

Knee Arthroscopy with or without Debridement Policy

CRITERIA BASED ACCESS

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Application Form	only required where criteria not is not met Generic IFR application form

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VERSION CONTROL**

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General Principles

Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Individual Funding Request (IFR) Panel by submission of an IFR application.

1. Clinicians should assess their patients against the criteria within this policy prior to treatment.
2. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment.
3. On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.
4. Patients with an elevated BMI of 30 or more are likely to receive fewer benefits from surgery and should be encouraged to lose weight further prior to seeking surgery. In addition, the risks of surgery are significantly increased. (Thelwall, 2015)
5. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing. (Loof S., 2014)

Background

Knee Arthroscopy is a surgical technique whereby a small telescope is inserted into a joint to inspect, diagnose and treat intra-articular problems. It is used to treat cartilage (chondral) surface damage (eg debridement / microfracture), meniscal damage (partial meniscectomy or meniscal repair), for removal of loose bodies, for synovial biopsy, for washout of infection, as part of ligament reconstruction surgery (eg ACL reconstruction) and as part of extensor mechanism realignment surgery (tibial tubercle osteotomy or MPFL reconstruction). It has also been used historically for the treatment of osteoarthritis (irrigation / washout or general debridement), but this is not evidence-based and is not routinely funded by the CCG.

Early direct access to MRI scanning of the knee has become commonplace, believing that performance of this investigation replaces the traditional clinical skills. The first investigation after an adequate history and examination should be a full series of x-rays of the knee (AP weight-bearing, flexed PA weight-bearing, lateral and skyline). If this shows arthritic change, even with partial joint space loss, then MRI scanning is generally unhelpful and should not be done. If MRI scanning is performed too early in the investigative pathway then over-diagnosis of degenerate meniscus lesions predominates (very often arthritic knees have an associated and often irrelevant meniscal tear). The MRI scan result then triggers referral to an orthopaedic surgeon with the expectation by the patient that the knee problem can be “cured” by a knee arthroscopy.

Efficacy of Knee Arthroscopy

Arthroscopic partial meniscectomy is one of the most common orthopaedic procedures, yet rigorous evidence of its efficacy is lacking. In a recent trial involving patients without knee osteoarthritis but with symptoms of a degenerative medial meniscus tear, the outcomes after arthroscopic partial meniscectomy were no better than those after a sham surgical procedure. (Sihvonen R1 & Group, 2014). But in other trials (eg Herrlin et al 2013) patients have been shown to benefit from arthroscopic meniscectomy if they have failed an appropriate initial period of conservative management.

In addition, the Evidence Development and Standards Branch, Health Quality Ontario conducted a literature search for studies published from January 2005 to February 2014 and concluded that the evidence does not show the superiority of arthroscopic debridement with or without meniscectomy in patients with osteoarthritis of the knee. (Evidence Development and Standards Branch, Health Quality Ontario , 2014).

This policy reflects this clinical evidence.

Risks

A knee arthroscopy is generally considered to be a safe procedure, but like all types of surgery it does carry some risks. It's normal to experience short-lived problems such as swelling, bruising, stiffness and discomfort after an arthroscopy. These will usually improve during the days or weeks following the procedure.

More serious problems are much less common, occurring in less than 1 in 100 cases. They include:

- a blood clot deep vein thrombosis (DVT) can cause pain and swelling in the affected limb
- infection inside the joint/septic arthritis can cause a high temperature (fever), pain and swelling in the joint
- bleeding inside the joint which often causes severe pain and swelling
- accidental damage to the nerves that are near the joint – this can lead to numbness and some loss of sensation, which may be temporary or permanent

NOTE:

If clinical assessment suggests the patient may have a “Red flag” condition and therefore treatment is needed urgently, refer for treatment without delay and without further reference to the criteria within this policy. **Red flag conditions include:**

- Septic Arthritis/infection,
 - Carcinoma,
 - bony fracture,
 - avascular necrosis
 - A “locked knee” with complete block to extension
- (NHS Choices, 2015)

POLICY - Criteria to Access Treatment – CRITERIA BASED ACCESS

Knee arthroscopy (with or without osteoarthritis) is not routinely funded by the Clinical Commissioning Group (CCG) and is subject to this restricted policy.

The CCG does not routinely commission

1. Arthroscopic lavage and debridement as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies). [2008, amended 2014] **OR**
2. Where the patient has previously had an arthroscopy to treat the affected knee that was ineffective or of limited benefit **OR**
3. Intractable knee pain with normal MRI scan even if considered likely the patient has the potential to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon **OR**
4. For diagnostic purposes only

The CCG will fund knee arthroscopy in adults only where:

1. The patient has had full series of weight-bearing x-rays to exclude a diagnosis of arthritis as a cause of symptoms, and Clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (i.e. unstable meniscal tear, ligament rupture or loose body within the knee) that is amenable to arthroscopic treatment **OR**
2. The patient has confirmed early stage knee osteoarthritis (minimal joint space loss on weight bearing films) with regular clinically-significant mechanical symptoms such as true knee locking or intermittent sharp catching pain (not constant), suggesting that the treatment of a degenerate meniscal tear has a significant chance of improving symptoms

OR

3. The patient is suffering confirmed moderate knee arthritis which would be insufficient to consider joint replacement, but is experiencing true knee locking, suggesting that the treatment of an unstable meniscal fragment or loose body has a significant chance of improving symptoms

AND

4. Conservative management over a period of at least 3 months has been fully explored, and complied with, but treatment has failed. Conservative management can include advice, physio and support from the intermediate musculoskeletal services and pain management with non-steroidal anti-inflammatory drug (NSAID) painkillers. A trial of conservative management should be the first-line treatment for all patients with degenerative meniscal tears. (Khan M, 2014)

Note:

Evidence of symptoms and compliance with conservative management must be documented in the patient's clinical records and demonstrated in any referral to surgical provider.

Conservative management is not appropriate if a patient has any of the conditions listed as "red flags" above. In all of these circumstances, urgent referral to secondary care is advised

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 exist that warrant deviation from the rule of this policy. Applications cannot be considered from patients personally.

Provided these patients receive the full support of their general practitioner, or clinician, in pursuing their funding request an application may be made to the Individual Funding Request Panel for consideration.

It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the IFRP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context.

An application put forward for consideration must demonstrate some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question
- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067.

Or write to us: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email us:** somccg.pals@nhs.net

Connected Policies

Knee Replacement: Treatment will not be offered under this policy. Clinician's should refer to the intervention specific policy.

This policy has been developed with the aid of the following references:

British Orthopaedic Association / British Association for Surgery of the Knee joint statement on knee arthroscopy for degenerate meniscal tears – <http://www.boa.ac.uk/latest-news/boabaskresponse-to-media-reports-regarding-knee-arthroscopy/>

Evidence Development and Standards Branch, Health Quality Ontario . (2014). Arthroscopic Debridement of the Knee: An Evidence Update. Ontario: Ontario Health Technology Assessment Series.

Khan M, E. N. (2014). Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. Canadian Medical Association Journal.

Herrlin SV et al (2013) - Is arthroscopic surgery beneficial in treating non-traumatic, degenerative medial meniscal tears? A five year follow-up

Loof, S. D. (2014). Perioperative complications in smokers and the impact of smoking cessation interventions [Dutch]. Tijdschrift voor Geneeskunde, vol./is. 70/4 (187-192).

NHS Choices. (2015, April 27). NHS Choices. Retrieved from Arthroscopy: <http://www.nhs.uk/Conditions/Arthroscopy/Pages/Introduction.aspx>

NICE. (n.d.). Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. Retrieved from www.nice.org.uk:

<https://www.nice.org.uk/guidance/ipg230/chapter/1-guidance>

Sihvonen R1, P. M., & Group, F. D. (2014). Arthroscopic partial meniscectomy versus sham surgery for a degenerative meniscal tear. The New England Journal of Medicine.

Thelwall, S. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases, vol. 21, no. 11, p. 1008.e1.

<http://www.bmj.com/content/357/bmj.j1982>