General Commissioning Policy

<table>
<tr><td>Treatment</td><td colspan="2">Secondary care referral</td></tr>
<tr><td>For the treatment of</td><td colspan="2">Tendinopathies and musculoskeletal conditions</td></tr>
<tr><td>Background</td><td colspan="2">From April 2013 NHS England took over responsibility for commissioning activity in primary care, where initial conservative treatment takes place. NHS Hull CCG is responsible for commissioning activity in secondary care, and this policy sets out the referral criteria for musculoskeletal conditions and tendinopathies.
NHS Hull CCG will commission routine referrals to secondary care for those patients meeting the referral criteria below and routine surgical treatment for those patients with severe symptoms in whom all conservative treatments have been tried and failed.
However approval for extracorporeal shock wave therapy (ESWT) in secondary care must be requested via the IFR process because the benefits and risks are uncertain and there is a lack of long term outcome data.</td></tr>
<tr><td>Commissioning position</td><td>Site</td><td>Criteria for Referral to Secondary Care</td></tr>
<tr><td></td><td>Shoulder</td><td>Adhesive capsulitis (Frozen shoulder)
Conservative treatments include rest, painkillers, NSAIDs, corticosteroid injections (short term pain relief only), local anaesthetic injections, shoulder exercises and physiotherapy (stretching, massage and thermotherapy).
NHS Hull CCG will only commission referral to an orthopaedic surgeon (after an ultrasound scan) if symptoms are severe, causing significant problems and conservative treatments have not worked. Secondary care treatment options are: (i) manipulation under general anaesthetic with simultaneous injection of corticosteroid and local anaesthetic into shoulder joint OR (ii) arthroscopic capsular release via keyhole surgery and removal of any bands of scar tissue that have formed.</td></tr>
<tr><td></td><td></td><td>Supraspinatus tendonitis (impingement syndrome or painful arc syndrome)
Conservative treatments include rest, cessation of painful activity, physiotherapy, NSAIDs and analgesia. Corticosteroid and local anaesthetic injections may be used for persistent symptoms.
NHS Hull CCG will only commission referral to an orthopaedic surgeon (after an ultrasound scan) if symptoms are severe, causing significant problems and other treatments have not worked. Surgery can be done arthroscopically or as open surgery and involves removal of impinging structures and /or repair of damaged rotator cuff muscles.</td></tr>
<tr><td></td><td></td><td>Calcific tendonitis
Acute and chronic symptoms can resolve spontaneously. Conservative treatments include rest, NSAIDs, corticosteroid injections and physiotherapy
NHS Hull CCG will only commission referral to an orthopaedic surgeon (after an ultrasound scan) if symptoms are severe, causing significant problems and other treatments have not</td></tr>
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Notes

1. This Policy will be reviewed in the light of new evidence, or guidance from NICE.
2. General Commissioning Policies are agreed by the Planning and Commissioning Committee on behalf of NHS Hull CCG.

		worked. Surgery can be done arthroscopically or as open surgery and involves removal of calcific deposits from the tendon. However calcification can recur (up to 18% of cases) following surgical treatment. ESWT may be commissioned after IFR approval.
	Elbow	*Medial and lateral epicondylitis (tennis or golfer's elbow)* Conservative treatments include rest, modification of activities, cold compress, painkillers, NSAIDs, orthotic support (splints), physiotherapy and corticosteroid injections (short term pain relief). NHS Hull CCG will only commission referral to a plastic or orthopaedic surgeon if pain is severe and persistent and where conservative approaches have not been effective. ESWT may be commissioned after IFR approval, or alternatively the treatment of last resort is surgical removal of the damaged bit of tendon.
	Wrist	*De Quervains Tenosynovitis* Conservative treatments include activity avoidance, splints, NSAIDs, gentle stretching and corticosteroid injections to reduce pain. Surgery is rarely required and usually reserved for patients with persisting pain. NHS Hull CCG will only commission referral to a plastic surgeon if symptoms are severe, causing significant problems and after failure of at least one steroid injection. Many cases respond to further steroid injections with a modified technique (due to variant wrist anatomy). The treatment of last resort is to surgically inspect the sheath surrounding the involved tendon or tendons, and then open the sheath to release the pressure and restore free tendon gliding.
		Flexor and extensor carpi ulnaris tendinitis Conservative management includes NSAID medications, splinting and occupational therapy, including stretching and strengthening. Diagnostic local anaesthetic injections and/or corticosteroid injections can also be helpful. Surgery is rarely required and NHS Hull CCG will only commission referral to a plastic surgeon if pain is persistent despite maximal conservative management.
	Digits	*Adult Trigger finger/thumb (stenosing tenosynovitis)* Conservative treatments include steroid injections and splinting. Steroid injections can provide permanent or temporary relief of symptoms in the majority of patients with intermittent triggering. NHS Hull CCG will only commission referral to a plastic surgeon if symptoms are severe, recurrent or causing significant problems and other conservative treatments have not worked. Referral is also commissioned in populations who are unlikely to benefit from steroid injections (eg. a diabetic with many digits affected and severe symptoms). Surgery involves division of the flexor sheath of the digit, either by conventional open, or percutaneous, release. This is an effective treatment with a high success rate, low complication rate and short recovery period (3-4 weeks).

		Paediatric Trigger Thumb NHS Hull CCG will commission early referral to plastic surgery for children with severe and prolonged flexion deformity or where there is diagnostic uncertainty. (Differential diagnoses include hypoplastic or clasped thumbs which require early treatment). After confirmed diagnosis, up to 78% of cases of paediatric trigger thumb resolve spontaneously, sometimes assisted by splinting and passive stretching. Where surgical release of the flexor sheath of the thumb is appropriate, it is almost always successful and usually performed as a day-case under a short general anaesthetic.
		Dupuytrens contracture Spontaneous resolution does not occur; however in general nodules do not require treatment. However if contractures are causing loss of hand function or if there has been rapid progression of the condition over a few months NHS Hull CCG will commission referral to plastic surgery for assessment and treatment. Treatment in secondary care might include Percutaneous Needle Fasciotomy (NICE IPG 43) or surgical treatment such as limited segmental fasciotomy.
	Hip	*Greater Trochanteric Pain Syndrome* The condition is usually self-limiting over weeks or months. Conservative treatments include limiting activity, applying an ice pack, a month of treatment with paracetamol or NSAIDs, weight loss if BMI >30 and up to 3 injections of steroid and local anaesthetic. Physiotherapy may help if a steroid injection does not improve symptoms. NHS Hull CCG will only commission referral to secondary care for advice and further treatment if the condition is severe or persistent. ESWT may be commissioned after IFR approval.
	Knee	*Bursitis, Tendonitis, Arthritis, Cartilage Tears and Gout.* Unless infection is suspected or present, conservative treatment includes corticosteroid injection (no more than once every three months) into the knee joint for relief of moderate to severe pain. The injection may be combined with a local anaesthetic. In osteoarthritis, pain relief may only last for up to 4 weeks. Corticosteroid injections are just one aspect of a treatment programme which may also include NSAIDs, knee exercises, knee braces and walking aids. NHS Hull CCG will only commission referral to secondary care (after an ultrasound scan) for advice and further treatment if the condition is severe or persistent. Intra-articular hyaluronic acid injections into the knee by specialist consultants in secondary care will only be commissioned, after agreement via the IFR process, in cases where it has been demonstrated that all the relevant criteria are fulfilled. [See separate commissioning policy for Hyaluronic Acid Injections.]
	Ankle	*Achilles tendinopathy* There is insufficient evidence to determine the most appropriate treatment for acute or chronic achilles tendonitis. There is no clear evidence that steroid injections are beneficial (they can weaken the tendon) but other possible treatments are analgesics, short term NSAIDs, ice, rest, increased warm-up/stretching exercises, physiotherapy and heel lifts (orthotic devices). For most people, symptoms usually clear within 3-6 months of starting treatment. NHS Hull CCG will only commission referral to secondary care if symptoms are severe or causing significant problems and other conservative treatments have

		not worked. Secondary care treatment option are ESWT (after IFR approval) or surgery. Surgery involves either removing nodules or adhesions that have developed within the damaged tendon, or making a lengthways cut in the tendon to help to stimulate healing. Complications from surgery are uncommon but can include problems with wound healing.
		Ankle impingement syndrome Conservative treatments include NSAIDs, ice packs, strengthening and stretching exercises, bracing and orthotics. NHS Hull CCG will only commission referral to an orthopaedic surgeon for assessment if symptoms are severe, causing significant problems and other treatments have not worked. Surgery usually involves using arthroscopic methods to remove the bone spur, inflamed tissue, or scar tissue.
	Heel	*Plantar fasciitis* Conservative treatments include rest, ice application, NSAIDs, stretching exercises, podiatry, orthoses or strapping, night splints or an injection of corticosteroid and local anaesthetic. (Consideration should be given to whether the injection requires ultrasound guidance, if so a referral should be made to secondary care.) NHS Hull CCG will only commission referral if symptoms are severe, recurrent or causing significant problems and other conservative treatments have not worked. ESWT may be commissioned after IFR approval.
Effective from	October 2013 *(This policy supercedes Hull PCT policy T12a/10 'Minor Surgery – Injections' dated June 2011)*	
Summary of evidence / rationale	Tendinopathy is a broad term encompassing painful conditions occurring in and around tendons in response to overuse. Recent basic science research suggests little or no inflammation is present in these conditions. Thus, traditional treatment modalities aimed at controlling inflammation such as corticosteroid injections and nonsteroidal anti-inflammatory drugs (NSAIDS) may not always be the most effective options. A systematic review of the literature to determine the best treatment options for tendinopathy concluded NSAIDS and corticosteroids appear to provide pain relief in the short term, but their effectiveness in the long term has not been demonstrated. Surgery remains the last option due to the morbidity and inconsistent outcomes. The ideal treatment for tendinopathy remains unclear. (Andrews 2008)	
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Review Date	June 2018	
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Related NHS Hull CCG policies:

- Extracorporeal Shockwave Therapy (ESWT)
- Carpal Tunnel Syndrome (surgery)
- Ganglion (surgery)
- Hyaluronic acid injections for knee osteoarthritis

References:

1. Andrews and Murrell, 2008, Treatment of Tendinopathy: What Works, What Does Not, and What is on the Horizon. Clin Orthop Relat Res. 2008 July; 466(7): 1539–1554. http://www.ncbi.nlm.nih.gov/pubmed/18446422
2. C A Speed, Corticosteroid injections in tendon lesions. BMJ. 2001 August 18; 323(7309): 382–386 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1120980/
3. Davidson, S et al. A Primary Care Perspective on Keloids. Medscape J Med. 2009; 11(1): 18. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654675/?tool=pubmed
4. British Society for Surgery of the Hand. BSSH Evidence for Surgical Treatment (BEST) http://www.bssh.ac.uk/education/guidelines
5. Woodward and Gellman (2013) Calcifying Tendonitis Treatment & Management http://emedicine.medscape.com/article/1267908-treatment

Useful websites:

Map of Medicine
http://nhsevidence.mapofmedicine.com/evidence/map/plantar_fasciitis2.html

nhs.uk
http://www.nhs.uk/Conditions/Frozen-shoulder/Pages/Treatment.aspx
http://www.nhs.uk/Conditions/Tennis-elbow/Pages/Treatment.aspx
http://www.nhs.uk/Conditions/heel-pain/Pages/Treatment.aspx

Patient.co.uk
http://www.patient.co.uk/health/achilles-tendinopathy
http://www.patient.co.uk/doctor/Keloid-Scars.htm
http://www.patient.co.uk/health/Greater-Trochanteric-Pain-Syndrome.htm
http://www.patient.co.uk/doctor/joint-injection-and-aspiration