependent differences between the clinical outcomes achieved by microfracture and autologous chondrocyte implantation in the treatment of cartilage defects of the knee? Journal of Orthopaedic Science 2013; 18(6): 940-948 <http://www.ncbi.nlm.nih.gov/pubmed?term=23934147>

## 2. Autologous blood injection for tendinopathy

### Proposed policy:

Autologous cartilage transplantation in knee joints will not be funded by the CCG in line with NICE Technology Appraisal 89 unless agreed via the Individual Funded Request process. <http://www.nice.org.uk/Guidance/TA89>

### Summary of current evidence:

NICE guidance [IPG438] was published in January 2013; a subsequent Cochrane review also concluded that there is currently insufficient evidence to support the use of autologous blood injection for tendinopathy.

The current evidence supports the proposed commissioning policy.

### Current evidence:

A 2014 Cochrane review came to the same conclusion as the 2013 NICE Guidance [IPG438].<sup>1,2</sup> The evidence base is comprised of a diverse collection of small trials. While there is very low quality evidence from a subset of these small trials for a marginal short-term benefit in pain from platelet-rich therapies; other very low quality evidence indicates that the use of platelet-rich therapies does not appear to have a clinically relevant effect on short-term or long-term function. Very low quality evidence showed no difference in adverse effects between platelet-rich therapy and no platelet-rich therapy or placebo. Overall, and for traumatic injuries and tendinopathy individually, the authors conclude there is currently insufficient evidence to support the use of platelet-rich therapies.<sup>1</sup>

There are a number of ongoing trials on this topic that are likely to be included in future updates of the Cochrane review.

### References:

1. Moraes VY, Lenza M, Tamaoki MJ, Faloppa F, Belloti JC. Platelet-rich therapies for musculoskeletal soft tissue injuries. Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No.: CD010071. DOI: 10.1002/14651858.CD010071.

pub3. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010071.pub3/full>  
2. NICE Interventional procedures guidance [IPG438]. Autologous blood injection for tendinopathy. NICE January 2013 <http://www.nice.org.uk/guidance/IPG438>

## 3. Bunions

### Proposed policy:

Requests for the removal of symptomatic bunions will only be considered if specific criteria are met, as detailed below.

Requests for the removal of symptomatic bunions will only be considered where conservative methods of management have failed. Conservative management techniques include:

- Avoiding high heel shoes and wearing wide fitting leather shoes which stretch
- Applying ice and elevating painful and swollen bunions
- Non-surgical treatments such as bunion pads, splints, insoles or shields available from community pharmacies

AND the patient suffers from:

**EITHER** severe deformity (overriding toes) that causes significant functional impairment\*

**OR** severe pain that causes significant functional impairment\*

\* Significant functional impairment is considered as:

- Symptoms which prevent the patient fulfilling vital work or educational responsibilities, or
- Symptoms which prevent the patient carrying out vital domestic or carer activities

Guidance from the Royal College of Surgeons of England

<http://www.rcseng.ac.uk/healthcare-bodies/docs/Painfuldeformedgreattoeinadults.pdf>

### Summary of current evidence:

We did not identify any new systematic reviews since the publication of the Royal College of Surgeons of England (RCS) guidance in 2013.

The proposed policy is in line with the limited evidence available.

### Current evidence:

We did not identify any new systematic reviews since the publication of the Royal College of Surgeons of England (RCS) guidance in 2013.

The RCS guidance references a Cochrane review from 2004 which was withdrawn from The Cochrane Library in 2009 for being substantially out-of-date. That review had found very limited evidence to suggest surgery may be beneficial compared with orthoses or no treatment.<sup>1</sup>

The RCS guidance also references NICE guidance [IPG 332] published in 2010, which states that evidence about minimally invasive surgical correction techniques is limited and inconsistent and should only be used with special arrangements for clinical governance, consent and audit or research.<sup>2</sup>

### References:

1. Ferrari J, Higgins JPT, Prior TD. Interventions for treating hallux valgus (abduc-



tovalgus) and bunions. Cochrane Database of Systematic Reviews 2004, Issue 1. Art. No.: CD000964. DOI: 10.1002/14651858.CD000964.pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000964.pub3/abstract>

2. NICE Interventional procedures guidance [IPG 332]. Surgical correction of hallux valgus using minimal access techniques. NICE February 2010 <http://www.nice.org.uk/Guidance/IPG332>

## 4. Carpal Tunnel Syndrome

### Proposed policy:

Carpal tunnel surgery is a low priority procedure for patients with intermittent or mild to moderate symptoms. The exception to this are patients who have not responded to 3 months of conservative management, including:

- At least 8 weeks of night-time use of wrist splints and/or
- Corticosteroid injection in appropriate patients

Carpal Tunnel Syndrome is already included in the IFR policy and to confirm:

The CCG will fund carpal tunnel surgery where:

- Symptoms persist or recur after conservative therapy with either local corticosteroid injections and/or nocturnal splinting

OR

- There is neurological deficit, for example sensory blunting, thenar muscle wasting or motor weakness

OR

- There are severe symptoms that significantly interfere with daily activities

Guidance from the Royal College of Surgeons of England <http://www.rcseng.ac.uk/healthcare-bodies/docs/Treatmentofpainfulinglingfingers.pdf>

The British Society for Surgery of the Hand Guidance [http://www.bssh.ac.uk/education/guidelines/carpal\\_tunnel\\_syndrome.pdf](http://www.bssh.ac.uk/education/guidelines/carpal_tunnel_syndrome.pdf)

Referral guidance: Consider referral for electromyography and nerve conduction studies if the diagnosis is uncertain.

*\*Taken from the Northumberland CCG Value Based Clinical Commissioning Policies*

### Summary of current evidence:

The evidence comparing surgical treatment with splinting or steroid injections is limited, but suggests there may be better outcomes following surgery compared with splinting. Further research in to surgery for patients with mild symptoms has been recommended.

The proposed commissioning policy appears to be in line with the current limited evidence on this topic.

### Current evidence:

A 2008 Cochrane review based on four RCTs suggested surgery produced better outcomes compared with splinting, but it was unclear whether there was a better response with surgery when compared to steroid injections.<sup>1</sup> The severity of patients'

symptoms included in the four trials was unclear, however the review authors stated that further research is needed to determine the effect of surgery in patients with mild symptoms.

A more recent scoping report by Healthcare Improvement Scotland found little new evidence published since the 2008 Cochrane review.<sup>2</sup> The report concluded that there is limited clinical and cost effectiveness data on this topic and that the conclusions of the Cochrane review have not been changed by any research published up to November 2012.

Methods of surgery have been compared in a Cochrane review of 28 studies. The authors concluded, based on low quality evidence, that open and endoscopic surgical release techniques are about as effective as each other.<sup>3</sup>

Splinting has been compared with non-surgical treatments in another Cochrane review, which included 19 studies and concluded that there is limited evidence that a splint worn at night is more effective than no treatment in the short-term.<sup>4</sup>

## References:

1. Verdugo RJ, Salinas RA, Castillo JL, Cea JG. Surgical versus non-surgical treatment for carpal tunnel syndrome. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD001552. DOI: 10.1002/14651858.CD001552. pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001552.pub2/full>
2. Healthcare Improvement Scotland. Can wrist splints or steroid injections reduce the need for decompression surgery in carpal tunnel syndrome? Technologies scoping report number 15, 2013. [http://www.healthcareimprovementscotland.org/our\\_work/technologies\\_and\\_medicines/shtg\\_scoping\\_reports/technologies\\_scoping\\_report\\_15.aspx](http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg_scoping_reports/technologies_scoping_report_15.aspx)
3. Vasiliadis HS, Georgoulas P, Shrier I, Salanti G, Scholten RJPM. Endoscopic release for carpal tunnel syndrome. Cochrane Database of Systematic Reviews 2014, Issue 1. Art. No.: CD008265. DOI: 10.1002/14651858.CD008265. pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008265.pub2/full>
4. Page MJ, Massy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel syndrome. Cochrane Database of System-

atic Reviews 2012, Issue 7. Art. No.: CD010003. DOI: 10.1002/14651858.CD010003. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010003/full>

## 5. Discectomy for lumbar disc prolapse

### Proposed policy:

Discectomy surgery is only commissioned in adult patients who meet the following criteria:

- The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms; AND
- The patient has radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement;

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign); AND
- Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, bed rest etc.) provided that analgesia is adequate and there is no imminent risk of neurological deficit.

### Summary of current evidence:

There is limited evidence to suggest discectomy provides faster relief and may be cost-effective compared with conservative treatment. The effectiveness and cost-effectiveness of minimally invasive lumbar discectomy is unclear.

The proposed policy appears to be in line with the current evidence.

### Current evidence:

A UK health technology assessment reviewed the clinical and cost effectiveness of a range of treatments for sciatica, including lumbar discectomy. The findings support the use of disc surgery.<sup>1</sup>

A Cochrane review of surgery for lumbar disc prolapse included 42 studies published up to the beginning of 2007.<sup>2</sup> Only four RCTs compared discectomy with conservative management; the strongest evidence showed discectomy was more effective than chemonucleolysis, and chemonucleolysis was more effective than placebo. Overall, the authors concluded that for carefully selected patients with sciatica due to lumbar disc prolapsed, discectomy provides faster relief than conservative management although its effectiveness in addressing underlying disc

disease is unclear. Microdiscectomy gives broadly comparable results to standard discectomy. There is insufficient evidence to draw firm conclusions about the effectiveness of minimally invasive techniques.

A recent Cochrane review of 11 studies (1172 people) suggested that more research is needed to identify appropriate indications for minimally invasive discectomy as an alternative to standard microdiscectomy or open discectomy.<sup>3</sup> These findings follow an earlier review which suggested minimally invasive discectomy and open discectomy produced substantial and equivalent improvements in leg pain for patients with lumbar radiculopathy, although due to limitations of the evidence this may not have been a reliable conclusion.<sup>4</sup>

A cost-utility analysis in The Netherlands found recovery rates from sciatica caused by lumbar disc herniation were similar, but faster with early surgery compared with prolonged conservative care.<sup>5</sup> The analysis found that, taking into account reduction in absenteeism from work, early surgery was likely to be cost effective, but patient preference might indicate the best strategy. A US cost-utility analysis found standard open discectomy to be moderately cost-effective compared with non-surgical management.<sup>6</sup>

Relevant NICE interventional procedures guidance:

- Percutaneous endoscopic laser lumbar discectomy [IPG 300], found inadequate quantity and quality of evidence therefore should only be used with special arrangements for clinical governance, consent, and audit or research.<sup>7</sup>
- Automated percutaneous mechanical lumbar discectomy [IPG 141]: says there are uncertainties about efficacy and should not be used without special arrangements for consent and for audit or research.<sup>8</sup>

NICE are developing guidance on:

- Percutaneous transforaminal endoscopic lumbar discectomy.<sup>9</sup>
- Insertion of an annular disc implant at lumbar discectomy.<sup>10</sup>

## References:

1. Lewis R, Williams N, Matar HE, Din N, Fitzsimmons D, Phillips C et al. The clinical effectiveness of management strategies for sciatica: systematic review and economic model. *Health Technology Assessment* 2011; 15(39) [http://www.journalslibrary.nihr.ac.uk/\\_\\_data/assets/pdf\\_file/0007/64726/FullReport-hta15390.pdf](http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0007/64726/FullReport-hta15390.pdf)
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3. Rasouli Mohammad R, Rahimi-Movaghar Vafa, Shokraneh Farhad, Moradi-Lakeh Maziar, Chou Roger. Minimally invasive

discectomy versus microdiscectomy/open discectomy for symptomatic lumbar disc herniation. *Cochrane Database of Systematic Reviews: Reviews* 2014; Issue 9 <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010328.pub2/full>

4. Dasenbrock HH, Juraschek SP, Schultz LR, Witham TF, Sciubba DM, Wolinsky JP, Gokaslan ZL, Bydon A. The efficacy of minimally invasive discectomy compared with open discectomy: a meta-analysis of prospective randomized controlled trials. *Journal of Neurosurgery Spine* 2012; 16(5): 452-462. <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=12012024835>
5. van den Hout W B, Peul W C, Koes B W, Brand R, Kievit J, Thomeer R T. Prolonged conservative care versus early surgery in patients with sciatica from lumbar disc herniation: cost utility analysis alongside a randomised controlled trial. *BMJ* 2008; 336(7657): 1351-1354. <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=22008100707>
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7. NICE Interventional procedures guidance [IPG300] Percutaneous endoscopic laser lumbar discectomy. NICE May 2009. <http://www.nice.org.uk/guidance/IPG300>
8. NICE Interventional procedures guidance [IPG141] Automated percutaneous mechanical lumbar discectomy. NICE November 2005. <https://www.nice.org.uk/guidance/ipg141>
9. NICE Interventional procedure guidance in development. Percutaneous transforaminal endoscopic lumbar discectomy. NICE anticipated publication date to be confirmed. <http://www.nice.org.uk/guidance/indevelopment/GID-IP1223>
10. NICE Interventional procedure guidance in development. Insertion of an annular disc implant at lumbar discectomy. NICE anticipated publication date November 2014 <http://www.nice.org.uk/guidance/indevelopment/GID-IP956>

## 6. Dupuytren's contracture

### Proposed policy:

Dupuytren's contracture 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))

Northumberland CCG 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

*\*Based on NHS North West London policy*

Treatment with Collagenase can be considered as an alternative to surgery based on clinical opinion and NETAG guidance available here: <http://www.netag.nhs.uk/files/appraisal-reports/Collagenase%20-Xiapex-%20for%20Dupuytren's%20contracture%20-%20NETAG%20appraisal%20report%20-%20Aug2011.pdf>

NICE Guidance: Needle fasciotomy for Dupuytren's contracture  
<http://www.nice.org.uk/nicemedia/live/11116/31124/31124.pdf>

The British Society for Surgery of the Hand Guidance  
[http://www.bssh.ac.uk/education/guidelines/dd\\_guidelines.pdf](http://www.bssh.ac.uk/education/guidelines/dd_guidelines.pdf)

### Radiotherapy for Dupuytren's contracture

Northumberland CCG concludes there is insufficient evidence of efficacy or cost effectiveness of radiotherapy for Dupuytren's Contracture. Radiotherapy will therefore not normally be funded by the NHS. Radiotherapy should only be offered as part of an externally funded, ethically approved, randomised clinical trial, meeting the governance requirements of NICE IPG 368. <https://www.nice.org.uk/guidance/ipg368>

### Summary of current evidence:

There is limited evidence that percutaneous needle fasciotomy is associated with higher recurrence of contracture compared with open partial fasciectomy or collagenase injections.

The proposed policy appears to be in line with the current limited quality evidence on this topic.

## Current evidence:

The NICE guidance on needle fasciotomy, produced in 2004, states that there was adequate evidence to support the use of the procedure (with normal arrangements for consent, audit and clinical governance).

A rapid review published in 2013 found limited evidence that percutaneous needle fasciotomy was associated with a higher recurrence of Dupuytren's contracture compared with open partial fasciectomy or collagenase injections.<sup>1</sup> The majority of the data came from a previous systematic review (2011) of 13 studies which had a number of methodological limitations, and did not describe the severity of patients' symptoms which makes it difficult to apply their findings to other populations.<sup>2</sup> Additional data for the rapid review<sup>1</sup> came from 5-year follow up of a quasi-randomised controlled trial in patients with contracture > 30° in the MCP or PIP joint.

The rapid review analysis of three economic evaluations suggested needle fasciotomy was cost effective<sup>1</sup> however, this appears to be based on data from the US and Canada<sup>3,4</sup> which may not be applicable to a UK setting. One of the analyses concluded that open partial fasciectomy was not cost effective compared with needle fasciotomy and collagenase injections but the paper provided insufficient information to be confident in the conclusions.<sup>4</sup>

The NETAG guidance on collagenase could be updated with the outcomes from new RCTs identified and presented by the National Horizon Scanning Service in April 2012.<sup>5</sup> A protocol for a Cochrane review on surgery for Dupuytren's contracture has been published but it is unclear when the full review will be available.<sup>6</sup> A UK Health Technology Assessment on collagenase is due to be published in May 2015.<sup>7</sup>

We found no new systematic reviews on radiotherapy for Dupuytren's contracture since the publication of NICE [IPG368].<sup>8</sup>

## References:

1. Canadian Agency for Drugs and Technologies in Health (CADTH). Needle or open fasciotomy for dupuytren: rapid response - summary with critical appraisal. 2013. <http://www.cadth.ca/media/pdf/htis/dec-2013/RC0510%20Dupuytren%20Final.pdf>
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5. Horizon Scanning Centre. Collagenase clostridium histolyticum (Xiapex) for Dupuytren's contracture - first line. April 2012. <http://www.hsc.nihr.ac.uk/topics/collagenase-clostridium-histolyticum-xiapex-for-du/>
6. Davis T, Becker GW, Rodrigues JN, Ball C, Giele H, Hobby J, Zhang W. Surgery for Dupuytren's contractures of the fingers (Protocol). *Cochrane Database of Systematic Reviews* 2012, Issue 10. Art. No.: CD010143. DOI: 10.1002/14651858.CD010143. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010143/full>
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8. NICE interventional procedures guidance [IPG368]. Radiation therapy for early Dupuytren's Disease. NICE November 2010. <http://www.nice.org.uk/guidance/IPG368>

## 7. Epidural injections for lumbar back pain

### Proposed policy:

Lumbar interlaminar, transforaminal and caudal epidural injections for adult patients with radicular pain are commissioned when the following criteria are met:

- The patient has radicular pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement;

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign);  
AND
- Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, rest etc.)

Patients may receive up to three injections to diagnose and achieve therapeutic effect. If therapeutic effect is achieved, patient may receive up to six injections in total, minimum 2-3 months apart as part of a comprehensive pain management programme (including physiotherapy, psychological support, medication and patient education).

Occasionally, epidural injections may be the only effective treatment for a cohort of patients. These patients may be considered for prior approval for further epidural injections if they demonstrate sustained benefit from the procedure objectively evidenced and

- must have participated in a comprehensive back pain programme including psychology and physiotherapy e.g. Coping with pain course and
- must have been considered for denervation procedures and
- must have had a surgical review and must participate in self-directed physiotherapy.

### Summary of current evidence:

There is evidence that epidural injections relieve short-term low back pain associated with disc herniation and radiculitis, spinal stenosis/discogenic pain and post-surgery syndrome.

The proposed policy is in line with current evidence on this topic.

### Current evidence:

A UK health technology assessment reviewed the clinical and cost effectiveness of a range of treatments for sciatica, including epidural injections. Overall improvement was found with epidural corticosteroid injections compared with inactive control or usual care.<sup>1</sup>

A number of reviews have looked at caudal,

interlaminar and transforaminal epidural injections for back pain caused by disc herniation and radiculitis, spinal stenosis/discogenic pain, and post-surgery syndrome. There is evidence from a number of RCTs and non-randomised studies in two reviews, that caudal epidural injections (with or without steroids) relieves short-term pain in all conditions although the size of the effect



was not clearly reported in either review.<sup>2,3</sup> The effectiveness of interlaminar epidural injections, based on a review of 26 studies, varied by condition but was generally more successful than local anaesthetic plus steroids.<sup>4</sup> A review of 25 studies suggested similar findings for transforaminal epidural injections, with the strongest evidence in people with back pain caused by disc herniation with radiculitis.<sup>5</sup>

One recent review included 23 RCTs of all three forms of epidural injection for pain associated with disc herniation only and from a limited analysis, concluded that injections under fluoroscopic control improved pain and function in well-selected patients with disc herniation.<sup>6</sup>

A UK health technology assessment produced in 2005 found epidural injections for sciatica produced only transient benefits and were not considered to be good value for money in the NHS.<sup>7</sup> The cost effectiveness model reported in the HTA by Lewis et al. supports a stepped approach to management of sciatica rather than direct referral for surgery (but it is unclear whether epidural injections alone are cost effective).<sup>1</sup>

An analysis concluding that caudal epidural injections showed cost utility at less than \$2,200 per year of QALY contains serious flaws that mean the findings may not be reliable.<sup>8</sup>

## References:

1. Lewis R, Williams N, Matar HE, Din N, Fitzsimmons D, Phillips C, Jones M, Sutton A, Burton K, Nafees S, Hendry M, Rickard I, Chakraverty R, Wilkinson C. The clinical effectiveness and cost-effectiveness of management strategies for sciatica: systematic review and economic model. *Health Technology Assessment* 2011; 15(39): 1-578 [http://www.journalslibrary.nihr.ac.uk/\\_\\_data/assets/pdf\\_file/0018/59112/ExecutiveSummary-hta15390.pdf](http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0018/59112/ExecutiveSummary-hta15390.pdf)
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4. Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, Datta S, Abdi S, Hirsch JA. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. *Pain Physician* 2012; 15(4): E363-E404 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=12012038261>
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6. Manchikanti L, Benyamin RM, Falco FJ, Kaye AD, Hirsch JA. Do epidural injections provide short- and long-term relief for lumbar disc herniation? A systematic review. *Clinical Orthopaedics and Related Research* 2014; /02/11:1-17. <http://www.ncbi.nlm.nih.gov/pubmed/24515404>
7. Price C, Arden N, Coglán L, Rogers P. Cost-effectiveness and safety of epidural steroids in the management of sciatica. *Health Technology Assessment* 2005; 9(33): 1-74 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=32005001133>
8. Manchikanti L, Falco FJ, Pampati V, Cash KA, Benyamin RM, Hirsch JA. Cost utility analysis of caudal epidural injections in the treatment of lumbar disc herniation, axial or discogenic low back pain, central spinal stenosis, and post lumbar surgery syndrome. *Pain Physician* 2013; 16(3): E129-E143 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=22013021315>

## 8. Exogen Ultrasound Bone Healing

### Proposed policy:

Exogen Ultrasound Bone Healing will not be funded by the CCG unless agreed via the Individual Funded Request process in line with Nice Guidance.

<http://www.nice.org.uk/guidance/MTG12>

### Summary of current evidence:

There are a number of subsequent good quality systematic reviews that support the recommendations of the January 2013 NICE guidance. The evidence suggests effectiveness only for non-union of fractures.

The current evidence therefore supports the proposed commissioning policy.

### Current evidence:

There are two systematic reviews on this topic published in June 2014. The evidence report for the NICE 2013 guidance was published in 2012.<sup>1</sup> The first looked at 13 RCTs (737 patients) comparing the effects of low-intensity pulsed ultrasound (LIPUS) and pulsed electromagnetic fields (PEMF) for bone growth stimulation in acute fractures.<sup>2</sup> They found insufficient evidence to conclude a benefit of PEMF or LIPUS bone growth stimulation in reducing the incidence of non-unions when used for treatment in acute fractures. Based on studies with serious heterogeneity, the results suggest PEMF and LIPUS significantly shorten time to radiological union for acute fractures undergoing non-operative treatment and acute fractures of the upper limb. Furthermore, PEMF or LIPUS bone growth stimulation accelerates the time to clinical union for acute diaphyseal fractures.

A Cochrane review also published in June 2014 identified 11 controlled trials with 566 participants and 589 fractures for inclusion.<sup>3</sup> The studies included conservatively managed complete and stress fractures of upper and lower limbs, and operatively managed fractures of lower limbs. The author's concluded that while there may be a potential benefit, the currently available evidence is insufficient to support the routine use of

this intervention in clinical practice. The Cochrane review matched the findings of a 2012 review that found weak evidence that low-intensity pulsed ultrasound supports radiographic healing in delayed unions and non-unions.<sup>4</sup>

### References:

1. Yang Y, Glover M, Bayliss S, Pokhrel S, Lord J, Buxton M. EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing. NICE External Assessment Centre report. 2012. 1-115 <http://www.nice.org.uk/guidance/mtg12/resources/exogen-ultrasound-bone-healing-system-for-long-bone-fractures-with-nonunion-or-delayed-healing-assessment-report2>
2. Hannemann PF, Mommers EH, Schots JP, Brink PR, Poeze M. The effects of low-intensity pulsed ultrasound and pulsed electromagnetic fields bone growth stimulation in acute fractures: a systematic review and meta-analysis of randomized controlled trials. *Archives of Orthopaedic and Trauma Surgery* 2014; 134(8): 1093-1106 <http://rd.springer.com/article/10.1007/s00402-014-2014-8/fulltext.html#Sec13>
3. Griffin Xavier L, Parsons Nick, Costa Matthew L, Metcalfe David. Ultrasound and shockwave therapy for acute fractures in adults. *Cochrane Database of Systematic Reviews: Reviews* 2014; Issue 6. Art. No.: CD008579. DOI: 10.1002/14651858.CD008579.pub3.
4. Bashardoust TS, Houghton P, MacDermid JC, Grewal R. Effects of low-intensity pulsed ultrasound therapy on fracture healing: a systematic review and meta-analysis. *Am J Phys Med Rehabil* 2012; 91(4): 349-67. <http://www.ncbi.nlm.nih.gov/pubmed/21904188>

## 9. Facet joint injections for back pain

### Proposed policy:

One medial branch block for the diagnosis and one injection for the management of cervical, thoracic and lumbar back pain is commissioned as specified below:

- Facet joint pain is confirmed by controlled diagnostic local anaesthetic block AND
- The pain has lasted for more than one year (except in case of trauma) AND
- The pain has resulted in moderate to significant impact on daily functioning (assessed using a validated tool such as Oswestry Disability Index) AND
- All conservative management options (exercise, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed AND
- The patient is part of a comprehensive pain management programme (including physiotherapy, psychological support, medication and patient education)
- If patient is unable to co-operate with physiotherapy treatment due to pain offer facet joint injection followed by return to the physiotherapy programme (minimum 8 weeks)

Intra-articular facet joint injections are low priority procedures.

Occasionally, facet joint injections may be the only effective treatment for a cohort of patients. This patients may be considered for prior approval for further facet joint injections if they demonstrate sustained benefit from the procedure objectively evidenced AND

- must have participated in a comprehensive back pain programme including psychology and physiotherapy e.g. Coping with pain course and
- must have been considered for denervation procedures and
- must have had a surgical review and
- must participate in self-directed physiotherapy.

### Summary of current evidence:

Several systematic reviews on this topic were summarised by the Canadian Agency for Drugs and Technologies in 2011. Overall the evidence was conflicting and had a number of limitations. There is some evidence of short-term benefit for therapeutic lumbar facet joint injections, but questions remain about the effectiveness of therapeutic cervical injections, and diagnostic lumbar and cervical injections.

The policy appears to be in line with the current limited quality evidence on this topic.

### Current evidence:

A 2011 Canadian rapid review<sup>1</sup> identified 6 systematic reviews, one health technology assessment, one RCT and five non-randomised studies published since a 2007 Canadian rapid review.<sup>2</sup>

The 2011 rapid review found the systematic

reviews and health technology assessment to be limited by the quality of the included studies.<sup>1</sup> Despite conflicting findings in the evidence, the rapid review concluded that there was some evidence of short-term benefit for therapeutic lumbar facet joint injections, but evidence of longer term benefit is

unclear. The majority of the evidence was in populations who had failed to respond to conventional treatment; and the review only included studies with active comparators. The reviewers concluded that there was no evidence to support the use of therapeutic cervical facet joint injections. The clinical efficacy of diagnostic lumbar and cervical facet joint injections was unclear. No conclusions could be drawn about the cost effectiveness and safety of diagnostic or therapeutic injections.

### References:

1. Canadian Agency for Drugs and Technologies in Health (CADTH). Facet joint injection as diagnostic and therapeutic tools for pain of the cervical and lumbar spine: a review of clinical and cost-effectiveness. Rapid response report, 2011 [http://www.cadth.ca/media/pdf/htis/jan-2011/L0246\\_Facet\\_Joint\\_Injections.pdf](http://www.cadth.ca/media/pdf/htis/jan-2011/L0246_Facet_Joint_Injections.pdf)
2. Zakaria D, Skidomre B. Facet joint as a diagnostic and therapeutic tool for spinal pain: a review of clinical and cost effectiveness. Canadian Agency for Drugs and Technologies in Health, HTA Issue 77, March 2007 [http://www.cadth.ca/media/pdf/I3003\\_tr\\_Facet\\_Joint\\_Injections\\_e.pdf](http://www.cadth.ca/media/pdf/I3003_tr_Facet_Joint_Injections_e.pdf)

## 10. Ganglia

### Proposed policy:

Funding will be considered only where the ganglion is very painful or there is doubt about the diagnosis or it is causing significant functional impairment.

Ganglia are benign fluid filled, firm and rubbery lumps attached to the adjacent underlying joint capsule, ligament, tendon or tendon sheath. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%).

Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates up to 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

Surgical treatment for ganglia will only be funded in accordance with the criteria specified below.

- The ganglia are symptomatic;

OR

- There is functional impairment

When completing an IFR request include reference to the degree of pain and restriction of normal activities caused by the ganglion.

*\*Taken from the Northumberland CCG Value Based Clinical Commissioning Policies*

The British Society for Surgery of the Hand Guidance <http://www.bssh.ac.uk/education/guidelines/ganglion.pdf>

### Summary of current evidence:

There is some limited evidence that surgery reduces the recurrence of ganglia within six months but it is associated with a higher risk of more serious complications compared with aspiration or reassurance.

The current evidence supports the proposed policy.

### Current evidence:

An Australian health technology assessment reviewed five studies published between 1997 and 2007 which looked at clinical treatments for wrist ganglia.<sup>1</sup> Three studies showed surgery to be more effective than aspiration in preventing recurrence within six months, although one study found surgery to be no more effective than aspiration

or reassurance. Surgery also appeared to be associated with more severe and a higher rate of complications. There was a lack of evidence comparing surgery or aspiration with reassurance. Given the limitations of the evidence (lack of randomised studies, most studies didn't report inclusion/exclusion criteria, small sample sizes) the review

concluded that aspiration was the preferred clinical treatment because of the lower complication rates. Surgical excision should be a last resort as the benefits are insufficient to warrant the higher risk of complications.

A protocol for a Cochrane review on this topic was published in 2005 but the review is yet to appear.<sup>2</sup>

### References:

1. Australian Safety and Efficacy Register of New Interventional Procedures -Surgical. Rapid Review - Clinical treatments for wrist ganglia. Report No. 63. Stepney: Australian Safety and Efficacy Register of New Interventional Procedures -Surgical (ASERNIP-S). Report No. 63. 2008 [http://www.surgeons.org/media/310861/Clinical\\_treatment\\_for\\_wrist\\_ganglia.pdf](http://www.surgeons.org/media/310861/Clinical_treatment_for_wrist_ganglia.pdf)
2. Vroon P, Scholten RJ, van Weert HCPM. Interventions for ganglion cysts in adults (Protocol). Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD005327. DOI: 10.1002/14651858.CD005327. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005327/full>

## 11. Hip resurfacing

### Proposed policy:

Northumberland CCG will only fund hip resurfacing for metal on metal hip resurfacing arthroplasty in accordance with NICE TA44.

<https://www.nice.org.uk/guidance/ta44>

### Summary of current evidence:

Metal-on-metal hip resurfacing arthroplasty is a reasonable treatment option for patients with end stage hip osteoarthritis, good bone quality, and proper anatomy around the affected joint. The use of prostheses with a revision rate of 5% or less at 10 years is recommended.

The proposed policy should be modified to refer to the updated NICE TA304. The current evidence supports a commissioning policy based on the updated NICE guidance.

### Current evidence:

In February 2014, NICE TA44 Guidance on the use of metal on metal hip resurfacing arthroplasty was updated and replaced with NICE technology appraisal TA304: Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip. The key change in the guidance is the use of prostheses that have rates (or projected rates) of revision of 5% or less at 10 years (amended from 10% or less at 10 years).<sup>1</sup>

The Ontario Health Technology Advisory Committee recommendation states that metal-on-metal hip resurfacing arthroplasty is a reasonable treatment option for young male patients with end stage hip osteoarthritis, good bone quality, and proper anatomy around the affected joint. Dated August 2012, these guidelines contain a rate of revision of 10% at 10 years.<sup>2</sup>

A cost-utility analysis of metal on metal hip resurfacing compared to conventional total hip replacement in young active adults cautiously concluded that on average, metal on metal hip resurfacing seemed preferable and more cost-effective than total hip replacement for younger and male patients in Canada.<sup>3</sup> However an economic evaluation

carried out in the UK secondary care setting concluded that the cost-effectiveness of resurfacing arthroplasty was promising but not proven, in the UK.<sup>4</sup>

A Cochrane review is currently underway comparing hip resurfacing with total arthroplasty for osteoarthritis and other non-traumatic diseases of the hip, however there is no indication of when this might be completed.<sup>5</sup>

### References:

1. NICE technology appraisals [TA304]: Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip (review of technology appraisal guidance 2 and 44). NICE February 2014 <https://www.nice.org.uk/guidance/ta304>
2. Sehatzadeh S, Kaulback K, Levin L. Metal-on-metal hip resurfacing arthroplasty: an analysis of safety and revision rates. Toronto: Medical Advisory Secretariat (MAS). Volume 12(19). 2012 <http://www.hqontario.ca/en/documents/eds/2012/safety-mom.pdf>
3. Heintzbergen S, Kulin NA, Ijzerman MJ, Steuten LM, Werle J, Khong H, Marshall DA. Cost-utility of metal-on-metal hip resurfacing compared to conven-

tional total hip replacement in young active patients with osteoarthritis. *Value in Health* 2013; 16(6): 942-952 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=22013043059>

4. Edlin R, Tubeuf S, Achten J, Parsons N, Costa M. Cost-effectiveness of total hip arthroplasty versus resurfacing arthroplasty: economic evaluation alongside a clinical trial. *BMJ Open* 2012; 2(5): e001162 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=22012043648>

5. Xu H, He ML, Xiao ZM, Cao Y. Hip resurfacing versus traditional total hip arthroplasty for osteoarthritis and other non-traumatic diseases of the hip (Protocol). *Cochrane Database of Systematic Reviews* 2013, Issue 12. Art. No.: CD010851. DOI: 10.1002/14651858.CD010851. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010851/full>



## 12. Knee arthroscopy

### Proposed policy:

Northumberland CCG will fund knee arthroscopy in adults where:

- Clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body)

AND

- Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.
- In rare cases, intractable knee pain considered likely to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon.
- There is continuing diagnostic uncertainty following MRI, such that a Consultant Knee Surgeon recommends diagnostic arthroscopy.

Arthroscopy is not commissioned:

- For diagnostic purposes only (noting the exception above);
- To provide arthroscopic washout alone as a treatment for chronic knee pain due to osteoarthritis. This procedure may be appropriate in conditions such as septic arthritis

This policy restriction does not apply where there is an urgent need for investigation/treatment.

*\*Based on South Gloucestershire CCG Policy*

NICE Guidance: Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. <http://www.nice.org.uk/guidance/IPG230>

### Summary of current evidence:

We did not identify any new evidence since the publication of the NICE [IPG230] on knee arthroscopy. Relevant NICE guidance on osteoarthritis was updated in Feb 2014 (previously [CG 59], now [CG 177]) with no significant change to the recommendation on arthroscopy and debridement for osteoarthritis.

The existing limited evidence supports the proposed policy.

### Current evidence:

While NICE guidance [IPG230] found adequate evidence to support the use of knee arthroscopy, it notes that the specialist advisers stated there is uncertainty about the efficacy of the procedure and that patient selection is important, for example patients with early osteoarthritic changes and those with large effusions are among those most likely to benefit.<sup>1</sup>

NICE guidance [CG177] Osteoarthritis: Care and management in adults, was updated in February 2014.<sup>2</sup> This version clarifies the wording of the 2008 recommendation about arthroscopy, which now reads: "Do not refer for arthroscopic lavage and debridement as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechan-

ical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies).”

Evidence about patient populations who might benefit most from knee arthroscopy is lacking. A Spanish health technology assessment (2008) involved a systematic review and a consensus consultation with experts to determine relevant clinical indications for performing knee arthroscopy.<sup>3</sup> Unfortunately the indications identified are not included in the English translation, which only covers the executive summary.

One poor quality US cost-effectiveness analysis suggested that knee arthroscopy is cost-effective but the findings may not be applicable to a UK setting.<sup>4</sup>

## References:

1. NICE interventional procedures guidance [IPG230]. Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. NICE August 2007 <http://www.nice.org.uk/guidance/IPG230>
2. NICE guidelines [CG177] Osteoarthritis: Care and management in adults. NICE February 2014 <http://www.nice.org.uk/guidance/cg177>
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4. Lubowitz JH, Appleby D. Cost-effectiveness analysis of the most common orthopaedic surgery procedures: knee arthroscopy and knee anterior cruciate ligament reconstruction. *Arthroscopy* 2011; 27(10): 1317-1322 <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=22011001782>

## 13. Non-specific low back pain

### Proposed policy:

Surgical treatment for non-specific low back pain is considered to be a procedure of low clinical priority. These procedures are therefore not normally funded.

Consider referral for surgical opinion only for people who:

- have completed an optimal package of care, including a combined physical and psychological treatment programme of minimum of 6 weeks

AND

- continue to have severe non-specific low back pain for which they would consider surgery

AND

- multidisciplinary assessment suggests that benefits of intervention will exceed the risks and full attempt at non-invasive treatment greater than 1 year has been tried.

Only offer an MRI scan for non-specific low back pain within the context of a referral for an opinion on spinal fusion surgery.

A clinician who suspects that there is a specific cause for their patient's low back pain should arrange the relevant investigations. The management of the following conditions is not covered by this policy: malignancy, infection, fracture, ankylosing spondylitis and other inflammatory disorders, radicular pain resulting from nerve root compression or cauda equina syndrome.

Back pain with possible serious pathologies, red flag symptoms, should be referred urgently as per usual practice.

### Summary of current evidence:

NICE guidance [CG88] on non-specific low back pain makes recommendations regarding referral for surgery. This guidance is currently being updated and is scheduled for publication in Nov 2016. We did not identify any new systematic reviews evaluating surgery for non-specific low back pain subsequent to the 2009 NICE guidance [CG88].

The proposed policy is within the current NICE guidance on this topic, but could be refined further.

### Current evidence:

The current 2009 NICE guidance (CG88) on non-specific low back pain (defined as pain that has lasted for more than 6 weeks but less than 12 months) makes the following recommendations regarding referral for surgery:<sup>1</sup>

1. 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.

2. Offer anyone with psychological distress appropriate treatment for this before referral for an opinion on spinal fusion.

3. Refer the patient to a specialist spinal surgical service if spinal fusion is being considered. Give due consideration to the possible risks for that patient.

4. Do not refer people for any of the following procedures:

- intradiscal electrothermal therapy (IDET)
- percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
- radiofrequency facet joint denervation.

NICE guidance on persistent non-specific low back pain [CG88] is currently being updated and is due for publication in November 2016.<sup>2</sup> The definition of non-specific low back pain for the updated guidance has been expanded to include people with sciatica, and restrictions on the duration of back pain have been removed.

We did not identify any new systematic reviews evaluating surgery for non-specific low back pain following the publication of the NICE guidance in 2009. However we identified a number of systematic reviews (which are not summarised here) evaluating the effectiveness of non-surgical treatments for non-specific low back pain, including pharmacological therapies, ultrasound, exercise, yoga, acupuncture, massage, and education.

## References:

1. NICE guidelines [CG88]. Low back pain: early management of persistent non-specific low back pain. NICE May 2009. <https://www.nice.org.uk/guidance/cg88>
2. NICE guidelines in development. Low back pain and sciatica. Update of NICE Clinical Guideline 88. NICE anticipated publication date November 2016. <https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0681>

## 14. Trigger finger

### Proposed policy:

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)
- exercising/massaging the affected finger(s) to relieve pain
- 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 in the area of tendon sheath thickening.

This advice relates to both percutaneous release and open surgery. These interventions have the intended outcome of reducing pain, discomfort and disability. Northumberland CCG will commission surgical release of trigger finger in any of the following circumstances:

- The patient has co-morbidities associated with an increased risk of trigger finger (e.g. rheumatoid arthritis or diabetes mellitus) and the patient's symptoms have not improved with at least 4 months of conservative treatment (e.g. NSAIDs, splintage, physiotherapy)

OR

- The patient's symptoms have not resolved despite at least one steroid injection in the last 4 months.

OR

- The specialist opinion is that surgery is needed promptly to prevent the development of flexion contractures
- 

*\*Based on Blackpool CCG policy*

The British Society for Surgery of the Hand Guidance <http://www.bssh.ac.uk/education/guidelines/trigger.pdf>

### Summary of current evidence:

One systematic review found equivalent outcomes for percutaneous release and open surgery, and found percutaneous release surgery less likely to fail compared with corticosteroid injections.

The proposed policy appears to be in line with the current evidence on this topic.

### Current evidence:

A recent systematic review of seven RCTs (676 people) found that there were no differences in failure rates and the frequency of complications between percutaneous release and open surgery for trigger finger.<sup>1</sup> The review also found that treatment failure

was less likely with percutaneous release surgery compared with one corticosteroid injection. The review authors state that the indications for treatment differed from trial to trial, however they did not describe the characteristics of the patient populations

included in the trials. This makes it difficult to determine how relevant the review conclusions are to other populations.

We found a 2012 protocol for a Cochrane review of surgery for trigger finger but it is unclear when the review will be published.<sup>2</sup>

A 2009 Cochrane review of corticosteroid injections for trigger finger included two very small, poor quality randomized controlled trials.<sup>3</sup> Corticosteroid injection with lidocaine showed better short term effects compared with lidocaine alone however given the limitations of the evidence this conclusion may not be reliable.

### References:

1. Wang J, Zhao JG, Liang CC. Percutaneous release, open surgery, or corticosteroid injection, which is the best treatment method for trigger digits? *Clinical Orthopaedics and Related Research* 2013; 471(6): 1879-1886 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3706641/>
2. Ventin FC, Lenza M, Tamaoki MJS, Gomes dos Santos JB, Faloppa F, Belloti JC. Surgery for trigger finger. *Cochrane Database of Systematic Reviews* 2012, Issue 6. Art. No.: CD009860 <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009860/full>
3. Peters-Veluthamalingal C, van der Windt DAWM, Winters JC, Meyboom-de Jong B. Corticosteroid injection for trigger finger in adults. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD005617. DOI: 10.1002/14651858.CD005617.pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005617.pub2/full>

## Appendix 1



