Appendix 1 – Adoption of Evidence Based Interventions where no Sussex wide CEC policy existed

1. Injections for nonspecific low back pain without sciatica

Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain. For people with non-specific low back pain the following injections should not be offered:

- Facet joint injections
- Therapeutic medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above radiofrequency denervation can be offered according to nice guideline (ng59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block. Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.

2. Dupuytren's contracture release in adults

Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.

An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for:

- Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.
  or
- Severe thumb contractures which interfere with function

NICE concluded that collagenase should only be used for:

a. Participants in the ongoing clinical trial (HTA-15/102/04)
   or
b. Adult patients with a palpable cord if:
   i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints;
   and

ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

3. Arthroscopic shoulder decompression for subacromial shoulder pain

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases.

To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy.

Non-operative treatments such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered.

The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

4. Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA)

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.

Alternative Treatments
There are a number of alternatives to surgery that can improve the symptom of snoring.

These include:

- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)