
HUMBER CCG'S EVIDENCE-BASED INTERVENTIONS POLICY DOCUMENT

Interventions subject to Prior Approval or an Individual Funding Request

JANUARY 2020 (VERSION 2)

EAST RIDING OF YORKSHIRE, HULL AND NORTHERN LINCOLNSHIRE CCGS

Colorectal Interventions

Intervention	Surgery for Anal Fissure - Adults
For the treatment of	Anal Fissures in Adults
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment for Anal Fissures should be considered for adults who meet at least one of the following criteria:</p> <ul style="list-style-type: none"> • Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease • Chronic fissures that have not healed after 8 weeks of treatment with adequate dietary treatment measure, stool softeners or laxatives and treatment with topical GTN 0.4% ointment or if not tolerated diltiazem 2% ointment twice a day for 8 weeks. Stress to patients the importance of adherence. • Check if patient taking Nicorandil (a risk factor)
Evidence/Summary of Rationale	See Clinical Knowledge Summary for Anal Fissure July 2016
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Surgery for Anal Fissure - Children
For the treatment of	Anal Fissures in Children (under 18)
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment for Anal Fissures should be considered for children who meet at least one of the following criteria:</p> <ul style="list-style-type: none"> • Presenting with an anal fissure for the first time, with a clear history of severe constipation as causation, where the anal fissure has not healed after two weeks despite GTN 0.05% to 0.1% ointment. This should be prescribed by a specialist as it is not licensed for use in people aged less than 18 years. • Presenting with an anal fissure without a clear history of severe constipation, refer at first presentation. • Recurrent anal fissures.
Evidence/Summary of Rationale	See Clinical Knowledge Summary for Anal Fissure July 2016
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Botulinum toxin type A for Anal Fissure
For the treatment of	Anal Fissure (Adults only)
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment should only be considered commissioned for treating chronic or recurrent anal fissures in adults only when all the criteria outlined below are met:</p> <ul style="list-style-type: none"> • The condition has failed to heal spontaneously • Chronic symptoms (pain and / or rectal bleeding) have persisted for more than 6 weeks • All other appropriate non-surgical, pharmacological (e.g. topical diltiazem, glyceryl trinitrate [GTN]) and dietary treatments have been tried and failed. <p>One treatment with Botulinum toxin A will be commissioned - if the anal fissure fails to heal during the three-month period after injection, and chronic symptoms persist, surgical intervention may be indicated.</p>
Evidence/Summary of Rationale	<p>NICE evidence review: (ref 4) Evidence from 2 systematic reviews and 4 further randomised controlled trials (RCTs) suggests that botulinum toxin type A injection is less effective than surgery, no better or worse than topical glyceryl trinitrate (GTN; mostly 0.2% ointment) or isosorbide dinitrate, and no better than placebo or lidocaine at healing anal fissure. The Medicines and Healthcare products Regulatory Agency (MHRA) has warned healthcare professionals about the rare but serious risk of toxin spread when using all types of botulinum toxin.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Haemorrhoid Surgery
For the treatment of	Surgical removal of haemorrhoids.
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Surgical treatment should only be considered for those that do not respond to non-operative measures of management (For example, as a 1st line management: eating more fibre and drinking more water. As a 2nd line management: outpatient treatment in the form of banding or injection) or if the haemorrhoids are more severe, specifically:</p> <ul style="list-style-type: none"> • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or • Irreducible and large external haemorrhoids

	In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.
Evidence/Summary of Rationale	Haemorrhoid surgery can lead to complications. Pain and bleeding are common and pain may persist for several weeks. Urinary retention can occasionally occur and may require catheter insertion. Infection, iatrogenic fissuring (tear or cut in the anus), stenosis and incontinence (lack of control over bowel motions) occur more infrequently. Evidence-Based Interventions: Guidance for CCG's 2018.
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	12 week trial of Percutaneous Tibial Nerve Stimulation (PTNS) – Faecal Incontinence
For the treatment of	Adults with refractory Faecal Incontinence
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment is not indicated in cases that are asymptomatic.</p> <p>Requests for a 12 week trial of PTNS for faecal incontinence will be considered for patients who fulfil all of the following criteria:</p> <ul style="list-style-type: none"> • Voiding diary data is kept to record frequency and severity of episodes • Symptoms refractory to ≥12 months of first line treatment to include: <ul style="list-style-type: none"> - dietary management - antidiarrhoeal medication - pelvic floor muscle and anal sphincter training (where appropriate)
Evidence/Summary of Rationale	<p>Incontinence definition as per: NICE IPG 395: faecal incontinence, the loss of ability to control a person's anal sphincter and bowel movement, resulting in leakage of faeces.</p> <p>Percutaneous SNS helps to correct erroneous messages sent along these nerve pathways and involves the placing of electrodes in a sacral nerve and stimulation via an internal device. A temporary procedure is followed by permanent implantation if it produces symptom relief. The battery life for the permanent implant is approximately 7-9 years.</p> <p>PTNS achieves a modulatory effect similar to that of SNS through a less invasive route, but its exact mechanism of action is unclear. A fine needle is inserted just above the ankle next to the Posterior Tibial Nerve and a surface electrode is placed near the arch of the foot. Stimulation of the nerve produces a motor and sensory response. Initial treatment usually consists of 12 outpatient sessions lasting 30 minutes, usually weekly. NICE IPG 395 states that PTNS for faecal incontinence has no major safety concerns but the evidence only points to short term efficacy in a</p>

	limited number of patients. The large placebo-controlled study (RELAX 2012) found urgency and incontinence improve more than frequency with a magnitude of improvement considerably larger than that after anticholinergic medication.
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Continued Percutaneous Tibial Nerve Stimulation (PTNS) – Faecal Incontinence
For the treatment of	Adults with refractory Faecal Incontinence
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Requests for an additional 12 weeks of PTNS for faecal incontinence will be considered for patients who fulfil all of the following criteria:</p> <ul style="list-style-type: none"> • They have already undertaken an approved 12 week trial of PTNS • The trial has resulted in a 50% or more improvement in symptoms (measured as a weekly reduction in incontinence episodes).
Evidence/Summary of Rationale	<p>Incontinence definition as per: NICE IPG 395: faecal incontinence, the loss of ability to control a person’s anal sphincter and bowel movement, resulting in leakage of faeces.</p> <p>Percutaneous SNS helps to correct erroneous messages sent along these nerve pathways and involves the placing of electrodes in a sacral nerve and stimulation via an internal device. A temporary procedure is followed by permanent implantation if it produces symptom relief. The battery life for the permanent implant is approximately 7-9 years.</p> <p>PTNS achieves a modulatory effect similar to that of SNS through a less invasive route, but its exact mechanism of action is unclear. A fine needle is inserted just above the ankle next to the Posterior Tibial Nerve and a surface electrode is placed near the arch of the foot. Stimulation of the nerve produces a motor and sensory response. Initial treatment usually consists of 12 outpatient sessions lasting 30 minutes, usually weekly. NICE IPG 395 states that PTNS for faecal incontinence has no major safety concerns but the evidence only points to short term efficacy in a limited number of patients. The large placebo-controlled study (RELAX 2012) found urgency and incontinence improve more than frequency with a magnitude of improvement considerably larger than that after anticholinergic medication.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Ear, Nose and Throat Interventions

Intervention	Botulinum toxin type A for Spasmodic Dysphonia
For the treatment of	Spasmodic Dysphonia
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Botox injections into the vocal cords should be considered for patients in whom:</p> <ul style="list-style-type: none"> • Spasmodic dysphonia has been diagnosed by a Consultant Otolaryngologist (and a more generalised dystonia has been ruled out by a Consultant Neurologist) • Speech and language therapy has not adequately improved the voice quality • The resulting communication difficulties are interfering significantly with daily living
Evidence/Summary of Rationale	<p>The Clinical Practice Guideline states” “Botulinum toxin is beneficial despite the potential need for repeated treatments considering the lack of other effective interventions for spasmodic dysphonia.” Botulinum toxin injections into the muscles that are spasming have thus become the mainstay of therapy starting in the late 1980s. Voice therapy for treating spasmodic dysphonia is useful as an adjunct to botulinum toxin, but voice therapy alone for treating spasmodic dysphonia does not work for everyone and study results have not been consistent.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Grommets for Glue Ear in Children
For the treatment of	Glue Ear (Otitis Media with Effusion) in Children
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>The NHS will only commission this surgery for the treatment of glue ear in children</p>

	<p>when the criteria set out by the NICE guidelines are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit:</p> <ul style="list-style-type: none"> • All children must have had specialist audiology and ENT assessment. • Persistent bilateral otitis media with effusion over a period of 3 months. • Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz • Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. • Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. • The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance. • It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum. <p>Evidence-Based Interventions: Guidance for CCG's 2018</p>
Evidence/Summary of Rationale	<p>In most cases, glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Irrigation of the external Auditory Canal
For the treatment of	Ear Wax
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Prior to referral to acute care for an ear problem, evidence must be collated to show the treatments received in primary care. A referral for ear wax removal to acute care is only commissioned for patients meeting at least one of the criteria set out below:</p> <ul style="list-style-type: none"> • The patient has previously undergone ear surgery (other than grommets insertion that have been extruded for at least 18 months); • Has a recent history of Otagia and /or Otitis media middle ear infection (in the

	<p>past 6 weeks);</p> <ul style="list-style-type: none"> • Recurrent Acute Otitis Externa which is not responding to primary care treatment; • Has a current perforation or history of ear discharge in the past 12 months; • Has had previous complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo; • Two attempts at irrigation of the ear canal following intensive use of ear wax softeners in primary care are unsuccessful; • Cleft palate, whether repaired or not. • Painful or acute otitis externa with an oedematous ear canal and painful pinna. • Presence of a foreign body in the ear • Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness. • Confusion or agitation, as they may be unable to sit still. • Inability to cooperate, for example young children and some people with learning difficulties. <p>Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances warrant deviation from the rule of this policy.</p> <p>Individual cases will be reviewed at the Commissioner’s Individual Funding Request Panel upon receipt of a completed request form from the patient’s GP, Consultant or Clinician. Requests cannot be considered from patients personally.</p>
Evidence/Summary of Rationale	The vast majority of patients presenting with problems to primary care will be managed in primary care with advice or irrigation.
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Rhinoplasty/Septorhinoplasty/Septoplasty
For the treatment of	Nasal Deformities
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Consideration will not be given to cosmetic Rhinoplasty.</p> <p>Rhinoplasty may be considered medically <u>necessary only in</u> limited circumstances and where the case details clinical rationale in accordance with the evidence base as follows:</p> <ol style="list-style-type: none"> 1. When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate; 2. Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when all of the following criteria are met: <ul style="list-style-type: none"> • Airway obstruction will not respond to septoplasty and turbinectomy alone;

	<p><i>and</i></p> <ul style="list-style-type: none"> • Nasal airway obstruction is causing significant symptoms (e.g. chronic rhinosinusitis, difficulty breathing); <i>and</i> • Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy; <i>and</i> • Photos demonstrate an external nasal deformity, <i>and</i> • There is an average 50% or greater obstruction of nares (eg 50 % obstruction of both nares, or 75 % obstruction of one nare and 25 % obstruction of other nare, or 100 % obstruction of one nare), documented by endoscopy, CT scan or other appropriate imaging modality. <p>There are, however, contra indications that need to be addressed such as:</p> <ul style="list-style-type: none"> • Unstable mental status (e.g. unstable patient with schizophrenia) • Unrealistic patient expectations • Previous rhinoplasty within the last 9-12 months (applies only to major rhinoplasties) • Poor perioperative risk profile • History of too many previous rhinoplasties, resulting in an atrophic skin–soft tissue envelope and significant scarring • Nasal cocaine users
Evidence/Summary of Rationale	Guidance on commissioning is provided by the Modernisation Agency Document ‘Information for Commissioners of Plastic Surgery Services’, which was prepared by the British Association of Plastic and Reconstructive Surgery.
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Endocrine Interventions

Intervention	Endoscopic Thoracic Sympathectomy - Hyperhidrosis
For the treatment of	Hyperhidrosis
Commissioning Position	This intervention is NOT routinely commissioned.
	<p>This intervention is a Category One Evidence Based Intervention; therefore, any requests to fund must be made as an Individual Funding Request.</p> <p>In view of the risk of side effects, requests will only be considered via the IFR process for patients that meet all of the following criteria:</p> <ul style="list-style-type: none"> • Suffering from severe and debilitating primary hyperhidrosis • Refractory to other treatments. (These may include topical agents, oral medication, botulinum toxin injections and iontophoresis.) <p>In addition to the criteria above, evidence of clinical exceptionality must be provided.</p>
Evidence/Summary of Rationale	<p>Endoscopic Thoracic Sympathectomy does not work as well for those with excessive axillary (armpit) sweating.</p> <p>NICE guidance indicates that the evidence base for the efficacy and safety of this procedure is “adequate” but there is a risk of serious complications (including death from major intrathoracic bleeding); it is not always effective; and it can cause hyperhidrosis (“compensatory”) elsewhere on the body (in around 80% of cases, of whom 33% reported symptoms that were “severe” or “incapacitating”).</p> <p>The primary indication is palmar hyperhidrosis because it is less effective for axillary symptoms. It should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been refractory to other treatments.</p> <p>Further research is required to establish good patient selection and to identify which patient characteristics might predict severe side-effects.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Fertility Interventions

Intervention	Vasectomy under General Anaesthetic
For the treatment of	Removal of Male Fertility
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p>
	<p>Surgical intervention should be considered for patients where there is:</p> <ul style="list-style-type: none"> • Previous documented adverse reaction to local anaesthesia; • Scarring or deformity (e.g. due to cryptorchidism or from previous scrotal surgery or trauma) that makes vasectomy under local anaesthetic difficult to achieve; • The patient is on anticoagulation therapy (increased risk of postoperative haematoma formation) <p>Fear of the procedure, or patient choice, are not adequate reasons for requesting vasectomy under GA.</p>
Evidence/Summary of Rationale	<p>Most vasectomies are carried out under local anaesthetic. This means only the scrotum and testicles will be numbed and the patient will be awake for the procedure. The procedure should not be painful but may feel slightly uncomfortable. Most men will only need a local anaesthetic.</p> <p>The RCOG Guidelines (4) recommend a general anaesthetic is used where:</p> <ul style="list-style-type: none"> • There is a history of allergy to local anaesthetic; • Surgery has been carried out before on the scrotum or genital area. <p>The RCOG Guidelines also recommend:</p> <ul style="list-style-type: none"> • A 'no-scalpel' approach, as there are lower levels of complications such as bleeding, pain and infection; • The use of fascial interposition or diathermy; • That clips are not used, due to high failure rates ; • That local anaesthesia is used wherever possible; • Effective contraception be used before the operation and until follow-up tests show that the vasectomy has been successful; • Practitioners must be trained to the level of the FSRHC requirement
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

General Surgery

Intervention	Cholecystectomy
For the treatment of	Biliary Tract Problems
Commissioning Position	<p>This intervention is routinely commissioned and does not require Prior Approval or application for funding via the Individual Funding Request (IFR) process providing the criteria below are met.</p>
	<p>Referral for Cholecystectomy will only be funded if the patient fulfils ANY of the criteria below:</p> <ul style="list-style-type: none"> • Symptomatic gallstones with a thickened gallbladder wall • A dilated common bile duct on ultrasound <ul style="list-style-type: none"> • Asymptomatic gallstones with abnormal liver function test (LFT) results • Asymptomatic gall bladder polyp(s) reported on ultrasound • Symptomatic gall bladder 'sludge' reported on ultrasound <p>Elective cholecystectomy surgery will only be commissioned where the patient fulfils ANY of the criteria below:</p> <ul style="list-style-type: none"> • Symptomatic gallstones • Gall bladder polyp(s) larger than 8mm or growing rapidly • Common bile duct stones • Acute pancreatitis <p>Documentation that the threshold criteria are fulfilled is mandatory and the referral letter or form should, as a minimum, contain a clear indication of the grounds for referral against the threshold criteria:</p> <ul style="list-style-type: none"> • any relevant medical history and current medication; • any known factors affecting the patients fitness for day surgery; • a recent ultrasound report conducted within 2 months at the point of referral; • recent liver function test report conducted within 1 month at point of referral. <p>Cholecystectomy should be performed laparoscopically in patients with an uncomplicated abdomen and in the absence of contra-indications. (The standard laparoscopic approach uses several small incisions in the abdomen).</p> <p>Cholecystectomy should be offered as a day case procedure in the absence of contra-indications. Routine laparoscopic cholecystectomy does not generally require a consultant outpatient follow up.</p> <p>If the gall bladder is sent for histological examination, the results should be reviewed by the requesting consultant and communicated to the GP.</p> <p>Secondary providers offering cholecystectomy must be able to offer intraoperative on-table cholangiography and have arrangements in place for urgent access to ERCP and interventional radiology for the management of postoperative complications.</p> <p>Patients should be encouraged by their GP and surgeon to lose weight prior to any surgery and given appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards.</p> <p>GPs can refer patients for a surgical opinion whilst patients lose weight and surgeons (and anaesthetists) can consider the safety of surgery. There is a clinical balance between risk of surgical complications with obesity and with potential complications of gallstones whilst delaying surgery</p>

Evidence/Summary of Rationale	Cholecystectomy is the surgical removal of the gall bladder. Prophylactic Cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic Cholecystectomy or incidental Cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of
	complications, the magnitude of the risk does not warrant prophylactic Cholecystectomy. Primary and secondary care discussions with patients should include identifying options (surgery vs no surgery), including the risks and benefits of each.
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Gynaecological Interventions

Intervention	Hysterectomy for Heavy Menstrual Bleeding
For the treatment of	Heavy menstrual bleeding.
Commissioning Position	This intervention is NOT routinely commissioned. This intervention is a Category One Evidence Based Intervention; therefore, any
	requests to fund must be made as an Individual Funding Request. Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility. This intervention will only be commissioned where the IFR application demonstrates that the criteria outlined in the NICE guidance have been met. Evidence-Based Interventions: Guidance for CCG's 2018
Evidence/Summary of Rationale	NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding (HMB). ¹³ Heavy periods can be reduced by using medicines or intrauterine systems (IUS) or losing weight (if necessary).
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Labiaplasty / Vaginaplasty
For the treatment of	Malformed, enlarged labia / vulva causing functional discomfort which has not responded to conservative management.
Commissioning Position	The NHS will routinely commission reconstructive Labiaplasty / Vaginaplasty: <ul style="list-style-type: none"> • following surgery for cancer • repair after trauma (including tears / scars from childbirth). <p>All other requests for Labiaplasty / Vaginaplasty are NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>There are circumstances where Labiaplasty / Vaginaplasty may be considered where the following are met:</p> <ul style="list-style-type: none"> • Where the woman is 18 years of age or older • Where the woman has completed pubertal development (RCOG, 2013). • Where the labia / vulva causes functional discomfort • Where simple measures to relieve functional discomfort are not successful (Harsh soaps and shower gels in the genital area should be avoided. The use of emollients should be recommended, as well as comfortable underwear). • Where the clinician's sensitive genital examination (visual inspection) has determined that benign labial disease, significant congenital malformation or structural anomalies are identified. <p>Labiaplasty / Vaginaplasty for cosmetic purposes is NOT commissioned.</p> <p>The Royal College of Gynaecology recommends that Labiaplasty or Vaginaplasty should not be offered to children below 18 years of age owing to anatomical development during puberty. If a child is referred via IFR, please note this will be passed directly to CCG Safeguarding in the first instance and does not guarantee IFR consideration.</p>

	British Society for Paediatric & Adolescent Gynaecology (2013). <i>Position Statement: Labial reduction surgery (Labiaplasty) on adolescents.</i>
Evidence/Summary of Rationale	<p>Labiaplasty / Vaginaplasty for cosmetic purposes has no clinical benefit.</p> <p>RCOG states that the risk of revisional surgery in patients who receive surgery prior to completion of pubertal development is high.</p> <p>There are risks of infection and bleeding post-surgery, loss of sensation and dissatisfaction with appearance.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Minor Surgery Procedures

Intervention	Benign Skin Lesions – Surgical Removal
For the treatment of	Symptomatic benign skin lesions
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>This policy refers to the following benign lesions when there is diagnostic certainty and they meet the criteria listed below:</p> <ul style="list-style-type: none">• benign moles (excluding large congenital naevi)• solar comedones

	<ul style="list-style-type: none"> • corn/callous • dermatofibroma • lipomas • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata <p>The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:</p> <ul style="list-style-type: none"> • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue • If left untreated, more invasive intervention would be required for removal • Facial viral warts • Facial spider naevi in children causing significant psychological impact • Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic. <p>The following are outside the scope of this policy recommendation:</p> <ul style="list-style-type: none"> • Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines. • Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care. • Removal of lesions other than those listed above. <p>Referral to dermatology or plastic surgery:</p> <ul style="list-style-type: none"> • The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria. • Requests for treatment where a patient meets the criteria do not require prior approval or an IFR. • This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.
Evidence/Summary of	There is little evidence to suggest that removing benign skin lesions to improve

Rationale	appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning. Evidence-Based Interventions: Guidance for CCG's 2018.
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Chalazia Removal
For the treatment of	Chalazia (meibomian cysts). Benign lesions on the eyelids due to blockage and swelling of an oil gland.
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:</p> <ul style="list-style-type: none"> • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision, demonstrated by visual fields test • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions <p>Evidence-Based Interventions: Guidance for CCG's 2018.</p>
Evidence/Summary of Rationale	The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a "watch and wait" approach will lead to resolution of many chalazia without the risks of surgery.
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Neurological and Pain Interventions

Intervention	Botulinum toxin type A for Chronic Migraine
For the treatment of	Prophylaxis of headaches in adults with Chronic Migraine
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>The CCG will only commission the use of Botox as an option for the prophylactic</p>
	<p>treatment of chronic migraine in adults in accordance with NICE Guidance TAG 260 in cases where ALL of the following criteria are fulfilled:</p> <ul style="list-style-type: none"> • The patient is under the care of the specialist neurology service and has been assessed as meeting the definition for chronic migraine • The patient has chronic migraine that significantly interferes with their daily routine despite appropriate use of symptomatic medication • Symptoms have not responded to at least three prior pharmacological prophylaxis therapies • The condition has been appropriately managed for medication overuse. <p>NB. Treatment with botulinum toxin type A should be stopped in people whose condition:</p> <ul style="list-style-type: none"> • is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) <p>OR</p> <ul style="list-style-type: none"> • has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months (which is not covered in Allergan's licence for Botox).
Evidence/Summary of Rationale	<p>The treatment has been appraised by NICE, which considered evidence from two phase III randomised controlled trials, PREEMPT 1 and PREEMPT 2 as well as the pooled analysis of results from these trials. Prior to publication of the NICE Guidance the North East Treatment Advisory Group and the Scottish Medicines Consortium had appraised the same trial evidence and concluded that the treatment should not be recommended for the prevention of migraine because of uncertainty around its cost-effectiveness. NICE also concluded that although the treatment effects were generally in favour of Botox, the actual magnitude of treatment benefit was modest, but was nevertheless clinically meaningful in people whose chronic migraine had not responded to 3 prior treatments. As in the previous appraisals NICE also noted the large placebo effect, concerns over blinding being maintained in the PREEMPT trials, the lack of long term clinical trial data and numerous concerns over the manufacturer's economic modelling. However after a revised model was submitted using the NICE preferred assumptions, it was concluded that £18,900 was the most plausible ICER (incremental cost effectiveness ratio) per QALY (quality adjusted life year) and that this was considered an appropriate use of NHS resources, with certain specified criteria</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Functional Electrical Stimulation (FES)
For the treatment of	Foot Drop
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Skin surface Functional Electrical Stimulation should be considered in the following circumstances:</p> <ul style="list-style-type: none"> • The individual has an upper motor neuron lesion resulting from stroke, multiple sclerosis (MS), cerebral palsy (CP) or spinal cord injury (SCI) (but has an intact peroneal nerve); • There is evidence that the foot drop interferes significantly with the individual's day to day living; • There is evidence that FES has been recommended for the individual after a thorough assessment of their suitability by the local NHS physiotherapy service or MDT specialising in rehabilitation. <ul style="list-style-type: none"> • The request to the IFR Panel must include evidence that first line treatments have been tried and failed. • First-line treatment is usually physiotherapy or the use of an ankle foot orthosis (AFO). Agreed to delete these lines? Evidence will be required to demonstrate that first line treatments have been tried. • Other options may include medical therapy, electrical stimulation of the affected nerves and surgery. These options can be used alone or in combination with one another. <p>If Prior Approval is granted it is expected that the patient will demonstrate a positive trial of FES before proceeding to a permanent stimulator. In this case it will not be necessary to seek further permission to proceed with the surface electrode device, the 'Odstock drop foot stimulator', but individual funding approval must be sought if an implanted electrode is being considered.</p>
Evidence/Summary of Rationale	<p>A body of evidence, based largely on uncontrolled observational studies in patients with stroke with drop foot and patients with multiple sclerosis with drop foot, using heterogeneous outcome measures, indicates that functional electrical stimulation (FES) (mainly using surface electrodes) is associated with improved walking speed and reduced walking effort.</p> <p>There are preliminary findings of a therapeutic effect of FES use in patients in the chronic phase of stroke rehabilitation. Three large randomised controlled trials are underway in chronic stroke patients which may provide data on comparison with the ankle foot orthosis.</p> <p>There are few safety concerns around the use of surface-applied FES and patient acceptability appears to be high, however the use of implanted electrodes may be associated with more serious adverse events.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Ophthalmology Interventions

Intervention	Cataracts Surgery
For the treatment of	Cataracts
Commissioning Position	<p>This intervention is routinely commissioned and does not require Prior Approval or application for funding via the Individual Funding Request (IFR) process providing the criteria below are met.</p> <p>Prior to referral for cataracts, the referral should be made using the agreed referral form and should only be made where the patient has been provided with approved information in a suitable format (e.g. Royal College of Ophthalmologists leaflet 'Understanding Cataracts') and is willing to undergo surgery.</p> <p>Surgery for cataract extractions should only be funded for patients whose visual impairment is mainly attributable to cataracts, and after correction (e.g. with glasses</p>

	<p>or other adjustments):</p> <ul style="list-style-type: none"> • Have a best corrected visual acuity of 6/12 or worse with both eyes open <p>AND</p> <ul style="list-style-type: none"> • have significant effects on daily living e.g. with mobility (difficulty with steps, risk of falls, ability to drive), independent living, or reading <p>OR</p> <ul style="list-style-type: none"> • have diabetes and removal of the cataract is necessary to facilitate effective retinal screening <p>OR</p> <ul style="list-style-type: none"> • have glaucoma and / or narrow drainage angles and cataract surgery is required to control intra-ocular pressure
<p>Evidence/Summary of Rationale</p>	<p>Cataracts affect over a third of people aged over 65. Smoking and diabetes (associated with BMI > 30) are further risk factors for cataract.</p> <p>80-90% of patients report a benefit from surgery, which include improved clarity of vision and improved colour vision. This in turn has implications for a positive impact on other health and social care needs including a reduction in slips, trips and falls amongst the elderly.</p> <p>There are risks associated with cataract surgery, some common and many very rare; however complications are usually treatable and reasonably good outcomes can be expected.</p> <p>Royal College of Ophthalmologists published guidelines on the management of cataract recognise that “Visual acuity is the most common measurement of visual function as it can be quickly and easily measured” but goes on to point out that “the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity.” This can, however, be hard to quantify objectively.</p> <p>A best corrected visual acuity (BCVA) of better than 6/12 [Snellen], in the worse eye, normally allows a patient to function without significant visual difficulties. In population studies using BCVA as an indicator of morbidity, BCVA better than 6/12 is not considered a visually impairing cataract and acuity of 6/9 is considered a good outcome post-surgery. This applies to both first and second eye surgery.</p> <p>Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is better than 6/12. However, the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract.</p> <p>There is no set level of vision for which an operation is essential. The rate at which cataracts progress is unpredictable. Reading glasses are usually needed after cataract surgery, and some people may require glasses for distance vision who did not previously require them.</p> <p>Cataract surgery does not always result in an improvement in visual acuity or patient satisfaction with visual function.</p>
<p>Effective From</p>	<p>1st April 2019</p>
<p>Policy Review Date</p>	<p>1st April 2021</p>

Intervention	Second Eye Cataracts Surgery
For the treatment of	Cataracts
Commissioning Position	<p>This intervention is routinely commissioned and does not require Prior Approval or application for funding via the Individual Funding Request (IFR) process providing the criteria below are met.</p> <p>Second Eye Surgery should be funded, after post-operative review, if:</p> <ul style="list-style-type: none"> • There is resultant significant anisometropia (difference in refractive error between the two eyes of more than 1.00D) which would result in poor binocular vision or diplopia.
Evidence/Summary of Rationale	<p>Cataracts affect over a third of people aged over 65. Smoking and diabetes (associated with BMI > 30) are further risk factors for cataract.</p> <p>80-90% of patients report a benefit from surgery, which include improved clarity of vision and improved colour vision. This in turn has implications for a positive impact on other health and social care needs including a reduction in slips, trips and falls amongst the elderly.</p> <p>There are risks associated with cataract surgery, some common and many very rare; however complications are usually treatable and reasonably good outcomes can be expected.</p> <p>Royal College of Ophthalmologists published guidelines on the management of cataract recognise that "Visual acuity is the most common measurement of visual function as it can be quickly and easily measured" but goes on to point out that "the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity." This can, however, be hard to quantify objectively.</p> <p>A best corrected visual acuity (BCVA) of better than 6/12 [Snellen], in the worse eye, normally allows a patient to function without significant visual difficulties. In population studies using BCVA as an indicator of morbidity, BCVA better than 6/12 is not considered a visually impairing cataract and acuity of 6/9 is considered a good outcome post-surgery. This applies to both first and second eye surgery.</p> <p>Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is better than 6/12. However, the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract.</p> <p>There is no set level of vision for which an operation is essential. The rate at which cataracts progress is unpredictable. Reading glasses are usually needed after cataract surgery, and some people may require glasses for distance vision who did not previously require them.</p> <p>Cataract surgery does not always result in an improvement in visual acuity or patient satisfaction with visual function.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Intravitreal Therapies for Eye Disease
For the treatment of	Eye Disease
Commissioning Position	<p>This intervention is routinely commissioned and does not require Prior Approval or application for funding via the Individual Funding Request (IFR) process, unless outside of the criteria listed below:</p> <p>CCG commissioning of the use of intravitreal therapies in eye disease as set out below:</p> <p>A) Wet Age Related Macular Degeneration (ARMD)</p> <p>Ranibizumab therapy is routinely commissioned in line with NICE TAG 155, where all of the following circumstances apply in the eye to be treated:</p> <ul style="list-style-type: none"> • The best possible visual acuity (VA) after correction with glasses or contact lenses is between 6/12 and 6/96. • There is no permanent damage to the fovea • The area affected by ARMD is no larger than 12 times the size of the area inside the eye where the optic nerve connects to the retina. • There are signs that the condition has been getting worse. (i.e. blood vessel growth, as indicated by fluorescein angiography, or recent VA changes) <p>and</p> <ul style="list-style-type: none"> • The manufacturer provides ranibizumab with the discount agreed in the patient access scheme (as revised in 2012). <p>NB. Treatment should be stopped if:</p> <ul style="list-style-type: none"> • Vision in the treated eye falls below 15 letters on 2 consecutive visits • Vision falls by 30 letters or more compared to the best recorded vision • There is evidence of deterioration of the lesion morphology despite treatment. <p>Requests for treatment in patients with wet ARMD where the above NICE criteria are not met must be submitted for consideration to the CCG IFR (Individual Funding Request) Panel outlining the rationale for expected clinical benefit. Such cases might include those where visual loss is due to fluid rather than scarring or where vision in the other eye is already poor.</p> <p>Aflibercept (Eylea) is an alternative, licensed (Nov 2012) intravitreal injection for wet ARMD, recommended in the NICE TAG 294 which uses the same eligibility criteria as NICE TAG 155. Both aflibercept and ranibizumab have the same mode of action and are equivalent in terms of efficacy and safety.</p> <p>The CCG commissions the use of aflibercept in patients with wet age-related macular degeneration if:</p> <ul style="list-style-type: none"> • it is used in accordance with the recommendations for ranibizumab in NICE TAG 155; and • the manufacturer provides aflibercept solution for injection with the discount agreed in the patient access scheme. <p>NB. It has been locally agreed that Consultant Ophthalmologists may, in selected ARMD patients, 'switch' between the use of Eylea and Lucentis in 'heavy users' of either drug or where there is a sub-optimal response or an allergic reaction.</p>

This is also in line with advice from NICE and the Royal College of Ophthalmologists.

Requests for treatment in patients with wet ARMD where the above criteria are not met must be submitted for consideration to the CCG IFR (Individual Funding Request) Panel.

B) Diabetic macular oedema (DMO) / retinopathy

Ranibizumab therapy is routinely commissioned in line with NICE TAG 274 in patients where:

- the retina has a central retinal thickness of 400 micrometres or more at the start of treatment; **and**
- the manufacturer provides ranibizumab with the discount agreed in the patient access scheme (as revised in 2012).

In addition, in line with NICE TAG 301 the CCG routinely commissions Fluocinolone acetonide (Iluvien) intravitreal implants for people with chronic DMO who have an intra-ocular lens implant in the eye to be treated if their diabetic macular oedema has failed to respond to other treatments.

Requests for treatment in patients with DMO where the NICE criteria are not met must be submitted for consideration to the CCG IFR Panel.

C) Macular oedema due to retinal vein occlusion (RVO)

Ranibizumab therapy is routinely commissioned as an option for treating visual impairment caused by macular oedema in line with the criteria in NICE TAG 283:

- following central retinal vein occlusion (CRVO); **or**
- following branch retinal vein occlusion (BRVO) in patients where treatment with laser photocoagulation has failed or is deemed unsuitable due to the extent of macular haemorrhage; **and**
- only if the manufacturer provides ranibizumab with the discount agreed in the patient access scheme (as revised in 2012).

The CCG also routinely commissions the use of Ozurdex in line with NICE TAG 229 for patients where laser therapy has failed or is contraindicated due to extensive haemorrhage.

The CCG also routinely commissions the use of Eylea (Aflibercept) in line with NICE TAG 305 as an option for patients with central retinal vein occlusion (CRVO) only if the manufacturer provides aflibercept solution for injection with the discount agreed in the patient access scheme.

Requests for treatment in patients with RVO where the NICE criteria are not met must be submitted for consideration to the CCG IFR Panel.

D) Myopic Choroidal Neovascularisation (Myopic CNV)

The CCG routinely commissions Ranibizumab therapy as an option for treating visual

	<p>impairment caused by myopic CNV in line with the criteria in NICE TAG 298 only if the manufacturer provides ranibizumab with the discount agreed in the patient access scheme (as revised in 2012).</p> <p>E) Inflammatory CNV</p> <p>Ranibizumab is currently unlicensed for this indication. Requests for ranibizumab treatment in patients with inflammatory CNV must be submitted for consideration to the CCG IFR Panel. Treatment will only be considered in patients where all the following criteria are met:</p> <ul style="list-style-type: none"> • Sub/juxta foveal CNV associated with underlying inflammatory disease; and • Intra-retinal OR sub-retinal fluid on OCT scans OR leakage on FFA <p>Where treatment is approved, both myopic and inflammatory CNV should be treated with a single injection of ranibizumab on an 'as needed' basis from the outset.</p> <p>Re-treatments will only be commissioned (after application to the CCG IFR Panel) in cases where:</p> <ul style="list-style-type: none"> • Intra/sub-retinal fluid is seen on OCT scans (persistent or recurrent); or • Lesion leakage is documented on FFA. <p>F) Visual Loss due to Vitreo-Macular Traction</p> <p>The CCG routinely commissions Ocriplasmin (Jetrea, single injection) therapy as an option for treating visual impairment in adults caused by vitreomacular traction in line with the criteria in NICE TAG 29, where the following criteria are met:</p> <ul style="list-style-type: none"> • no epiretinal membrane (a thin layer of scar tissue over their retina, the light-sensitive area at the back of the eye); and • a macular hole (up to 400 micrometers) in the centre of their retina or • severe sight problems. <p>G) Other eye disease</p> <p>Requests for treating other rarer eye diseases with intravitreal therapies outside licensed indications must be submitted to the CCG IFR Panel for consideration together with accompanying evidence of previous treatments and the expected clinical benefit from the requested treatment.</p>
<p>Evidence/Summary of Rationale</p>	<p>Wet Age Related Macular Degeneration</p> <p>NICE TAG 155 considered data from 4 RCTS: MARINA, ANCHOR, PIER and FOCUS trials. The 3 published trials reported mean increases in visual acuity in the 0.5 mg ranibizumab group compared with baseline. In addition, for wet ARMD aflibercept showed equivalence to ranibizumab (given monthly) when studied within the VIEW 1+2 RCTS. It can be given as an automatic 2 monthly dose in the first year (7 injections in total) - compared to a mean of 6 injections with ranibizumab as required - but the fixed aflibercept dosing reduces the need to assess the eye regularly and allows partial booking of the first year of treatment. In the second year of the VIEW studies; aflibercept and ranibizumab were again compared head to head using an as required 'prn' regime and again both drugs showed equivalence. The mechanism of</p>

injection and the safety profile appear identical between the two drugs and the price of both drugs has reduced under the recent patient access scheme.

Diabetic macular oedema (DMO) / retinopathy

NIICE TAG 274 concluded treatment of DMO with ranibizumab was cost effective as long as patients could access a discounted drug cost via the patient access scheme and there was a more tightly defined eligibility criteria, i.e. patients with greater than 400 micrometres of diabetic macular oedema. Evidence came from the RESTORE trial which showed gains in best corrected VA with ranibizumab were greatest in the subgroup of people with central foveal thickness greater than 300 micrometres, with no evidence for a benefit in adding laser to ranibizumab.

The Fluocinolone acetonide intravitreal implant (Iluvien) despite it being substantially more expensive it has the advantage that 70% of patients will only need 1 injection over 3 years

Macular oedema due to central retinal vein occlusion (CRVO)

CRVO has been untreatable until recently and patients with this condition have a very poor natural history. Of those presenting with vision poorer than 6/60, only 20% get any spontaneous visual improvement. Prior to the advent of intra-vitreous therapies the central visual loss in these patients would have been untreatable. The CRUISE trial, a phase III prospective, randomized, double masked, multicentre clinical trial involving 392 patients with CRVO, indicated that a 6 month improvement in VA is maintained after ranibizumab therapy - the mean letter gain is 14.9 letters with monthly 0.5mg ranibizumab injections versus 0.8 letters with sham treatment.

Macular oedema due to branch retinal vein occlusion (BRVO)

Some patients with BRVO get better spontaneously in the first year, so the RCOphth recommends initially observing for 3 months prior to considering macular argon laser therapy if the patient's vision is between 6/12 and 6/60 and the condition has been present for 3 to 12 months. However argon laser can generate ocular co-morbidity including central scotoma, visual loss and late onset choroidal neovascularisation. In patients for whom treatment with laser photocoagulation either has not been beneficial or is deemed unsuitable due to the extent of macular haemorrhage or ischaemia, ranibizumab is commissioned as a treatment option.

Ozurdex (dexamethasone implant) is also now recommended by NICE as an option for treating retinal vein occlusions. Evidence came from the 2 GENEVA trials multi-centre, randomised, parallel group, sham-controlled studies with identical designs, involving 1,267 patients with macular oedema secondary to BRVO or CRVO. Both studies consisted of an initial 6-month masked phase, followed by a further 6-month, open-label period. In the initial 6-month phase patients were randomised to receive a single administration of either DEX 700µg intravitreal implant or sham (needleless applicator). In the open-label phase, patients received

Myopic CNV

Patients with CNV caused by pathological myopia previously offered photodynamic therapy (PDT) did well at avoiding 8 letters of visual loss at 1 yr. with PDT. However long term benefit is often lost due to retinal pigment epithelial atrophy. Recent evidence suggests ranibizumab therapy in these patients can deliver an average mean 12.78 letter gain in an eye with no prior treatment at 12 months and that eyes previously treated with PDT may not achieve such a good prognosis. Most patients with myopic CNV are young and given the guarded prognosis with PDT are keen to

	<p>regain vision and would opt for Lucentis therapy, which is now recommended as a treatment option by NICE. PDT should however remain available according to patient preference e.g. for those who are needle phobic. (The numbers of patients with myopic CNV estimated to be treated with ranibizumab at Hull Eye Hospital is about 9 per year).</p> <p>Inflammatory CNV</p> <p>Patients with inflammatory CNV have conventionally been treated with PDT or systemic or depot steroids. Response to these agents is variable and steroid treatments in particular are well recognised as inducing glaucoma and cataract formation. A recent case series proved Anti-VEGF therapy increased visual acuity to better than 20/30 in 5/6 eyes at 6 months.</p> <p>Visual Loss from Vitreo-Macular Traction</p> <p>Vitreo-retinal traction is a degenerative condition in which the vitreous gel in the centre of the eye is pathologically adherent to the retinal surface causing structural damage that can impair the vision. Previously the only option was surgery to remove the vitreous gel but the use of one Ocriplasmin injection in the affected eye gives an alternative less invasive treatment option for some patients. Repeat injections are not recommended.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Orthopaedic Interventions

Intervention	Arthroscopic Lavage and Debridement
For the treatment of	Osteoarthritis
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Arthroscopic Lavage and Debridement should not be offered as part of treatment for osteoarthritis, unless:</p> <ul style="list-style-type: none"> • the person has knee osteoarthritis • with a clear history of mechanical locking <p>Please note, gelling, 'giving way' and X-ray evidence of 'loose' bodies are not sufficient indications for arthroscopic lavage and debridement.</p>
Evidence/Summary of Rationale	<p>Specialist Advisers stated that there is uncertainty about the efficacy of this procedure. They listed the key efficacy outcomes as relief of pain and reduction of mechanical symptoms.</p> <p>A systematic review on arthroscopic washout (lavage) for osteoarthritis of the knee was published in 2003.¹⁰ The review identified five RCTs (one of which was considered to be good quality) and two non-randomised studies. The review concluded from the RCTs that there was no evidence that arthroscopic washout or debridement improves patient-reported pain, function or disability compared with non-arthroscopic treatments</p> <p>A second systematic review was published in 2005.¹¹ The review identified four RCTs, three of which were included in the previous review; one was a more recent publication. The review concluded that there was insufficient evidence to compare</p>
	the clinical effects of arthroscopic lavage and other treatments for osteoarthritis of the knee. Although none of the trials found a significant effect, small sample sizes and methodological weaknesses made it difficult to conclude that effects were truly absent.
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Bunion Surgery
For the treatment of	Bunions
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment for Bunions should only be considered for patients where:</p> <ul style="list-style-type: none"> • Conservative measures have failed (these include trying accommodative footwear, considering orthoses and using appropriate analgesia.) <p>AND</p> <ul style="list-style-type: none"> • The patient suffers from severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment <p>OR</p> <ul style="list-style-type: none"> • Severe deformity (with or without lesser toe deformity) that causes significant functional impairment OR prevents them from finding adequate footwear
	<p>OR</p> <ul style="list-style-type: none"> • Recurrent or chronic ulceration or infection
Evidence/Summary of Rationale	<p>NICE CKS makes clear that referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes</p> <p>Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery.</p> <p>Referral for orthopaedic or podiatric surgery consultation may be of benefit if the deformity is painful and worsening; the second toe is involved; the person has difficulty obtaining suitable shoes; or there is significant disruption to lifestyle or activities.</p> <p>If the person is referred for consideration of surgery, advise that surgery is usually done as a day case. Bunion surgery may help relieve pain and improve the alignment of the toe in most people (85%–90%); but there is no guarantee that the foot will be perfectly straight or pain-free after surgery.</p> <p>Complications after bunion surgery may include infection, joint stiffness, transfer pain (pain under the ball of the foot), hallux varus (overcorrection), bunion recurrence, damage to the nerves, and continued long-term pain.</p> <p>There is very little good evidence with which to assess the effectiveness of either conservative or operative treatments or the potential benefit of one over the other.</p> <p>Untreated HV in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even amputation.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Dupuytren's Contracture Release - Adults
For the treatment of	Dupuytren's contracture
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.</p>
	<ul style="list-style-type: none"> • An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for either: <ul style="list-style-type: none"> - finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. - severe thumb contractures which interfere with function • NICE concluded that collagenase should only be used for either: <ul style="list-style-type: none"> - Participants in the ongoing clinical trial (HTA-15/102/04), or - Adult patients with a palpable cord if: <ul style="list-style-type: none"> ▪ there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints; <p style="margin-left: 40px;">And</p> <ul style="list-style-type: none"> ▪ needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon
Evidence/Summary of Rationale	<p>Contractures left untreated usually progress and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.</p> <p>Common complications after collagenase injection are normally transient and include skin breaks and localised pain. Tendon injury is possible but very rare.</p> <p>Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Knee Arthroscopy - Osteoarthritis
For the treatment of	Patients with osteoarthritis.
Commissioning Position	This intervention is NOT routinely commissioned. This intervention is a Category One Evidence Based Intervention; therefore, any
	requests to fund must be made as an Individual Funding Request.
Evidence/Summary of Rationale	<p>Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.</p> <p>Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.</p> <p>More effective treatment includes exercise programmes, losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement or joint preserving surgery such as osteotomy is appropriate.</p> <p>Evidence-Based Interventions: Guidance for CCG's 2018.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Plastic Surgery Interventions

Intervention	Breast Enlargement Surgery
For the treatment of	Adults with Amastia or Congenital abnormalities related to Breast Development
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category One Evidence Based Intervention; therefore, any requests to fund must be made as an Individual Funding Request.</p> <p>Requests will only be considered via the IFR process in women meet the following criteria:</p> <ul style="list-style-type: none"> • 18 years of age or older • BMI is within the range 18-25 <p>AND</p> <ul style="list-style-type: none"> • certain congenital abnormalities such as Poland's syndrome, constricted tubular breast, pectus deformity, or chest wall asymmetry associated with scoliosis <p>OR</p> <ul style="list-style-type: none"> • a complete absence of breast tissue (Amastia) in one or both breasts is causing severe functional or medical problems.
Evidence/Summary of Rationale	<p>Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery (such as implant replacement) is common. In fact, it is estimated that one in three women will require further surgery within 10 years of their initial operation. It should be noted that not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.</p> <p>Information for commissioners of Plastic Surgery - referrals and guidelines in Plastic Surgery <i>Modernisation Agency (Action on Plastic Surgery)</i></p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Breast Reduction Surgery
For the treatment of	Women with breast hyperplasia (enlargement), where breasts are large enough to

	<p>cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.</p>
<p>Commissioning Position</p>	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Surgery will not be funded for cosmetic reasons. The NHS will only consider breast reduction for women if all the following criteria are met:</p> <ul style="list-style-type: none"> • The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. • In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes. • Body mass index (BMI) is <27 and stable for at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. • Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation. <p>*As part of individual CCG pathways for Breast Surgery, Infra-Red Scanning may be used to obtain measurements to confirm compliance with the criteria above.</p> <p>Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above.</p> <p>Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.</p> <p>This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.</p>
<p>Evidence/Summary of Rationale</p>	<p>One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.</p>

	Evidence-Based Interventions: Guidance for CCG's 2018.
Effective From	1 ST April 2019
Policy Review Date	1 st April 2021

Intervention	Scar Revision and Skin Resurfacing
For the treatment of	Scars
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>The CCG will routinely commission scar revision surgery only in patients where ALL of the following criteria apply:</p> <ul style="list-style-type: none"> • The scarring is a consequence of previous NHS surgery, burns or trauma; <p>and</p> <ul style="list-style-type: none"> • The scarring is causing adverse physical consequences (due to contraction, tethering or recurrent breakdown); significant functional impairment (for example obstruction of orifice or vision); bleeding or suspicion of malignancy; <p>and</p> <ul style="list-style-type: none"> • Where clinically appropriate, proactive conservative therapies (steroid injections, vitamin E creams, silicone therapy, pressure garments, medication or massage) aimed at arresting the development of adverse, keloid or hypertrophic scarring have been tried but have not been effective; <p>and</p> <ul style="list-style-type: none"> • At least 18 months of the natural healing process has passed. <p>Where revision surgery is required in patients whose circumstances do not quite meet the above criteria, the secondary care Consultant must seek approval from the CCG via the IFR process.</p> <p>The CCG will not routinely commission scar therapy or surgery, including skin resurfacing, in secondary care for any of the categories listed below:</p> <ul style="list-style-type: none"> • Hypertrophic or keloid scars that are not causing adverse consequences or functional impairments (e.g. keloid scarring after ear piercing) • Scarring / ulceration from chronic tattoo breakdowns • Post-acne scarring • Scars resulting from self-harm • Scar treatment for skin rejuvenation or other cosmetic purposes <p>In these cases, individual requests for scar treatment / revision must come from primary care, and if approved via the IFR process this would allow referral to secondary care to assess and/or treat as clinically appropriate, including surgery.</p> <p>All IFR requests for scar revision must include details of the cause, appearance, size and location of the scarring (clinical photographs may help); the outcome of any previous conservative therapies and the extent and nature of the adverse effects that the scarring is causing to the individual.</p>
Evidence/Summary of Rationale	In line with the Modernisation Agency guidelines for Plastic Surgery, surgery undertaken exclusively to improve appearance is excluded from NHS provision in the absence of previous trauma, disease or congenital deformity.
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Respiratory Interventions

Intervention	Sleep Study
For the treatment of	Referral to secondary care sleep medicine services for assessment (e.g. via home-based overnight sleep study) of
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Requests for approval for referral for Sleep studies should be based on any of the following criteria:</p> <ul style="list-style-type: none"> • Patient has symptoms of excessive daytime sleepiness (EDS) that score >10 on the Epworth Sleepiness Score (ESS) combined with objective clinical judgement that indicates need for referral • Patient displays symptoms of chronic snoring as well as witness apnoeic episodes or daytime sleepiness with a score of >10 on the Epworth Sleepiness Score (ESS)
	<ul style="list-style-type: none"> • Sleepiness in dangerous situations, even with a normal ESS score, in combination with symptoms associated with obstructive sleep apnoea/hypopnoea • Excessive daytime sleepiness, despite a normal time in bed at night, which may interfere with his/her driving ability/occupation <p>Conservative management addressing lifestyle factors such as weight reduction, smoking and alcohol intake should commence at the earliest opportunity.</p> <p>It is a legal requirement on every driver not to drive when their ability to drive safely is impaired, including when they are tired.</p> <p>Untreated OSAHS leads to an increased risk of motor accidents. It is the responsibility of drivers to cease driving until their symptoms resolve and inform the DVLA if appropriate (as advised by clinicians). The DVLA are usually willing to allow car drivers to continue driving once they are established on a successful therapy and reviewed by clinicians at intervals of not more than 3 years.</p>
Evidence/Summary of Rationale	There is some evidence that clinical history and physical examination alone are not as reliable for diagnosing obstructive sleep apnoea as an overnight sleep study and treatment pathways suggest that PSG is the most accurate means of confirming a diagnosing of adult sleep apnoea. However, some guidelines have suggested that a home based sleep study may be useful, cost-effective and convenient for patients and can significantly speed up the investigation pathway, compared with an overnight inpatient stay.
Effective From	1 ST April 2019
Policy Review Date	1 ST April 2021

Intervention	Trial of Continuous Positive Airway Pressure (CPAP) for Obstructive Sleep Apnoea
For the treatment of	Sleep Apnoea
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Treatment trial to include the issue of a single CPAP device for a 6 month period, will only be commissioned for patients where the following criteria are met:</p> <ul style="list-style-type: none"> • Diagnosis of moderate/severe OSAHS, confirmed by sleep study where appropriate, indicating at least 15 episodes per hour of sleep • OSAHS is interfering significantly with activities of daily living • They have signed an agreement to appropriately insure and maintain the CPAP device and return it to the service if treatment stops or reimburse the full replacement cost of the device to the NHS. <p>Conservative management addressing lifestyle factors such as weight reduction,</p>
	<p>smoking and alcohol intake should continue.</p> <p>It is a legal requirement on every driver not to drive when their ability to drive safely is impaired, including when they are tired.</p> <p>Untreated OSAHS leads to an increased risk of motor accidents. It is the responsibility of drivers to cease driving until their symptoms resolve and inform the DVLA if appropriate (as advised by clinicians). The DVLA are usually willing to allow car drivers to continue driving once they are established on a successful therapy and reviewed by clinicians at intervals of not more than 3 years.</p>
Evidence/Summary of Rationale	The evidence for treatment of symptomatic patients with mild OSA is not as strong. However, there may be people with mild severity grading, who have considerable OSA symptoms affecting their quality of life that may benefit from CPAP (e.g. lorry drivers).
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Continued Continuous Positive Airway Pressure (CPAP) for Obstructive Sleep Apnoea
For the treatment of	Sleep Apnoea
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Treatment continuation will only be commissioned for patients where the following criteria are met:</p> <ul style="list-style-type: none"> • During the trial period the patient utilised the device in excess of 70% of nights. • During the trial period the patient utilised the device on average in excess of 4 hours per night. • The trial outcome has clinically indicated that the patient is benefitting from the device. There is improvement in their AHI or Epworth Scores. <p>It is a legal requirement on every driver not to drive when their ability to drive safely is impaired, including when they are tired.</p> <p>Untreated OSAHS leads to an increased risk of motor accidents. It is the responsibility of drivers to cease driving until their symptoms resolve and inform the DVLA if appropriate (as advised by clinicians). The DVLA are usually willing to allow car drivers to continue driving once they are established on a successful therapy and reviewed by clinicians at intervals of not more than 3 years.</p>
Evidence/Summary of Rationale	The evidence for treatment of symptomatic patients with mild OSA is not as strong. However, there may be people with mild severity grading, who have considerable OSA symptoms affecting their quality of life that may benefit from CPAP (e.g. lorry drivers).
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Urological Interventions

Intervention	Circumcision – Male Adults
For the treatment of	Clinical Health indications requiring surgical removal of foreskin(over 18 years old)
Commissioning Position	<p>Circumcision is NOT commissioned for cultural, religious or cosmetic reasons.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>It must be noted that any potentially malignant lesions of the prepuce or those causing diagnostic uncertainty must be referred via the 2 week wait pathway and do not require funding approval.</p> <p>Any of the following clinical indications must be present:</p> <ul style="list-style-type: none"> • Congenital abnormalities with functional impairment • Distal scarring of the preputial orifice • Painful erections secondary to a tight foreskin • Recurrent bouts of infection (balanitis/balanoposthitis) • Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepuccial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin). • Lichen sclerosus (balanitis xerotica obliterans) -chronic inflammation leading to a rigid fibrous foreskin. • Pain on intercourse

	<ul style="list-style-type: none"> • Traumatic injury
Evidence/Summary of Rationale	<p>The BMA states that to circumcise for therapeutic reasons where medical research has shown other techniques (such as topical steroids or manual stretching under local anaesthetic) to be at least as effective and less invasive, would be unethical and inappropriate. Common risks of surgical circumcision include bleeding, local sepsis, oozing, discomfort >7 days, meatal scabbing or stenosis, removal of too much or too little skin, urethral injury, amputation of the glans and inclusion cyst. Furthermore, long-term psychological trauma and possible decreased sexual pleasure have also been reported. There are claims that there may be health benefits associated with this procedure, for example a lower rate of penile cancer and a reduced chance of sexual transmitted diseases (including HIV among heterosexual men). However, the overall clinical and cost-effectiveness evidence is inconclusive. Condoms are far more effective (98% effective if used correctly) than circumcision for preventing STIs.</p>
Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Circumcision – Male Children
For the treatment of	Clinical Health indications requiring surgical removal of foreskin (under 18 years old)
Commissioning Position	<p>Circumcision is NOT commissioned for cultural, religious or cosmetic reasons.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>It must be noted that any potentially malignant lesions of the prepuce or those causing diagnostic uncertainty must be referred via the 2week wait pathway and do not require funding approval.</p> <p>Referral to secondary care for children should only be made if there are any of the following circumstances:</p> <ul style="list-style-type: none"> • Distal scarring of the preputial orifice • Balanitis Xerotica Obliterans • Painful erections secondary to a tight foreskin • Recurrent bouts of infection (balanitis/balanoposthitis)
Evidence/Summary of Rationale	<p>The BMA states that to circumcise for therapeutic reasons where medical research has shown other techniques (such as topical steroids or manual stretching under local anaesthetic) to be at least as effective and less invasive, would be unethical and inappropriate. Common risks of surgical circumcision include bleeding, local sepsis, oozing, discomfort >7 days, meatal scabbing or stenosis, removal of too much or too little skin, urethral injury, amputation of the glans and inclusion cyst. Furthermore, long-term psychological trauma and possible decreased sexual pleasure have also been reported. There are claims that there may be health benefits associated with this procedure, for example a lower rate of penile cancer and a reduced chance of sexual transmitted diseases (including HIV among heterosexual men). However, the overall clinical and cost-effectiveness evidence is inconclusive. Condoms are far more effective (98% effective if used correctly) than circumcision for preventing STIs.</p>

Effective From	1 st April 2019
Policy Review Date	1 st April 2021

Intervention	Hydrocele Correction
For the treatment of	Hydrocele
Commissioning Position	<p>This intervention is NOT routinely commissioned</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered present.</p> <p>Treatment should only be considered if:</p> <ul style="list-style-type: none"> • Aspiration has failed or considered inappropriate • The hydrocele is large (>3cm in size) • The hydrocele is recurrent • There is atypical presentation (malignancy excluded)
Evidence/Summary of Rationale	<p>Hydroceles (fluid collection around the testicles) may be present at birth and are common, affecting around one male baby in every 10. They do not usually require treatment as they often disappear on their own during the first 2 years of life. The CCG will fund treatment for hydroceles in children if they do not disappear by the age of 2. Less commonly, hydroceles can develop in adult men and may follow infection, injury or radiotherapy. Often hydroceles are asymptomatic. Therefore, in adults treatment is not funded unless the hydrocele is causing significant symptoms.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	12 week trial of Percutaneous Tibial Nerve Stimulation (PTNS) – Urinary Incontinence
For the treatment of	Adults with refractory Urinary Incontinence
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Treatment is not indicated in cases that are asymptomatic.</p> <p>Requests for a 12 week trial of PTNS for urinary incontinence due to overactive bladder (OAB) syndrome in men and women will be considered for patients who fulfil all the following criteria:</p> <ul style="list-style-type: none"> • The patient has a confirmed diagnosis defined by urodynamic assessment and has been reviewed by a Urology MDT. • The patient is unable to perform clean, intermittent self-catheterisation • Evidence of the condition having a severe and debilitating impact on activities of daily living • Voiding diary data is kept to record frequency and severity of episodes • Symptoms refractory to ≥12 months of first line treatments including: <ul style="list-style-type: none"> - behavioural and lifestyle modification (diet, weight management, modification of fluid intake) - bladder retraining and catheterisation

	<ul style="list-style-type: none"> - pelvic floor muscle training - anticholinergic drugs - Botox injections have been unsuccessful or deemed inappropriate
Evidence/Summary of Rationale	<p>Incontinence definition as per NICE IPG 362: urinary urgency, with or without urge incontinence, usually with frequency and nocturia.</p> <p>Percutaneous SNS helps to correct erroneous messages sent along these nerve pathways and involves the placing of electrodes in a sacral nerve and stimulation via an internal device. A temporary procedure is followed by permanent implantation if it produces symptom relief. The battery life for the permanent implant is approximately 7-9 years.</p> <p>PTNS achieves a modulatory effect similar to that of SNS through a less invasive route, but its exact mechanism of action is unclear. A fine needle is inserted just above the ankle next to the Posterior Tibial Nerve and a surface electrode is placed near the arch of the foot. Stimulation of the nerve produces a motor and sensory response. Initial treatment usually consists of 12 outpatient sessions lasting 30 minutes, usually weekly. NICE IPG 362 concludes “current evidence on PTNS for OAB syndrome shows it is efficacious in reducing symptoms in the short and medium term, with no major safety concerns.” NICE CG171 (2013) says there is good evidence to suggest that conservative treatment should include Botulinum Toxin A for refractory detrusor over activity in women. The large placebo-controlled study (RELAX 2012) found urgency and incontinence improve more than frequency with a magnitude of improvement considerably larger than that after anticholinergic medication.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Continued Percutaneous Tibial Nerve Stimulation (PTNS) – Urinary Incontinence
For the treatment of	Adults with refractory Urinary Incontinence
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>Continued PTNS for urinary incontinence due to overactive bladder (OAB) syndrome in men and women will be considered for patients who fulfil all the following criteria:</p> <ul style="list-style-type: none"> • They have already undertaken an approved 12 week trial of PTNS • The trial has resulted in a 50% or more improvement in symptoms (measured as a weekly reduction in incontinence episodes).
Evidence/Summary of Rationale	<p>Incontinence definition as per NICE IPG 362: urinary urgency, with or without urge incontinence, usually with frequency and nocturia.</p> <p>Percutaneous SNS helps to correct erroneous messages sent along these nerve pathways and involves the placing of electrodes in a sacral nerve and stimulation via an internal device. A temporary procedure is followed by permanent implantation if</p>

	<p>it produces symptom relief. The battery life for the permanent implant is approximately 7-9 years.</p> <p>PTNS achieves a modulatory effect similar to that of SNS through a less invasive route, but its exact mechanism of action is unclear. A fine needle is inserted just above the ankle next to the Posterior Tibial Nerve and a surface electrode is placed near the arch of the foot. Stimulation of the nerve produces a motor and sensory response. Initial treatment usually consists of 12 outpatient sessions lasting 30 minutes, usually weekly. NICE IPG 362 concludes “current evidence on PTNS for OAB syndrome shows it is efficacious in reducing symptoms in the short and medium term, with no major safety concerns.” NICE CG171 (2013) says there is good evidence to suggest that conservative treatment should include Botulinum Toxin A for refractory detrusor over activity in women. The large placebo-controlled study (RELAX 2012) found urgency and incontinence improve more than frequency with a magnitude of improvement considerably larger than that after anticholinergic medication.</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Varicoceles (Adolescents)
For the treatment of	Adolescent males (aged 10-17) with Grade II or Grade III Scrotal Swelling
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>For diagnostic uncertainty, patients should be referred via the 2 week wait pathway.</p> <p>Urgent referral to a urologist will be funded if:</p> <ul style="list-style-type: none"> • A varicocele appears suddenly and is painful. • The varicocele does not drain when lying down • There is a solitary right-sided varicocele <p>Referral to a urologist will be considered, provided the patient:</p> <ul style="list-style-type: none"> • is aged 10 - 17 • Has Grade II or III and asymmetrical testes • If experiencing pain or discomfort • If there are concerns about reduced ipsilateral testicular volume. • If the patients or parents/guardians are concerned by the appearance, or symptoms, and cannot be fully reassured in primary care. <p>Treatment will not be considered for adolescent males with:</p> <ul style="list-style-type: none"> • Subclinical or grade I varicocele. NICE advises treatment is not necessary and clinicians should provide advice and reassurance. • Grade II or III varicocele and symmetrical testes. NICE advises observation with annual examinations.
Evidence/Summary of Rationale	<ul style="list-style-type: none"> - Sub-clinical — detected only by Doppler ultrasound. - Grade I (small) — palpable only with Valsalva manoeuvre. - Grade II (moderate) — palpable without Valsalva manoeuvre. - Grade III (large) — visible through the scrotal skin <p>Around 25% of boys who present with a grade II or III varicocele and testes of equal size will ultimately develop testicular growth arrest.</p> <p>Patients can expect a 50–80% chance of ipsilateral catch-up growth of the affected testis following surgery this may take up to 6 months.</p> <p>The RCS recommends that varicocele should not be treated unless there are significant functional problems (or signs of ipsilateral testicular growth arrest in adolescents</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Intervention	Varicoceles (Adults)
For the treatment of	Adult males (18+) with Scrotal Swelling
Commissioning Position	<p>This intervention is NOT routinely commissioned.</p> <p>This intervention is a Category Two Evidence Based Intervention; therefore, any requests for funding should in the first instance be made via the Prior Approval System. If unsuccessful via Prior Approval the referring clinician can choose to submit an Individual Funding Request if exceptionality is considered to be present.</p> <p>For diagnostic uncertainty, patients should be referred via the 2 week wait pathway.</p> <p>Urgent referral to a urologist will be funded if:</p> <ul style="list-style-type: none"> • A varicocele appears suddenly and is painful. • The varicocele does not drain when lying down • There is a solitary right-sided varicocele <p>Referral to a urologist will be considered, provided the patient:</p> <ul style="list-style-type: none"> • is aged 18 or older • Has Grade II or III symptomatic varicocele, or with abnormal semen parameters • If experiencing pain or discomfort <p>Treatment will not be considered for adult males with:</p> <ul style="list-style-type: none"> • Sub-clinical or grade I varicocele – NICE advised that treatment is not necessary and semen analysis should be offered if fertility is a concern. • Grade II or III asymptomatic varicocele and normal semen parameters. NICE advises observation with semen analysis every 1–2 years.
Evidence/Summary of Rationale	<ul style="list-style-type: none"> - Sub-clinical — detected only by Doppler ultrasound. - Grade I (small) — palpable only with Valsalva manoeuvre. - Grade II (moderate) — palpable without Valsalva manoeuvre. - Grade III (large) — visible through the scrotal skin <p>Patients can expect a 50–80% chance of ipsilateral catch-up growth of the affected testis following surgery this may take up to 6 months.</p> <p>The National Institute for Health and Care Excellence (NICE) recommends that men should not be offered surgery for varicoceles as a form of fertility treatment, because it does not improve pregnancy rates</p>
Effective From	1 st November 2019
Policy Review Date	1 st November 2021

Appendix 2 – References

(in order of appearance)

COLORECTAL INTERVENTIONS

Surgery for Anal Fissure (Adults and Children)

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Clinical Knowledge Summaries Anal Fissures

Botulinum Toxin type A for Anal Fissure

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Percutaneous Tibial Nerve Stimulation (PTNS) for Faecal Incontinence

NICE IPG 395 (May 2011) Percutaneous Tibial Nerve stimulation (PTNS) for faecal incontinence

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Sacral Nerve Stimulation (SNS) Adults with Faecal Retention

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EAR, NOSE AND THROAT INTERVENTIONS

Botulinum toxin type A for Spasmodic Dysphonia

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Grommets for Glue Ear in Children

NICE guidance: <https://www.nice.org.uk/Guidance/CG60>

Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3

Irrigation of the external Auditory Canal

NICE Clinical Knowledge Summary - <http://cks.nice.org.uk/earwax>

ENDOCRINE INTERVENTIONS

Endoscopic Thoracic Sympathectomy

NICE Clinical Knowledge Summary – Hyperhidrosis

NICE IPG 487 (May 2014) Endoscopic Thoracic Sympathectomy for primary hyperhidrosis of the upper limb: guidance

FERTILITY INTERVENTIONS

Vasectomy under GA

RCOG Faculty of Sexual & Reproductive Health Care. UK Medical Eligibility Criteria for Contraceptive Use. 2009. (Section on Male Surgical Sterilization pp101-104)

NICE Clinical Knowledge Summaries. Contraception -management. Male sterilization (last revised June 2012)

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GENERAL SURGERY

Cholecystectomy

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<http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones>

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NICE IPG 346 - Single incision laparoscopic cholecystectomy. NICE Interventional Procedure Guideline (May 2010)<http://guidance.nice.org.uk/IPG346>

GYNAECOLOGY INTERVENTIONS

Hysterectomy for Heavy Menstrual Bleeding

NICE guidance: <https://www.nice.org.uk/guidance/ng88>.

NHS website: <https://www.nhs.uk/conditions/heavy-periods/#Causes>

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Labiaplasty/Vaginaplasty

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MINOR SURGERY PROCEDURES

Benign Skin Lesions – Surgical Removal

Higgins JC, Maher MH, Douglas MS. Diagnosing Common Benign Skin Tumors. *Am Fam Physician*. 2015 Oct 1;92(7):601-7. PubMed PMID: 26447443.

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NEUROLOGICAL AND PAIN INTERVENTIONS

Botulinum toxin type A for Chronic Migraine

NICE TAG 260 (June 2012) Migraine (chronic) - botulinum toxin type A <http://guidance.nice.org.uk/ta260>

PREEMPT 1 Aurora S K, Dodick D W, Turkel C C ,et al. Onabotulinumtoxin A for treatment of chronic migraine: results from the double-blind, randomized, placebo controlled phase of the PREEMPT 1 trial. Cephalalgia 2010;30:793-803. <http://cep.sagepub.com/content/30/7/793.abstract>

PREEMPT 2 Diener H C, Dodick D W, Aurora S K ,et al. Onabotulinumtoxin A for treatment of chronic migraine: results from the double-blind, randomized, placebo controlled phase of the PREEMPT 2 trial. Cephalalgia 2010;30:804-14. <http://cep.sagepub.com/content/30/7/804.abstract>

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<http://www.netag.nhs.uk/files/appraisalreports/Botox%20for%20chronic%20migraine%20-%20NETAG%20appraisal%20report%20-Sept%202011- %20WEB%20VERSION.pdf>

Scottish Medicines Consortium advice on Botox for the Prophylaxis of headaches in adults with chronic migraine (April 2011)

http://www.scottishmedicines.org.uk/SMC_Advice/Advice/692_11_botulinum_toxin_type_a_BOTOX/689_11_botulinum_toxin_type_a_Botox

OPHTHALMOLOGY INTERVENTIONS

Cataract Surgery (including Second Eye Cataracts)

Driving eyesight rules Jan 2015

Royal College of Ophthalmologists Feb 2015 Commissioning Guide: Cataract Surgery Clinical Knowledge Summaries: Cataracts. Due during 2017

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Healthcare Improvement Scotland Technologies scoping report 9: What is the impact of using thresholds for first-eye cataract surgery on the delivery of the cataract service?

English National Health Service's Savings Plan May Have Helped Reduce The Use Of Three 'Low-Value' Procedures Sophie Coronini-Cronberg et al Health Affairs March 2015

Cataract surgical rates: is there overprovision in certain areas? Sparrow Br J Ophthalmol 2007 91: 852-853

Evidence review: cataract surgery Hampson and Briggs; Cheshire West and Chester public health collaborative service May 2014

Sophie Coronini-Cronberg, member of Royal College of Ophthalmologists working group commissioned by NICE to develop commissioning guidelines (see ref 2) and Honorary Research Fellow, Department of Primary Care and Public Health, Imperial College London (personal communication)

Cambridge and Peterborough CCG Cataracts policy March 2014.

Intravitreal Therapies for Eye Disease

NICE Technology Appraisal Guidance 155 (issued August 2008, updated May 2012) Macular degeneration (age-related) - ranibizumab and pegaptanib. <http://www.nice.org.uk/ta155>

Royal College of Ophthalmologists (2009) Guidelines for the Management of wet ARMD
http://www.rcophth.ac.uk/core/core_picker/download.asp?id=1185&filetitle=Age%2DRelated+Macular+Degeneration+2009+Guidelines+for+Management%2Dupdate

Scottish Medicines Consortium (March 2013) Advice on aflibercept 40mg/mL solution for intravitreal injection (Eylea®) in adults for the treatment of neovascular (wet) age-related macular degeneration.
http://www.scottishmedicines.org.uk/files/advice/aflibercept_Eylea_FINAL_March_2013_Amended_030413_for_website.pdf

Statement from The Royal College of Ophthalmologists in response to the SMC Decision to accept Eylea® for wet AMD (April 2013). <http://www.rcophth.ac.uk/news.asp?section=24&itemid=1350&search>

NICE Technology Appraisal Guidance 294 (July 2013) Aflibercept solution for injection for treating wet age-related macular degeneration. <http://www.nice.org.uk/nicemedia/live/14227/64572/64572.pdf>

Jeffrey S. Heie et al for the VIEW 1 and VIEW 2 Study Groups (2012) Intravitreal Aflibercept (VEGF Trap-Eye) in Wet Age-related Macular Degeneration. Ophthalmology. 2012 Dec;119(12):2537-48
[http://www.aaojournal.org/article/S0161-6420\(12\)00865-2/abstract](http://www.aaojournal.org/article/S0161-6420(12)00865-2/abstract)

NICE Technology Appraisal Guidance 274 (Feb 2013) Ranibizumab for the treatment of diabetic macular oedema <http://www.nice.org.uk/ta274>

NICE Technology Appraisal Guidance 283 (May 2013). Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion
<http://www.nice.org.uk/nicemedia/live/14169/63851/63851.pdf>

NICE Technology Appraisal Guidance 229. (July 2011) Dexamethasone intravitreal implant for the treatment of macular oedema secondary to retinal vein occlusion
<http://www.nice.org.uk/nicemedia/live/13541/55611/55611.pdf>

NICE Technology Appraisal Guidance 298 (Nov 2013) Ranibizumab for treating choroidal neovascularisation associated with pathological myopia. <http://www.nice.org.uk/nicemedia/live/14305/65827/65827.pdf>

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<http://www.nature.com/eye/journal/v23/n6/full/eye200988a.html>

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Haller JA et al. Randomized, sham-controlled trial of dexamethasone intravitreal implant in patients with macular edema due to retinal vein occlusion. Ophthalmology. 2010 Jun;117(6):1134-46 e3. (GENEVA study group) <http://www.eretina.com/Paper/Ozurdex%20RVO%20study.pdf>

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NICE Technology Appraisal Guidance 297 (Oct 2013) Vitreomacular traction - ocriplasmin
<http://guidance.nice.org.uk/ta297> 22) NICE Technology Appraisal Guidance 301 (Nov 2013) Diabetic macular oedema - fluocinolone acetonide intravitreal implant (rapid review of TA271) (TA301)
<http://guidance.nice.org.uk/ta301>

NICE Technology Appraisal Guidance 305 (Feb 2014) Macular oedema (central retinal vein occlusion) - aflibercept solution for injection (TA305) <http://guidance.nice.org.uk/ta305>

RCO Statement (Feb 2014) The Royal College of Ophthalmologists' College Statement: Choice of anti VEGF agents for wet AMD treatments. http://www.rcophth.ac.uk/core/core_picker/download.asp?id=2006

Stalmans P, et al. ; MIVI-TRUST Study Group. Enzymatic vitreolysis with ocriplasmin for vitreomacular traction and macular holes. N Engl J Med. 2012 Aug 16;367(7):606-15

ORTHOPAEDIC INTERVENTIONS

Arthroscopic Lavage and Debridement

<https://www.nice.org.uk/guidance/cg177>

<https://www.nice.org.uk/guidance/ipg230>

Bunion Surgery

NICE Clinical Knowledge Summaries

Royal College of Surgeons Painful deformed great toe (2013) – under revision

Abhishek A; Roddy E; Zhang W; Doherty M. Are hallux valgus and big toe pain associated with impaired quality of life? A cross-sectional study. *Osteoarthritis Cartilage* 2010 Jul;18(7):923-6

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http://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/dupuytren's_disease_leaflet_2016.pdf

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Krefter C, Marks M, Hensler S, Herren DB, Calcagni M. Complications after treating dupuytren's disease. A systematic literature review. *Hand surgery & rehabilitation.* 2017, 36: 322-9.

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6. NICE, 2017. Collagenase clostridium histolyticum for treating Dupuytren's contracture. :
<https://www.nice.org.uk/guidance/ta459>

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Knee Arthroscopy

NICE guidance: <https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf492463117>

NICE guidance: [https://www.nice.org.uk/guidance/ipg230/chapter/1- Guidance](https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance)

NICE guidance: <https://www.nice.org.uk/donotdo/referral-forarthroscopic-lavage-and-debridement-should-not-be-offered-as-partof-treatment-for-osteoarthritis-unless-the-person-has-kneeosteoarthritis-with-a-clear-history-of-mechanical-locking-not>

British Orthopaedic Association and the Royal College of Surgeons: <https://www.rcseng.ac.uk/-/media/files/rcs/standards-andresearch/commissioning/boa--painful-oa-knee-guide-final-2017.pdf>

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Gynaecomastia

Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2>

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Godwin Y, (2012) Gynaecomastia: considerations and challenges in treating male patients with varying body Habitus. Eur J Plast Surg 2012; 35:55–64

http://download.springer.com/static/pdf/681/art%253A10.1007%252Fs00238-011-0582-1.pdf?originUrl=http%3A%2F%2Flink.springer.com%2Farticle%2F10.1007%2Fs00238-011-0582-1&token2=exp=1450357409~acl=%2Fstatic%2Fpdf%2F681%2Fart%25253A10.1007%25252Fs00238-11-0582-1.pdf%3ForiginUrl%3Dhttp%253A%252F%252Flink.springer.com%252Farticle%252F10.1007%252Fs00238-011-0582-1*~hmac=a66bbf7da6481b8d1eb83e6bb9b1b051fa74bdae93a24951d2656d611bd6e8b1#page-1

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<http://www.ncbi.nlm.nih.gov/pubmed/21477170>

Scar Revision and Skin Resurfacing

Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London <http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/informationfor-commissioners-of-plastic-surgery-services.pdf>

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http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922716/pdf/jcad_3_5_20.pdf

RESPIRATORY INTERVENTIONS

Sleep Study, Trial and Continuous Positive Airway Pressure (CPAP) for Obstructive Sleep Apnoea

Specialised Services National Definitions Set (SSNDS) No.29 Specialised Respiratory Services (adult) third edition 2009 [http://www.specialisedservices.nhs.uk/library/26/Specialised Respiratory Services_adult.pdf](http://www.specialisedservices.nhs.uk/library/26/Specialised_Respiratory_Services_adult.pdf)

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Brietzke SE, Katz ES, Roberson DW., Can history and physical examination reliably diagnose paediatric obstructive sleep apnoea/ hypopnea syndrome? A Systematic review of the literature, 2004, Otolaryngology - Head and Neck Surgery, Elsevier
<http://www.ncbi.nlm.nih.gov/pubmed/15577775>

NICE Clinical Knowledge Summary – Sleep Apnoea <http://cks.nice.org.uk/sleep-apnoea#!diagnosisadditional/A-358754:2>

<https://cks.nice.org.uk/obstructive-sleep-apnoea-syndrome#!scenario>

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UROLOGICAL INTERVENTIONS

Circumcision (Male Adults and Male Children)

Female Genital Mutilation Act 2003 <http://www.legislation.gov.uk/ukpga/2003/31>

Female Genital Mutilation: multi-agency practice guidelines. Department of Health, February 2011
<https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practiceguidelines>

Royal College of Surgeons Commissioning guide: Foreskin conditions October 2013
<http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions>

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Hydrocele Correction

<https://cks.nice.org.uk/scrotal-swellings#!scenario:8>

Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Incontinence

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NICE CG 171 (Sept 2013) Urinary incontinence: the management of urinary incontinence in women.
<http://guidance.nice.org.uk/CG171>

Gabriele Gaziev et al. (2013) Percutaneous Tibial nerve stimulation (PTNS) efficacy in the treatment of lower urinary tract dysfunctions: a systematic review. Gaziev et al. BMC Urology 2013, 13:61
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Varicoceles

<https://cks.nice.org.uk/varicocele>

VASCULAR INTERVENTIONS

Appendix 3 – OPCS Codes

COLORECTAL INTERVENTIONS	
Surgery for Anal Fissure (Adults and Children)	H56.4, H562
Botulinum Toxin type A for Anal Fissure	S53.2 with X85.1 and Z49.2, H568
Haemorrhoid Surgery	H51, H511, H512, H513, H518, H519
Percutaneous Tibial Nerve Stimulation (PTNS) for Faecal Incontinence	A704 (both permanent and 12 week trial)

EAR, NOSE AND THROAT INTERVENTIONS	
Botulinum toxin type A for Spasmodic Dysphonia	E381
Grommets for Glue Ear in Children	D151, D158, D159
Irrigation of the external Auditory Canal	Primary procedure code D071
Rhinoplasty/Septorhinoplasty/Septoplasty	E02.3, E02.4, E02.5, E02.6, E028, E073, E022, E027, E029, E036, E037, E071, E072, E078, E079

ENDOCRINE INTERVENTIONS	
Endoscopic Thoracic Sympathectomy	A752

FERTILITY INTERVENTIONS	
Vasectomy under GA	N17.1, N17.2, N17.8, N17.9, N17*

GENERAL SURGERY	
Cholecystectomy	J181, J182, J183, J184, J185, J188, J189

GYNAECOLOGY INTERVENTIONS	
Hysterectomy for Heavy Menstrual Bleeding	Q071, Q072, Q073, Q074, Q075, Q076, Q078, Q079, Q081, Q082, Q083, Q088, Q089
Labiaplasty/Vaginaplasty	P05.5, P05.6, P05.7, P213, P214, P215, P218, P219

MINOR SURGERY PROCEDURES

Benign Skin Lesions – Surgical Removal	S05.1, S05.2, S05.3, S05.4, S05.5, S05.8, S05.9, S06.1, S06.2, S06.3, S06.4, S06.5, S06.8, S06.9, S08.1, S08.2, S08.3, S08.8, S08.9, S09.1, S09.2, S09.3, S09.8, S09.9, S10.1, S10.2, S10.3, S10.8, S10.9, S11.1, S11.2, S11.3, S11.4, S11.8, S11.9, D02.1, F02.1, B353, C101, D022, D028, D029, E091, E096, F022, F028, F029, S066, S067, S105, S115, E092
Chalazia Removal	C12*

NEUROLOGICAL AND PAIN INTERVENTIONS

Botulinum toxin type A for Chronic Migraine	X85.1 , S532
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OPHTHALMOLOGY INTERVENTIONS

Cataract Surgery (including Second Eye Cataracts)	C75*, C71*, C72*, C73*, C74*
Intravitreal Therapies for Eye Disease	C794

ORTHOPAEDIC INTERVENTIONS

Arthroscopic Lavage and Debridement	W85.2
Bunion Surgery	W15*, W59*, W79*, W03*, W083, W131, W132, W133, W144, W44*, W571, W572, W578
Dupuytren’s Contracture Release - Adults	(Surgery) T521, T522, T525, T526, T541, (CCH Injections) T578
Knee Arthroscopy	W852

PLASTIC SURGERY INTERVENTIONS

Gynaecomastia	B31.1, B275
Scar Revision and Skin Resurfacing	S10.3, S11.3, S60.1, S60.2, S09.1, S09.2, S60.4

RESPIRATORY INTERVENTIONS

Sleep Study, Trial and Continuous Positive Airway Pressure (CPAP) for Obstructive Sleep Apnoea	U331, E913
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UROLOGICAL INTERVENTIONS

Circumcision (Male Adults and Children)	N30.3
Hydrocele Correction	T193
Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Incontinence	A704
Varicoceles	N192