

KNEE MENISCAL TEAR SURGERY CRITERIA BASED ACCESS (CBA) POLICY

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Application Form	EBI Generic application form if appropriate to apply

**KNEE MENISCAL TEAR
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VERSION CONTROL

Document Status:	Current policy
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DOCUMENT CHANGE HISTORY

Version	Date	Comments
2122.v1	Dec 2021	Policy title changed from Locked Knee – Meniscal Tear to Knee Meniscal Tear
2122.v2	July 2022	Amendment from SCCG to NHS Somerset ICB. New PALS email address

Equality Impact Assessment (EIA)	N/A
Quality Impact Assessment QIA.	August 2021 v1
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1 GENERAL PRINCIPLES (CBA)

- 1.1 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 ICB Evidence Based Interventions Service (EBI) by submission of an EBI application form
- 1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment
- 1.3 Treatment should only be undertaken where the criteria have been met and 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
- 1.4 Referring patients to secondary / community care without them meeting the criteria or funding approval not secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment
- 1.5 On limited occasions, the ICB 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
- 1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment
- 1.7 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate
- 1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery.
<https://www.sciencedirect.com/science/article/pii/S1198743X15007193>
(Thelwall, 2015)
- 1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY CRITERIA BASED ACCESS – CBA

- 2.1 There are a number of occasions when arthroscopic meniscal surgery can be considered as a first-line treatment;
- Firstly, patients who have a **locked knee** need urgent assessment
 - If a bucket handle tear of the meniscus is present, most cases need arthroscopic repair or resection of the meniscus
 - Secondly where the patient has had an acute injury and an MRI scan reveals a potentially repairable meniscus tear, an arthroscopic meniscal repair should be considered
- 2.2 Patients with a clear history of a significant acute knee injury and and/or who have a **recurrent locking** knee may have a repairable meniscal tear and should undergo referral to intermediate or secondary care and there should be consideration of an MRI investigation
- 2.3 The majority of patients who initially present in primary/intermediate care with knee symptoms, no red flags and no history of acute knee injury or a locked knee **DO NOT NEED AN MRI** investigation and can be treated with non-operative supportive measures
- 2.4 Where symptoms have not settled after three months of non-operative treatment an MRI scan should be considered. In cases with an unstable meniscal tear on MRI, arthroscopic meniscal surgery may be indicated
- 2.5 Patients with persistent mechanical knee symptoms should be referred to an orthopaedics assessment service and consideration of an MRI scan of the knee to investigate for a meniscal tear and/or other pathology
- 2.6 Degenerate meniscal tears and Osteoarthritis (OA) are extremely common in the general population.

MRI is not recommended for a suspected degenerative meniscal tear unless there are mechanical symptoms e.g. locking or lack of improvement with conservative treatment e.g. exercise/therapy, weight loss, bracing, topical or oral analgesia

Arthroscopic Meniscectomy

- 2.7 The use of arthroscopic surgery to treat degenerate meniscal tears should follow published BASK guidelines

The bone & Joint Journal - Arthroscopic meniscal surgery
A National Society Treatment Guideline and Consensus Statement
<https://online.boneandjoint.org.uk/doi/pdf/10.1302/0301-620X.101B6.BJJ-2019-0126.R1>

British Association for Surgery of the Knee BASK meniscal guideline
[Meniscal surgery guidelines - Professional \(baskonline.com\)](https://www.baskonline.com/guidelines/meniscal-surgery-guidelines-professional)

- 2.8 The majority of patients with a meniscal tear should be initially treated non-operatively and should not have arthroscopic meniscectomy as a first line treatment.

Non-operative treatment is highly effective and many patients treated this way will improve and do not require surgery

Non-operative treatment:

- Patient education using verbal and written materials
- Physiotherapy
- Weight loss interventions
- Exercise should comprise both local muscle strengthening
- and general aerobic fitness
- Paracetamol and topical NSAIDs should be first line pharmacological pain management strategies

- 2.9 Patients considering arthroscopic knee surgery should go through a shared decision-making process and have a good understanding of the risks of surgery. The procedure is a relatively safe intervention but does carry a low risk of infection and deep vein thrombosis, both of which are serious complications

- 2.10 Routine use of arthroscopy for degenerative knee disease, where no specific target pathology has been identified (e.g. proven meniscal tear and persistent symptoms), is not recommended. Use of arthroscopy in patients with generic degenerative knee disease and no specific target pathology has not been found to be clinically beneficial and is unlikely to be cost-effective

Using agreed guidelines for employing arthroscopic surgery to treat meniscal tear pathology and avoiding indiscriminate use will reduce unwarranted variation in clinical care

3 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

- 3.1 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
- 3.2 Completion of a **Generic EBI Application Form** by a patient's GP or Consultant is required

- 3.3 Applications cannot be considered from patients personally
- 3.4 Only electronically completed EBI applications will be accepted to the EBI Service
- 3.5 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 EBI service. This will reassure the service that the patient has a reasonable expectation of the outcome of the application and its context
- 3.6 EBI applications are reviewed and considered against clinical exceptionality
- 3.7 For further information on 'clinical exceptionality' please refer to the NHS England information using the link below page 9-13;
<https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-individual-funding-requests.pdf>
- 3.8 Social, Emotional and Environmental factors *i.e. income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application
- 3.9 Where appropriate photographic supporting evidence can be forwarded with the application form
- 3.10 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

4 ACCESS TO POLICY

- 4.1 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
- 4.2 **Or write to us:** NHS Somerset ICB Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email us:** somicb.pals@nhs.net

5 REFERENCES

- The following sources have been considered when drafting this policy:
- 5.1 Kise NJ, Risberg MA, Stensrud S, Ranstam J, Engebretsen L, Roos EM.

- Exercise therapy versus arthroscopic partial meniscectomy for degenerative meniscal tear in middle aged patients: randomised controlled trial with two year follow up. *BMJ*2016;354:i3740. doi:10.1136/bmj.i3740 pmid:27440192
- 5.2 . Khan M, Evaniew N, Bedi A, Ayeni OR, Bhandari M. Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. *CMAJ*2014;186:1057-64. doi:10.1503/cmaj.140433 pmid:25157057.
- 5.3 Thorlund JB, Juhl CB, Roos EM, Lohmander LS. Arthroscopic surgery for degenerative knee: systematic review and meta-analysis of benefits and harms. *BMJ*2015;350:h2747. doi:10.1136/bmj.h2747 pmid:26080045.
- 5.4 Devji T, Guyatt GH, Lytvyn L, et al. Application of minimal important differences in degenerative knee disease outcomes: a systematic review and case study to inform BMJ Rapid Recommendations. *BMJ Open* 2017;7:e015587.doi:doi:10.1136/bmjopen-2016-015587.
- 5.5 Brignardello-Peterson R, Guyatt GH, Schandelmaier S, et al. Knee arthroscopy versus conservative management in patients with degenerative knee disease: a systematic review. *BMJ Open*2017;7:e016114. doi:10.1136/bmjopen-2017-016114.
- 5.6 Marsh JD, Birmingham TB, Giffin JR, et al. Cost-effectiveness analysis of arthroscopic surgery compared with non-operative management for osteoarthritis of the knee. *BMJ Open*2016;6:e009949. doi:10.1136/bmjopen-2015-009949 pmid:26758265.
- 5.7 <https://www.nice.org.uk/guidance/cg177/chapter/1-Recommendations>
8. McGroary B, Weber K, Lynott JA, et al. American Academy of Orthopaedic Surgeons. The American Academy of Orthopaedic Surgeons evidencebased clinical practice guideline on surgical management of osteoarthritis of the knee. *J Bone Joint Surg Am*2016;98:688-92. doi:10.2106/JBJS.15.01311 pmid:27098328.
- 5.8 National Institute for Health and Clinical Excellence. Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis (Interventional procedures guidance IPG230). 200: <http://www.nice.org.uk/guidance/ipg230>. <https://www.nice.org.uk/guidance/ipg230/chapter/2-Theprocedure>.
- 5.9 Adelani MA, Harris AH, Bowe TR, Giori NJ. Arthroscopy for knee osteoarthritis has not decreased after a clinical trial. *Clin Orthop Relat Res*2016;474:489-94. doi:10.1007/s11999-015-4514-4 pmid:26290345.
- 5.10 Siemieniuk RAC, Harris IA, Agoritsas T, et al. Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline. *BMJ* 2017;257:j1982. doi:10.1136/bmj.j1982.
- 5.11 Gauffin H, Tagesson S, Meunier A, Magnusson H, Kvist J. Knee arthroscopic surgery is beneficial to middle-aged patients with meniscal symptoms: a prospective, randomised, single-blinded study. *Osteoarthritis Cartilage*2014;22:1808-16. doi:10.1016/j.joca.2014.07.017 pmid:25086401.
- 5.12 Sihvonen R, Englund M, Turkiewicz A, Järvinen TL. Finnish Degenerative Meniscal Lesion Study Group. Mechanical symptoms and arthroscopic partial meniscectomy in patients with degenerative meniscus tear: a secondary analysis of a randomized trial. *Ann Intern Med*2016;164:449-55. doi:10.7326/ M15-0899 pmid:26856620.
- 5.13 S. G. F. Abram, D. J. Beard, A. J. Price, BASK Meniscal Working Group. Bone Joint J 2019;101-B:652–659. Arthroscopic meniscal surgery a national society treatment guideline and consensus statement: <https://doi.org/10.1302/0301-620X.101B6.BJJ-2019-0126.R1>.
- 5.14 A. J. Price, F. S. Haddad, D. J. Beard. Bone Joint J 2019;101-B:625–626. New guidelines for the use of arthroscopic meniscal knee surgery. Published Online:1 Jun 2019: <https://doi.org/10.1302/0301-620X.101B6.BJJ-2019-0550>.
- 5.15 Abram SGF, Judge A, Beard DJ, Price AJ. *Lancet*. 2018 Nov
- 5.16 392(10160):2194-2202. Adverse outcomes after arthroscopic partial meniscectomy: a study of 700 000 procedures in the national Hospital Episode Statistics database for England. doi: 10.1016/S0140-6736(18)31771-9. Epub 2018 Sep 24.
- 5.17 <https://www.nice.org.uk/guidance/cg177>.
- 5.18 <https://online.boneandjoint.org.uk/doi/pdf/10.1302/0301-620X.101B6.BJJ-2019-0126.R1>.
- 5.19 Arthroscopic partial meniscectomy for meniscal tears of the knee: a systematic review and meta-analysis <http://dx.doi.org/10.1136/>

- bjsports-2018-100223.
- 5.20 <https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.101B6.BJJ-2019-0126.R1>.
- 5.21 <https://www.sciencedirect.com/science/article/pii/S0968016018303934>.