Surgical Threshold Policy

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

PRIMARY HIP REPLACEMENT SURGERY

Scope

This policy covers referrals for primary total hip replacement (THR) or hip resurfacing. Total hip replacement (THR) generally involves removal of the head of the femur (thigh bone) and its replacement with a metal or ceramic prosthesis that fits into the remaining bone. The ball end of the artificial femur then fits into a cup-like socket (acetabular cup) that is installed in the patient's pelvis. This policy does not cover hip replacement for acute trauma, sepsis, malignancy or avascularnecrosis.

Note: Revision hip replacement and all complex procedures are funded by NHS England and not the CCG: https://www.england.nhs.uk/wp-content/uploads/2013/06/d10-spec-orthopaedics.pdf

Policy

Referral for treatment should be through the MSK service/pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma.

Hip Resurfacing is a low priority treatment and will not be funded without exceptional case panel approval.

The CCG will **ONLY** fund referral for consideration of THR in patients meeting the following criteria. All referrals should meet these criteria prior to referral unless exceptional, in which case the exceptional funding section of the proforma should document explicitly the reason for exceptional circumstances.

1 Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations as defined in Table 1[i] **AND**

2. Symptoms ***refractory*** to ***at least 6 months*** maximal conservative management.

PRIOR CONSERVATIVE MANAGEMENT MUST INCLUDE ALL OF THE FOLLOWING:

Medication

- The patient should be taking optimal tolerated doses of analgesia. Patients should have gained an understanding of their correct uses (Paracetamol, NSAIDs or Opioid analgesics).

AND

Physiotherapy

- NICE 'core' treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy must have been given.
  Note: With radiographic evidence of bone on bone osteoarthritis, physiotherapy / exercises are not required for a surgical referral.

AND

Patient Education and Orthosis

- Patient education such as elimination of damaging influence on hips (by reducing weight loading), activity modification (avoid impact and excessive exercise) and lifestyle adjustment.
- Patients must have been advised about, and/or assessed for, clinically appropriate walking aids and home adaptations.

AND

Lifestyle improvement

- It is strongly advised to reduce BMI to less than 35 kg/m2 as this will reduce surgical risks and revision rates.
- Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – **see stop smoking policy.**

Patients' (and carers' as appropriate) expectations of surgery, and the likely degree of additional benefit that may be obtained from surgery compared with continuing conservative management, must have been discussed in primary/intermediate care

[i]Table 1: Classification of surgical criteria

Level of pain	Definition
Slight	▪ Sporadic Pain. ▪ Pain when climbing and descending stairs. ▪ Allows daily activities to be carried out (those requiring great physical ability may be limited). ▪ Medication: Aspirin, Paracetamol or NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) to control pain with no/few side effects.
Moderate	▪ Occasional pain. ▪ Pain when walking on level surfaces (half an hour, or standing). ▪ Some limitation of daily activities. ▪ Medication: Aspirin, Paracetamol or NSAIDs to control pain with no/few side effects.
Intense	▪ Pain of almost continuous nature. ▪ Pain when walking short distances on level surfaces or standing less than half an hour. ▪ Activities of daily living (ADL)* significantly limited. ▪ Continuous use of NSAID for treatment to take effect. ▪ Requires the sporadic use of support systems (walking stick, crutches).
Severe	▪ Continuous pain. ▪ Pain when resting. ▪ Activities of daily living* significantly limited constantly. ▪ Continuous use of analgesics-narcotics/NSAIDs with adverse effects or no response. ▪ Requires more constant use of support systems (walking stick, crutches).
Functional limitations	**Definition**
Minor	▪ Functional capacity adequate to conduct normal activities and self-care. ▪ Walking capacity of about one hour. ▪ No aids needed.
Moderate	▪ Functional capacity adequate to perform only a few or none of the normal activities and self-care. ▪ Walking capacity of about one half hour. ▪ Aids such as a cane/walking stick are needed.
Severe	▪ Largely or wholly incapacitated. ▪ Walking capacity of less than half an hour or unable to walk or bedridden. ▪ Aids such as a cane, a walker or wheelchair are required.

*__ADL__ includes activities such as meal preparation, laundry, housekeeping, shopping, using the phones, driving or using public transport.

Rationale and Evidence

NICE TA304[1] states that "Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years". For hip resurfacing, data from current trials[2,3] and the National Joint Registry[4] indicate that 10-year revision rates are currently much higher than this (11.5%). Nevertheless, hip resurfacing may be considered via the exceptional route. Male patients are likely to be considered more favourably due to lower revision rates. Morbidly obese patients have been shown to have a 65.5% increase in revision rates for THR compared with patients with normal BMI (18.5–25)[5] and weight loss should be encouraged to improve outcome.

Numbers of People Affected

Rates of primary hip replacement have increased worldwide. In a UK 2004 study[6], rates in England were shown to have increased by 18% from 1991 to 2000 to 38,425 procedures per year (77.6 per 100,000). Currently, it is estimated that 80,000 procedures are conducted in England and wales each year[7].

References

1. National Institute for Health and Care Excellence Technology appraisal guidance 304. Total hip replacement and resurfacing arthroplasty for end stage arthritis of the hip (review of technology appraisal guidance 2 and 44).
2. Marshall D A, et al. Hip Resurfacing versus Total Hip Arthroplasty: A Systematic Review Comparing Standardized Outcomes. Clin. Orthop. Relat. Res. 472, 2217–2230 (2014).
3. Pailhé R, et al. Hip resurfacing: a systematic review of literature. Int. Orthop. 36, 2399–2410 (2012).
4. National Joint Registry for England, Wales and Northern Ireland. 14th Annual report 2017.
5. Culliford D, Maskell J, et al. A population-based survival analysis describing the association of BMI on time to revision for total hip and knee replacement: results from the UK GPRD. BMJ open 2013.
6. Dixon, T, Shaw, M, Ebrahim, S & Dieppe, P. Trends in hip and knee joint replacement: socioeconomic inequalities and projections of need. Ann. Rheum. Dis. 63, 825–830 (2004).
7. National Joint Registry. (2017). Available at: http://www.njrcentre.org.uk/njrcentre/Patients/Jointreplacementstatistics/tabid/99/Default.aspx.

Glossary

Arthritis:	an inflammation of one or more joints in the body, though the term is used to describe almost all problems associated with the joints.
Avascularnecrosis	death of bone tissue due to a lack of blood supply.
Osteoarthritis:	of the hip and knee is the result of progressive degeneration of the cartilage of the joint surface.
Prosthesis:	an artificial device used to replace a part of the body that is damaged, painful or not working properly.

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Policy to be reviewed:	March 2020
Reference:	onedrive\CPF Pols & Working Area\Surg Threshold Pols\CCG Policies\primary hip replacement\agreed\ HIP REPLACEMENT JULY 2018 V7 – EC Panel Advice Edit