NHS North Central London (NCL)

Policy for:

Individual Funding Requests (IFR)

Low Priority Treatments (LPT)

(May 2011)
Appendix 4

List of Low Priority Treatments (LPTs)

*Low Priority Treatments policy*, implemented from 1st September 2010, included the following procedures:

- Ventilation tube (grommet) insertion for otitis media with effusion (glue ear)
- Tonsillectomy and adenoidectomy (separately or in combination)
- Cochlear implants
- Varicose veins, reticular veins, telangiectasia
- Dental implants
- Surgical treatment of carpal tunnel syndrome
- Hysterectomy for menorrhagia (heavy menstrual bleeding)
- Cosmetic surgery, including minor skin surgery
- Wisdom tooth (third molar) removal
- Male circumcision and other genital surgery for cosmetic or non significant functional problems
- Ganglions
- Dupuytren’s contracture
- Trigger finger
- Bartholin’s cysts
- Hyperhidrosis
- Dilatation and curettage for heavy menstrual bleeding in women aged under 40 years
- Surgical treatment of chronic sinusitis
- Temporo-mandibular joint (TMJ) dysfunction
- Minor oral surgery for retained roots
- Varicocoele
- Refashioning scars
- Complementary medicine of all types
- Reversal of sterilisation
- Treatment of ME/chronic fatigue syndrome outside NHS service level agreements

*Low Priority Treatments extended policy*, to be implemented from 1st April 2011, includes the following additional procedures:

- Knee washout for osteoarthritis
- Apexectomy
- Unilateral bone anchored hearing aids for unilateral deafness (implanted one side) & Bilateral bone anchored hearing aids (implanted both sides)
- Autologous Cartilage Implantation (ACI)
- Injections for non-specific back pain
- Spinal Fusion for chronic low back pain
- Spinal cord stimulation
- Surgical discectomy (standard or micro), percutaneous discectomy, coblation therapy and laser discectomy for lumbar disc herniation
- Surgery for snoring
  - laser-assisted uvulopalatoplasty (LAUP)
  - uvulopalatopharyngoplasty (up3)
  - radiofrequency ablation of soft palate (RFA)
- Caesarean section for non clinical reasons
Appendix 5:

A list of ‘low priority’ treatments that will not be funded routinely but only on consideration of individual patient circumstances, i.e. on a ‘prior approval’ basis

<table>
<thead>
<tr>
<th>Treatment that will not be routinely funded</th>
<th>Potential exceptions, but subject to consideration on an individual patient basis and in the context of all of the criteria in the framework of principles in this document</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilation tube (grommet) insertion for otitis media with effusion (glue ear)</td>
<td>Children between the ages of 3 and 12 years at the time of the proposed treatment who have otitis media with effusion (OME) where:</td>
<td>the evidence of effectiveness is limited</td>
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<tr>
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<td>surgery may resolve glue ear and improve hearing in the short term compared with non-surgical treatment, but there is less certainty about long-term outcomes and large variation in effect between children</td>
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<td>a Cochrane review showed that the benefits of grommets in children is small compared with myringotomy or non-surgical treatment. The effect of grommets on hearing diminished during the first year. It recommended an initial period of watchful waiting for most children with OME.</td>
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<td>there continues to be debate about how best to select children for surgery and there is a high rate of spontaneous resolution of glue ear, particularly in younger children</td>
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<td></td>
<td>the Scottish Intercollegiate Guidelines Network (SIGN) recommend that children under three years of age with persistent bilateral otitis media with effusion and hearing loss of &lt;=25 dB but no speech and language, development or</td>
</tr>
</tbody>
</table>

1 Cochrane review: Grommets for hearing loss associated with otitis media with effusion. January 2005
For children with cleft palate, in addition to the above age criterion, a proposal to insert grommets is made by the multi-disciplinary team managing the patient and they agree that (i) hearing aids have been tried and failed or are considered to be wholly inappropriate, (ii) grommet insertion is to be undertaken at the time of primary closure of the cleft palate.

**NOTE:** The insertion of ventilation tubes is not considered to be a low priority treatment when the procedure is a key component of another procedure such as repairing the tympanic membrane.

### Tonsillectomy and Adenoidectomy (separately or in combination)

- In children, where there is significant severe impact on quality of life indicated by at least seven episodes of tonsillitis in the preceding year, or five episodes/year in each of the preceding two years, or three episodes/year in the preceding three years, and documented evidence of absence from school or attendance at GP or other healthcare setting.  
  3
- Obstructive sleep apnoea confirmed by overnight oxygen saturation monitoring.
- In adults with proven recurrent group A streptococcal pharyngitis (GAHSP)  
  4
- Quinsy associated with tonsillitis, requiring 2 or more episodes of tonsillitis.

- A revised Cochrane systematic review in 2008,  
  5 concluded that Adenoid-/tonsillectomy is effective in reducing the number of episodes of sore throat and days with sore throats in children, the gain being more marked in those most severely affected.
- SIGN national guideline on management of sore throat and indications for tonsillectomy published April 2010 recommended watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.
- It should be noted, that those considering

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2 SIGN. Diagnosis and management of childhood otitis media in primary care. February 2003
3 Adapted from Management of sore throat and indications for tonsillectomy. A national clinical guideline. SIGN Publication Number 117. April 2010
4 Tonsillectomy versus watchful waiting in recurrent streptococcal pharyngitis in adults: Randomised controlled trial. BMJ 2007;334(7600):939-41..
| Hospital visits | Tonsillectomy or adenotonsillectomy for themselves or their children, and those advising them, should be aware of two important uncertainties which may affect their treatment decisions. They must acknowledge some uncertainty about whether or not their symptoms are primarily due to their tonsils and realise that adeno-/tonsillectomy is not a panacea for all types of sore throat. There is also uncertainty about the likelihood that these will continue in the future, which is only partly predictable from the frequency and severity of symptoms they have experienced in the past. |
| Grommets and adenoidectomy represents a trade off between benefits and harms; adenoidectomy on its own is of unknown effectiveness. |

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6 Clinical Evidence. Review of adenotonsillectomy. 2005
**Cochlear implants**

Normally, Cochlear implants will only be funded where the patient meets the criteria of the National Institute for Health and Clinical Excellence technology appraisal guideline on this treatment precisely and in full and then only if the least expensive implant available is used assuming that this is clinically appropriate.

A cochlear implant in one ear is recommended as a possible option for everyone with severe to profound deafness if they do not get enough benefit from hearing aids after trying them for 3 months. Cochlear implants in both ears are recommended for the following groups with severe to profound deafness only if they do not get enough benefit from hearing aids after trying them for 3 months and the implants are placed during the same operation:

- children
- adults who are blind or have other disabilities which mean that they depend upon hearing sounds for spatial awareness.

In all cases, if more than one type of cochlear implant is suitable, the least expensive should be used.

**Varicose veins, reticular veins, telangiectasia**

- substantial skin changes including varicose eczema, lipodermatosclerosis, moderate to severe oedema;
- intractable ulceration secondary to venous stasis;
- bleeding from a varicosity that has eroded the skin or they have bled and are at risk of bleeding again; or
- recurrent phlebitis (more than one documented episode)
- severe and persistent pain and swelling interfering with activities of daily living and requiring chronic pain management
- severe symptoms attributable to the venous disease not acceptably relieved by 6 months documented conservative management including compression hosiery and exercise
- symptoms attributable to varicose veins are common but their relationship to visible trunk varices is not clear
- most patients with varicose veins are never harmed by them and good explanation and reassurance are fundamental.
- the National Institute for Health and Clinical Excellence has published detailed guidance on what treatment should be considered for varicose veins and when
- treatment for reticular veins and telangiectasia is generally considered to be cosmetic (see section

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8 Campbell B. Clinical Review- Varicose veins and their management. BMJ. 2006;333:287-292 (5 August)
<table>
<thead>
<tr>
<th>Dental implants</th>
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<th>Dental implants</th>
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<th>Primary predictors of implant failure are poor bone quality, chronic periodontitis, systemic diseases, smoking, unresolved caries or infection, advanced age, implant location, short implants, acentric loading, an inadequate number of implants, and absence/loss of implant integration with hard and soft tissues. Inappropriate prosthesis design also may contribute to implant failure. Implant treatment for patients who have undergone irradiation to the maxilla and/or mandible has a significantly higher failure rate. Patients who are over 60 years of age, smoke, have a history of diabetes or head and neck radiation, or are postmenopausal and on hormone replacement therapy experience significantly increased implant failure compared with healthy patients.</th>
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<tbody>
<tr>
<td>Surgical treatment of carpal tunnel syndrome</td>
<td>symptoms persisting after conservative therapy with local corticosteroid injection and/or nocturnal splinting</td>
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<td>Hysterectomy for menorrhagia (heavy menstrual bleeding)</td>
<td>documented medical contra-indication to Minera® coil insertion when other treatments have failed or are contraindicated</td>
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<td>NICE has published clinical guidelines on menorrhagia which do not necessarily require a prior trial of treatment before hysterectomy. These guidelines include recommendations on the use of other procedures, currently covered by NICE</td>
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<td>severe anaemia, unresponsive to transfusion or other treatment whilst a Mirena trial is in progress</td>
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### Cosmetic surgery, including minor skin surgery

- recent sexually transmitted infection (if not fully investigated and treated)
- distorted or small uterine cavity (with proven ultrasound measurements)
- genital malignancy
- active trophoblastic disease

### Interventional procedures guidance, which should be considered in the context of a patient pathway for managing menorrhagia

- This includes (but is not limited to) –
  - Abdominoplasty
  - breast reduction/augmentation
  - face lifts and similar facial surgery, including blepharoplasty
  - acne treatment other than with drugs
  - skin flap excision, e.g. after substantial weight loss
  - pinnaplasty
  - removal or obliteration of benign skin lesions including, but not limited to –
    - benign pigmented moles
    - comedones
    - corn/callouses
    - lipomas
    - milia
    - molluscum contagiosum
    - sebaceous, epidermoid or pilar cysts
    - seborrhoeic keratoses
    - basal cell papillomas
    - skin tags (including anal tags)
    - spider naevae and other telangiectasia
    - warts
    - xanthelasma
    - neurofibromata
    - rosacea

- cosmetic surgery, including minor skin surgery
| Wisdom tooth (third molar) removal | - unrestorable caries  
- non-treatable pulp and/or periapical pathology  
- cellulitis  
- abscess and osteomyelitis  
- fracture of tooth,  
- internal / external resorption of the tooth or adjacent teeth  
- disease of follicle including cyst / tumour  
- tooth/teeth impeding surgery or reconstructive jaw surgery  
- when a tooth is involved in or within the field of tumour resection | See NICE guidance\(^\text{12}\) |

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<tr>
<th><strong>Male circumcision and other genital surgery for cosmetic or non significant functional problems</strong></th>
<th><strong>Female circumcision is prohibited by under the Prohibition of Female Circumcision Act 1995</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- plaque formation and pericoronitis depending on severity and frequency of episodes.</td>
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</table>
| - scarring of the opening of the foreskin making it non-retractable (i.e. pathological phimosis). This is unusual before 5 years of age  
- recurrent, significantly troublesome episodes of infection beneath the foreskin  
- restoration of functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous |  |
| **Ganglions** |  |
| - significant pain or dysfunction unrelieved by aspiration or injection  
- in patients presenting with significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts  
- diagnostic uncertainty |  |
| **Dupuytren’s contracture** |  |
| - function of hand is significantly impeded or deformity is significantly disabling so that everyday living activities cannot be undertaken and surgery is likely to resolve this |  |
| **Trigger finger** |  |
| - the patient has failed to respond to conservative measures (e.g. hydrocortisone injections); or  
- the patient has significant fixed deformity | A Cochrane review has shown that corticosteroid injections can be effective for the treatment of trigger finger, but evidence is limited by being based on two small studies in secondary care, and there were only data available for effectiveness of up to four months. The authors concluded that the initial treatment for patients should be corticosteroid injection rather than surgery, and other non-invasive interventions such as |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Indications</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Bartholin’s cysts</td>
<td>significant infection and/or rapid growth causing significant pain that is unresolved by non-surgical treatment</td>
<td>splinting may also be appropriate first-line interventions.(^{13})</td>
</tr>
</tbody>
</table>
| Hyperhidrosis                            | significant focal hyperhidrosis and a 1–2 month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition  
  - intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone | There is no evidence that this procedure has any therapeutic value |
| Dilatation and curettage for heavy menstrual bleeding in women aged under 40 years |                                                                             | NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for 3 months for treatment in the first instance.\(^{14}\)  
  Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.\(^{14}\)  
  Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.\(^{15}\) |
| Surgical treatment of chronic sinusitis  | suspected complications, e.g. periorbital infection  
  - suspected sinonasal tumour  
  - ENT referral may be appropriate if there is:  
    - recurrent or chronic sinusitis of uncertain cause  
    - unremitting or progressive facial pain  
    - a trial of intranasal corticosteroids for three months has been ineffective  
    - a significant anatomical abnormality |                                                                      |

\(^{14}\) http://www.cks.nhs.uk/sinusitis/management/quick_answers#-369973 (accessed 8 February 2010)  
\(^{15}\) NICE Balloon catheter dilation of paranasal sinus ostia for chronic sinusitis. IPG 273 NICE September 2008.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporo-mandibular joint (TMJ) dysfunction</td>
<td>There is little evidence available on the safety and efficacy of surgery for this condition. Conservative therapy includes self care practices e.g. eating soft foods, jaw stretching, ice packs, and pain relief. Stabilisation splints (bite guards) are the most widely used treatments for TMJ disorders. Failure to respond to conservative treatment is not an indication to proceed to irreversible treatments such as TMJ replacement. There is limited evidence of effectiveness and no agreed diagnostic classification scheme for TMJ replacement.</td>
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</table>
| Minor oral surgery for retained roots   | Symptomatic retained roots may be removed in the dental surgery under local anaesthetic. Referral to a specialist may be necessary:  
- where anatomical or pathology considerations make the extraction difficult,  
- where the patient has medical complications,  
- where the operator does not have the relevant training or experience, or  
- where previous attempts at extraction have failed | GDC guidelines indicate that ‘particular care must be taken when referring patients for treatment under general anaesthesia or sedation’  
It is also in line with minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals. |
| Varicocoele                            | persistent discomfort or pain despite adequate conservative management | There is no evidence that treating varicocoele can help male sub-fertility problems                                                                                                                     |
| Refashioning scars                     | following severe burns or severe trauma and/or where there is a significant difficulty in undertaking everyday living activities, including severe psychosocial problems following facial scarring |                                                                                                                                                                                                       |
| Complementary medicine of all types    | there is some evidence that some forms of complementary treatments can be effective in certain conditions |                                                                                                                                                                                                       |

16 Minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals, Sue Gregory, 2006
## Reversal of sterilisation

- extreme personal circumstances, e.g. establishing a stable relationship with a new partner following the death of the patient’s partner and all children when there are no children living with the patient and their new partner

Most studies are retrospective and success rate variable.\(^{17}\)

The Royal College of Obstetricians and Gynaecologists guidelines on male and female sterilisation advise that men and women requesting sterilisation should understand that the procedure is intended to be permanent, they should be given information about the success rates associated with reversal, should this procedure be necessary.\(^{18}\)

### Treatment of ME/chronic fatigue syndrome outside NHS service level agreements

No evidence has been forthcoming from units purporting to specialise in this condition to support claims of treatment success.

Clinical guidance from the National Institute for Health and Clinical Excellence provides information for health care providers on how this condition could be managed, but do not place any obligation on service commissioners.\(^{19}\)

### Knee washout for osteoarthritis

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 i.e. (not gelling, ‘giving way’ or X-ray evidence of loose bodies)

NICE issued full guidance to the NHS on Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis in August 2007.\(^{20}\)

Subsequent to this, a more specific recommendation was made as part of the

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<table>
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<tr>
<th>Procedure</th>
<th>Indications</th>
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<tbody>
<tr>
<td>Apicectomy</td>
<td>• Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth. For example, obliterated root canals, small teeth with full coverage restorations where conventional access may jeopardise the underlying core. It is recognised that non-surgical root canal treatment is the treatment of choice in most cases • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where a biopsy of periradicular tissue is required • Where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected • Where procedures are required that require either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non surgical root canal re-treatment because of patient considerations</td>
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<tr>
<th>Unilateral bone anchored hearing aids for unilateral deafness (implanted one side)</th>
<th>Unilateral bone anchored hearing aids for unilateral deafness: Severe unilateral conductive deafness in children</th>
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</table>
| | • case by case basis centred on the child’s audiometric data, development and communication needs<sup>24</sup>  
• a trial period with a sufficiently powerful bone anchored hearing aid on a headband is recommended before a decision on implantation |
| Bone anchored hearing aids are only appropriate for patients with conductive or mixed deafness for whom air conduction hearing aids are ineffective or inappropriate.  
Comprehensive patient assessment and a trial of bone conductor technology as well as extensive counselling are all essential before the implantation of bone anchored hearing aids.  
There is evidence for the clinical effectiveness of unilateral bone anchored hearing aids in selected groups of patients. The evidence base for use of bilateral bone anchored hearing aids is weak. |

<sup>24</sup> Bone anchored hearing aids for children and young people: Guidelines for professionals working with deaf children and young people: Guidelines for professionals. National Deaf Childrens Society. March 2010
| **Autologous Cartilage Implantation (ACI)** | If conservative treatment and arthroscopic treatment has failed and is part of a clinical trial in accordance with NICE technology appraisal recommendations | ACI has been most commonly used as a treatment for cartilage defects in the knee, there are few studies of its use in other joints. NICE concluded ACI is not recommended for treating knee problems caused by damaged articular cartilage, unless it is used in studies that are designed to produce good-quality information about the results of the procedure. These results should include measuring any improvement in patients’ quality of life, and the benefits and risks of ACI over a long period of time. If ACI is offered as part of a clinical study, the doctor should explain that there are uncertainties about the long-term benefits of this procedure and the possible risks, such as locking of the knee, infections and not being able to fully straighten the leg.\(^\text{25}\) There is insufficient evidence to support use of ACI in ankle joint cartilage defects.\(^\text{26,27}\) |
---|---|---|
| **Injections for non-specific back pain** | | • NICE CG88 (2009) guideline states injections of therapeutic substances should not be used for |


| Spinal Fusion for chronic low back pain | Fusion surgery for chronic low back pain may be considered if:  
- severe pain continues despite an ‘active rehabilitation programme’ (cognitive intervention combined with exercises is recommended when available) that has been undertaken for 2 years.  
NICE guidelines recommend the patient is referred to a specialist spinal surgical service if spinal fusion is being considered and to give due consideration to the possible risks for that patient. |
| Spinal cord stimulation | Spinal cord stimulation will be considered as a treatment option for adults with chronic pain of neuropathic origin who:  
- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management, and  
- who have had a successful trial of stimulation as part of NICE Technology appraisal TA159.  
Spinal cord stimulation is not recommended as a treatment option for adults with chronic pain of ischaemic origin except in the context of research as part of a clinical trial. |


the assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed.
| Surgical discectomy (standard or micro), percutaneous discectomy, coblation therapy and laser discectomy for lumbar disc herniation | Surgical discectomy (standard or micro) will be considered for a carefully selected group of patients with symptoms and confirmatory signs of lumbar radiculopathy, disc herniation confirmed on magnetic resonance imaging at a corresponding level and side to the symptoms, who have not responded to conservative treatment for over 6 weeks \[33\] \[34\] | Surgical discectomy for carefully selected patients with sciatica due to a prolapsed lumbar disc appears to provide faster relief from the acute attack than non-surgical management. However, any positive or negative effects on the lifetime natural history of the underlying disc disease are unclear \[35\] At present, unless or until better scientific evidence is available, automated percutaneous discectomy, coblation therapy and laser discectomy should be regarded as research techniques \[35\] |

| Surgery for snoring | Evidence of objective reductions in snoring sound parameters for UP3, LAUP, RFA and Pillar implants was limited and equivocal \[36\] NICE recommends that RFA should not be used without special arrangements for audit, consent and research \[37\] In the management of primary snoring it should be highlighted that, given the absence of risk to health |

- laser-assisted uvulopalatoplasty (LAUP)
- uvulopalatopharyngoplasty (UP3)
- radiofrequency ablation of soft palate (RFA)

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34 Weinstein JN, Torteson TD, Lurie JD et al. Surgical vs Nonoperative Treatment for Lumbar Disk Herniation. JAMA 2006 296
35 Gibson JA, Waddell G. Surgical interventions for lumbar disc prolapse. Cochrane Database of Systematic Reviews 2007, Issue 2
from snoring without apnoea or hypopnoea, and an absence of excessive daytime sleepiness, the patient is effectively being treated to decrease the social disturbance caused to their bed partner and family.

| Caesarean section for non clinical reasons | There is a close benefit/risk ratio for caesarean section for non clinical reasons. Caesarean section rates are progressively rising in many parts of the world. One suggested reason is increasing requests by women for caesarean section in the absence of clear medical indications. There is no evidence from randomised controlled trials, upon which to base any practice recommendations regarding planned caesarean section for non-medical reasons at term. Maternal request is not on its own an indication for CS and specific reasons for the request should be explored, discussed and recorded. When a woman requests a CS in the absence of an identifiable reason, the overall benefits and risks of CS compared with vaginal birth should be discussed and recorded. |

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