7 General surgery, urology and vascular

7.1 Bariatric surgery in adults (primary surgery)

Category	Restricted (prior approval required)

Background

Weight loss surgery, also called bariatric or metabolic surgery, is sometimes used as a treatment for people who are very obese. The most common types of weight loss surgery are gastric bypass, sleeve gastrectomy and gastric banding.

Bariatric surgery in adults became the commissioning responsibility of CCGs in April 2017. Commissioning of specialist morbid obesity services for children, including bariatric surgery and associated care, remains the responsibility of NHS England.

Policy

Prior approval is required for this procedure (see Appendix A).

Bariatric surgery in adults is not routinely funded by CCGs except where all of the following criteria are fulfilled:

- The patient has either:
  - a BMI of ≥40, OR
  - a BMI of 35–40 and other significant obesity related disease (e.g. type 2 diabetes mellitus or high blood pressure) that could be improved if they lost weight, OR
  - Asian family origin, recent onset* type 2 diabetes mellitus and a BMI of >32.5
- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The individual has recently received and complied with a local specialist weight management programme (tier 3) for a duration considered appropriate by the multi-disciplinary team (MDT)**.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

Continued overleaf

- A formalised MDT led process for the screening of co-morbidities and the detection of other significant diseases has been completed. These should include identification, diagnosis, severity/ complexity assessment, risk stratification/ scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.
- The specialist hospital bariatric MDT agrees surgery is indicated; for each patient a risk:benefit evaluation should favour bariatric surgery. In addition the bariatric surgery team must satisfy themselves that there are no contraindications for surgery, risks have been minimised and the patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure.

**Consistent with NICE CG189, recent onset is defined as diagnosis within the previous 10 years.*

*** Note additional eligibility criteria are in place for access to tier 3 specialist weight management services across Kent and Medway. Contact relevant CCG for their current commissioning policy on tier 3 specialist weight management services.*

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

The eligibility criteria stipulated in this policy are broadly consistent with the eligibility criteria used by NHS England prior to April 2017 and those recommended in NICE Clinical Guideline (CG) 189.

NICE CG189 also recommends extending the availability of bariatric surgery to people with new onset type 2 diabetes mellitus and a BMI of 30–35. However, NICE made this recommendation with less certainty than their other recommendations on bariatric surgery, reflecting the less compelling evidence base supporting it. In the context of the quality of the underpinning evidence, the strength of the NICE recommendation and the limited resources available, funding bariatric surgery for people with new onset type 2 diabetes mellitus and a BMI of 30–35 is not currently a priority for Kent and Medway CCGs.

The separate BMI criterion on people of Asian family origin reflects the observation that diabetes tends to occur at lower BMIs in this population due to greater abdominal adiposity. It may therefore be appropriate to consider bariatric surgery at lower thresholds in these individuals.

7.2 Bariatric surgery in adults (revision surgery)

Category	Restricted (prior approval required)

Background

Revision surgery is defined by NHS England as surgery clinically indicated to treat complications arising more than 90 days after the index surgical procedure. Early re-operation (i.e. surgery less than 90 days of the index surgical procedure) is regarded as a complication of the primary surgical procedure.

Policy

Prior approval is required for this procedure (see Appendix A).

Revision of bariatric surgery* will be funded as per NHS England Clinical Guidance on revision surgery for complex obesity (2016):

a) Revision surgery will be routinely funded for patients presenting with a clinical history, symptoms and/ or signs that suggest acute/ acute on chronic/ worsening medical and/ or surgical complications – related to their primary obesity operation. This will include patients with adverse anatomical complications of the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/ or the gastro-jejunal junction.

b) Revision surgery will not be routinely funded for patients who have failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight (unless criterion 'a' is met).

c) Revision surgery will not be routinely funded for patients who have comorbidities which have persisted or re-emerged following primary obesity surgery (unless criterion 'a' is met).

d) Where patients have had their primary obesity surgery outside of NHS contracts but subsequently present at NHS facilities as clinical emergencies, the NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment.

**Revision surgery is defined by NHS England as surgery clinically indicated to treat complications arising >90 days after the index surgical procedure. Early re-operation (i.e. surgery <90 days of the index surgical procedure) should be regarded as a complication of the primary surgical procedure and will be the responsibility of the provider undertaking the primary bariatric operation.*

Continued overleaf

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

This policy is consistent with NHS England Clinical Guidance on revision surgery for complex obesity (2016). NICE Clinical Guideline (CG) 189 Obesity (2014) does not make recommendations on eligibility for revision surgery.

7.3	Brow-lift
Category	Not routinely funded
Policy	This procedure is not routinely funded.

7.4 Divarication of rectus abdominis muscles (surgical repair of)

Category Restricted (prior approval not required)

Background

Diastasis recti or divarication of the rectus abdominis muscles describes the separation of the two rectus muscles, usually as a result of the linea alba thinning and stretching. Divarication of rectus muscles is normally considered a cosmetic condition as it does not carry the risks of a true hernia, like strangulation of contents.

Surgical correction of rectus divarication can be undertaken in combination with an abdominoplasty to improve appearance. Alternatively the rectus abdominis muscles can be repaired via a simple midline incision.

Policy

- Surgical repair of divarication of rectus abdominis muscles in combination with abdominoplasty is not routinely funded for any patient group
- Surgical repair of divarication of rectus abdominis muscles via midline incision will only be funded where both of the following criteria are met:
    - It is undertaken in combination with umbilical hernia repair, where the patient fulfils relevant criteria for the latter, *and*
    - Umbilical hernia repair is coded as the primary procedure

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

There is some evidence to suggest that umbilical hernias are more likely to recur following repair where rectus divarication is present. An abdominoplasty approach would be done only for cosmetic reasons.

7.5 Elective hernia repair in adults (including use of biological meshes)

Category	Elective hernia repair is funded provided criteria set out in this policy are met (prior approval not required); biological meshes are not routinely funded.

Background

A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. This policy relates to four types of hernia:

- Inguinal hernias occur in the groin; they are the most common type of hernia and mostly affect men.
- Umbilical hernias occur in the abdomen.
- Incisional hernias are iatrogenic; they occur through a previously made incision in the abdominal wall, normally a scar left from a previous surgical operation.
- Femoral hernias are an uncommon type of hernia; they occur in the groin. Unlike inguinal hernias, femoral hernias occur more frequently in women.

Hernia repair involves replacement and securing of the tissue or bowel back into the abdomen. In some cases a mesh is placed over the hole and fixed using fine stitches to strengthen the area. Meshes can be either synthetic or biological. A synthetic mesh consists of a polymer base but can vary in chemical composition. Biological meshes can be derived from human, porcine or bovine tissue and be composed of dermal, pericardial or intestinal submucosa tissue. The tissue is decellularised to leave a collagen matrix and some are chemically cross-linked.

Policy

<u>Inguinal hernia repair</u>

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Adults should be referred for surgical assessment if they:

- Demonstrate pain or discomfort significantly interfering with activities of daily living; AND meet at least one of the following:
  - A history of incarceration of, or real difficulty reducing, the hernia
  - An inguino-scrotal hernia
  - Increase in size month to month

Continued overleaf

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Umbilical hernia repair

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic umbilical hernias in adults. Adults should be referred for surgical assessment if they:

- Demonstrate pain or discomfort significantly interfering with activities of daily living; AND meet at least one of the following:
    - A history of incarceration of, or real difficulty reducing, the hernia
    - Increase in size month to month

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Incisional hernia repair

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic incisional hernias in adults. Adults should be referred for surgical assessment if they have:

- Pain/ symptoms interfering with activities of daily living AND conservative management e.g. weight loss, has been tried first where appropriate

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Femoral hernia repair

People with femoral hernias should be referred for consultation.

Biological meshes

Biological meshes for hernia repair are not routinely funded by Kent and Medway CCGs for any patient group.

The policies on elective hernia repair in adults and biological meshes are currently under review.

Rationale

There is evidence to suggest that watchful waiting is a reasonable strategy for patients with inguinal and incisional hernia and may lead to avoidance of surgery for a proportion of patients.

Continued overleaf

The Royal College of Surgeons (RCS), the Association of Surgeons of Great Britain and Ireland and The British Hernia Society have issued a commissioning guide for groin hernia (2013) recommending patients with asymptomatic groin hernias can be managed conservatively. 2014/15 PROMs data indicates that quality of life is likely to worsen or remain unchanged for 17–42% and 20–32% of English patients undergoing surgical repair of groin hernia respectively. Up to 8% of inguinal hernia repair patients may be left with persistent/ chronic pain following surgery.

There is no formal NICE guidance on indications for hernia repair. However, NICE Technology Appraisal (TA) 83 recommends laparoscopic surgery as one of the treatment options for repair of inguinal hernia (2004).

Femoral hernia repair is almost always recommended straight away because there is a higher risk of complications such as obstruction and strangulation developing in these cases.

The evidence base for the clinical effectiveness of biological meshes for hernia repair is poor and equivocal. Biological meshes (National Tariff exclusions) cost considerably more than synthetic meshes (included within tariff) and there is no evidence that they are cost-effective for the NHS.

7.6 Face lift (rhytidectomy)

Category	Restricted (prior approval not required)

Background

A facelift, also known as rhytidectomy, is an operation to lift up the facial skin and underlying muscles, so that the face has a tighter and smoother appearance.

Policy

This procedure is not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Congenital facial abnormalities unless the commissioning responsibility of NHS England*, *or*
- Facial palsy (congenital or acquired paralysis), *or*
- As part of the treatment of specific conditions affecting the facial skin unless the commissioning responsibility of NHS England*, *or*
- To correct the consequences of trauma, *or*
- To correct deformity following surgery

** Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.*

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

7.7 Gallstone disease in adults (laparoscopic cholecystectomy for the treatment of)

Category	Restricted (prior approval not required)

Background

Cholelithiasis (gallstones) is the term used to describe discrete, hard fatty or mineral deposits (calculus) that are formed in the gallbladder. The presence of one or more gallstones is referred to as gallstone disease. In the UK, around 10-15% of the adult population are thought to have gallstones. Eighty per cent of people with gallstones are asymptomatic; they are normally detected incidentally through imaging such as ultrasound or MRI as part of investigations for other conditions.

Stones may pass from the gallbladder into the common bile duct; these are then referred to as common bile duct (CBD) stones.

Surgery to remove the gallbladder (cholecystectomy) is the most common way to treat symptomatic gallstone disease. Cholecystectomy is normally undertaken laparoscopically as it results in a shorter length of stay, a faster recovery and smaller scars.

Policy

Gallbladder stones

- Patients with an incidental finding of stones in an otherwise normal gallbladder and biliary tree require no further investigation or referral; asymptomatic patients should not be referred to secondary care (see pages 59–60 for care pathway and information on primary care management)
- Surgery for asymptomatic gallstones is not routinely funded
- Laparoscopic cholecystectomy will be funded for people diagnosed with symptomatic gallbladder stones. The decision to operate should be made by the patient with guidance from the surgeon. This will include assessment of the risk of recurrent symptoms and complications of the gallstones and the risks and complication rates of surgery in relation to the individual patient's co-morbidities and preference.

Common bile duct stones

- Bile duct clearance and laparoscopic cholecystectomy will be funded for people with symptomatic or asymptomatic common bile duct stones

Continued overleaf

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

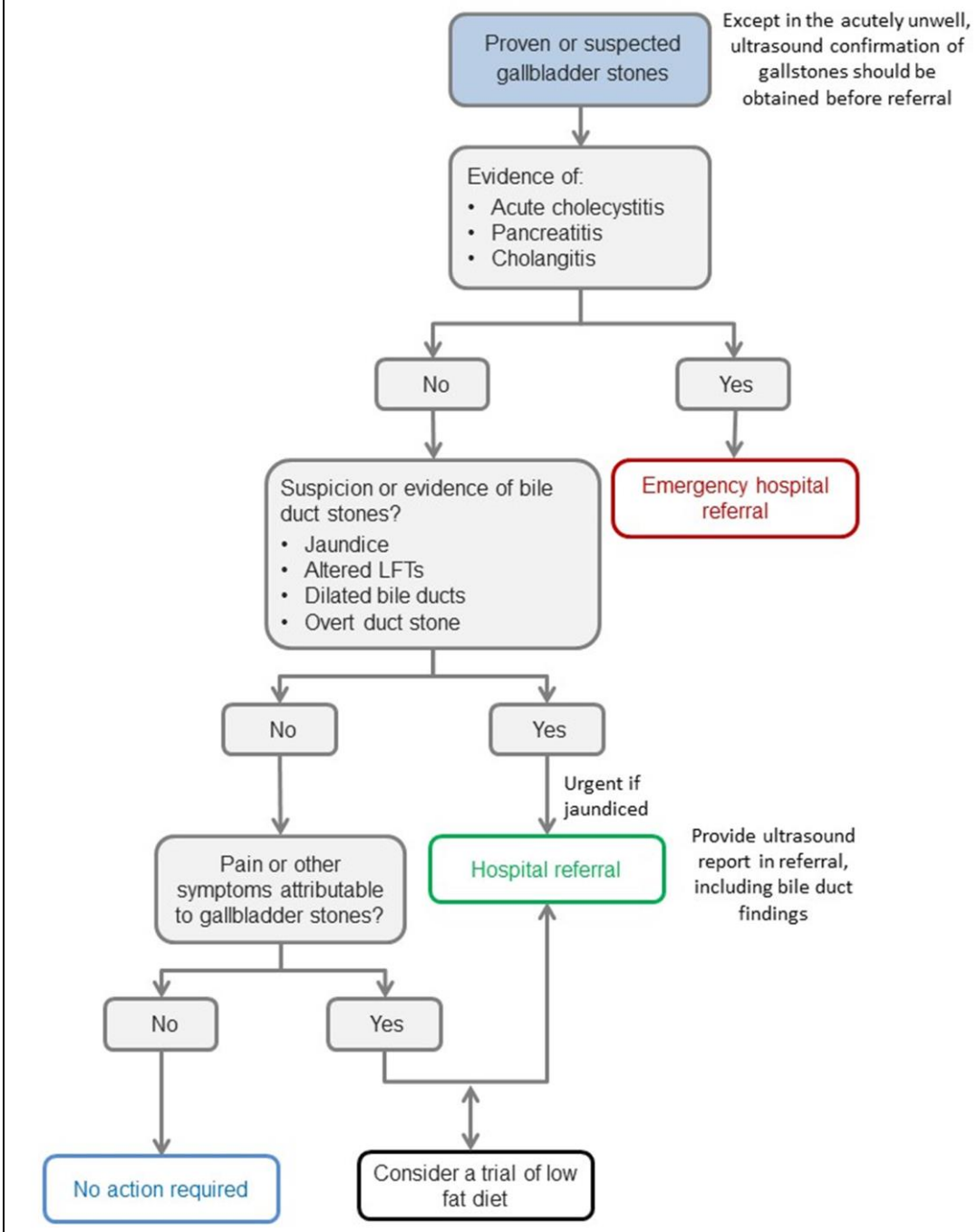
The policy on laparoscopic cholecystectomy for gallstone disease in adults is consistent with NICE Clinical Guideline 188 on Gallstone disease (2014) and commissioning guidance from the Royal College of Surgeons of England and the Association of Upper Gastrointestinal Surgeons of Great Britain (2016).

According to CG188, most people with asymptomatic gallbladder stones will not develop complications and there is currently no way of predicting which ones will. CG188 also noted that prophylactic treatment of asymptomatic gallstones is likely to be associated with higher risks of adverse events than leaving them untreated, and that offering unnecessary treatment to a large number of people would not be the best use of NHS resources.

CG188 recommends bile duct clearance and laparoscopic cholecystectomy should be offered to people with symptomatic or asymptomatic CBD stones because they are at risk of developing severe complications.

Continued overleaf

Treatment algorithm



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Box 5 – Primary care management

- Most patients with symptomatic gallstones present with a self-limiting attack of pain that lasts for hours only. This can often be controlled successfully in primary care with appropriate analgesia, avoiding the requirement for emergency admission. When pain cannot be managed or if the patient is otherwise unwell (e.g. sepsis), he or she should be referred to hospital as an emergency.
- Further episodes of biliary pain can be prevented in around 30% of patients by adopting a low fat diet. Fat in the stomach releases cholecystokinin, which precipitates gallbladder contraction and might result in biliary pain.
- Patients with suspicion of acute cholecystitis, cholangitis or acute pancreatitis should be referred to hospital as an emergency
- There is no evidence to support the use of hyoscine or proton pump inhibitors in the management of gallbladder symptoms
- Antibiotics should be reserved for patients with signs of sepsis
- There is no evidence of benefit from the use of non-surgical treatments in the definitive management of gallbladder stones (e.g. gallstone dissolution therapies, ursodeoxycholic acid or extracorporeal lithotripsy)
- Adults with symptomatic gallstone disease who have not had their gallbladder or gallstones removed are advised to avoid food and drink that triggers their symptoms

Source: RCS/ AUGIS commissioning guide (2016) on gallstone disease and NICE QS104 (2015).

7.8 Ganglion excision

Category	Restricted (prior approval not required)

Background

A ganglion cyst is a fluid-filled swelling that usually develops near a joint or tendon. The cyst can range from the size of a pea to the size of a golf ball.

Ganglion cysts look and feel like a smooth lump under the skin. They're made up of a thick, jelly-like fluid called synovial fluid, which surrounds joints and tendons to lubricate and cushion them during movement.

Ganglions can occur alongside any joint in the body, but are most common on the wrists (particularly the back of the wrist), hands and fingers.

Ganglions are harmless but can sometimes be painful. If they do not cause any pain or discomfort, they can be left alone and may disappear without treatment, although this can take a number of years.

Resources

Patient leaflet on ganglion excision developed by the NHS England EBI programme.

Policy

- NHS England and British Orthopaedic Foot and Ankle Society guidance recommends that asymptomatic ganglia do not require treatment (reassurance is all that is needed) and they often resolve spontaneously over time.

Wrist and feet ganglia

- Aspiration should be considered first line where this is clinically appropriate and safe and if there is pain or tingling/ numbness. If there is recurrence, repeat aspiration may be attempted, but referral should be considered, particularly if the presentation is not straight-forward.
- Surgical excision is only funded if all of the following criteria are met:
    - there is pain or tingling/ numbness
    - there is restricted hand/ foot function
    - aspiration has been tried (where appropriate).

Continued overleaf

Seed ganglia that are painful

- Aspiration should be considered first line where this is clinically appropriate and safe. If there is recurrence, repeat aspiration may be attempted, but referral should be considered, particularly if the presentation is not straight-forward.
- Surgical excision is only funded if aspiration has been tried (where appropriate) and painful seed ganglion persists or recurs.

Mucous cysts (finger and toe nails)

- Surgery is not funded unless there is recurrent spontaneous discharge of fluid or significant nail deformity.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Policy exclusions:

This policy does not apply if there is diagnostic uncertainty or suspicion of malignancy.

Rationale

This policy is consistent with NHS England EBI guidance on ganglion excision (2018) which has been approved by the British Society for Surgery of the Hand (BSSH). It is also consistent with evidence-based commissioning guidelines for ganglion cysts of the foot and ankle developed by the British Orthopaedic Foot and Ankle Society (BOFAS)

7.9 Gastro-electrical stimulation for gastroparesis

NHS England commissions all gastro-electrical stimulation services for adults with intractable gastroparesis (http://www.england.nhs.uk/).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

7.10 Haemorrhoid surgery

Category	Restricted (prior approval required for East Kent CCGs' patients only; prior approval not required for other Kent and Medway patients)

Background

Haemorrhoids, also known as piles, are swellings containing enlarged blood vessels found in the rectum and anus. In many cases, haemorrhoids don't cause symptoms and some people don't even realise they have them. When present, symptoms include: bleeding after passing a stool; itchy anus; a lump hanging down outside of the anus; mucus discharge after passing a stool; and soreness, redness and swelling around the anus.

Resources

- Patient leaflet on surgery to treat haemorrhoids developed by the NHS England EBI programme.
- Information on self-care, lifestyle changes and treatments, including a simple guide for patients on the pros and cons of different treatment options for haemorrhoids is available on NHS.uk.

Policy

Initial management

- Minimally symptomatic haemorrhoids may be safely observed in primary care
- Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water (see Box 6). If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or injection.

Criteria for surgery*

Surgical treatment will not be routinely funded unless patients meet one of the following criteria:

- Persistent grade 1 or 2 haemorrhoids that have not responded to lifestyle changes, pharmacological treatment and non-surgical treatments (i.e. rubber band ligation or injection sclerotherapy), *or*

Continued overleaf

- Where the haemorrhoids are more severe, specifically:
    - Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; *or*
    - Irreducible and large symptomatic external haemorrhoids

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Superior rectal artery embolisation for haemorrhoids and radiofrequency treatment for haemorrhoids are not funded as according to NICE IPG 627 (2018) and NICE IPG 589 (2017) respectively, current evidence on the safety and efficacy of both procedures is inadequate in quality and quantity.

**Surgical options include haemorrhoidectomy, stapled haemorrhoidopexy and haemorrhoidal artery ligation.*

Prior approval is required for this procedure for East Kent CCGs' (i.e. Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) patients only – see Appendix A.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Policy exclusions:

This policy does not apply to referrals for suspected cancer or other serious pathologies, or where urgent admissions are required.

Rationale

This policy is consistent with NHS England EBI guidance on haemorrhoid surgery (2018), which has been endorsed by the Association of Coloproctology of Great Britain and Ireland (ACPGBI). The policy is also consistent with relevant NICE guidance (TA128, IPG34, IPG342, IPG589, IPG627) and NHS England guidance on conditions for which OTC items should not routinely be prescribed in primary care.

Continued overleaf

Box 6 – Primary care management

Ensure stools are soft and easy to pass

- If the person is constipated, manage constipation*
- If the person is not constipated:
    - Advise adequate dietary fibre intake by eating a balanced diet containing whole grains, fruits, and vegetables; this should be done gradually to minimise flatulence and bloating.
    - Advise that adequate fluid intake is particularly important with an increased fibre diet to maintain soft, well-lubricated stools and to prevent intestinal obstruction.

Give lifestyle advice to aid healing of the haemorrhoid

- Advise on the importance of correct anal hygiene. The anal region should be kept clean and dry to aid healing and reduce irritation and itching. Recommend careful perianal cleansing with moistened towelettes or baby wipes, and to pat (rather than rub) the area dry.
- Advise against 'stool withholding' and undue straining during bowel movements, both of which can worsen the condition.

Manage any symptoms

- Consider recommending simple analgesia (such as paracetamol) for pain relief*. Avoid opioid analgesics (such as codeine) as they can cause constipation, and avoid nonsteroidal anti-inflammatory drugs (NSAIDs) if rectal bleeding is present.
- Consider recommending a topical haemorrhoidal preparation to provide symptomatic relief*.

Minimise risk of recurrence

- Advise the person that when the haemorrhoid has healed, they should continue with dietary and lifestyle measures to reduce the risk of recurrence.

*Source: Adapted from NICE CKS on haemorrhoids. * According to NHS England guidance, a prescription for the treatment of haemorrhoids, simple constipation or minor conditions associated with pain or discomfort should not routinely be offered in primary care. See NHS England guidance for more information on conditions for which OTC items should not routinely be prescribed in primary care, including general and specific exceptions.*

7.11 Male circumcision

Category	Restricted (prior approval required for East Kent CCGs' patients only; prior approval not required for other Kent and Medway patients)

Background

Circumcision is the surgical removal of the foreskin of the penis. The foreskin is the hood of skin covering the end of the penis (glans), which can be gently pulled back.

Policy

This procedure is not routinely funded except in the following circumstances:

- Pathological phimosis, *or*
- Recurrent episodes of balanoposthitis, *or*
- Suspicion or evidence of malignancy, *or*
- For biopsy where disease other than lichen sclerosus cannot be excluded

Prior approval is required for this procedure for East Kent CCGs' (i.e. Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) patients only – see Appendix A.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

Most healthcare professionals now agree that the risks associated with routine circumcision, such as infection and excessive bleeding, outweigh any potential benefits. According to guidance from the Royal College of Surgeons (RCS), the only absolute indications for circumcision are pathological phimosis* (the commonest cause is lichen sclerosus; balanitis xerotica obliterans [BXO] is an old fashioned descriptive term) and recurrent episodes of balanoposthitis.

Continued overleaf

According to RCS guidance, referrals from primary care for physiological phimosis account for a significant clinical workload in consultation time that could be avoided. Conservative management of the non-retractile foreskin is often under-recognised and practiced. This is of particular importance in the paediatric population where too many circumcisions are undertaken for physiological phimosis, thereby incurring avoidable morbidity. Whilst major morbidity and mortality following circumcision is very rare, these could be reduced and potentially avoided if surgical indications were more stringently applied. When physiological phimosis is diagnosed in a primary care assessment of foreskin condition, consultation should focus on reassurance and education of parents and child.

According to RCS guidance, circumcision in an adult may also be undertaken for premalignant conditions, carcinoma in situ (CIS) and for biopsy where disease other than lichen sclerosus cannot be excluded.

**Phimosis is a condition where the foreskin cannot be retracted over the glans penis; it may be physiological or pathological. Physiological phimosis refers to a normal foreskin where non-retractability is due to 'physiological' congenital adherence of the inner foreskin to the glans penis. There is no evidence of scarring. Pathological phimosis is associated with scarring of the foreskin opening leading to symptoms and non-retractability. In children up to and including 18 years of age, pathological phimosis must be distinguished from physiological adherence of the foreskin to the glans, which is normal and can be managed conservatively in most cases. The foreskin is still in the process of developing at birth and hence is often non-retractable up to the age of three years; in a small proportion of boys this natural process continues well into childhood. The proportion of partially or fully retractable foreskin at birth is 4%; 20% at 6 months; 50% at 1 year; 90% at 3–11 years; 95% at 12–13 years and 99% at 14+ years. Non-retractile ballooning of the foreskin and spraying of urine do not routinely need to be referred for circumcision although not all ballooning is related to physiological phimosis and spraying can be due to lichen sclerosus. If there is concern that any pathology is evident, or if there is diagnostic uncertainty, referral is indicated.*

7.12 Male sterilisation (vasectomy) – undertaken by a secondary care provider

Category	Restricted (prior approval required)

Background

Vasectomy (male sterilisation) is a surgical procedure, whereby the tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed with heat. This means that when a man ejaculates, the semen has no sperm and a woman's egg cannot be fertilised. A vasectomy has no effect on sex drive or ability to enjoy sex; the only difference is that the semen will not contain sperm.

Policy

This service is provided by primary/ community care, except in the following circumstance (in which case a secondary care provider will provide the service)*:

- Primary/ community care is unable to meet the needs of the patient for medical reasons. Prior approval is required for this procedure (see Appendix A).

**West Kent CCG does not routinely fund vasectomy undertaken in any settings.*

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

7.13 Penile implants

Category	Not routinely funded
Policy	

Penile implants are not routinely funded by Kent and Medway CCGs.

Commissioning responsibility for penile implants under some circumstances is with NHS England (http://www.england.nhs.uk/). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

7.14 Reversal of vasectomy

Category	Not routinely funded

Background

Vasectomy involves cutting, blocking or sealing the tubes that carry sperm from a man's testicles to the penis. Having a vasectomy should always be viewed as permanent sterilisation. This is because, although reversal is sometimes possible, it may not be successful. A reversal operation requires delicate microsurgery to join the tubes together again. Even with a successful operation, it still may not be possible to father a child.

Policy

Reversal of vasectomy is not routinely funded, where the person consented to sterilisation or where sterilisation was sanctioned in a legal ruling.

Rationale

Sterilisation is offered within the NHS as an irreversible method of contraception. Considerable time and expertise are expended in ensuring that individuals are made aware of this at the time of the procedure. Kent and Medway CCGs consider that it is inappropriate that NHS funds are used in reversing these procedures.

7.15 Upper gastrointestinal endoscopy for the investigations of dyspepsia

Category	Restricted (prior approval not required)

Background

Dyspepsia describes a range of symptoms arising from the upper gastrointestinal (GI) tract, but it has no universally accepted definition. The British Society of Gastroenterology (BSG) defines dyspepsia as a group of symptoms that alert doctors to consider disease of the upper GI tract, and states that dyspepsia itself is not a diagnosis. These symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, nausea or vomiting.

An endoscopy is a procedure, where the inside of the body is examined using a long thin, flexible tube that has a light source and a video camera at one end, called an endoscope. Images of the inside of the body are relayed to a television screen.

For an upper GI endoscopy, also known as a gastroscopy, the endoscope is inserted down the mouth and throat to look inside the oesophagus, stomach and duodenum.

Policy

Criteria for access to upper gastrointestinal (GI) endoscopy for the investigation of dyspepsia should be in line with NICE Clinical Guideline 184: *Gastro-oesophageal reflux disease and dyspepsia in adults* and NICE Guideline 12: *Suspected cancer: recognition and referral*.

Rationale

For rationale see NICE Clinical Guideline 184 and NICE Guideline 12.

7.16 Varicose veins – Referral criteria for specialist assessment

Category	Restricted (prior approval not required)

Background

Varicose veins are swollen and enlarged veins that usually occur on the legs and feet. They develop when the small valves inside the veins stop working properly. In a healthy vein, blood flows smoothly to the heart. The blood is prevented from flowing backwards by a series of tiny valves that open and close to let blood through. If the valves weaken or are damaged, the blood can flow backwards and collect in the vein, eventually causing it to be swollen and enlarged (varicose).

Policy

- Refer people with bleeding varicose veins to a vascular service immediately.
- Refer people to a vascular service if they have any of the following:
  - Suspected venous incompetence with an episode of superficial vein thrombophlebitis.
  - Lower-limb skin changes ascribed to venous disease, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
  - Late stage venous disease, e.g. severe skin changes, active (not healing) or healed ulceration, bleeding from varicose vein.
- Note that a referral to specialist services does not necessarily imply surgical management.
- The hierarchy for interventional treatment based on cost effectiveness and suitability is: endothermal ablation then ultrasound-guided foam sclerotherapy, then surgical removal.
- Transilluminated powered phlebectomy and cyanoacrylate glue occlusion are not recommended as treatment options for varicose veins as NICE IPG37 and NICE IPG526 state that current evidence on the safety and efficacy of these treatments is not adequate to support their use without special arrangements.

Continued overleaf

- Pregnant women presenting with varicose veins should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out other than in exceptional circumstances. Compression hosiery should be considered for symptom relief of leg swelling associated with varicose veins during pregnancy.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Rationale

This policy is broadly consistent with NICE Clinical Guideline 168 (2013) and NHS England EBI guidance (2018) on varicose veins with the exception that it does not recommend referral for patients with symptomatic varicose veins*.

There is no good evidence to identify patients with symptomatic varicose veins whose condition might deteriorate and who should be prioritised for treatment in the absence of complications.

Funding the referral and interventional treatment of people with symptomatic varicose veins would require substantial additional resources and funding. Kent and Medway CCGs have concluded that additional funding for this population is not currently a priority.

** Defined as veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).*