Clinical Threshold Pathways

Planned Care – QIPP

BEST Meeting

15.2.2017

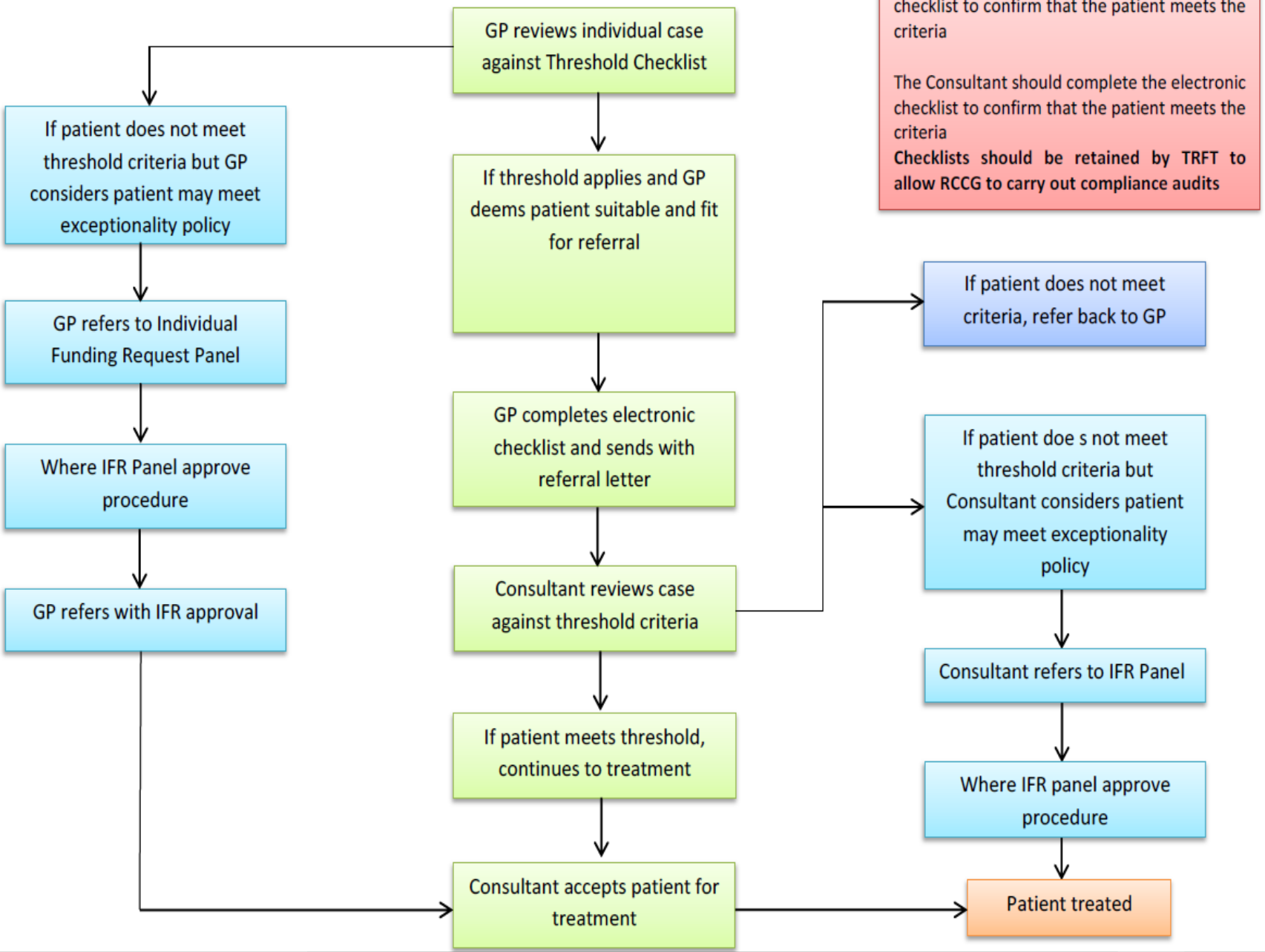
Why are we doing this?

- CCG QIPP Target for 2017/18 is £18m
- C4V Pack – opportunities for savings
- Areas of “Low clinical Value”
- Sharing Best Practice (stoke-on-Trent, North Staffs, Hardwick, SE London, Sandwell & W.Birmingham, Rotherham etc)
- Joint work across Y&H CCG’s

QIPP Areas in Planned Care

- ***Eye*** *:-* Cataract Surgery
- ***ENT*** :-
  - Grommet,
  - Tonsillectomy
- ***Skin benign*** Lesions
- ***Hand*** procedures :-
  - Carpal Tunnel,
  - Dupuytren's,
  - Ganglion,
  - Trigger finger
- Cholecystectomy
- Hernia Repair
  - Incisional
  - Inguinal
- ***Ortho*** *:-*
  - Hip
  - Knee Replacement
- Varicose Veins

CLINICAL THRESHOLDS REFERRAL PROCESS



NB

The GP should complete the electronic checklist to confirm that the patient meets the criteria

The Consultant should complete the electronic checklist to confirm that the patient meets the criteria

Checklists should be retained by TRFT to allow RCCG to carry out compliance audits

Next Steps…

- GP to use the ***Referral criteria checklist***

- If Pt ***meet*** the criteria
  - complete the ***Referral check list*** & ***Refer***

- If Pt ***does not meet*** the criteria
  - Reassure & give Patient Leaflet

QIPP Pathways

- ***Threshold criteria, IFR forms & PILS*** :-
- ***Paper*** forms/ **electronic** forms (soon)
- Integrated in ***Map of Medicine***
- ***BEST Website (clinical criteria check list)***
- 2* care will not get paid if the referral don't meet the Threshold criteria
- We need ***100% uptake*** & ownership from ***ALL*** GP's & ANP's to adopt & use these pathways

Clinical Threshold

- NHS England Referral Criteria
- Good clinical practice…..

Questions – end of each section

- ***Eye*** *:-* Cataract Surgery
- ***ENT*** :-
  - Grommet,
  - Tonsillectomy
- ***Skin benign*** Lesions
- Q
- ***Hand*** procedures :-
  - Carpal Tunnel,
  - Dupuytren's,
  - Ganglion,
  - Trigger finger
- Q
- Cholecystectomy
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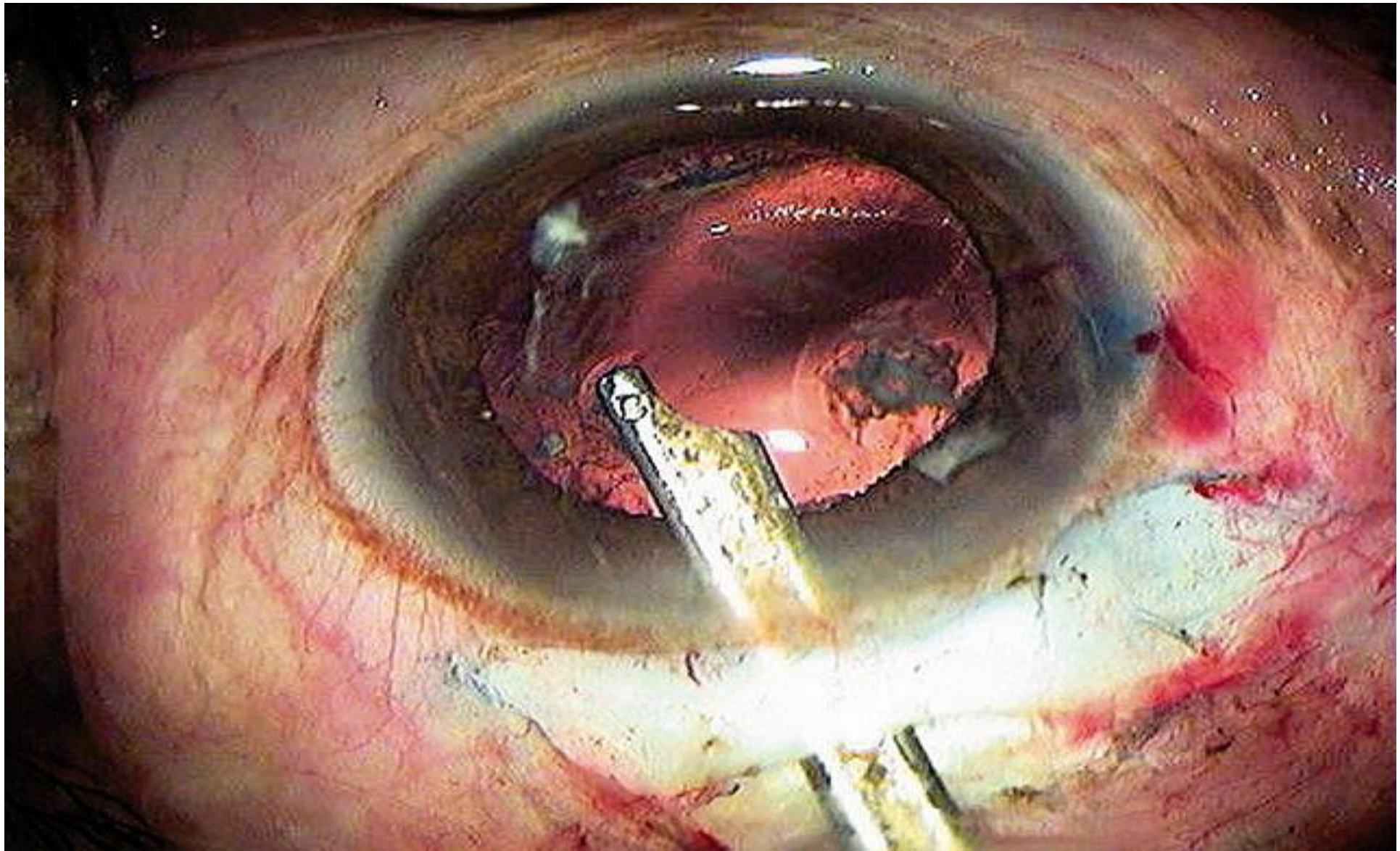
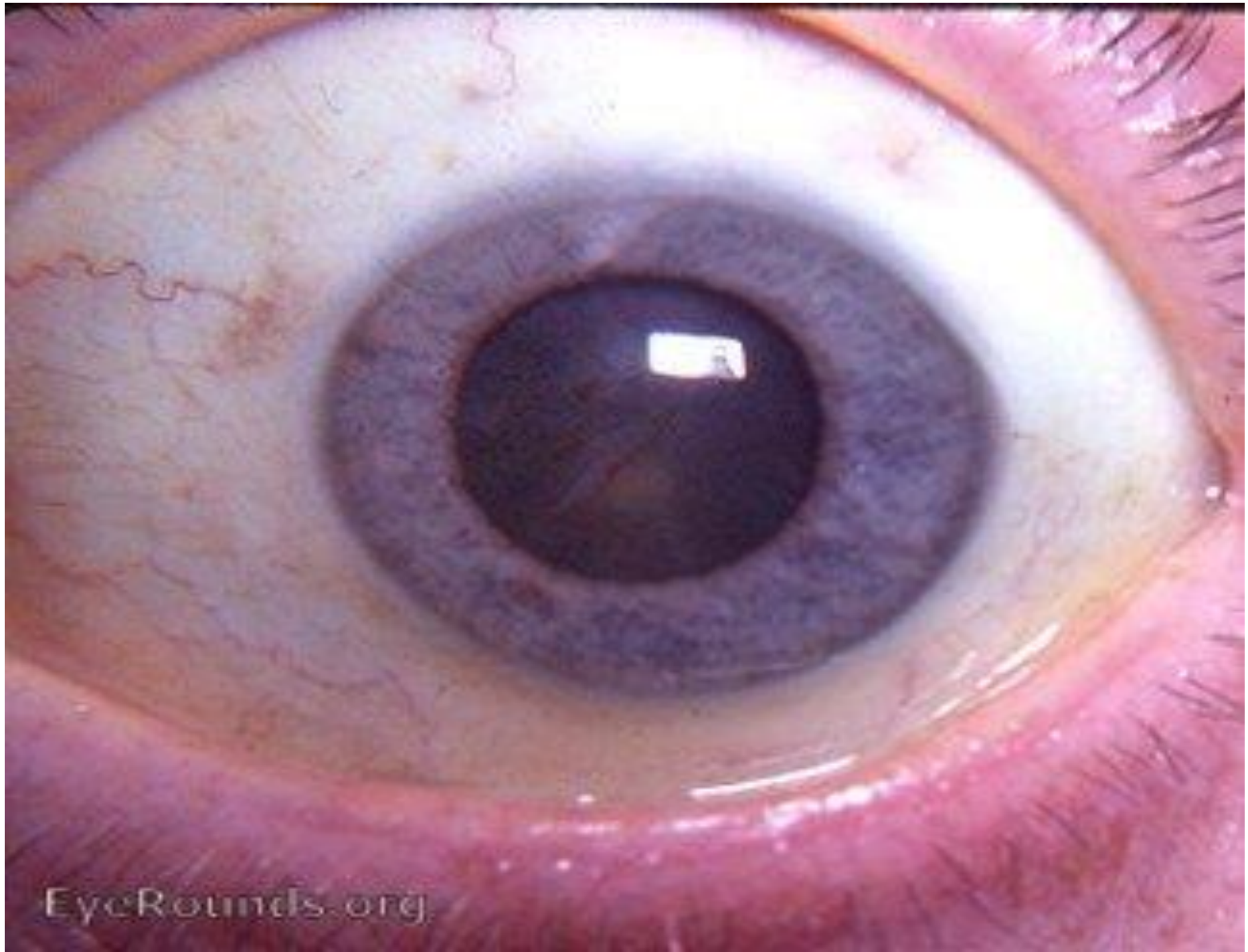
- ***Ortho*** *:-*
  - Hip
  - Knee Replacement
- Q

Cataracts



Case

- Mr. John Brown 68 year old
- Vision a bit blurred from right eye last few months
- Noticed on reading
- Drives

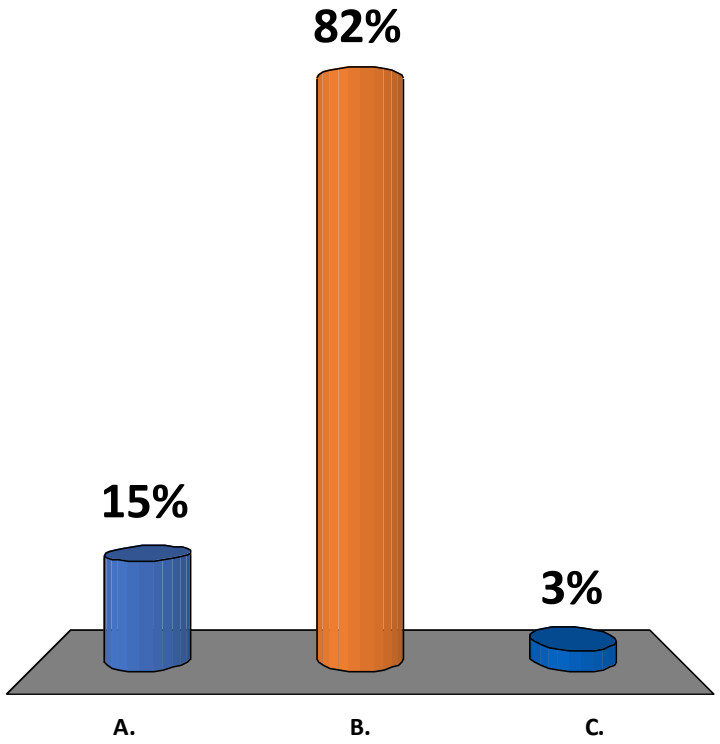

EyeRounds.org

What will you do next?

- Ophthalmologist ?
- Optician?
- Observe?

What will you do next?

A. Ophthalmologist ?
B. Optician?
C. Observe?



Case

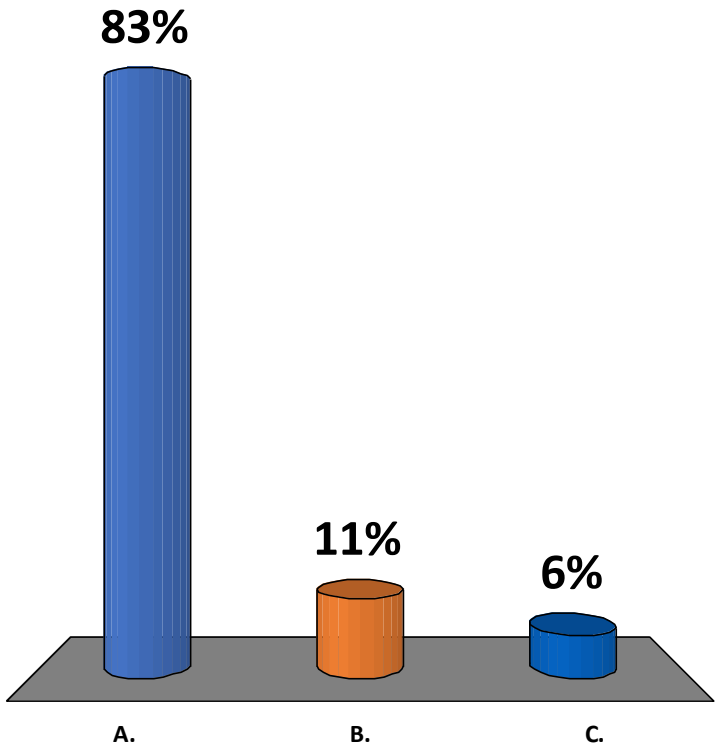
- 72 year old Mrs. Margaret Hadfield
- Vision blurred from both eyes R>>L
- Noticed on reading , watching TV, can’t knit
- Husband carer
- House bound

- COPD

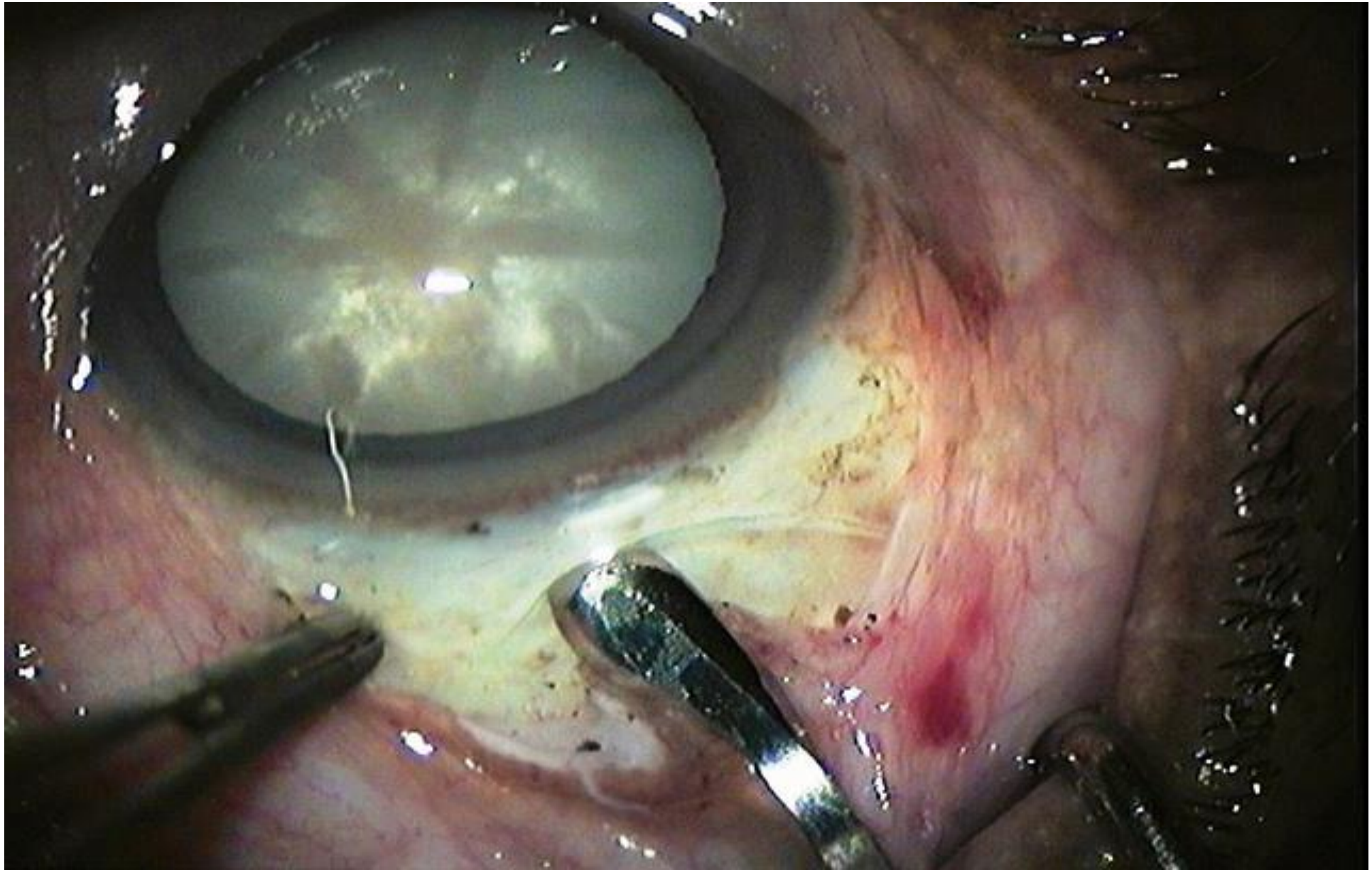

EYE ROUNDS.ORG

What will you do next?

A. Ophthalmologist ?
B. Optician?
C. Observe?



Does the patient want cataract surgery?



Opticians

- Visual Acuity
- Cataract assessment form
  - /13
  - Visual disability
  - Hearing disability
  - Other falls/driving/employed
  - Social functioning

1. Cataract - Clinical Threshold criteria for referrals

	Yes	No
Cataract causing visual impairment symptoms		
Patient wishes to undergo cataract surgery		
Score > = 3 on Cataract Assessment Form		

Cataract Assessment Form

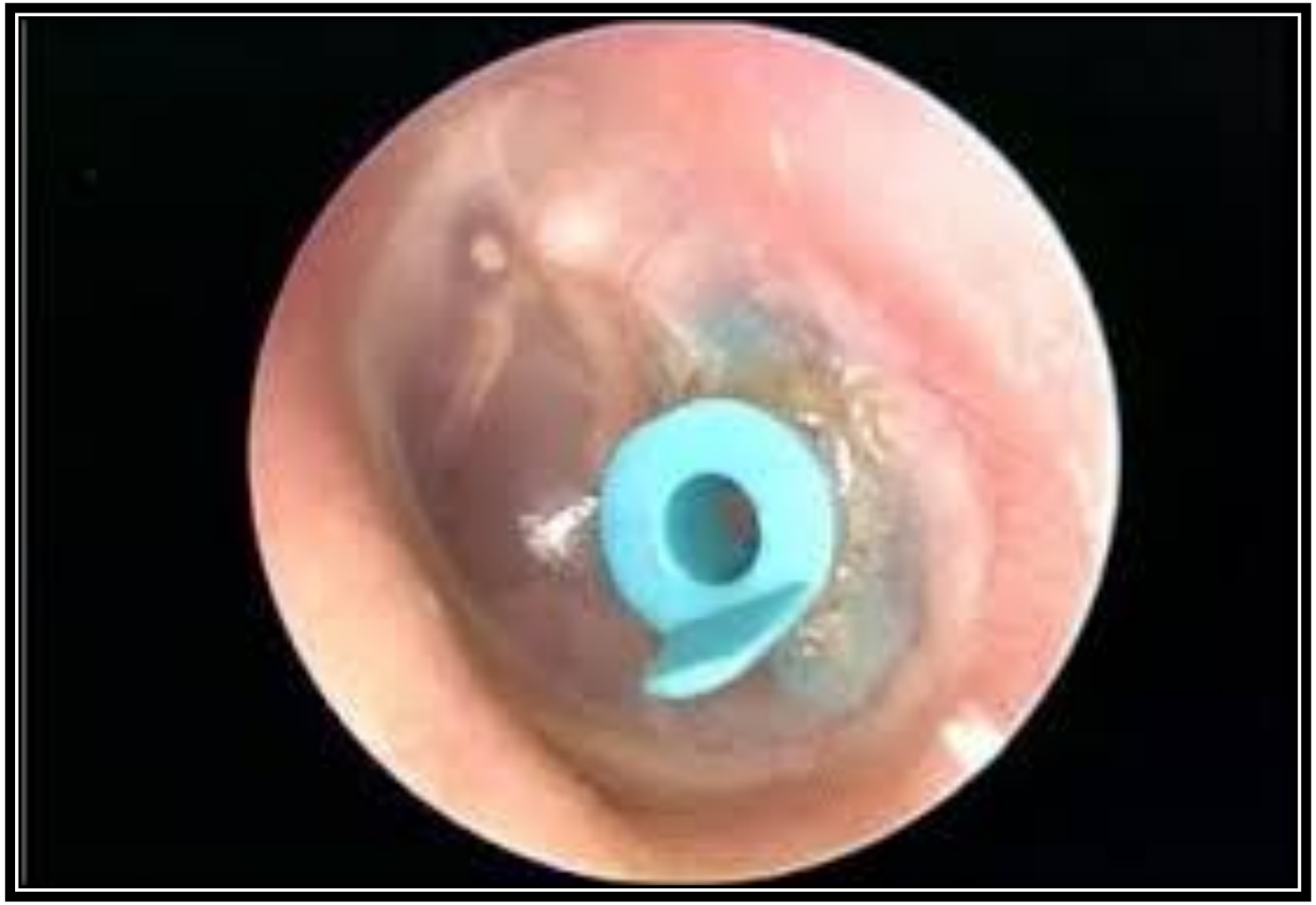
		Tick as appropriate	Score
Visual Disability	glare		2
	Difficulty reading		1
	Difficulty watching TV		1
	Difficulty performing Work/hobbies		1
Hearing Disability	Severe hearing impairment(deaf)		2
	Mild /moderate hearing		1

Cataract – learning point

- Dose the patient want cataract removed?
- We send to OPTICIANS for assessment
- 90% opticians are Accredited…

- We do NOT refer directly.. Unless….
- Some come back ONLY if unaccredited !
- We fill form in with detail…
- Form may change slightly…

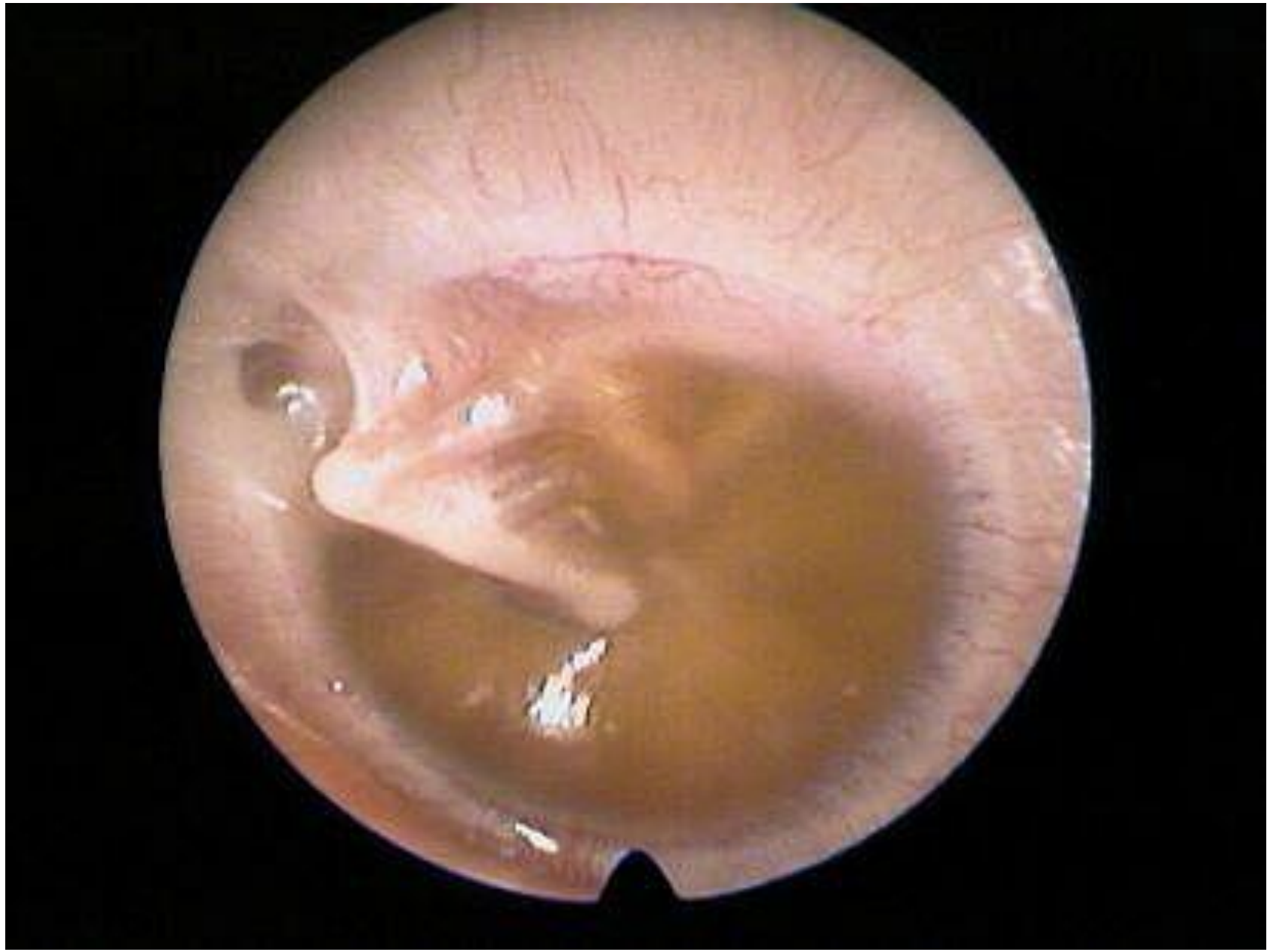
Grommets in Children -IFR



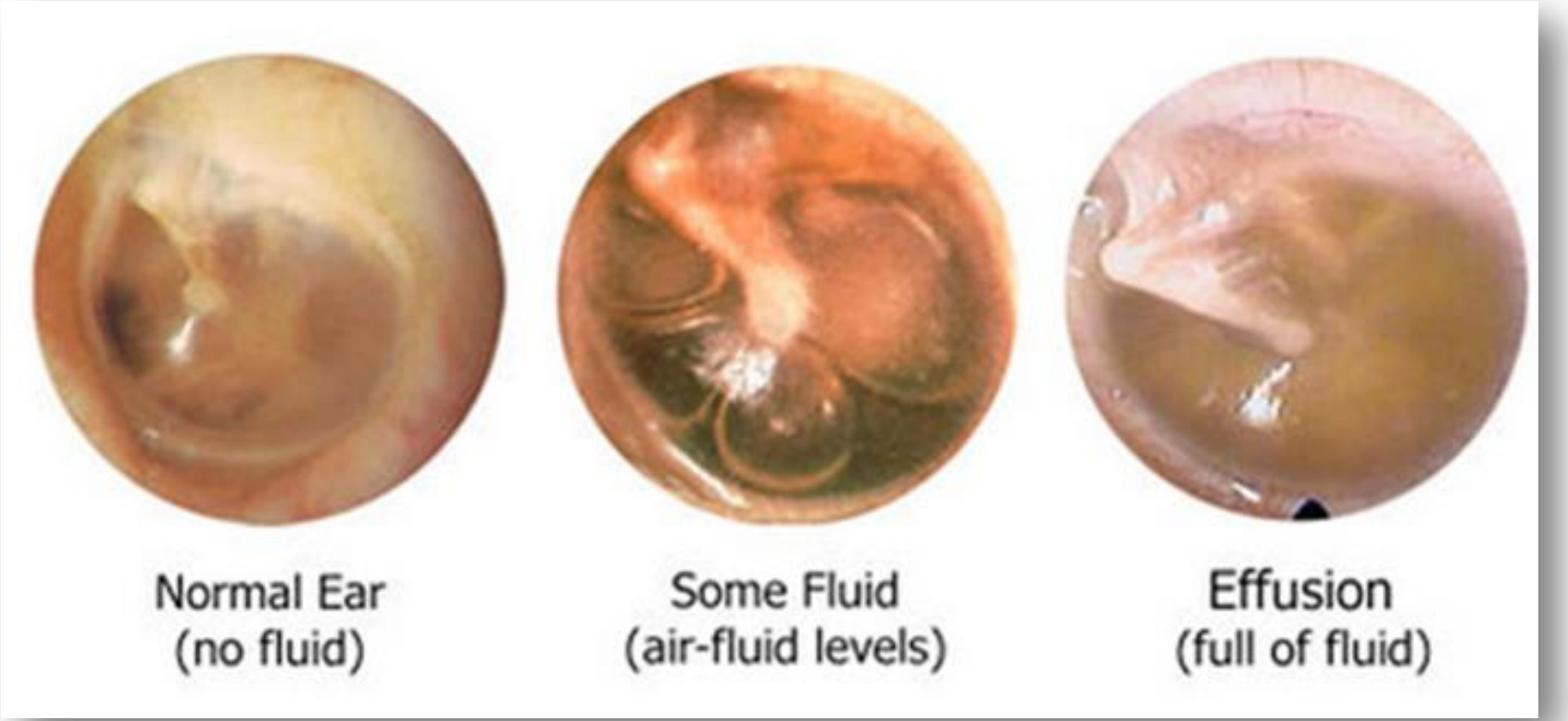
Case

- Charlie 3 year old
- TV loud
- Teacher at nursery complaining “ just doesn’t listen!”
- Similar consult 3 months ago.
- 5 episodes Otitis media already!

- What next?



On examination:



Hearing test

- 25 dB hearing loss in both ears .
- What next?

Clinical threshold for grommet referral in children.

- **Selection of any ONE Yes box qualifies for referral**

				Yes	No
A	OME persistent at least 3 months from date of diagnosis by GP to date of referral	AND the child is 3 years or older AND hearing loss of at least 25 dB in lower tones/frequency AND evidence of a disability as a result of the hearing loss : speech developmental delay OR Educational/ behavioural problems			
	OR				
B	A significant second health problem/disability	Down's syndrome Cleft palate Turner's syndrome	AND evidence of middle ear effusion BUT reliable hearing test may not be possible		
	OR				
C	Recurrent otitis media	At least 5 episodes of acute otitis media	requiring medical assessment/treatment in the		

- **Attach a copy of the Audiology/hearing report**

- **Refer via Individual Funding Request IFR, with audiology report and clinical threshold FORM.**

Case

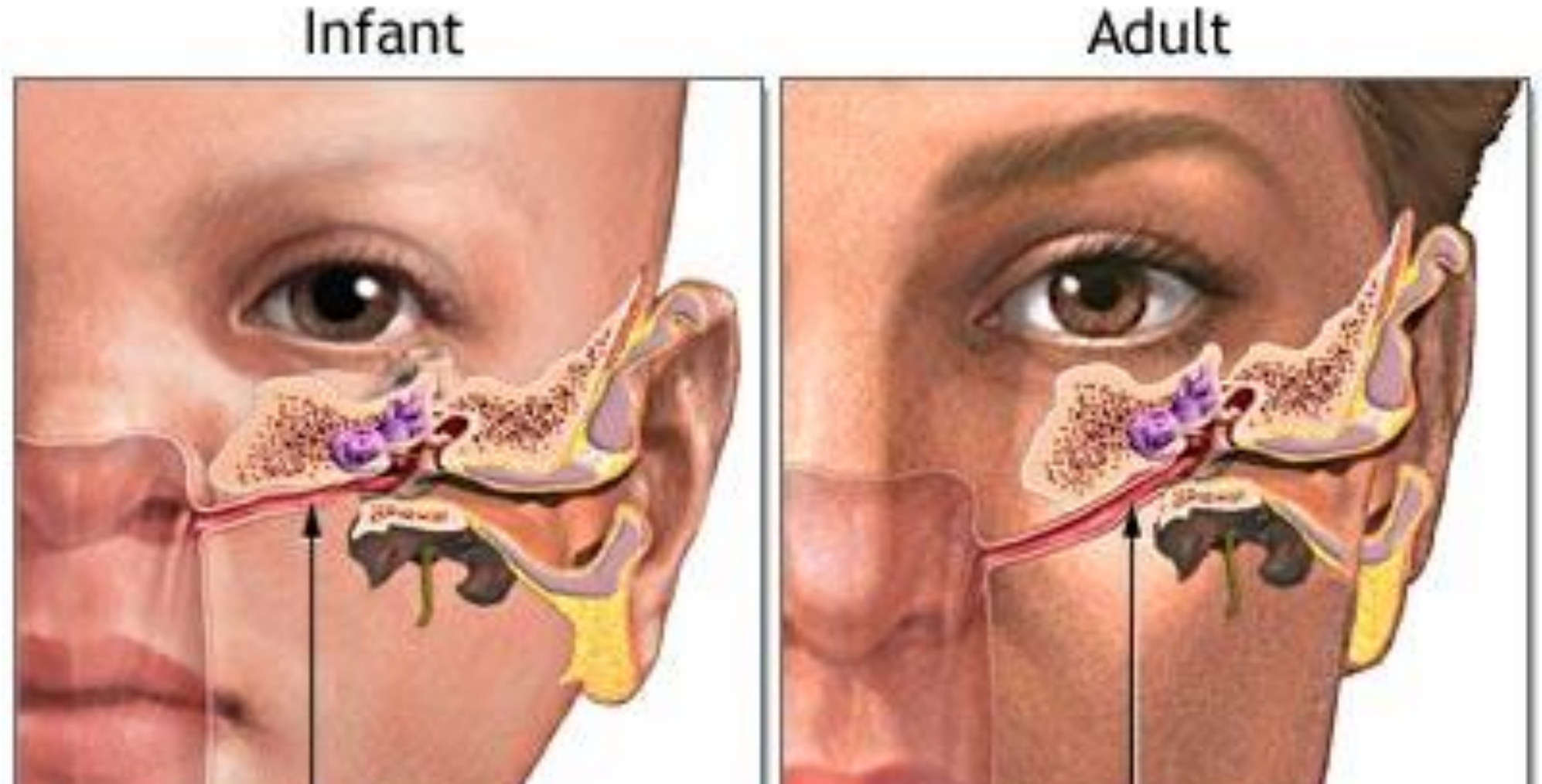
- Charlie 3 year old
- TV loud
- Teacher at nursery complaining “ just doesn’t listen!”
- Similar consult 3 months ago.
- 5 episodes Otitis media already!

25 dB hearing loss in both ears

Otitis Media with Effusion/Glue Ear

- Collection of serous/mucoid fluid within middle ear
- No signs of acute inflammation
- 1 - 6 years old
- winter months.
- Majority resolves within 3 months
- can recur
- 5-10% of cases last > a year.

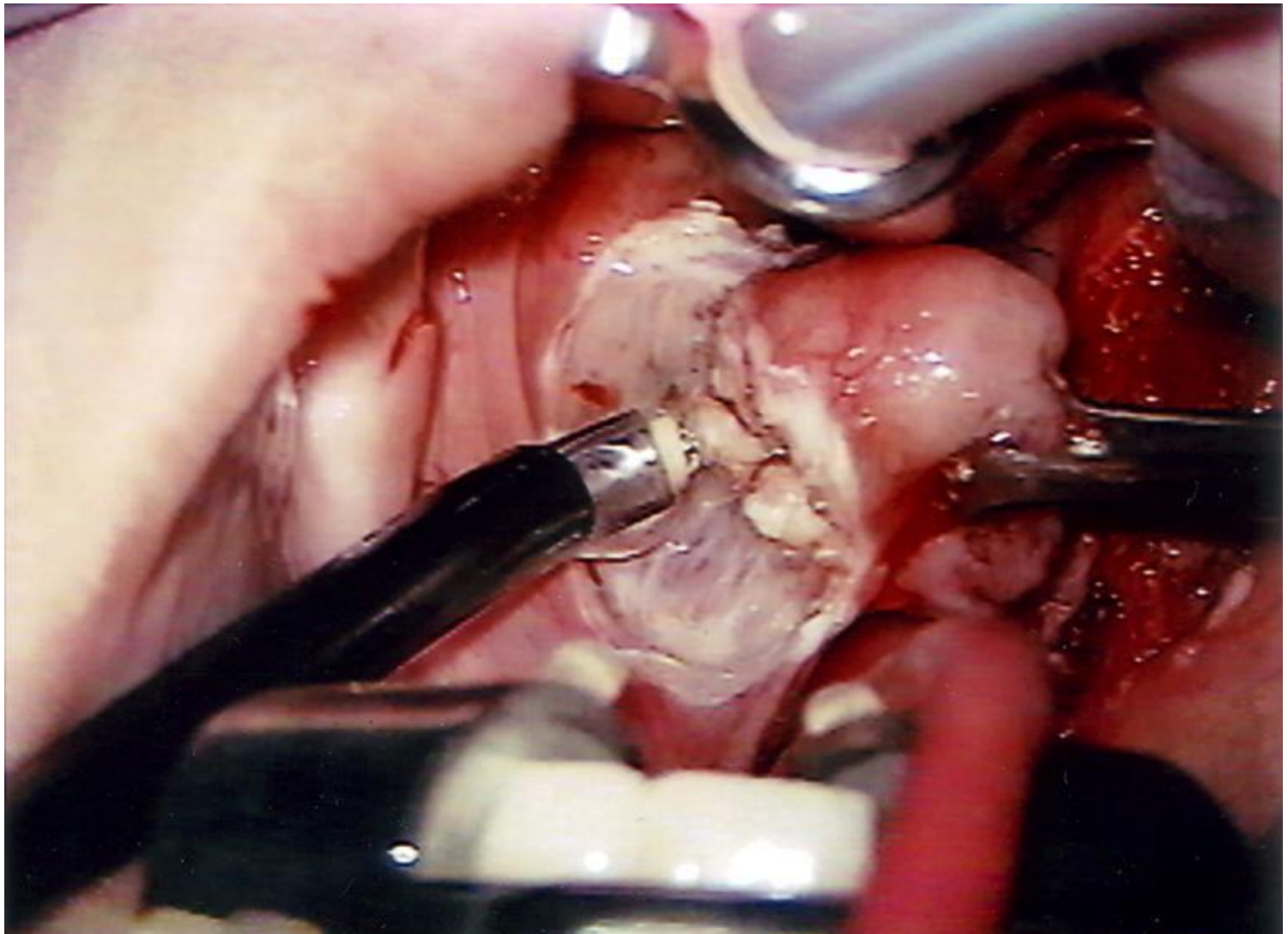
Glue Ear
(OME) Otitis media with effusion



Benefits of grommets?

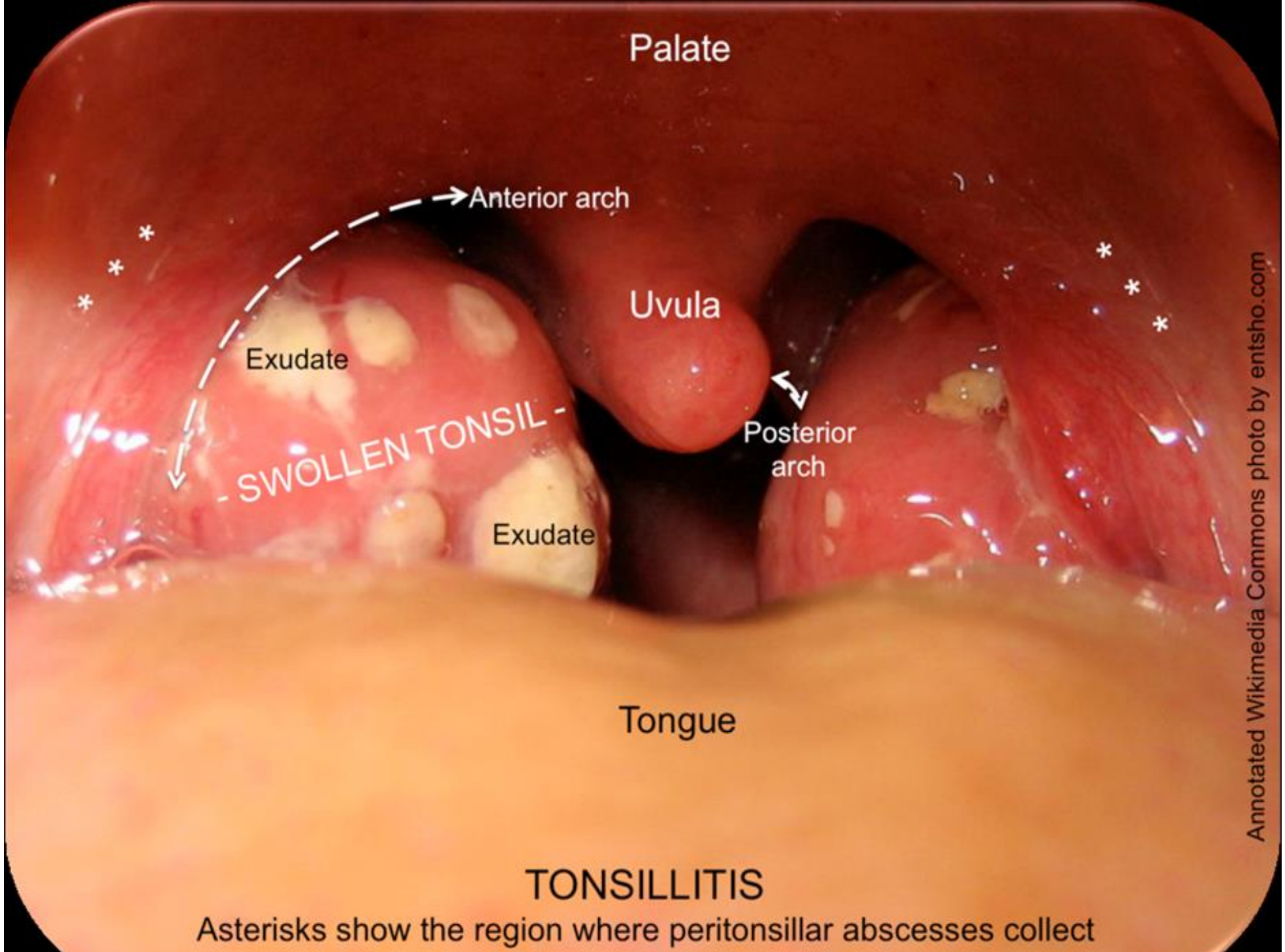
- insertion of ventilation tubes (grommets) improves hearing in children with (OME) for up to 12 months after surgery,
- but effect diminishes from 6 months onwards
- no evidence that language or speech development is improved.

Tonsillectomy/Adenoidectomy- IFR



Case

- Kathrine 13 year old
- “Can my daughter have her tonsils out please doctor?”
- 10 episodes of tonsillitis over last 2 years
- Each episode …the following criteria:-
  - Nodes
  - Exudates
  - Absence of cough
  - Temp

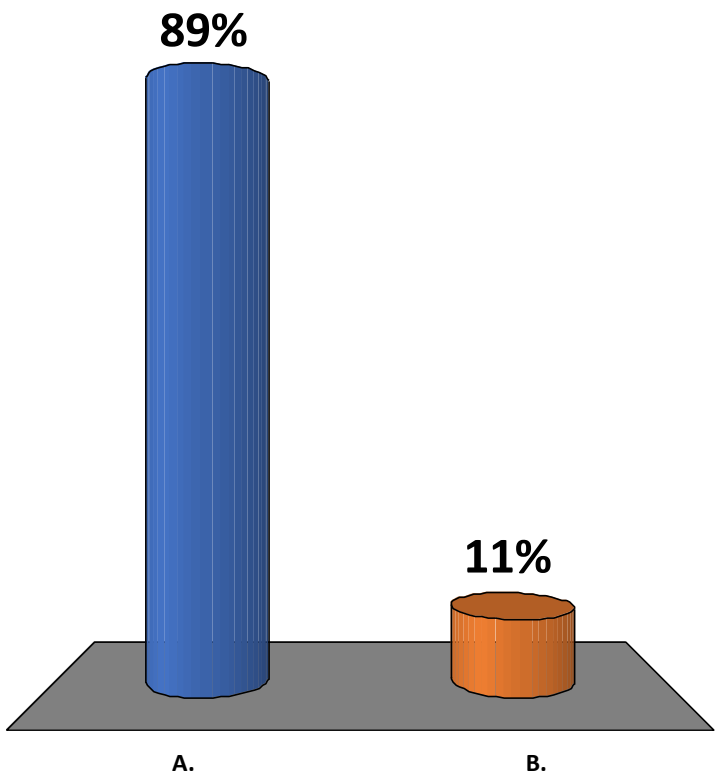


TONSILLITIS

Asterisks show the region where peritonsillar abscesses collect

Does she qualify for Tonsillectomy?

A. Yes
B. No

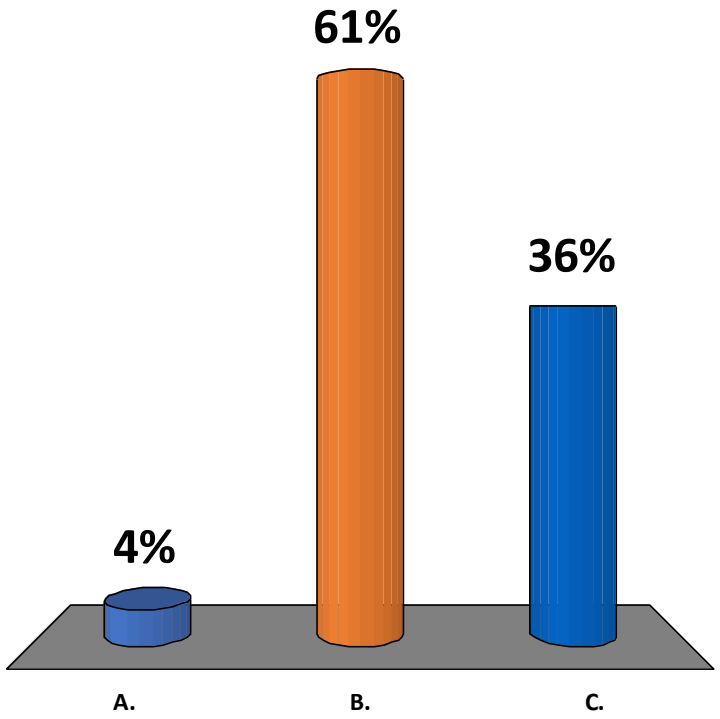


How many episodes of tonsillitis in last 12 months needed to proceed to tonsillectomy?

A. 3

B. 5

C. 7



A	Suspected malignancy			
	More than 1 episode of peri- tonsillar abscess (Quinsy)			
	Acute upper airway obstruction			
B	Recurrent sore throats Each episode must have evidence of 3 of the following: -Nodes-Anterior cervical -Exudates – tonsillar -Absence of cough -Temperature - History of fever	≥7 episodes in the last year		
		≥5 episodes in each of the last two year		

*Selection of any **ONE YES** box will qualify patient for referral.*

Please supply dates of disabling episodes of tonsillitis when the patient was treated over the last two years. These dates MUST be filled for patient to be accepted under Criteria B above.

Consider referring patients who do not meet the above criteria via IFR.

In Children- Tonsillectomies and or Adenoidectomy will be funded only in the following indications :

			Yes	No
C	Failure to thrive	Due to difficulty eating solid foods		
	Sleep apnoea	A confirmed clinical diagnosis		
	Significant impact on quality of life eg parental concern regarding:	Difficulty with breathing through the night		
		Loud and persistent noisy /mouth breathing leading to social difficulties		
		Difficulty eating solid foods that creates unreasonably slow eating		
		Difficulty exercising		

Consider referring patients who do not meet the above criteria via IFR.

If you ask for tonsillitis dates, reduction in referral by?????

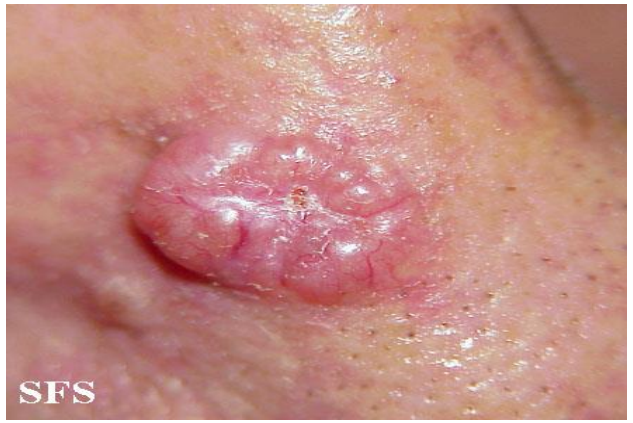
- 75%

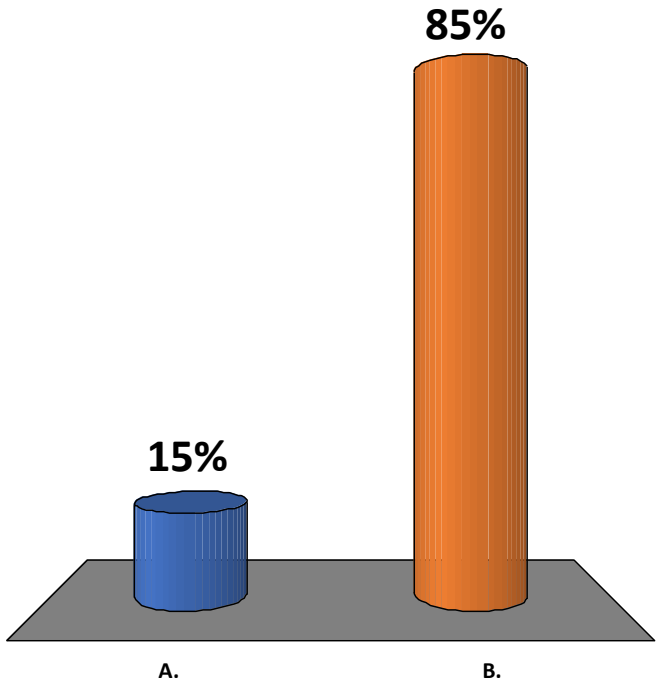
Benign Skin lesions

Q. Where are you going to refer this?

A. 2ww- skin cancer clinic?

✓ B. Urgent/routine dermatology minor op clinic





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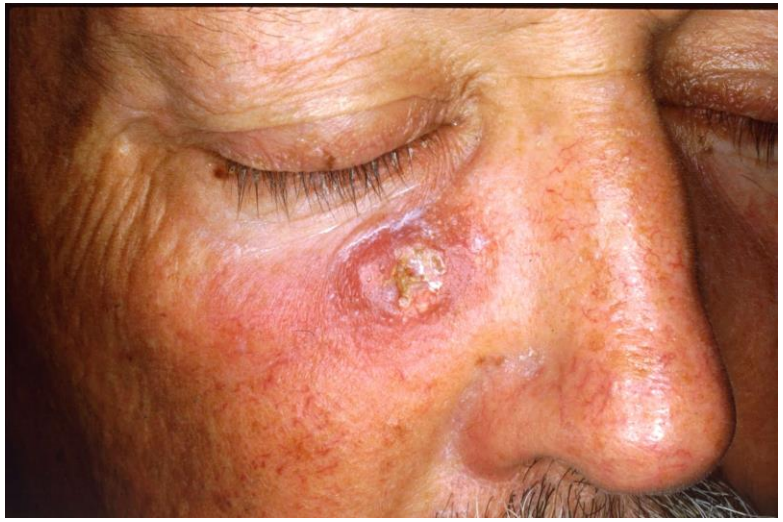
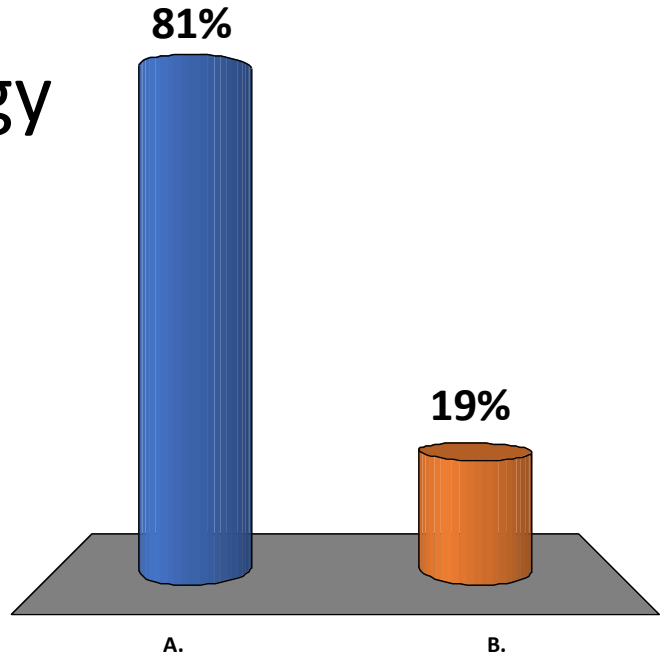




5. Benign Skin Lesions - Clinical Threshold Referral Criteria

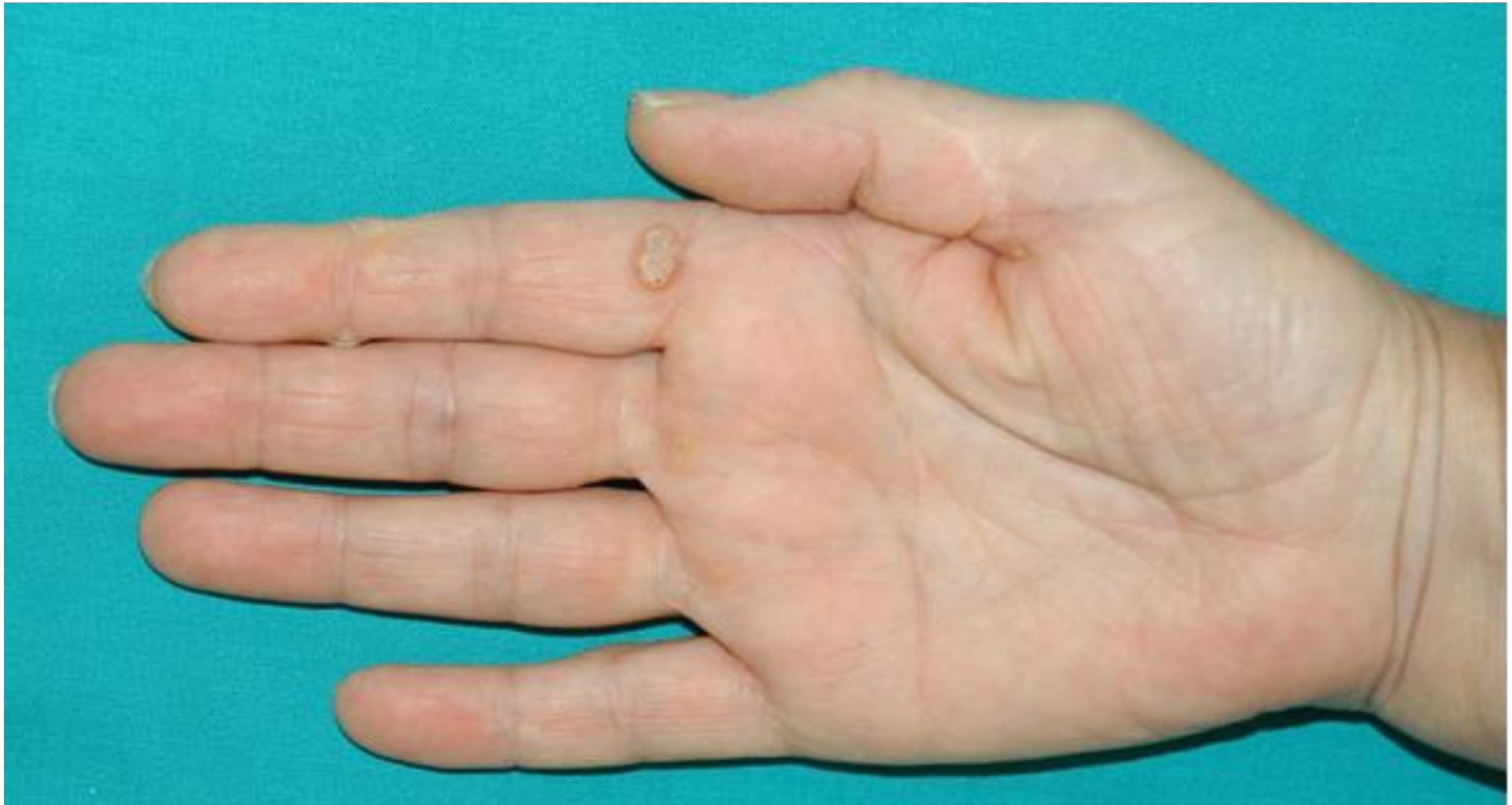
Any skin lesion that is suspicious of the following malignancies, should **NOT** be biopsied in general practice .

Malignant melanoma	Melanomas are *usually* 5mm or greater at the time of diagnosis.	See 2ww suspected skin cancer referral form
Squamous cell carcinoma	Commonly occur on face /scalp/or back of hand suspect in non- healing keratinised/crusted/ulcerated lesions immunocompromised /organ transplant patients with new or growing cutaneous lesion	See 2ww suspected skin cancer referral form
Basal cell carcinoma		Refer urgent/ routine Dermatology Minor ops clinic

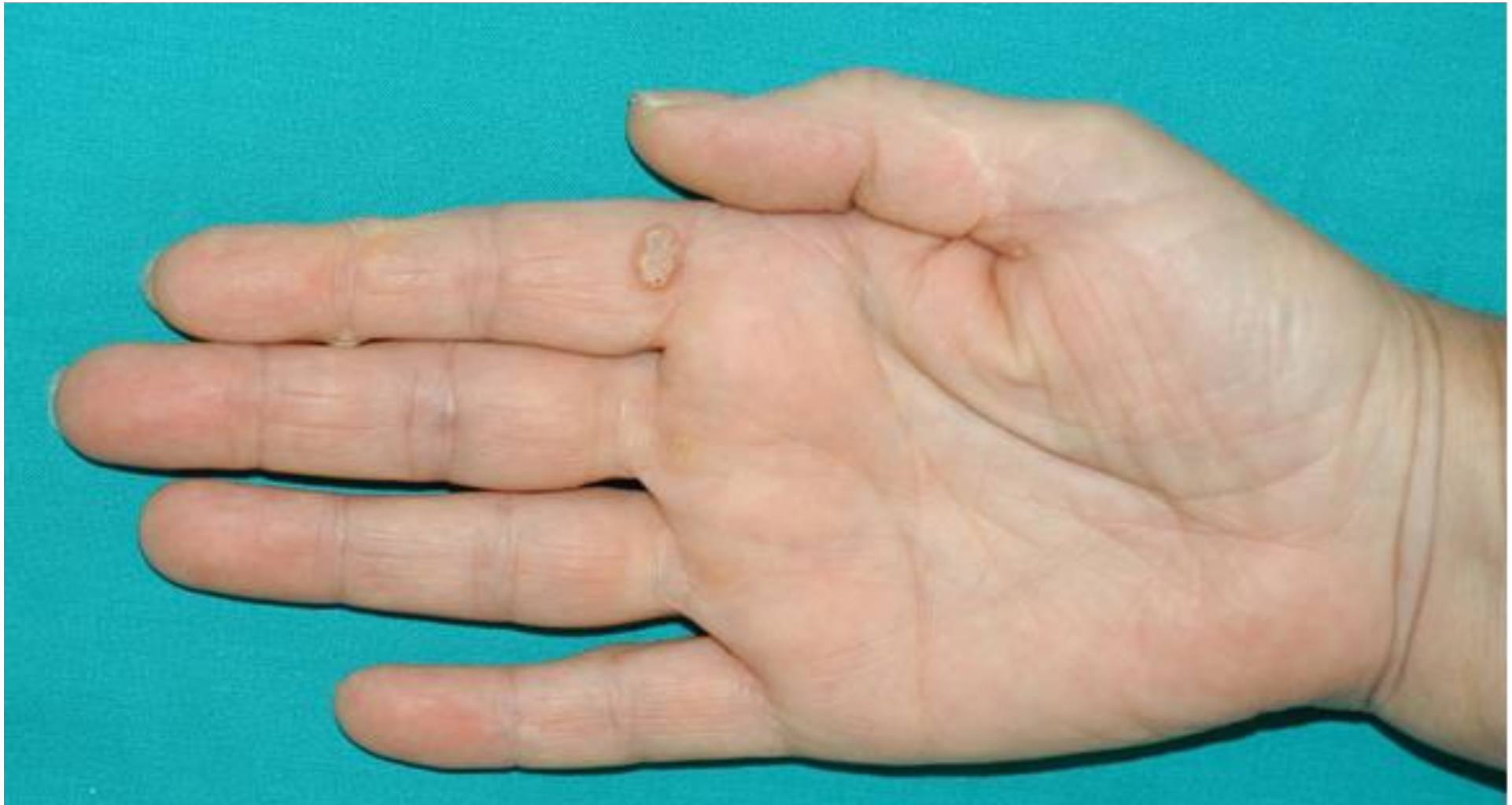
MAJOR FEATURES	Score
☐ Change in size	
☐ Irregular shape	
☐ Irregular colour	
MINOR FEATURES	
☐ Largest diameter 7mm or more	
☐ Inflammation	
☐ Oozing	
☐ Change in sensation	
TOTAL SCORE	

☐ Total score 3+ (must include one major feature)	**Refer 2ww Minor Ops**
☐ Total score <3 (or no major features)	**Monitor** or **Refer Routine/Urgent**

Q. What does your body need to get rid of this?



Q. What happens if you don’t have an immune system?



Acrochordon!

- Otherwise known as ….

Every attempt should be made to manage benign skin lesions in primary care.

Benign skin lesion should NOT be excised purely for cosmetic reasons.

Criteria for Commissioning

				Yes	No
A	Lesion is painful OR Lesion impairs function	AND Lesion unsafe to remove in primary care:	>10mm in size		
			Location eg (breast ,face)		
			Bleeding risk		
B	Viral warts In immunocompromised individual				
C	Patient Scores >20 in Dermatology Life Quality Index Score (DLQI) (DLQI available on BEST website)				

Selection of any **ONE YES** box qualifies patient for referral

Consider referring patients who do not meet the above criteria via IFR.

Top diagnostic tools

6CIT- dementia screening tool

ABCD2 Score -TIA / Barnsley TIA Clinic Referral Form

Acute Kidney Injury AKI

Alcohol Units

Asthma Peak Flow Monitor chart

Blood transfusion thresholds

Bristol Stool score

CENTOR Score/Fever SCORE

CHA2DS2 VASC /HAS BLED

CKD Algorithm

Dermatology Quality of Life Index DQLI

Epworth sleepiness score

Familial Hypercholesterolaemia- Simon Broome Criteria/ referral criteria

IPSS / fluid input/output chart /LUTS pathway

Iron deficiency Anaemia

Menstrual Diary/PMS symptoms/premenstrual syndrome diary

MRC Dyspnoea Scale Questions

NEWS -National Early warning Score

Pain Rating Scale

PHQ-9 Questions

Pneumonia -CURB Score

Paeds: Traffic Light System/ vital signs normal range

QRISK

URTI- evidence based on RTI

SKIN lesion recognition table 1/ table 2 / lesion terminology /skin cancer ABCDE Rule

Spirometry interpretation

DERMATOLOGY LIFE QUALITY INDEX (DLQI)

Hospital No: ..... **Date:** .....

Name: ..... **Score:** .....

Address: ..... **Diagnosis:** .....

.....

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please tick (✓) one box for each question.

1. Over the last week, how **itchy**, **sore**, **painful** or **stinging** has your skin been?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒

2. Over the last week, how **embarrassed** or **self conscious** have you been because of your skin?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒

3. Over the last week, how much has your skin interfered with you going **shopping** or looking after your **home** or **garden**?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

4. Over the last week, how much has your skin influenced the **clothes** you wear?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

5. Over the last week, how much has your skin affected any **social** or **leisure** activities?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

6. Over the last week, how much has your skin made it difficult for you to do any **sport**?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

7. Over the last week, has your skin prevented you from **working** or **studying**?
   - Yes ❒
   - No ❒ Not relevant ❒

   If "No", over the last week how much has your skin been a problem at **work** or **studying**?
   - A lot ❒
   - A little ❒
   - Not at all ❒

8. Over the last week, how much has your skin created problems with your **partner** or any of your **close friends** or **relatives**?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

9. Over the last week, how much has your skin caused any **sexual difficulties**?
   - Very much ❒
   - A lot ❒
   - A little ❒
   - Not at all ❒ Not relevant ❒

- Cataracts
- Grommets
- Tonsillectomy
- Benign skin lesions

- What if a surgery doesn’t offer minor ops for benign skin lesions?

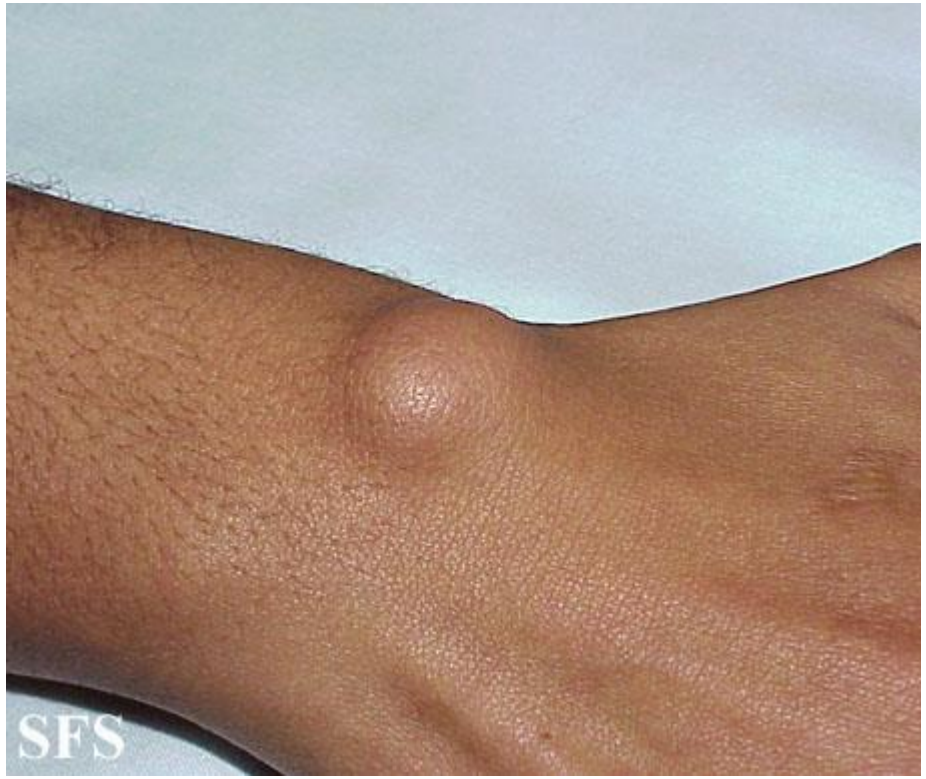
Hand Surgery !

Case Scenario

- A 40yr old male with P/C:- small cystic lump on his R.Hand – 2m. No pain / red flags. Machine operative (work). Wants advise

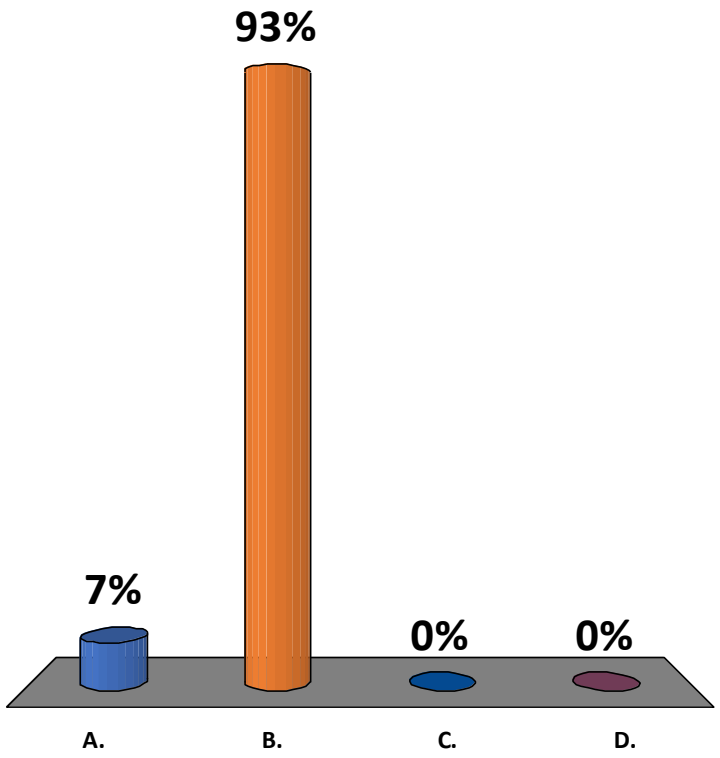
- O/E:- a small cystic lump of size 1.5cm on dorsum of R.Hand, not tender.

- O/E:- a small cystic lump of size 1.5cm on dorsum of R.Hand, not tender.



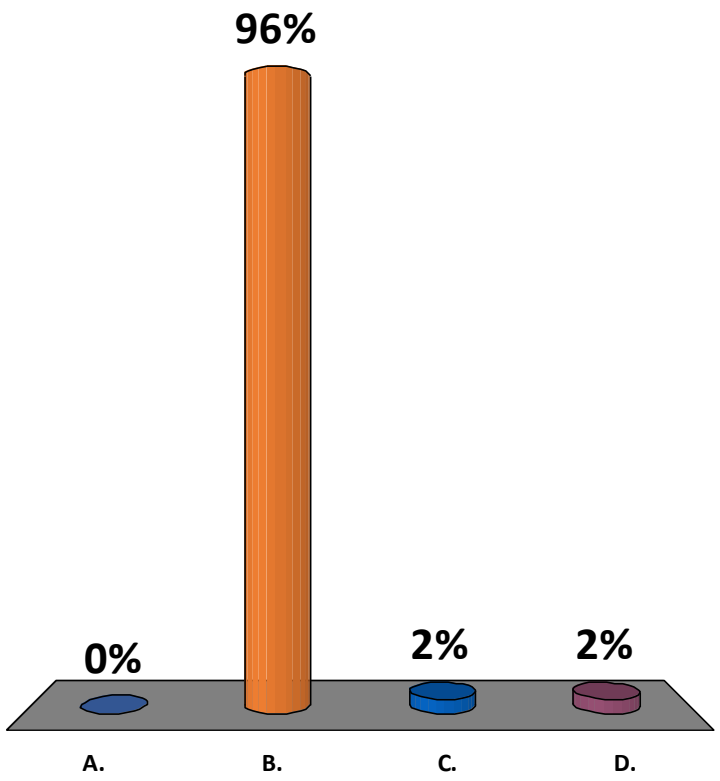
Case Scenario - Diagnosis?

A. Sebaceous cyst
B. Ganglion
C. Lipoma
D. A or B



How do you *Manage it ?*

A. Refer to surgeons
B. Reassure
C. Aspiration
D. Book Minor-ops



Ganglion

- ***Benign*** cyst
- Spontaneous resolution (up to 80%)
- ***Reassure***
- ***Aspiration*** – Recurrence up to 70%
- ***Excision*** – Most Invasive Rx – Recur in 40%
- ***Complications*** of surgery :- scar sensitivity, Joint stiffness, distal numbness, recurrence

Cost for each ganglion removal?

£892

Financial Impact /yr
if clinical threshold applied?

£58,000

6. Ganglion Cysts excision on the hand - Clinical Threshold Referral Criteria

A Ganglion cyst is a fluid- filled swelling that develops near a joint or a tendon.

The cyst can range from the size of a pea to the size of a golf ball.

Criteria for Commissioning

Barnsley CCG will only fund surgery in the following circumstances:

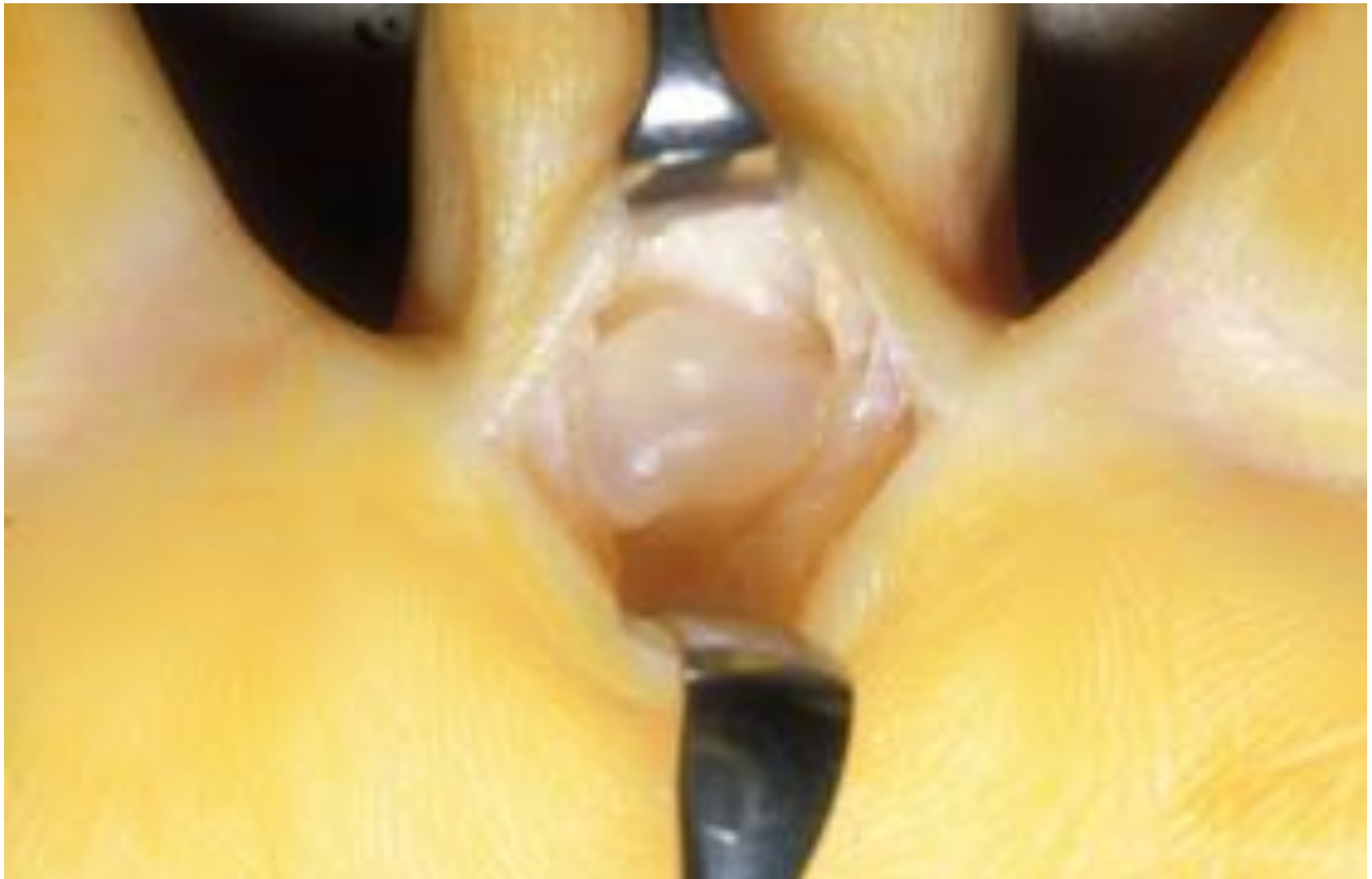
			Yes	No
A.	Ganglion on the wrist	with evidence of Neurovascular compromise		
		OR causing significant pain		
B.	Seed ganglia at the base of digits	Causing significant pain		
C.	Mucoid cyst at DIP joint	disrupting nail growth AND causing functional impairment OR pain		
		OR Cysts that tend to discharge (risk of septic arthritis in joint)		

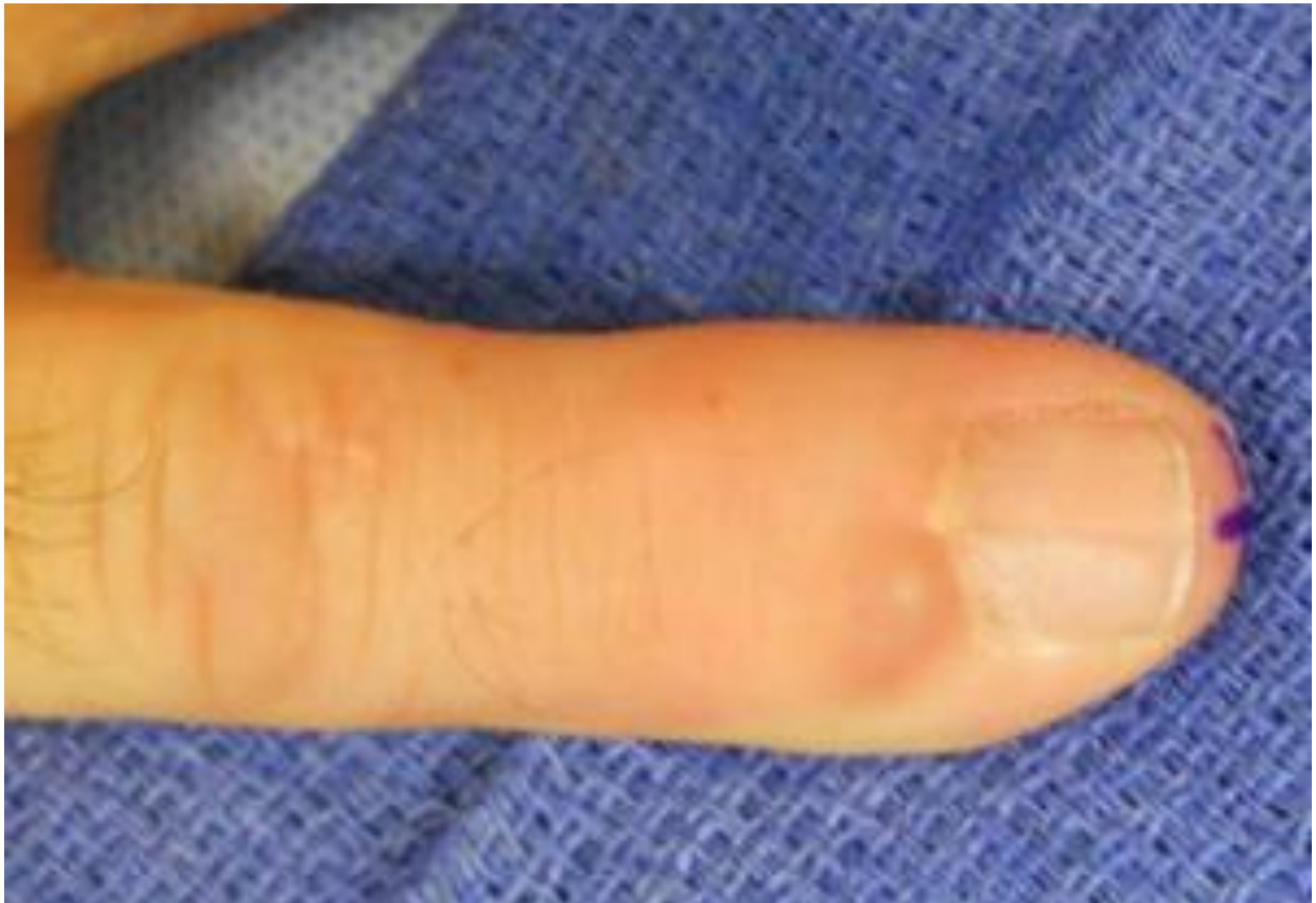
*Selection of any **ONE YES** box will qualify patient for referral.*

Consider referring patients who do not meet the above criteria via IFR.

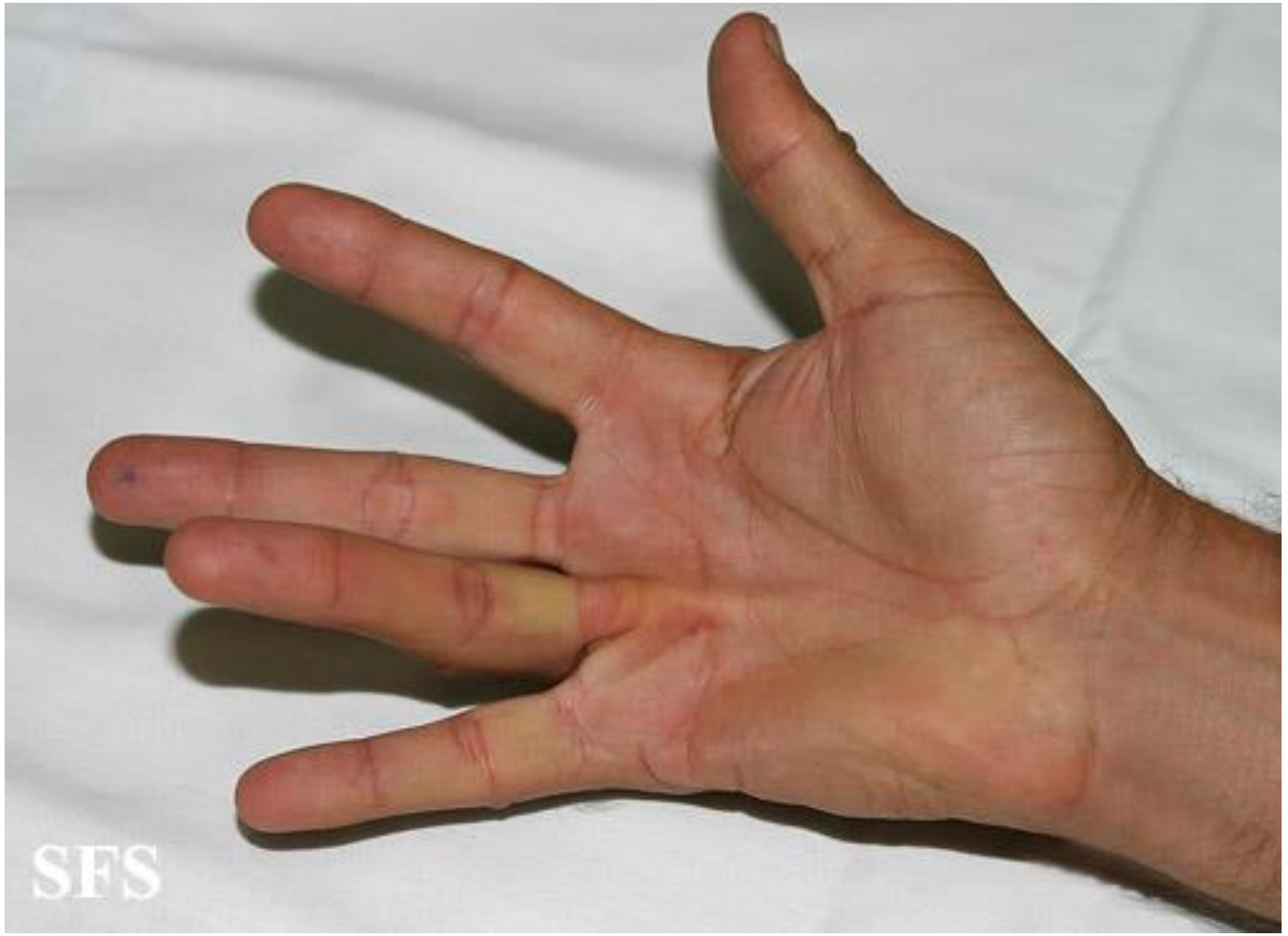
Seed ganglion

Seed ganglia – base of digit





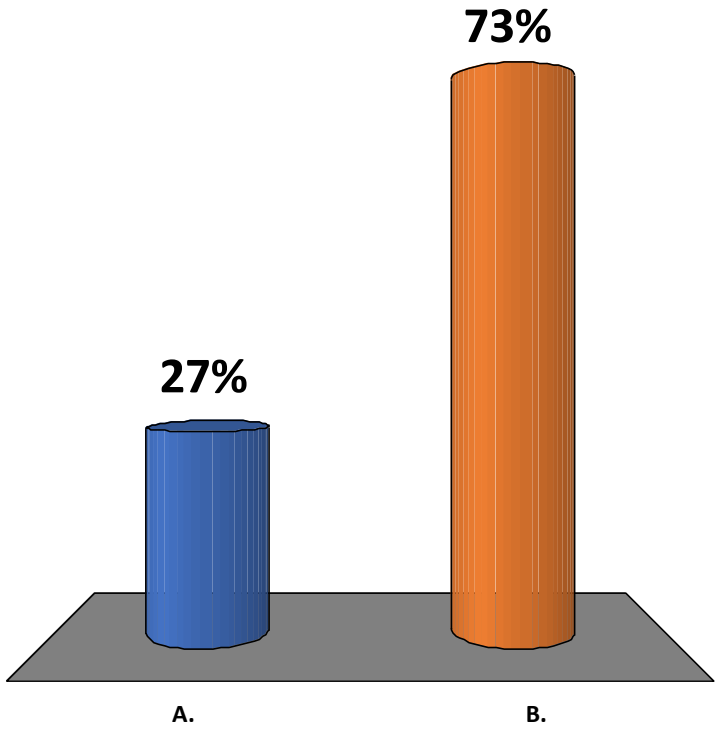
Dupuytren’s Contracture



Are steroid injections helpful?

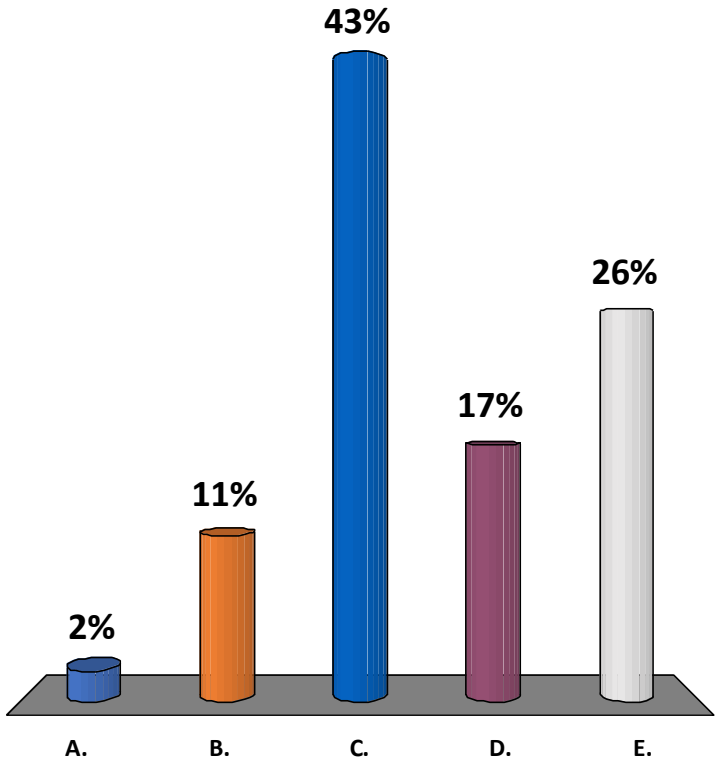
A. Yes

B. No

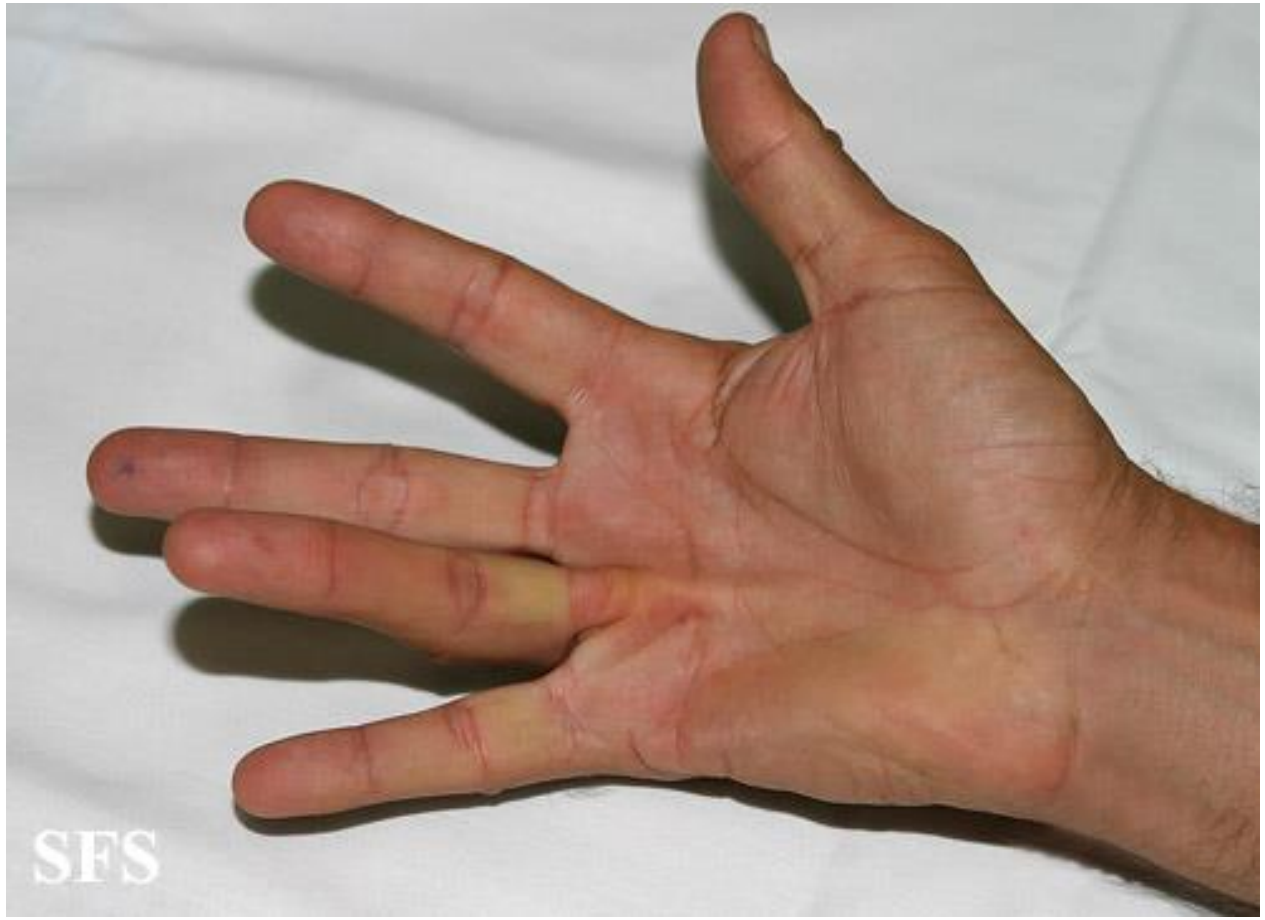


Above what angle flexion should these be referred ?

A. 10
B. 20
C. 30
D. 40
E. 50



What % of these recur post surgery?



What are the risk factors for recurrence post surgery?

- Young
- Original severe contracture
- Strong family hx

Criteria for Commissioning -Requests for surgical treatment of

Dupuytren's Contracture will be considered when:

		Yes	No
A	The patient has a 30 degree fixed flexion deformity at either: MCP- metacarpophalangeal joint PIP- Proximal interphalangeal joint		
	AND		
B	Patient cannot flatten their fingers or palm on a table		
	OR		
	There has been a rapid progress over a few months		

*Selection of one **YES** box from **BOTH A AND B** required to qualify patient for referral.*

Consider referring patients who do not meet the above criteria via IFR.

Dupuytren's Contracture

- Progressive disorder of palmar fascia causing fibrous tissue to shorten and thicken
- Cause unkown though genetic predisposition, trauma, inflammatory response, ischaemia and environmental factors have all been implicated

Epidemiology

- Usual onset from mid 50s onwards
- 45% bilateral – where unilateral more common on R (not related to hand dominance)
- MCP and PIP joints of any digit but 4th and 5th most common
- Affects 2m in UK – only small proportion require surgery

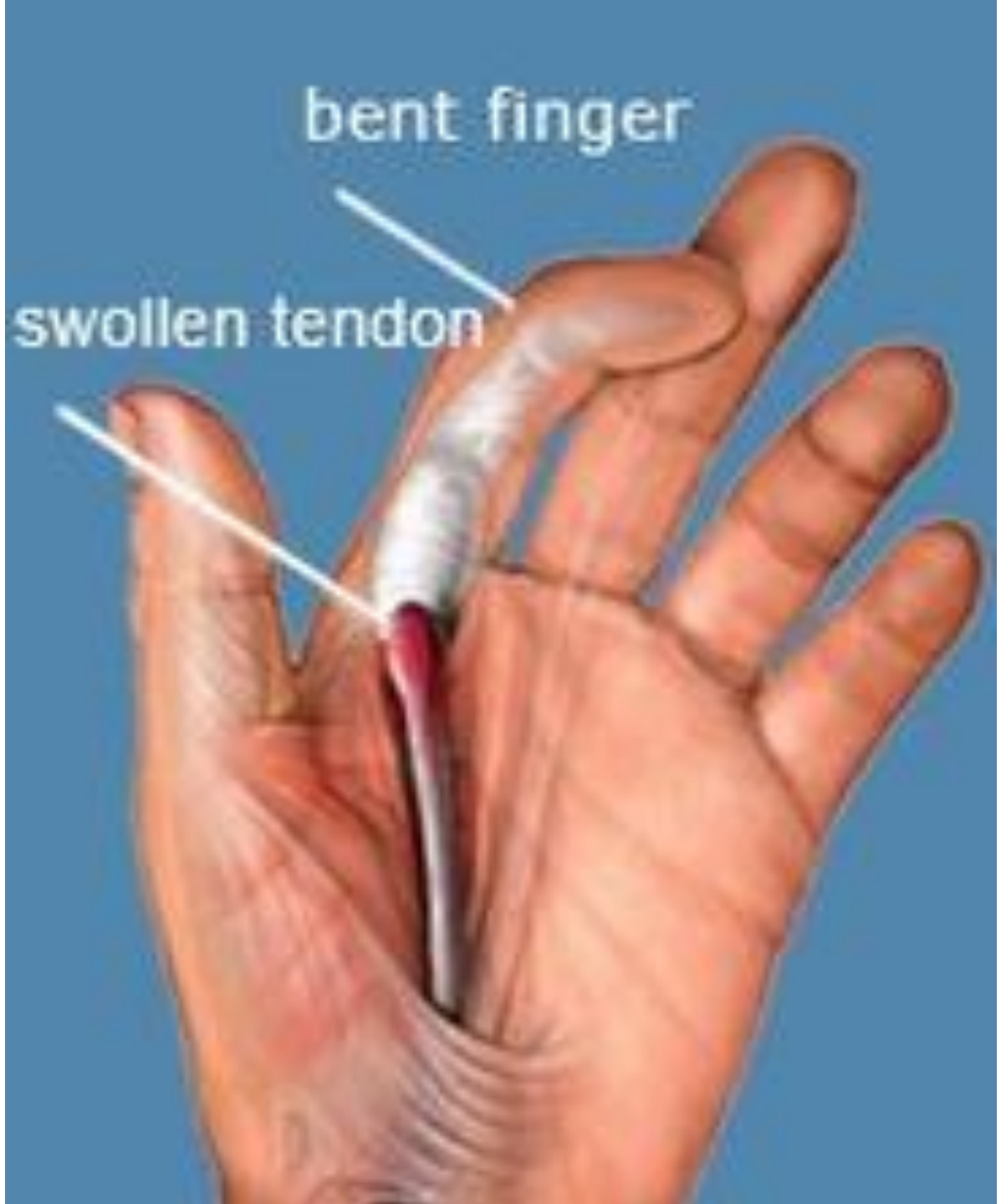
Risk Factors

- Smoking
- Alcohol (don’t need to be alcoholic!)
- Diabetes – especially insulin dependent
- Heavy manual work/vibration

Treatment

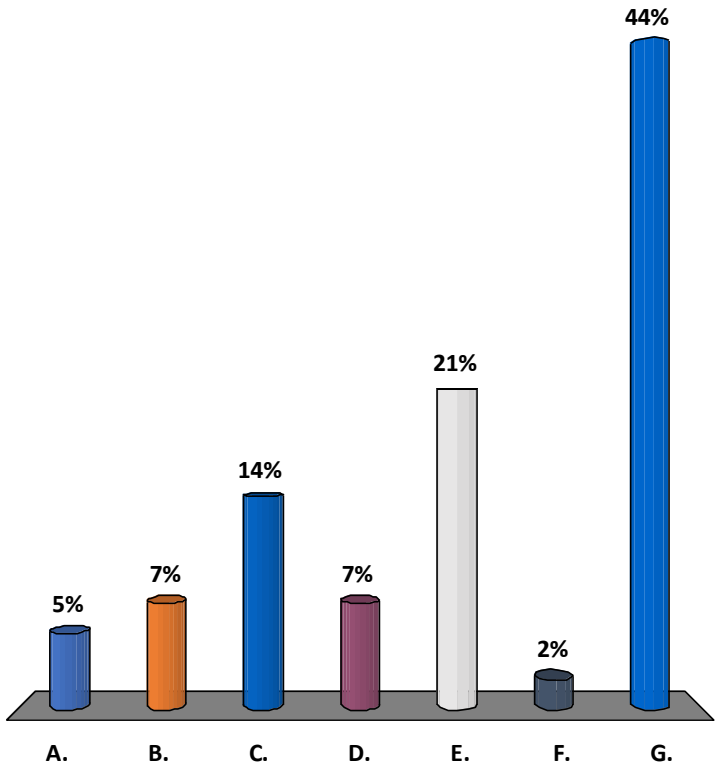
- Early referral recommended once threshold reached – can become irreversible
- Up to 12% can regress without treatment
- Segmental or regional fasciectomy
- Up to 50% recur after surgery

Trigger finger



Which of the following help?

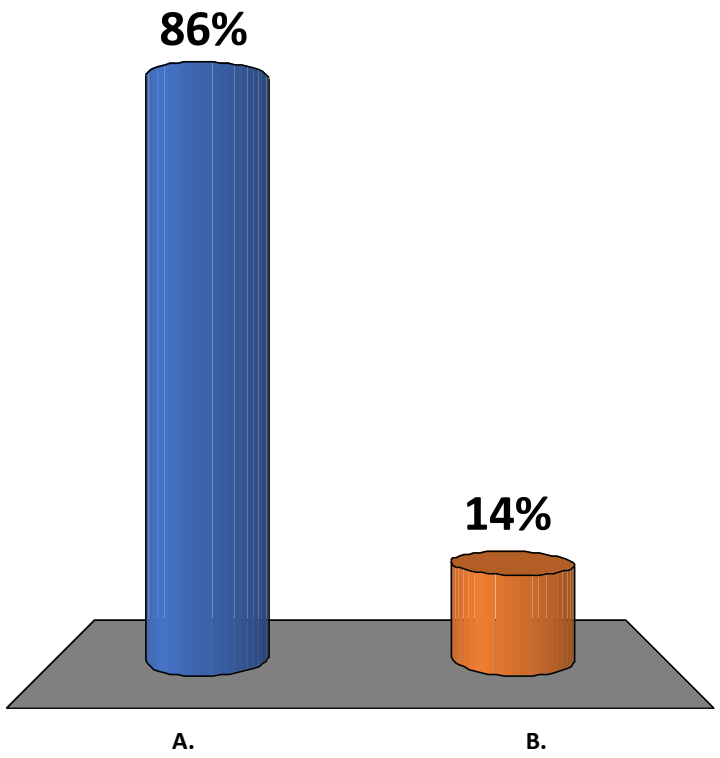
A. Massage
B. Rest
C. Splint
D. NSAID
E. A+ C+D
F. B+C+D
G. All of the above



Corticosteroid injections are effective in trigger fingers?

A. True

B. False



		Yes	No
A	**Failure to respond to Conservative/ non-invasive treatment methods listed below** Exercise/massage Rest from aggravating activity Splinting NSAIDS (if no contraindications)		
	AND		
B	**Failure to respond to** **At least one corticosteroid injection** (max 2 injections with a 10 week interval between injections)		
	OR		
	Fixed flexion deformity That cannot be corrected by conservative measures		
	OR		
	Where corticosteroid injection is contraindicated		

*Selection of one **YES** box from **BOTH A AND B** required to qualify patient for referral.*

Carpal Tunnel Syndrome

Risk factors

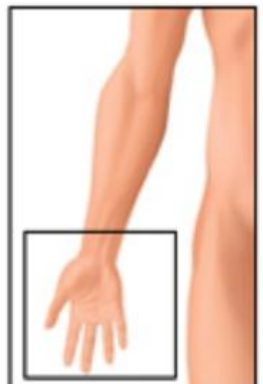
- Arthritis
- Diabetes
- ? Hypothyroid
- Work place – repetitive movements/ vibration
- Hormonal
  - Combined hormonal contraception
  - Menopause
  - pregnancy

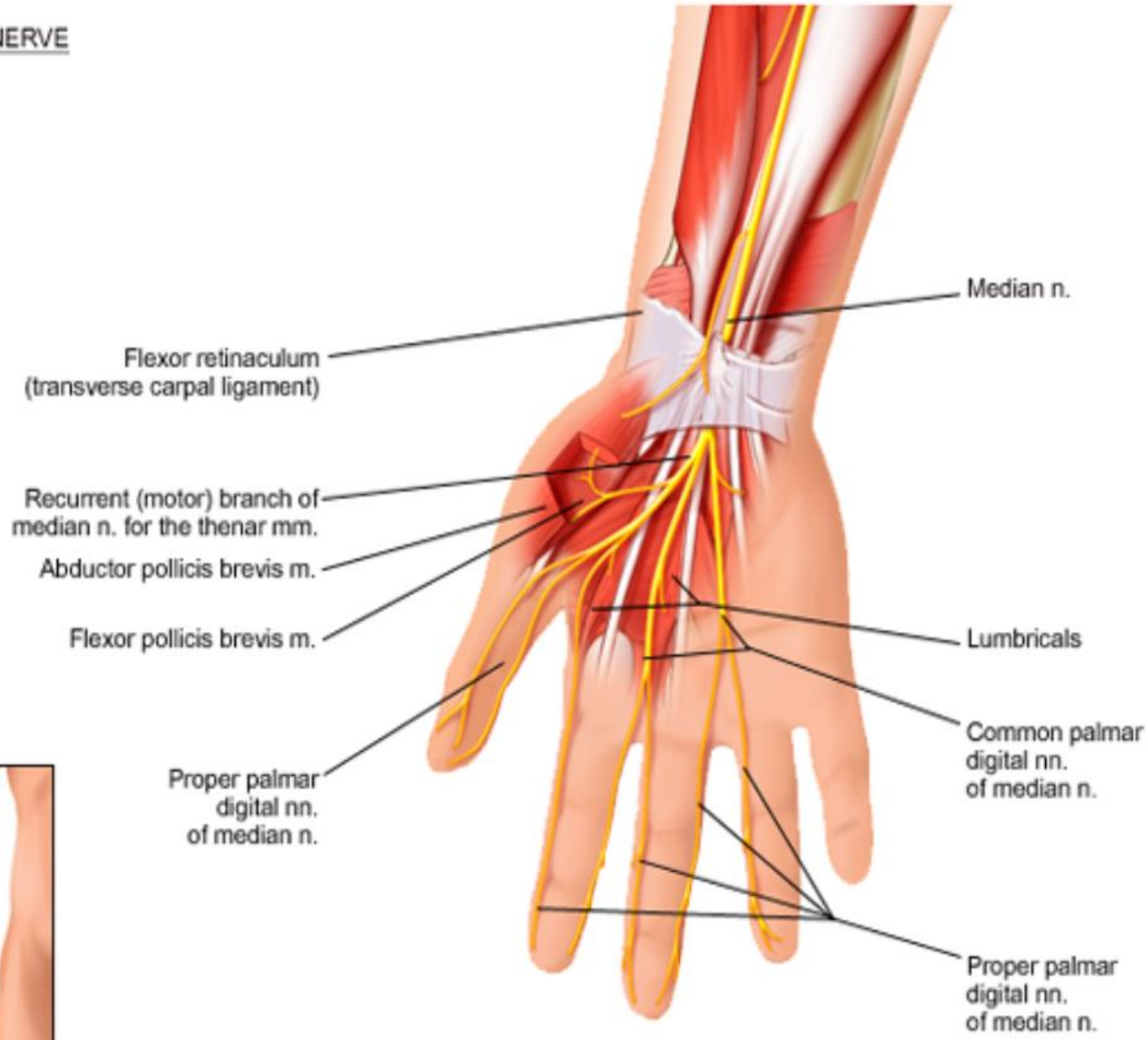
Practical ……

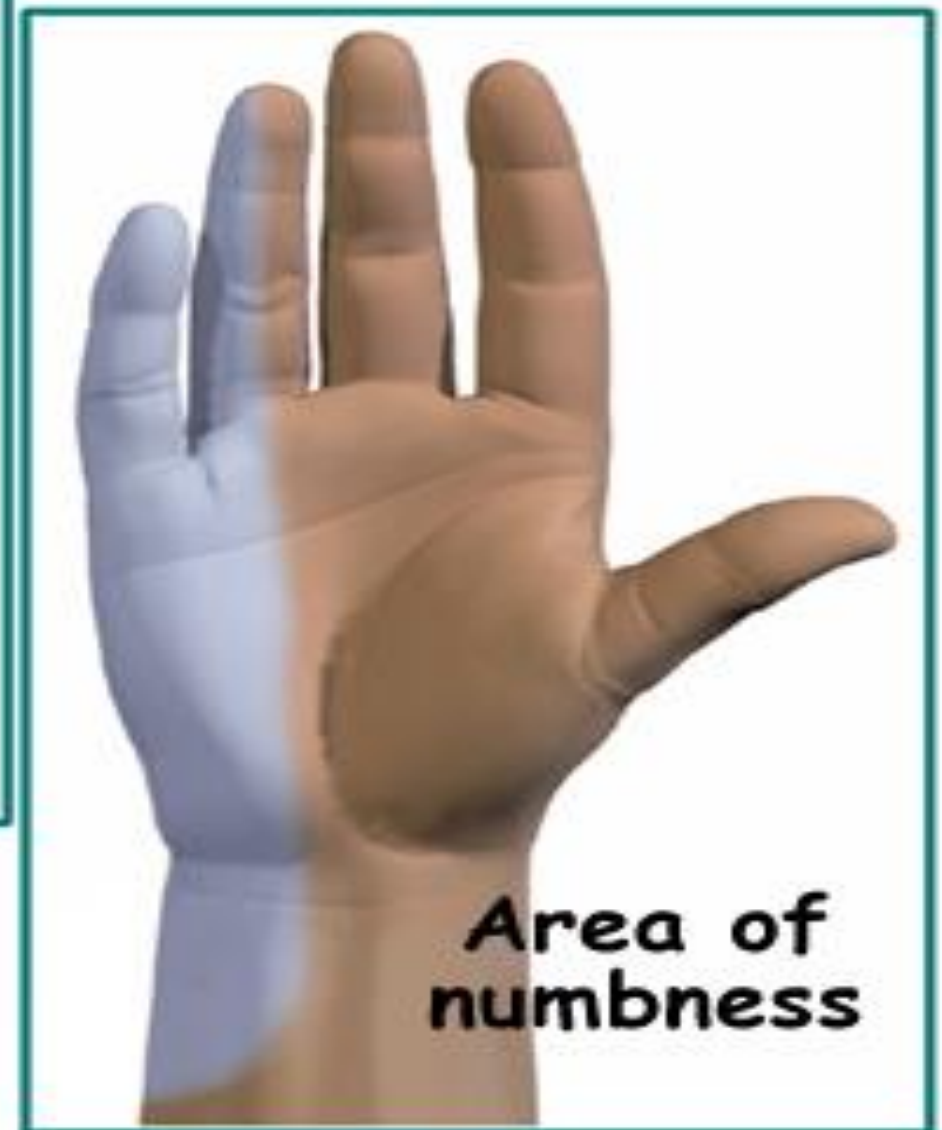
- Please test your neighbour’s median nerve!
- Sensory and motor

THE MEDIAN NERVE

Anterior view





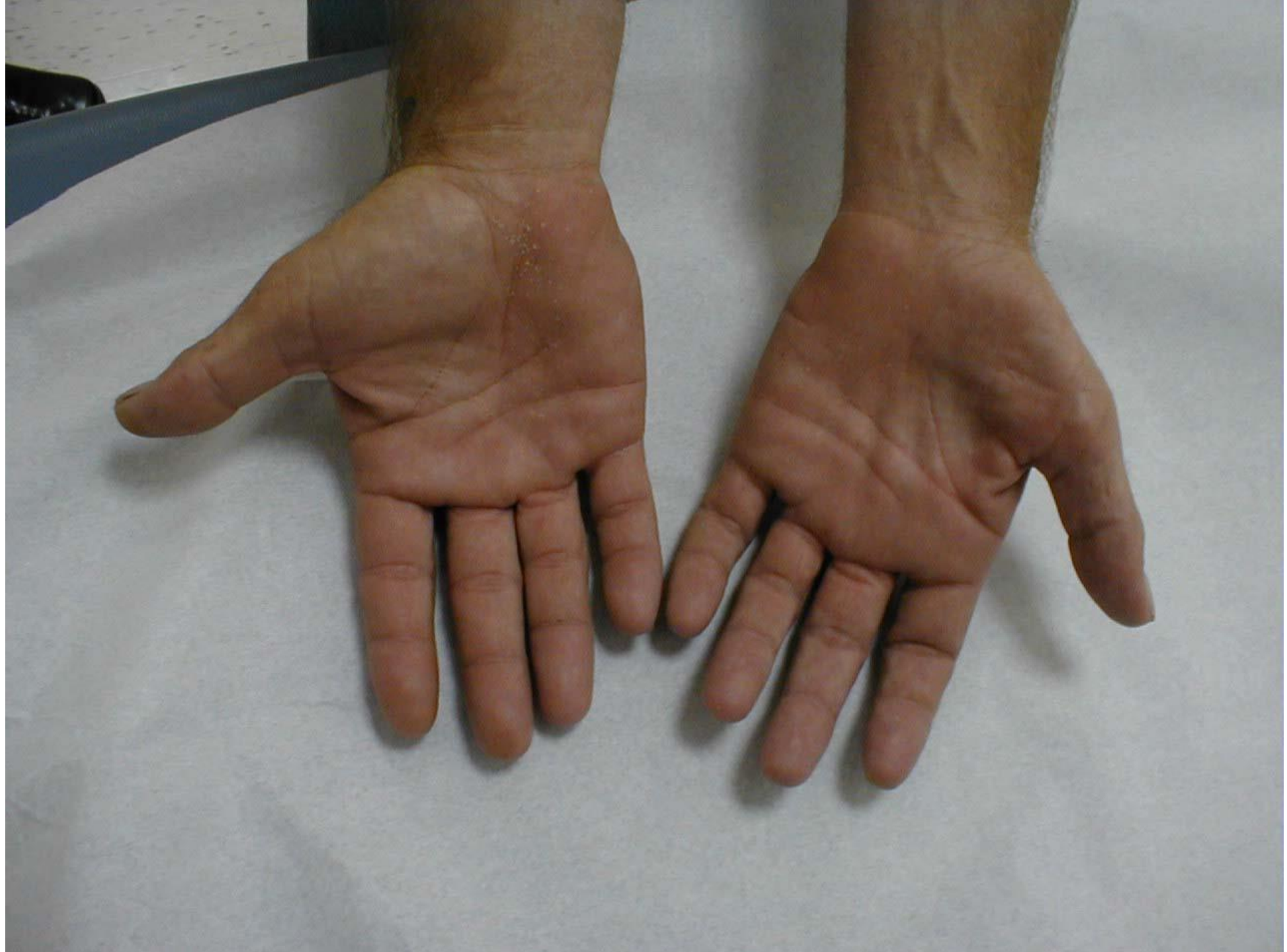


4 groups of muscles

- Lumbricals 1+2
- Opponens pollicis
- Abductor pollicis brevis
- Flexor pollicis brevis

- Phalen’s test
  - Wrist flexion
- Durkan’s test
  - Pressure
- Tinnel’s test

- Phalen’s + Durkan’s >>>Tinnel’s



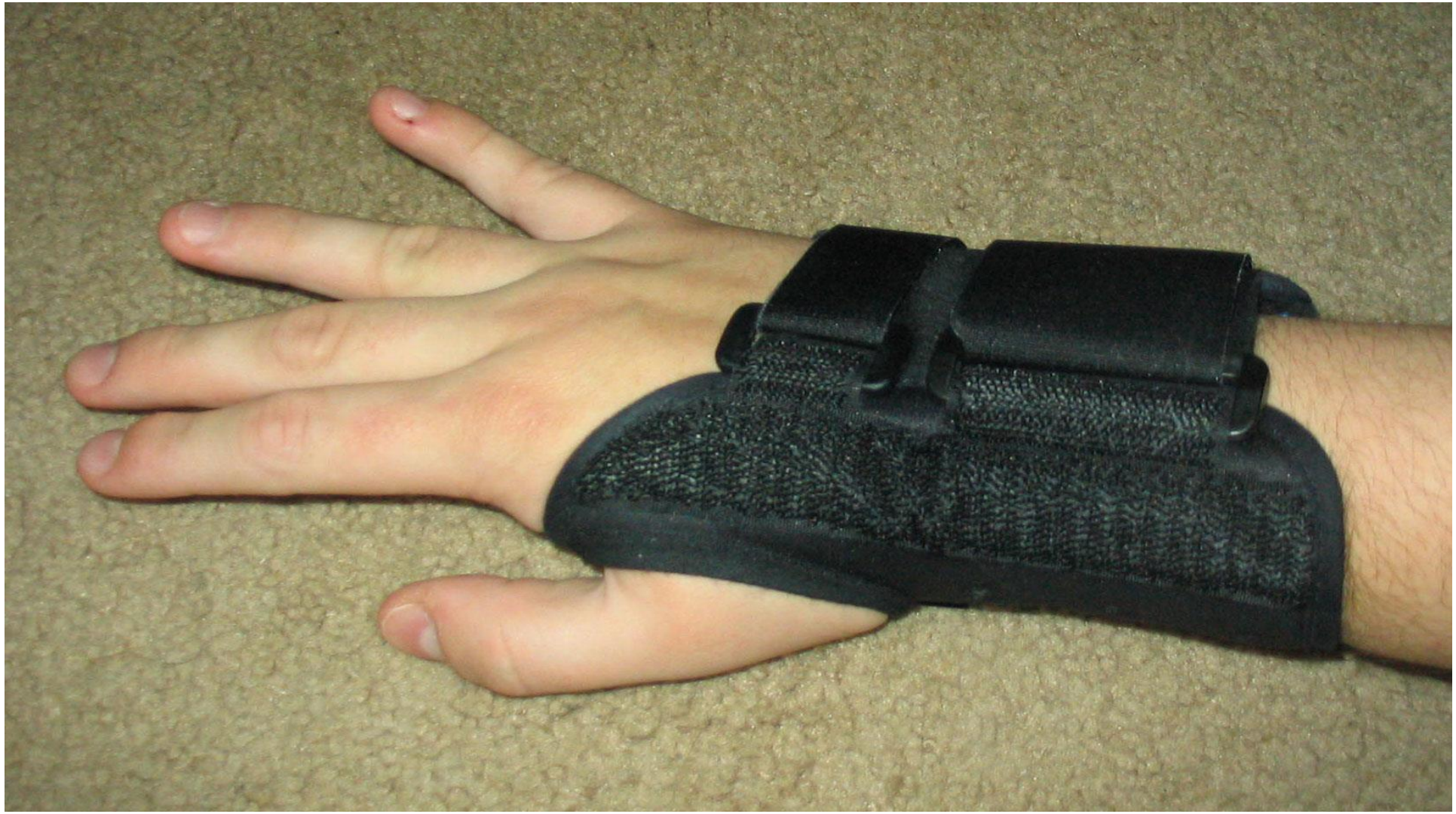
Requests for surgical treatment of Carpal tunnel syndrome will be considered when:

			Yes	No
A	There is neurological deficit These symptoms require immediate referral for surgery These patients should be assessed within 2 weeks and receive prompt surgery	Sensory blunting Weakness of grip Muscle wasting Progressive symptoms		
	OR			
B	Symptoms (tingling, burning, numbness, cramping) persists despite at least 4 months of conservative treatment with the following :	Workplace adaptation/OT assessment (where applicable) Nocturnal splinting - NOT for long term management (reassess in 6 weeks) Corticosteroid injection (reassess at 2 weeks)		

Selection of any **ONE YES** box qualifies patient for referral

Consider referring patients who do not meet the above criteria via IFR.

Splint- NOCTURNAL…review 6 weeks



Hand Surgery Questions

- Ganglion cyst
- Trigger finger
- Dupuytrens
- Carpal tunnel syndrome

- Who do we refer to for trigger finger injections?
- Dupuytrens- Sheffield Collagenase injection?
- Orthotics/OTC splints ? *******

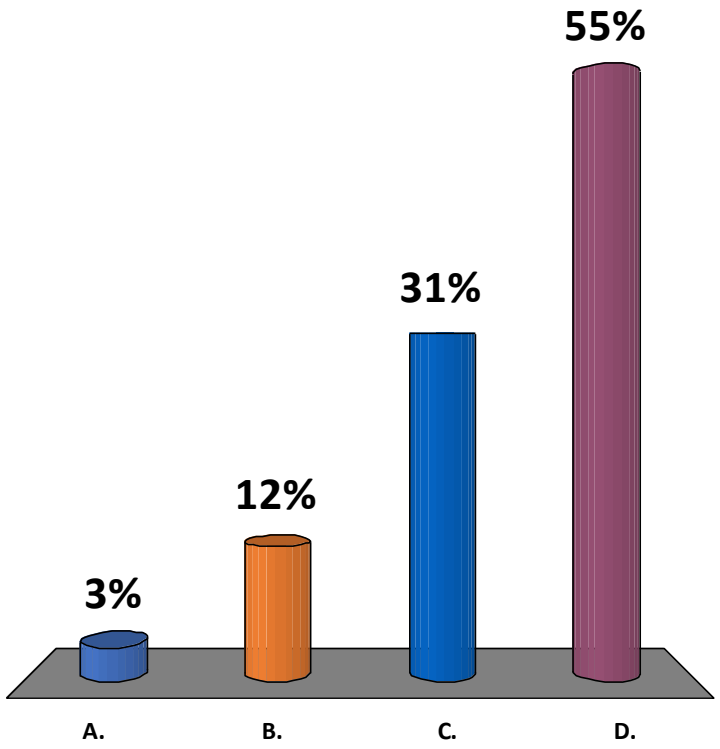
Cholecystectomy

Clinical Thresholds
Cholecystectomy

- Referral to secondary care creates the expectation of surgery.
- Gall stones are common.
- Abdominal pain is common.
- Biliary colic is relatively unusual.
- Cholecystectomy even in the best hands has significant complications.
- NICE advice no pain no surgery.

How common are gall stones?

A. 10%
B. 20%
C. 80%
D. 40%



Clinical Thresholds Cholecystectomy

- How common are gall stones?
- 20-40%

Clinical Thresholds Cholecystectomy

- Complications of surgery 1 – 12%
- Death 1:1000
- Infection, bleeding, bile leak, bile duct injury, DVT, PE etc.
- Post Cholecystectomy Syndrome up to 20% bloating, pain, diarrhoea

10.Gall bladder removal (Cholecystectomy) – Clinical Threshold Referral Criteria

Patients with asymptomatic gallstones DO NOT require a cholecystectomy.

Patients with gall stones who experience ONE episode of mild abdominal pain ONLY, can be managed with oral analgesia in primary care. Such patients should be advised to follow a low-fat diet. (See low fat diet sheet on BEST website- top tabs patient information sheets)

Patients with suspected gallbladder carcinoma OR severe complications, should be referred immediately without delay.

Criteria for Commissioning

	Yes	No

Criteria for Commissioning

			Yes	No
A	High risk of gallbladder cancer ie.	Gall bladder polyps ≥ 1cm (annual US for smaller asymptomatic polyps)		
		Porcelain gall bladder		
		Strong Family History (parent/child/sibling)		
B	Confirmed Complications from gallstones	Gall stone induced pancreatitis		
		Gall stone induced cholecystitis		
		obstructive jaundice caused by biliary calculi		
C	Increased risk of complications from gallstones	Presence of stones in the common bile duct		
D	High risk group of complications: Refer if these patients have been managed conservatively AND subsequently develop symptoms	Diabetes mellitus patients		
		Transplant recipients		
		Cirrhosis patients		

Selection of any **ONE YES** box qualifies patient for referral

Consider referring patients who do not meet the above criteria via IFR.

based on NHS England Referral Criteria

Abdominal wall hernia

Clinical Thresholds
Hernia repair

- Referral to secondary care creates the expectation of surgery.
- Tend to enlarge with time but time scale varies greatly between patients.
- Progress easily assessed as visible.
- Risk of strangulation small and tends to be over emphasised by private providers

Clinical Thresholds
Hernia repair

- Risks of surgery
- Short term 10% including haematoma, seroma and wound infection
- Long term 20% including recurrence (5-10%), local pain 7.5%, nerve pain/neuralgia 7.5%

			Yes	No
A	Umbilical Paraumbilical Midline Ventral hernias	Pain/discomfort causing significant functional impairment		
		OR Increase in size month on month		
		OR To avoid strangulation of bowel where hernia is ≥2cm		
B	Incisional hernia	Pain/discomfort causing significant functional impairment **AND** Appropriate conservative management has been tried first eg.weight loss where appropriate		

C	Inguinal hernia	Symptoms causing significant functional impairment		
		OR Hernia is difficult/impossible to reduce (confirmed by US or history of incarceration)		
		OR Inguino-scrotal hernia		
		OR Increase in size month on month		
D	Femoral hernia (suspected and visible)	should be referred directly to secondary care without prior approval due to increased risk of incarceration/strangulation.		

Selection of any **ONE YES** box qualifies patient for referral

Consider referring patients who do not meet the above criteria via IFR.

Hip and Knee

Mr. Chapman

- 76 yr old
- pain in Left hip 24 months
- Pain in Right knee 12 months

- What else do you want to know?

Mr. Chapman

- 76 yr old pain in left hip 24 months
- Right knee 12 months
- Lives alone
- CABG 12 mths ago
- Still drives
- Difficulty getting in and out chair
- Uses walking stick
- Pain stops from sleeping
- Pain stops him getting around the house
- Takes cocodamol 30/500

What are you going to do next?

- What will help ?
- What wont help?

OA- diagnosis – without X ray?

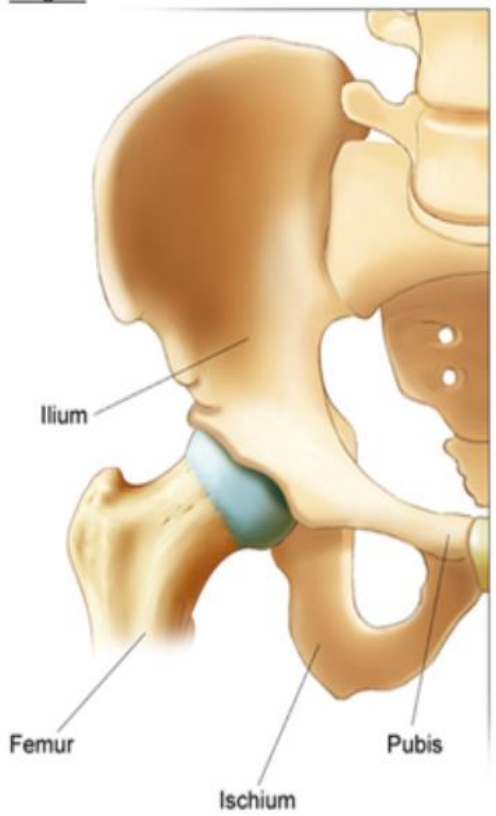
- >45 yrs old
- >3 month joint pains
- Morning stiffness lasts about ½ hr
- Alternative diagnosis unlikely

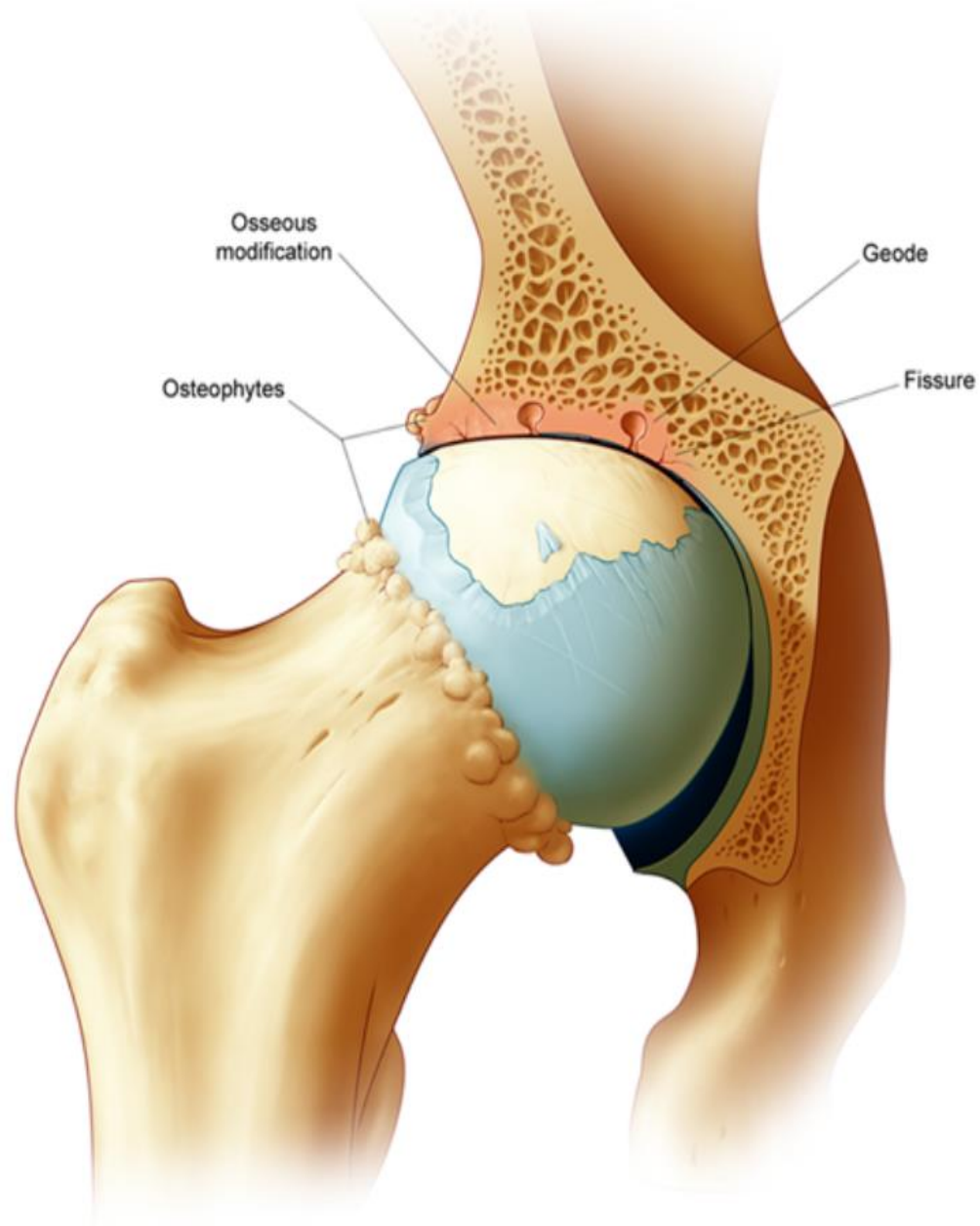
X ray Hip

- Marked degenerative change in the right hip with loss of the joint space , subchondral cystic change and osteophyte formation.

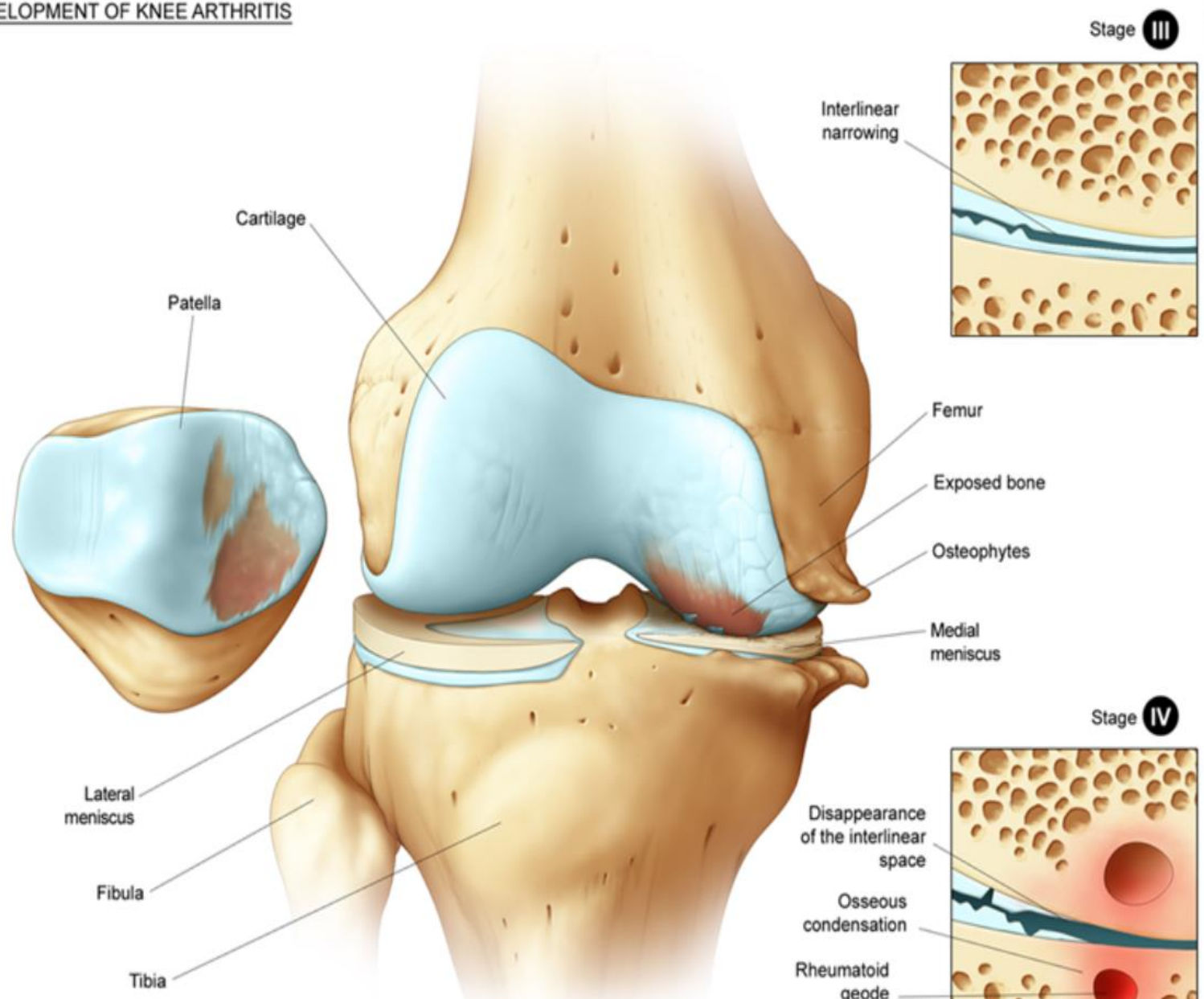
DEVELOPMENT OF HIP ARTHRITIS

Stage 3





DEVELOPMENT OF KNEE ARTHRITIS



Mx- core …

- Physical activity/exercise** (physio)
- Advice leaflet OA
- Weight loss

- Non surgical treatment

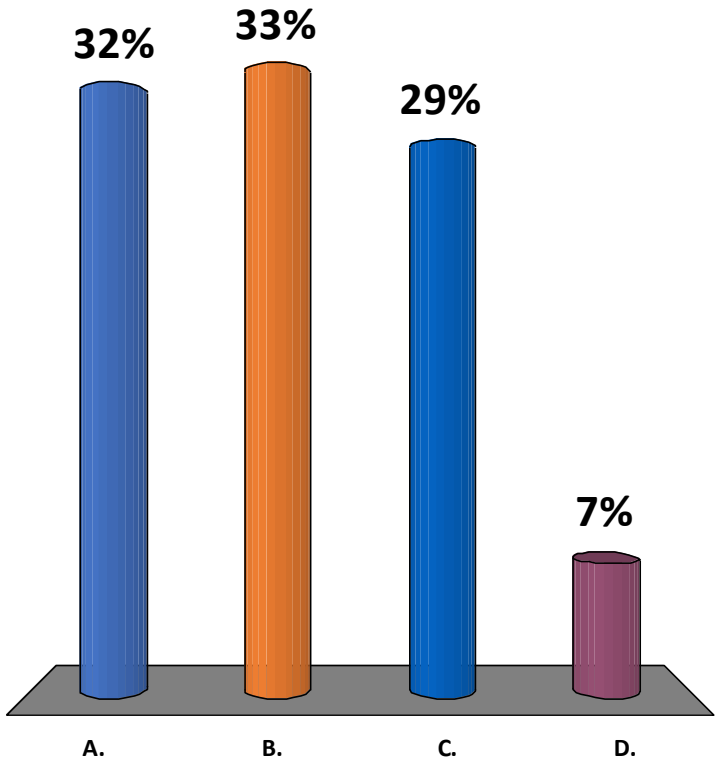
Exercise- does it really work?

- OA Hip
  - scale 0-100
  - Decreases pain/ increases function by 7 points
  - sustained > 3 months

- OA Knee
  - Even better improved function

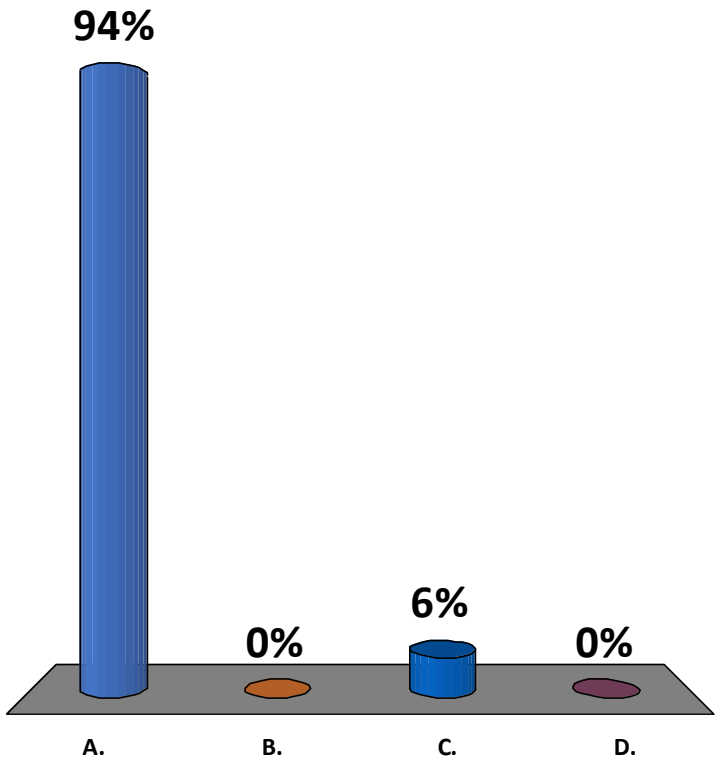
NSAIDS- topical v oral for knee pain pain scores over 12 months

A. Oral NSAID better
B. Topical NSAID better
✓ C. Both the same
D. unsure



NSAIDS- topical v oral for knee pain which one more side effects/adverse events?

- ✔ A. Oral NSAIDs
- B. Topical NSAID
- C. Both the same
- D. unsure



Treatment

- Analgesia
- NSAID- topical
  - NNT 3
  - Knee/hand
- Paracetamol
  - NNT 7
- Opiods if …
- NSAID oral +PPI …
  - Avoid if on aspirin
  - Lowest dose
  - Shortest time
- Joint injection
  - NNT 5
- Supports /Braces
- Local heat/cold
- TENS

Treatments

- Not recommended
- Arthroscopy
- Wedge sole inserts
- Glucosamine
- Acupuncture
- Hyaluranon

- Recommended
- Herbal ☺
- AND
- X ?

Mr. Chapman

- 76 yr old pain in left hip 12 months
- Lives alone
- CABG 12 mths ago
- Still drives
- Difficulty getting in and out chair
- Uses walking stick
- Pain stops from sleeping
- Pain stops him getting around the house
- Takes cocodamol 30/500

Does Mr.Chapman qualify for Hip replacement ?

13. Hip Replacement for Osteoarthritis - Clinical Threshold Referral Criteria

			Yes	No
A	Patient experiences severe/intense pain	Pain almost continuous (75-100%) of the day		
		Pain when walking short distances on level surface <20ft		
		Pain on standing less than half an hour		
		Pain on resting		
	OR			
	Symptoms have a substantial impact on their quality of life	Daily activities significantly limited (Unable to maintain home, cook, bathe or dress without difficulty or assistance)		
		Requires use of support systems (walking stick, cane, crutches, walker, wheelchair, carer)		
	AND			
B	Patient has a BMI <30			

14. Knee Replacement for Osteoarthritis - Clinical Threshold Referral Criteria

			Yes	No
A	Patient experiences severe/intense pain	Pain almost continuous (75-100%) of the day		
		Pain when walking short distances on level surface <20ft		
		Pain on standing less than half an hour		
		Pain on resting		
	OR			
	Symptoms have a substantial impact on their quality of life	Daily activities significantly limited (Unable to maintain home, cook, bathe or dress without difficulty or assistance)		
		Requires use of support systems (walking stick, cane, crutches, walker, wheelchair, carer)		
	AND			
B	Patient has a BMI <30			
	AND			
C	Patient is a confirmed non-smoker			

D	Conservative means tried for 6 months BUT failed to alleviate pain and disability	Weight loss (Document evidence)		
		Avoidance impact and excessive exercise		
		Good shock absorbing shoes		
	AND			
E	Symptoms refractory to non- surgical treatment	NSAIDS (if no contra indications)		
		Paracetamol or paracetamol based analgesia		
		Opioids if NSAIDS or paracetamol based analgesia not affective		
		Physiotherapy		
		Intra articular steroid injection		

Selection of **ONE YES** box form **EACH** of the categories **A to E** required for referral

Ensure that the maximum number of treatment options from D and E have been tried before referral.

If the above Criteria are not met. Does the patient meet the following exceptions?

	Yes	No
Patient's pain is so severe OR mobility is so compromised That they are in immediate danger of losing their independence AND that joint replacement would relieve this (refer through IFR)		
OR		
Patient's whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure (refer through IFR)		
OR		
Rapid onset of severe hip pain		

Patients with co-morbidities should be optimised prior to referral for possible

surgery

Patients with co- morbidities should be optimised prior to referral for possible surgery

		Yes	No
Diabetic	HbA1C <70 mmol/ml		
Hypertension	BP<140/85		
Anaemia			
	Men Hb >13		
	Women Hb >12		
Sleep Apnoea- Referred to sleep studies	STOP BANG Score > 5		

Based on NHS England Referral Criteria and Rotherham Clinical Threshold referral pathway

Alternatives

- Braces ***
- TENS
- Herbal !

Herbal

BEST non surgical treatment !

Treatment

- Analgesia
- NSAID- topical
  - NNT 3
  - Knee/hand
- Paracetamol
  - NNT 7
- Opiods if …
- NSAID oral +PPI …
  - Avoid if on aspirin
  - Lowest dose
  - Shortest time

- Joint injection
  - NNT 5
- Supports /braces
- Local heat/cold
- TENS

Herbal treatments

Walking stick

Questions

- Cholecystectomy
- Abdominal wall hernia repair
- Hip replacement
- Knee replacement

- Best analgesia for biliary colic?
- Indicators biliary colic rather than other cause of pain?