NHS
West Suffolk
Clinical Commissioning Group

THRESHOLD POLICY – T18a
HIP REPLACEMENT
(formerly T9)

Policy author:	West Suffolk CCG and Ipswich and East Suffolk CCG, with support from Public Health Suffolk.
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1. Eligibility Criteria

1.1 Patients should only be referred for consideration of hip replacement surgery for osteoarthritis if they experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life, as demonstrated by:

a) **EITHER** intense to severe persistent pain (defined in Table 1) leading to severe functional limitation (defined in Table 2) for a period of at least 3 months

b) **OR** moderate to severe functional limitation (defined in Table 2) affecting quality of life (in the opinion of the clinician(s) on the local CCG Hip Pathway) for a period of at least 3 months

c) **AFTER** having completed "Stage 2 – Preparation for Surgery" of the local CCG Hip pathway

d) **AND** the following core treatments for <u>at least 3 months</u>:

- <u>Patient education:</u> such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment
- <u>Activity and Exercise</u>: e.g. physiotherapy

e) **AND** <u>Weight loss</u>: IF the patient has a BMI>35kg/m^2 then they should have evidence of participating in a weight management programme in order to reduce the risks associated with joint replacement surgery. This should be for a period of at least 6 months prior to referral for surgery.

f) **AND** trialled appropriate Pain relief: Paracetamol-based analgesics, oral NSAIDs or COX-2 inhibitors for a minimum of 3 weeks. Opioid analgesics can be used effectively if paracetamol or NSAIDs are ineffective or poorly tolerated.

g) **AND** if the patient currently smokes then they should routinely be offered advice and support to help stop smoking, and patients should participate in a smoking cessation programme for a period of at least 3 months prior to referral for surgery.

NB: If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

1.2 Clinical exceptions to the criteria in this policy are:

a) Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this.

b) Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

1.3 Tables of pain classification and functional limitations can be found at the Appendix.

2. Rationale to the Decision

2.1 The policy has been revised in line with NICE Clinical Guideline 177 'Osteoarthritis: care and management'[4], NICE Quality Standard 87 for Osteoarthritis[5] and British Orthopaedic Association/Royal College of Surgeons commissioning guidance[6]: the duration of conservative measures (core treatments) has been reduced to at least 3 months, and the core treatments have been updated to reflect NICE guidance.

2.2 NICE Clinical Guidance 177 recommends that "Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery"[4]. However, in acknowledgement of the evidence of increased risk of post-operative complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review) and with metabolic syndrome[7], and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

3. References

Published literature that informed this policy (Please refer also to the Evidence Brief)

1. Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54.

2. Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502.

3. The International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2006. http://www.idf.org/webdata/docs/MetS_def_update2006.pdf.

4. National Institute for Health and Care Excellence. Osteoarthritis: Care and management in adults (NICE CG177). 2014. https://www.nice.org.uk/guidance/cg177/evidence/full-guideline-191761309.

5. National Institute for Health and Care Excellence. Osteoarthritis (NICE QS87). 2015. https://www.nice.org.uk/guidance/qs87.

6. British Orthopaedic Association, Royal College of Surgeons, British Hip Society. *Commissioning Guide: Pain Arising from the Hip in Adults*.; 2013. http://www.boa.ac.uk/pro-practice/pain-arising-from-the-hip-in-adults-commissioning-guide/.

7. Glance L, Wissler R, Mukamel D, et al. Perioperative outcomes among patients with the modified metabolic syndrome who are undergoing noncardiac surgery. *Anesthesiology*. 2010;113(4):859-872.

Appendix

Table 1: Classification of Pain Level[1]

Pain Level	
Slight	Sporadic pain. (May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain. (May be daily and occurs 50-75% of one's day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature. (Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches).
Severe	Continuous pain. (Occurs 100% of the time) Pain when resting. Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).

Table 2: Classification of Functional Limitations[2]

Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care. Walking capacity of between half and one hour. Aids such as a cane are needed occasionally.
Severe	Largely or wholly incapacitated. Walking capacity of less than half an hour. Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.