Bwrdd Iechyd Lleol
Local Health Board
Abertawe
Swansea

SWANSEA LOCAL HEALTH BOARD
LOW PRIORITIES COMMISSIONING POLICY

Board Approval
Swansea
27th February 2007
Version 1

Introduction
Local Health Boards need to continue to improve the cost-effectiveness of services, thereby securing the greatest health gain from the resources available. To do this, decisions must be based on the evidence of the clinical effectiveness of the services.

Background
Priorities for modernising the National Health Service are underpinned by achieving careful management of overall NHS resources to ensure people have access to high quality services and care, regardless of where they live.

Swansea Local Health Board has previously utilised the IMH Authority Policy on services not commissioned on the NHS (which was revised and updated in July 1999) in its decision making process. It is, however, important to update the evidence base included in this paper on a regular basis and provide recommendations on the procedures of limited effectiveness. This will then inform Health Service Commissioners of the most current evidence and guidelines for procedures which had previously been identified as having limited clinical effectiveness.

It should be noted that the policy restrictions are not absolute and exceptions can be made on clinical grounds.

Procedures Only To Be Commissioned As Exceptions
Some restricted procedures will be commissioned on the basis of the criteria detailed here. Others will be commissioned on a named patient basis only, with pre-approval required for consideration of funding through exceptionality.

Exceptionality (definition)
1. In order for funding to be agreed there must be some unusual or unique clinical factor about the patient that suggests that they are:
    i. Significantly different to the general population of patients with the condition in question
    ii. Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition
2. The fact that a treatment is likely to be efficacious for a patient is not, in itself, a basis for an exemption.
3. If a patient's clinical condition matches the 'accepted indications' for a treatment that is not funded, their circumstances are not, by definition, exceptional.
4. It is for the requesting clinician (or patient) to make the case for exceptional status.
5. Social value judgements are rarely relevant to the consideration of exceptional status.

If it is found that the commissioning criteria have not been properly applied by any service provider, then the LHB will not pay for those elective procedures.

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COMPLEMENTARY THERAPIES

General Remarks

Data used by the Nuffield Institute of Health meta-analysis for a range of complementary therapies (Reviewing the state of the evidence on efficacy and effectiveness of complementary therapies), Long and Mercer, 1995, has been reviewed and used for the following policy.

NPHS POLICY ADVICE	**Date of Issue:**	**14 January 2004**
	Revised:	**1 November 2005**

The Smallwood report 'The Role of Complementary and Alternative Medicine in the NHS' was commissioned by HRH Prince of Wales, to investigate the contribution which complementary and alternative medicines (CAM) could potentially make to the delivery of healthcare in the UK .
It does not constitute a full systematic review of the literature. The advice of the NPHS remains as previously stated - Research shows that there is at present no clear evidence of clinical effectiveness to support complementary therapies or alternative medicine (CAM).
Most complementary medicines and alternative therapies have not been subject to the trials familiar in orthodox treatments and their effectiveness is not clinically proven.

Acupuncture

The Local Health Board will not commission for the foreseeable future these services.

Homeopathy

The Local Health Board will not commission for the foreseeable future these services.

Osteopathy, Chiropractic and Spinal Manipulation Therapies

The Local Health Board will not commission for the foreseeable future these services.

All Other Complementary Therapies

The Local Health Board will not commission for the foreseeable future these services.

COSMETIC SURGERY/PLASTIC SURGERY

The provision of services comes under the auspices of *Health Commission Wales.*

General Remarks
Cosmetic surgery (surgery undertaken exclusively to improve appearance) will be excluded from NHS provision in the absence of previous trauma, disease or congenital deformity.

Issues around personal circumstances or concepts of "worth" to society will not feature in consideration of the referral.

Assessment of patients being considered for referral who may have an underlying genetic, endocrine or psychosocial condition should have had this fully investigated by a relevant specialist prior to the referral being made**.**

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be permitted**. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment.**

Patients with clear dysmorphophobia should be referred for psychological assessment**: such patients may subsequently be referred for a plastic surgical opinion by a psychiatrist.**

The Plastic Surgery specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.

Breast Procedures

- Female Breast Reduction (Reduction Mammoplasty)

Breast reduction surgery is an effective intervention that should be available on the NHS if the following circumstances are met:

- The patient is suffering from neck ache, backache and/or severe intertrigo.
- The wearing of a professionally fitted brassiere has not relieved the symptoms.
- The patient has a body mass index (BMI) of 25Kg/m2 or less.
- Only in very exceptional circumstances will girls under the age of 16 be considered for this procedure.

Following initial consideration of the referral by the Case Officer or equivalent, appropriate patients should ideally have an initial assessment prior to an appointment with a Consultant Surgeon to ensure that these criteria are met.

Rationale:
Breast reduction places considerable demand on the NHS resource (volume of cases and length of surgery) and yet has been shown to be a highly effective health intervention. There is published evidence showing that most women seeking breast reduction are not wearing a bra of the correct size and that a well fitted bra can sometimes alleviate the symptoms that are troubling the patient. The upper limit of normal BMI is 25 Kg/m2.

- Male Breast Reduction for Gynaecomastia

Surgery to correct gynaecomastia is allowable if the patient is post pubertal and of normal BMI i.e. 18 - 25Kg/m2.

There should be a pathway established to ensure that appropriate screening for endocrinological and drug related causes and to exclude testicular cancer through examination in Primary Care prior to making a referral.

Rationale:
Commonly gynaecomastia is seen during puberty and may correct once the post-pubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely it may be caused by an underlying endocrine abnormality or a drug related cause including the abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

- Breast Enlargement (Augmentation Mammoplasty)

Will only be performed by the NHS on an exceptional basis and will not be carried out for “small” but normal breasts or for breast tissue involution (including post partum changes).

Exceptions are for women with an absence of breast tissue unilaterally or bilaterally, or in women with a significant degree of asymmetry of breast shape and / or volume (one cup size difference). Such situations may arise as a result of:

- Previous mastectomy or excisional breast surgery.
- Trauma to the breast during or after development.
- Congenital amastia (total failure of breast development).
- Endocrine abnormalities.
- Developmental asymmetry.

- Patients must have a BMI within the range of 18Kg/m2 to 25 Kg/m2.

Patients who are offered breast augmentation in the NHS should be encouraged to participate in the U.K. national breast implant registration system and be fully counselled regarding the risks and natural history of breast implants. Patients should be provided with a copy of the DoH guidance booklet “Breast implants information for women considering breast implants”. (See website: www.doh.uk/bimplants).

It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time**.**

Rationale:
Demand for breast enlargement is rising in the U.K. Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery (such as implant replacement) at some point in the future, is common. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

- Revision of Breast Augmentation

Revisional surgery will only be considered if the NHS commissioned the original surgery**.**

If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the criteria for augmentation at the time of the revision.

Rationale:
Prior to the development of commissioning criteria such as this, a small number of patients underwent breast augmentation in the NHS for purely cosmetic reasons. There may however be clinical reasons why replacement of the implants remains an appropriate surgical intervention. For these reasons it is important that:

- Prior to implant insertion all patients are explicitly made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.
- Patients should also be made aware that implant removal in the future might not be automatically followed by replacement of the implant**.**

- Breast Lift (Mastopexy)

This is included as part of the treatment of breast asymmetry and reduction (see previous) but not for purely cosmetic/aesthetic purposes such as post-lactation ptosis. An exception may be made in severe cases (Regnault Grade 111) where the nipple lies below the infra-mammary fold and below the most projecting portion of the breast in the erect position.

Rationale:
Breast ptosis (droopiness) is normal with the passage of age and after pregnancy. Patients with breast asymmetry often have asymmetry of shape as well as volume and correction may require mastopexy as part of the treatment.

- Nipple Inversion

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this possibility be excluded**.**
Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

Rationale:
Idiopathic nipple inversion can often (but not always) be corrected by the application of sustained suction. Commercially available devices may be obtained from major chemists or online without prescription for use at home by the patient. Greatest success is seen if it is used correctly for up to three months.

An underlying breast cancer may cause a previously normal everted nipple to become indrawn: this must be investigated urgently.

<u>Facial Procedures</u>

➢ Face lifts and brow lifts (Rhytidectomy)

These procedures will not be commissioned for purely cosmetic reasons nor to treat the natural processes of ageing. They will however be considered for treatment of:

- Congenital facial abnormalities.
- Facial palsy (congenital or acquired paralysis).
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis.
- The correction of the consequences of trauma.
- To correct deformity following surgery.

Rationale:
There are many changes to the face and brow as a result of ageing that may be considered normal; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.

➢ Facial Atrophy

New-Fill procedures will not be commissioned.

Rationale: These procedures are not regarded as a commissioning priority.

➢ Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons), as demonstrated by:

- Impairment of visual fields in the relaxed, non-compensated state.
- Clinical observation of poor eyelid function, discomfort e.g. headache worsening towards the end of the day and / or evidence of chronic compensation through elevation of the brow.

Rationale:
Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However, if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

➢ Surgery on the lower eyelid (Lower lid blepharoplasty)

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale:
Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

➢ Surgery to reshape the nose (Rhinoplasty)

This procedure will not be commissioned purely for cosmetic reasons. It will be available on the NHS for:

- Problems caused by obstruction of the nasal airway.
- Objective nasal deformity caused by trauma.
- Correction of complex congenital conditions e.g. cleft lip and palate.

Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment.

- ➢ Correction of prominent ears (Pinnaplasty / Otoplasty).

To be available on the NHS the following criteria must be met:

- The patient must be under the age of 19 at the time of the referral.
- Patients seeking pinnaplasty should be seen by a Plastic Surgeon and following assessment, if there is any concern, assessed by a psychologist.

Rationale:
Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. The National Service Framework for Children defines childhood as ending at 19 years. Some patients are only able to seek correction once they are in control of their own healthcare decisions.

- ➢ Repair of external ear lobes (Lobules).

This procedure will only be available on the NHS for the repair of <u>totally</u> split ear lobes as a result of direct trauma.

Prior to surgical correction, patients should receive pre-operative advice to inform them of:

- Likely success rates.
- The risk of keloid and hypertrophic scarring in this site.
- The risk of further trauma with re-piercing of the ear lobule.

Rationale:
Many split earlobes follow the wearing of excessively heavy earrings with insufficient tissue to support them, such that the earring slowly “cheese-wires” through the lobule. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

- ➢ Correction of male pattern baldness

Is excluded from treatment on the NHS

Rationale:
So-called “male pattern” baldness is a normal process for many men at whatever age it occurs.

- ➢ Hair transplantation

Will not be available under the NHS, regardless of gender – other than in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

- Correction of hair loss (Alopecia)

Is available on the NHS when it is a result of previous surgery or trauma, including burns

- Operations on congenital anomalies of the face and skull

Is usually available on the NHS. Some such conditions are considered highly specialised and are commissioned in the U.K. through the National Specialist Commissioning Advisory Group.

Rationale:
The incidence of some congenital conditions affecting the cranio-facial skeleton is small and the treatment complex. It is considered that specialist teams, working in designated centres and subject to national audit, should carry out such procedures.

- Correction of post traumatic bony and soft tissue deformity of the face.

Procedures are available on the NHS.

Body Contouring Procedures

It is recognised that the consequences of morbid obesity will become an increasing problem for the NHS and that robust inclusion criteria need to be developed to ensure that appropriate patients benefit from interventions that change the body contour.

- "Tummy Tuck" (Apronectomy or Abdominoplasty)

Abdominoplasty and apronectomy may be offered to the following groups of patients who should have achieved a stable BMI between 18 and 25 Kg/m2 and be suffering from severe functional problems:

- Those with scarring following trauma or previous abdominal surgery.
- Those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds.
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years.
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery.

Severe functional problems **include:**

- Recurrent intertrigo beneath the skin fold.
- Experiencing severe difficulties with daily living i.e. ambulatory restrictions.
- Where previous trauma or surgical scarring (usually midline vertical, or multiple) leads to very poor appearance and results in disabling psychological distress or risk of infection.
- Problems associated with poorly fitting stoma bags.

Rationale:
Excessive abdominal skin folds may occur following weight loss in the previously obese patient and can cause significant functional difficulty. There are many obese patients who do not meet the definition of morbid obesity* but whose weight loss is significant enough to create these difficulties. These types of procedures, which may be combined with limited liposuction, can be used to

correct scarring and other abnormalities of the anterior abdominal wall and skin. It is important that patients undergoing such procedures have achieved and maintained a stable weight so that the risks of recurrent obesity are reduced. The availability of teams specialising in the surgical treatment of the morbidly obese (bariatric surgery) is limited, although this may rise with the implementation of NICE guidance in this area. Many patients therefore achieve their weight loss outside such teams and should not be disadvantaged in accessing body contouring surgery, if required.

(* For the purpose of this guidance, people are defined as having morbid obesity if they have a body mass index (BMI) either equal to or greater than 40kg/m2, or between 35kg/m2 and 40kg/m2 in the presence of significant co-morbid conditions that could be improved by weight loss).

- Other Skin Excision for Contour (e.g. buttock lift, thigh lift, arm lift (brachioplasty)

These procedures will only be commissioned in exceptional circumstances.

Rationale:
Whilst the patient groups seeking such procedures are similar to those seeking abdominoplasty (see previous), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance: in which case the procedure will not be available on the NHS.

- Liposuction

Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies). Liposuction is sometimes an adjunct to other surgical procedures. It will not be commissioned simply to correct the distribution of fat.

Dermatological treatments
A patient with a skin or subcutaneous lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment

Some benign skin lesions will continue to be excised in the acute sector for differential diagnosis.

- Pigmented Lesions

Removal of obviously clinically benign moles will not be commissioned purely for cosmetic reasons. In most cases the distinction between suspicious and purely benign moles is clear, *but suspicious pigmented lesions should always be referred and will always be seen.*

- Other Benign Skin Lesions

Removal of other obviously benign skin lesions will not be commissioned purely for cosmetic reasons. Such lesions will include seborrhoeic keratoses, skin tags, dermatofibromata, haemangiomata and epidermoid/pilar cysts.

Exceptions may be made if there is a history of recurrent infections, pain or bleeding.

- Viral Warts

In general patients with viral warts/verrucae and molluscum should not be referred.

Patients may be referred if:

- There is any doubt about the diagnosis
- Severe disabling warts despite six months of topical salicylic acid treatment +/- cryotherapy.
- Significant warts or mollusca in immunocompromised patients i.e. transplant patients.
- Facial warts other than plane wart

- Removal of small lipomata

This procedure will not be commissioned purely for cosmetic reasons. An exception may be made with large lipoma that interfere with function, or for treatment of multiple liopmatosis and neurofibromatosis

Rationale:
The decision to remove benign skin lesions from conspicuous sites is a balance between the appearance of the original lesion against the likely appearance of the surgical scar. It is therefore essential that the decision is made by a practitioner fully familiar with the factors affecting the outcome of surgery in these sites and that the excision is carried out by a trained practitioner using fine instruments and sutures in an appropriate surgical setting.

- Xanthelasma

Patients with xanthelasma should always have their lipid profile checked before referral to a specialist.

Many xanthelasmata may be treated with topical TCA or cryotherapy. Larger lesions or those that have not responded to these treatments may benefit from surgery if the lesion is disfiguring.

Rationale:
Xanthelasma (yellow fatty deposits around the eyelids) may be associated with abnormally high cholesterol levels and this should be tested for. They may be very unsightly and multiple and do not always respond to “ medical” treatments. Surgery can require “blepharoplasty type” operations and / or skin grafts.

- Tattoo Removal

The NHS will consider removal of tattoos in the following cases:

- Where the tattoo is the result of trauma, inflicted against the patient’s will (“rape tattoo”).
- The patient was not Gillick competent,* and therefore not responsible for their actions at the time of the tattooing.
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity. (Only considered in very exceptional

circumstances where the tattoo causes marked limitations of psychosocial function).

(* In the health realm, children are considered competent to make decisions on their own behalf when they are capable of understanding fully the nature of what is proposed. A competent child's refusal should not be overridden, save in exceptional circumstances.

The decision as to whether a child is Gillick competent (Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security, House of Lords, 1985) will usually be taken by health care professionals involved in the child's care, sometimes with input from clinical psychologists, teachers etc.

The DH issued revised guidance in July 2004 (gateway ref. 3382), which did not change the original advice. Whilst this advice specifically relates to sexual health and contraception, the general rules can be applied to all health care: a doctor or health professional is able to provide (contraception, sexual and reproductive) health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- She/he understands the advice provided and its implications.
- Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above).

Rationale:
Many patients seeking tattoo removal are from disadvantaged backgrounds that did not fully recognise the implications of a tattoo on subsequent employment and life opportunities. Most tattoos may be removed by a series of outpatient treatments using an appropriate laser.

- Skin Hypo-pigmentation

The recommended NHS suitable treatment for hypo-pigmentation is cosmetic camouflage. Access to a qualified camouflage beautician should be available on the NHS for this and other skin conditions requiring camouflage.

- Vascular Skin Lesions

NHS treatment is allowed for all vascular lesions except for small benign, acquired vascular lesions such as thread veins and spider naevi.

The planning of treatment of complex major vascular malformations is best carried out in a specialised multi-disciplinary team setting.

- Acne Vulgaris

The treatment of active acne vulgaris should be provided in primary care or through a dermatology service.

Patients with severe facial post-acne scarring can benefit from “resurfacing” and other surgical interventions, which may be available from the plastic surgery service (see “Skin Resurfacing” section).
http://www.nice.org.uk/pdf/Referraladvice.pdf

- Rhinophyma

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment.

Miscellaneous

- Skin “Resurfacing” Techniques

All resurfacing techniques, including laser, dermabrasion and chemical peels **may** be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled (see Acne Vulgaris).

- Botulinum Toxin

Botulinum toxin has many uses within the NHS. It is available for the treatment of pathological conditions by appropriate specialists in cases such as:

- Frey’s syndrome.
- Blepharospasm.
- Cerebral Palsy.
- Hyperhidrosis.

Botulinum toxin is not available for the treatment of facial ageing or excessive wrinkles.

- Hair Depilation (Hair Removal)

Hair depilation will only be commissioned on the NHS for patients who:

- Have undergone reconstructive surgery leading to abnormally located hair-bearing skin.
- Those with a proven underlying endocrine disturbance resulting in Hirsutism (e.g. polycystic ovary syndrome).
- Are undergoing treatment for pilonidal sinuses to reduce recurrence.
- Hirsutism leading to significant psychological impairment.

The method of depilation (hair removal) used should be diathermy electrolysis performed by a registered electrologist or laser. Where laser services are being developed reference to the available evidence base should be made.

NPHS Health Policy Advice (This advice will be reviewed in three years, August 2008 or earlier if any circumstances initiate a need for a review.)

- Laser Depilation

Studies suggest that laser depilation reduced hair growth in patients with unwanted hair, though multiple treatments may be required There is no clear definitive information on the best laser technique or energy level to use (STEER 2003; Vol 3: No. 13 Laser treatment for unwanted hair).

There are few studies comparing laser depilation with other methods of depilation. Of those studies undertaken, laser therapy is reported to be less painful that other depilation treatments, particularly electrolysis (where it is reported to be more reliable, practical and faster) and hot wax. The studies also indicate that there is a more significant decrease in the number of hairs at each laser treatment than by electrolysis and hot wax treatments.

The literature supports laser treatment for hair depilation as a safe, effective, temporary method. After 3 to 4 treatments 75% of patients achieve 70% hair removal. It is not considered a long-term method of hair removal as treatment may need to be repeated after 3 – 4 years, but some patients receive a long-term reduction in hair density after a single treatment.

There are a number of complications associated with laser treatment. Postoperative pigmentation, hypo pigmentation, purpura, blistering and crusting all tend to be transient. The risk of scarring is generally low but highest in cutaneous laser resurfacing.

Rationale:
Hirsutism is a common disorder, often resulting from conditions that are not life threatening, but it may signal more serious clinical pathology. Advances in topical hair growth retardants and laser hair removal methods offer new options. Electrolysis appears to offer a more permanent solution to hair removal.

Diagnostic Dilatation And Curettage
Effective Health Care Bulletin 9 has recommended that diagnostic dilatation and curettage (D&C) NHS Centre for Reviews & Dissemination. The Management of Menorrhagia Effective Health Care No. 9. 1995 **should not be performed on women aged under 40:** since the risks of anaesthesia, uterine perforation and cervical laceration outweigh the minimal potential benefit.

Newer methods of endometrial sampling appear to be at least as accurate as D&C, with high levels of acceptability and lower complication rates.

For women with dysfunctional uterine bleeding, a range of medical interventions are available (eg. recent BMJ paper comparing mefenamic acid with norethisterone etc).

There may be some exceptions to not commissioning D&C's for women under 40. Advice from gynaecologist will be sought by the Local Health Board on these cases on an individual basis.

Non Medical Circumcisions
Circumcision is an effective operative procedure with a range of medical indications. Some circumcisions are also requested for social, cultural or religious reasons; these non-medical circumcisions do not confer any measurable health gain but do carry measurable health risks.

This procedure is not commissioned. This supports the commissioning policy for circumcision adopted by Health Commission Wales.

Medical Indications
Circumcisions should continue to be performed for medical indications, including: phimosis seriously interfering with urine flow and/or associated with recurrent infection, some cases of paraphimosis, suspected cancer or balanitis xerotica obliterans, congenital urological abnormalities when skin is required for grafting and interference with normal sexual activity in adult males.

Osseo-Integrated Implants
Osseo-integrated implants are often effective, but they are expensive. Many patients can be treated adequately using alternative interventions. In view of the current financial situation, implants will not be commissioned. They will only be purchased in exceptional circumstances and when prior approval has been obtained by hospital dental staff.

This procedure is not available on cosmetic grounds.

The Royal College of Surgeons is consulting with the dental profession to develop a priority index of treatment needed for restorative dentistry. This guidance will be reviewed when a national document becomes available.

- Maxillofacial Defects

Osseo-integrated implants may be considered for some patients with:
- cancer
- congenital maxillo-facial defects
- major bone loss through trauma

In a number of cases, surgical treatment is unfortunately not possible for clinical reasons.

- Edentulous or Partially Dentate Patients

A very small number of patients with severe denture intolerance, who may have tried a well made and well adjected denture for at least one year without success, may be considered for an osseo-integrated implant.

This procedure may also be considered if a psychiatric or psychological opinion suggests real need for an individual patient.

Reversal of Vasectomy or Female Sterilisation
NPHS Policy Advice (2004)
(This public health advice will be reviewed in three years, January 2007 or earlier if any circumstances initiate a review.)

Reversal of sterilisation and reversal of vasectomy procedures are often effective.

The RCOG makes it explicit that “men and women seeking sterilisation should be advised that the procedure is intended to be permanent”. Any couple/patient should be fully counselled in accordance with RCOG guidelines before vasectomy or sterilisation is performed. Royal College of Obstetricians and Gynaecologists

National Evidence-Based Clinical Guidelines Male and Female Sterilisation, RCOG Press; 1999. www.rcog.org.uk

Reversal of vasectomy or female sterilisation will not be commissioned unless the sterilisation is the result of a surgical accident.

A list of exceptional circumstances cannot realistically be comprehensive, and each request should be considered on an individual basis.

Varicose Veins

Most primary care varicose veins require **no treatment**. The key role of primary care is to provide reassurance, explanation and education, including advice on exercise, leg elevation and weight reduction if necessary. Primary care is also involved in overseeing skin care and making recommendations about the use and application of hosiery and compression bandaging.

The LHB support and will follow the guidance issued by the National Institute for Clinical Excellence for the treatment of Varicose Veins National Institute for Clinical Excellence, Referral Advice, 2001. The wording of this exclusion has been taken from this guidance. http://www.nice.org.uk/pdf/Referraladvice.pdf.

The following will not be commissioned:

- Cosmetic reasons- unless severe psychological disturbance – which would need to be assessed prior to referral.
- Spider veins
- Flare veins

Surgery will only be considered if:

1. They are bleeding from a varicosity that has eroded the skin
2. They have bled from a varicosity and are at a risk of bleeding again
3. They have an ulcer which is progressive and/or painful despite treatment
4. They have an active or healed ulcer and/or progressive skin changes that may benefit from surgery
5. They have recurrent superficial thrombophlebitis
6. They have troublesome symptoms **attributable** to their varicose veins, or previous DVT and/or they and their GP feel that the extent, site and size of the varicosities are having severe impact on quality life.

With reference to point 6 above NICE notes that patients report symptoms such as aches, pains, restless legs, cramps, itchiness, heaviness and oedema. However, a link between symptoms and varicose veins can be difficult to establish.

Mild to moderate symptoms should be treated in primary care and should respond to gentle compression therapy. Standard treatment with class I or II compression hosiery should be prescribed. Severe peripheral vascular disease should be excluded by confirming that foot pulses are palpable or that Ankle Brachial Pressure Index (ABPI) is greater than 0.8.

If compression does not control the symptoms then reassessment of symptoms and potential cause should be revisited.

If symptoms of pain are severe this is likely to be due to other pathologies and other diagnoses should be considered, such as peripheral vascular disease, osteoarthritis, painful restless leg syndrome etc.

Orthodontic Treatments of an Essentially Cosmetic Nature

Orthodontic treatment is generally effective but treatment of minor irregularities causing no adverse effects is considered to be of low priority. They will only be purchased in exceptional circumstances and when prior approval has been given.

Discussion with the dental profession is currently taking place to firm up this advice and this will be issued when available.

These procedures will not be available on cosmetic grounds.

Treatment of IOTN (Index of orthodontic treatment need) Groups 1, 2 and elements of 3 i.e. minor irregularities causing no adverse effects will not be commissioned.

As with other exceptions treatment may be considered if a psychiatric or psychological need is identified for an individual patient.

Elective Surgery for the Treatment of Inguinal Surgery in Adults

The elective surgical treatment of asymptomatic or mildly symptomatic inguinal hernias in adults is low priority and patients will not routinely be offered surgery.

The BMJ Clinical Evidence[1] concluded that conservative management of unilateral inguinal hernia might be considered a reasonable strategy in people who have only mild symptoms, in whom the risk of hernia complications is low. There is good recently published evidence[2] that it is safe to manage asymptomatic or mildly symptomatic inguinal hernias non-operatively, i.e. with watchful waiting.

Surgery will only be considered if:

- There is a history of incarceration of, or real difficulty reducing, the hernia
- There is an inguino-scrotal hernia
- There is an Increase in size month to month
- There is pain or discomfort significantly interfering with activities of daily living
- It impacts on work-related issues: light duties because of hernia or off work/missed work/unable to work because of hernia

It is worth noting that hernia repair is not without complications, and therefore the risk/benefit for prophylactic surgery needs to be carefully considered.
Mortality: 0.01%-0.6%
Recurrence: 1.5-5% (at least)
Complications: Early – wound infection, haematoma, DVT, PE, all real but rates vary.
Late – paraesthesiae, anaesthesia, chronic pain (~10%-20%), testicular damage, chronic mesh infection.

To Note:
This policy will be reviewed in the light of new evidence or guidance from NICE.

[1] . BMJ Clinical Evidence www.clinicalevidence.com

[2] Fitzgibbons RJ, Giobbie-Hurder A, Gibbs Jo et al. Watchful Waiting vs. Repair of Inguinal Hernia in Minimally Symptomatic Men - A Randomized Clinical Trial. JAMA. 2006;295:285-292