

Humber Coast and Vale

Knee Arthroscopy Commissioning Policy

Intervention	Diagnostic & Therapeutic Arthroscopy Knee
OPCS Codes	<p>W85 Therapeutic endoscopic operations on cavity of knee joint</p> <p>W851 Endoscopic removal of loose body from knee joint</p> <p>W852 Endoscopic irrigation of knee joint</p> <p>W853 Endoscopic autologous chondrocyte implantation of knee joint</p> <p>W858 Other specified therapeutic endoscopic operations on cavity of knee joint</p> <p>W859 Unspecified therapeutic endoscopic operations on cavity of knee joint</p> <p>W87 Diagnostic endoscopic examination of knee joint</p> <p>W871 Diagnostic endoscopic examination of knee joint and biopsy of lesion of knee joint</p> <p>W878 Other specified diagnostic endoscopic examination of knee joint</p> <p>W879 Unspecified diagnostic endoscopic examination of knee joint</p>
For the treatment of	Diagnostic and Therapeutic Arthroscopy – Knee
Background	This policy defines the commissioning position for diagnostic and therapeutic knee arthroscopy.
Commissioning position	<p>Both diagnostic and therapeutic arthroscopy are NOT routinely commissioned:</p> <ul style="list-style-type: none"> • For diagnostic purposes for investigation of knee pain • To provide washout treatment (lavage) or debridement as a treatment for knee pain or arthritis (in line with NICE guidance, this should not be offered as part of a treatment for osteoarthritis unless the person has a clear documented history of mechanical locking)^{2, 3} • For symptoms of “giving way’ or X-ray evidence of loose bodies without true locking <p>If clinical assessment suggests the patient might have a red flag condition e.g. trauma, infection, carcinoma, bony fracture, avascular necrosis, or constant progressive non-mechanical pain, particularly at night), REFER without delay OR if there has been knee trauma causing fracture or ligament avulsion and arthroscopy is needed urgently.</p> <p>The CCG will ONLY commission therapeutic knee arthroscopy in adults where:</p> <ul style="list-style-type: none"> • the patient has clear mechanical features of true locking, or symptoms that worsen with conservative treatment, <p>AND</p> <ul style="list-style-type: none"> • conservative treatment has been tried over a 3 month period (This needs to include exercise, weight loss where appropriate, physiotherapy and maximal analgesic medication) <p>OR</p> <ul style="list-style-type: none"> • for patients with chronic knee pain, up to 6 months of comprehensive conservative treatment should be tried, including: <ul style="list-style-type: none"> - efforts to lose weight if BMI over 25, (as outlined in NICE guidance³), - lifestyle advice, including exercise or rest - optimum pharmacological treatments - self or physiotherapy guided mobilisation and strengthening exercises.

	<p>MRI scan should be the first line diagnostic for investigating knee pain with locking, in order to identify meniscal tears and loose bodies, in line with Radiology Guidance. The only exception is when there are contraindications to MRI (e.g. a pacemaker) or diagnostic uncertainty following a MRI scan OR if the patient has an anterior cruciate ligament reconstruction with metal screws affecting the MRI image quality.</p> <p>Treatment in all other circumstances is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request Panel.</p>
<p>Summary of evidence / rationale</p>	<p>For patients with non-traumatic knee injury, evidence shows that, on average, conservative treatment is as effective as arthroscopic knee surgery for some procedures. As long ago as 2002, a controlled trial addressing knee arthroscopy, using placebo or “sham” surgery as a comparator, showed no benefit⁴.</p> <p>Partial meniscectomy surgery showed no advantage over sham in one RCT of patients aged 35-65 years with degenerative meniscal tears without osteoarthritis⁵ and no advantage over physical therapy in two RCTs of older patients (>45 years) with osteoarthritis^{6, 7}. In a systematic review of RCTs of young patients (mean age ~20 years) with a first occurrence of patellar dislocation, there was no conclusive advantage of surgical treatments compared with non-surgical treatments⁸. In an RCT of patients with patellar femoral pain syndrome (18-40 years), mixed arthroscopic procedures and exercise resulted in equivalent improvements compared with exercise alone⁹.</p> <p>Although rates of post-operative complications are generally low, higher rates have been observed in children and young people^{10,11}. There may also be future knee damage associated with arthroscopic procedures^{12, 13} and a recent meta-analysis showed that the small benefit from arthroscopic knee surgery seen in middle aged or older patients with knee pain and degenerative knee disease was absent one to two years after surgery and was associated with an increase in significant harms such as deep vein thrombosis, pulmonary embolism, infection and death¹⁴.</p> <p>The paper concludes: “The small inconsequential benefit seen from interventions that include arthroscopy for the degenerative knee is limited in time and absent at one to two years after surgery. Knee arthroscopy is associated with harms. Taken together, these findings do not support the practice of arthroscopic surgery for middle aged or older patients with knee pain with or without signs of osteoarthritis”¹⁴.</p> <p>The Royal College of Surgeons/British Orthopaedic Association commissioning guide points out that “osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures as outlined by NICE¹.” Regarding knee arthroscopy, it states that lavage and debridement should be considered in patients:</p> <ul style="list-style-type: none"> • With clear history of mechanical symptoms e.g. locking that has not responded to at least 3 months of non-surgical treatment • Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy) <p>The RCS/BOA guidance also states (in line with NICE guidance) that “Knee arthroscopy, lavage and debridement should NOT be offered for patients with non-mechanical symptoms of pain and stiffness.”</p>

More recently, the BMJ has published two editorials about arthroscopic surgery for degenerative knee or knee pain^{16, 17}. They both explore the evidence for benefit and harm and point out that, although this is one of the most common surgical procedures, there is no convincing evidence for the procedure being beneficial beyond the placebo effect.

A series of rigorous trials summarised in two recent systematic reviews and meta-analyses provide clear evidence that arthroscopic knee surgery offers little benefit for most patients with knee pain^{14, 18}.

The most recent linked paper is a comparison between exercise therapy alone and arthroscopic partial meniscectomy alone (without any postoperative rehabilitation) in adults with a degenerative meniscal tear¹⁹. The authors found no between group differences in patient reported knee function at the two year follow-up, but greater muscle strength in the exercise group at three months.

Over time, the indications have extended from locked knees in young patients to all patients of all ages with knee pain and meniscus tears of any sort; tears which, on magnetic resonance imaging, have proved poorly associated with symptoms²⁰.

Essentially, the editorials say, good evidence has been widely ignored. The most recent editorial comments that arthroscopic surgery for knee pain continues unabated, as disinvestments in ineffective treatments are generally slow^{17, 21}. It calls for local commissioners to respond appropriately to the evidence, because “system level measures that result in more appropriate use of scarce medical resources are urgently required”.

In addition, it says that “in a world of increasing awareness of constrained resources and epidemic medical waste, what we should not do is (...) ignore the results of rigorous trials and allow continuing widespread use of procedures for which there has never been compelling evidence”.

Rationale for up to 12 months of conservative treatment in chronic knee pain

This policy therefore specifies that conservative treatment should primarily be used but, when this fails, referral for surgery is an option. In the trial of meniscal surgery compared with conservative treatment in patients without osteoarthritis, at earlier time points, outcomes favoured surgery, but by 12 months of conservative treatment, outcomes were equivalent⁵.

Therefore, to allow sufficient time for benefits of conservative treatment to be gained, and to allow for any potential natural healing of joint derangements, a minimum 12 months restriction has been selected for which conservative treatment should be attempted before any referral.

In this trial, cross-over from the conservative group to surgery over 12 months was low (7%). However, in other trials cross-over has been higher (around 30%)^{5,6}, suggesting that some patients will require more urgent surgery.

There may be some cases where symptoms re-occur on conservative management and these patients may benefit from surgery¹⁵. Therefore, this policy allows for patients with mechanical locking or worsening symptoms to be referred before the 12 month period of conservative management.

Restricted procedures

	<p>For some interventions, the evidence identifies a lack of effect or there is insufficient evidence to warrant their use. There is currently no NICE guidance on the use of many procedures but, for the procedures that have been assessed, those not recommended by NICE will not be funded without IFR approval.</p> <p>There is evidence (including from a Cochrane systematic review) that lavage does not improve patient outcome compared to sham^{2, 3, 24-26} and NICE does not recommend lavage². NICE recommends knee meniscus replacement with biodegradable scaffold only with special arrangements for clinical governance, consent and audit or research²⁷. NICE currently recommends that mosaicplasty should not be used without special arrangements for consent and audit or research²⁸.</p> <p>NICE does not currently recommend autologous chondrocyte implantation for the treatment of articular cartilage defects of the knee joint except in the context of on-going or new clinical studies²⁹. NICE recommends that arthroscopic trochleoplasty for patellar instability should only be used with special arrangements for clinical governance, consent and audit or research³⁰.</p> <p>There is some evidence that debridement is ineffective^{3, 24, 25}, but NICE recommends that debridement may be appropriate in cases where there is mechanical locking³.</p> <p>Restricted use of MRI MRI is a good diagnostic tool²², but may be inaccurate when used by less experienced staff²³ and its use is, therefore, restricted to secondary care or specialists working in CCG commissioned MSK services for this indication.</p> <p><i>Adapted (and updated) from evidence review in Knee arthroscopy for chronic knee pain Cambridgeshire and Peterborough CCG31, with thanks to Dr Raj Lakshman, Consultant Lead in Healthcare</i></p>
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