Surgical Threshold Policy

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

KNEE ARTHROSCOPY FOR CHRONIC KNEE PAIN

Scope

This policy covers the use of knee arthroscopy as a surgical intervention or diagnostic tool for chronic knee pain in adults. It does not cover arthroscopy recommended by an orthopaedic specialist in those under 18 years of age or in adults following acute injury* with suspected internal joint derangement, septic arthritis or suspected malignancy. Autologous chondrocyte implantation (ACI) is funded by NHS England in specialist centres as per criteria in NICE TA508.

Policy

Referral for treatment should be through the MSK service/pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma:

Primary/Community Care

Patients should be referred as per the pathway overleaf.

In patients with chronic knee pain, where evidence is provided that a comprehensive course of conservative treatment (rest, lifestyle advice, optimum pharmacological treatments and physiotherapy) has been tried for 12 months and failed, patients can be referred by physiotherapy/MSK for specialist consultation.

Where patients have true mechanical locking#, or symptoms that worsen with conservative treatment, physiotherapy/MSK may choose to make a referral after shorter periods of conservative treatment.

Referral for MRI scans should only be made by secondary care consultants or specialists working in CCG commissioned MSK services.

Secondary Care

Where a competent clinical examination or MRI scan has demonstrated clear evidence of a significant internal joint derangement which is likely to be the cause of the symptoms and suitable for treatment by knee arthroscopy, surgery will be funded.

However, the following are **Lower Clinical Priority** procedures and will not be funded without Exceptional Cases Panel approval:

1. Lavage or debridement of osteoarthritic knees, except in cases of true mechanical locking due to obstruction
2. Repair or debridement of degenerative meniscal tears, except in cases of true mechanical locking due to obstruction
3. Treatment of Patellofemoral pain syndrome
4. Use as a diagnostic tool, except in cases where there is on-going diagnostic uncertainty following both clinical examination and non-invasive imaging procedures (eg MRI) conducted by specialists.

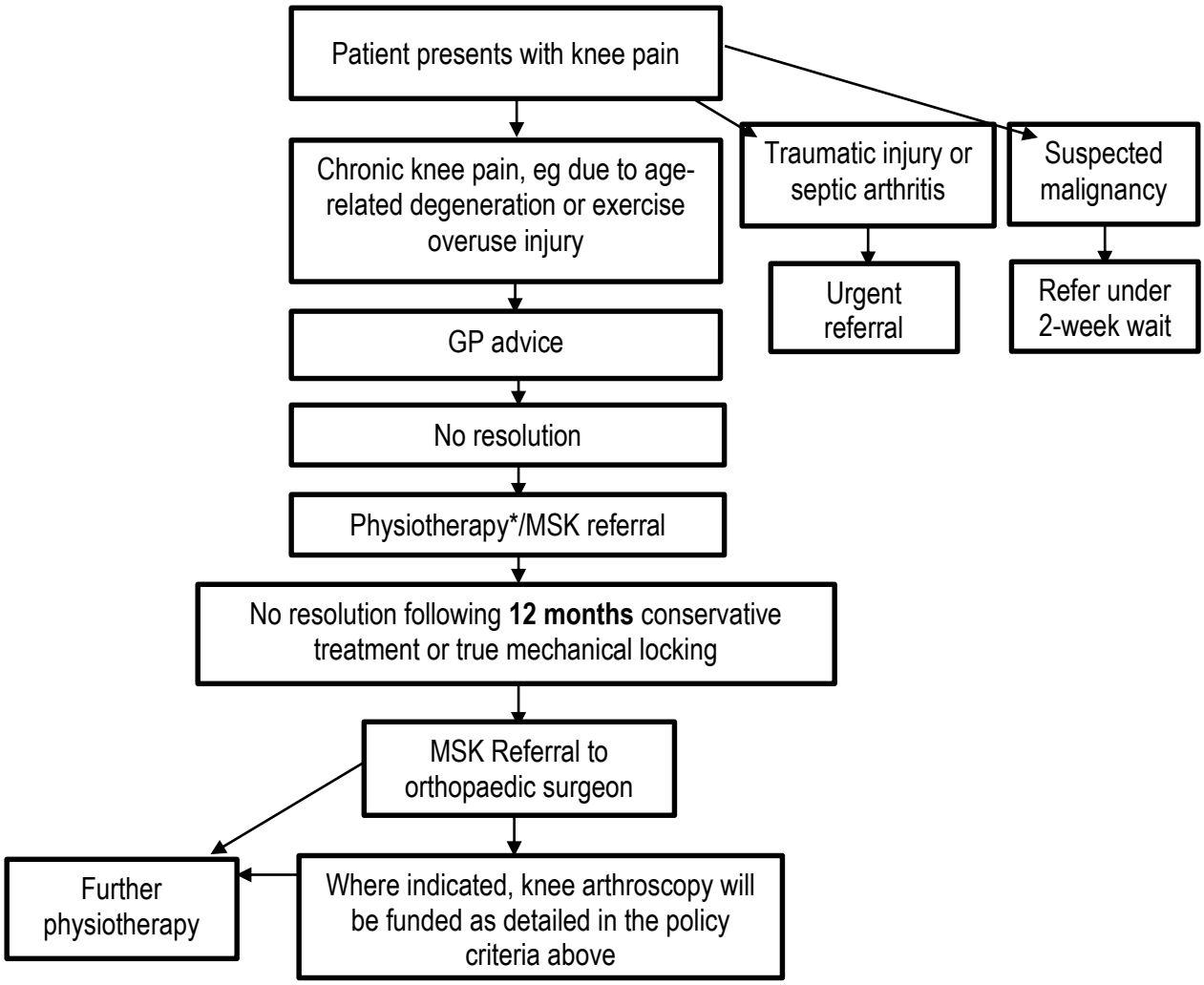
NOTE: Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – see stop smoking policy.

Patients who are overweight or obese should be offered referral to the appropriate weight management service.

* Suspected acute/traumatic onset meniscus tear should have a significant cause (eg sport, twisting while running, external force on the knee), compared to gradual onset that would be more consistent with degenerative meniscus tear.

\# An intermittent block to normal range of movement (usually extension).

Pathway



*Details available at: http://www.eoemskservice.nhs.uk/advice-and-exercises

Evidence and Rationale

Procedures that are not routinely funded

For some interventions, the evidence identifies a lack of effect and insufficient evidence to warrant their use. RCTs show some short-term (3-month) benefit but no longer-term (1-2 years) benefit of knee arthroscopy for patients with degenerative meniscal tears (repair, debridement)[1, 2].
RCTs of patients with osteoarthritis of the knees also show no benefit of lavage and/or debridement[1-4]. NICE guidance states that 'referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless there is a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).' Lavage in isolation is not indicated[5,6].

In an RCT of patients aged 35-55 years with knee pain and MRI-confirmed meniscal tear, comparing partial meniscectomy with skin incision, there was no statistically significant difference between the two groups at 2 years with both groups showing clinically relevant improvements[7]. In an RCT of patients with patellofemoral pain syndrome (18-40 years), mixed arthroscopic procedures and exercise resulted in equivalent improvements compared with exercise alone[8].

Other procedures

For arthroscopic articular cartilage surgery, including debridement of non-osteoarthritic joints, microfracture, autologous chondrocyte implantation and osteochondral autologous transplantation (Mosaicplasty), there is no robust evidence for their effectiveness[9]. Although there is an absence of evidence for the benefit of these procedures, there is currently no evidence that they have no benefit. Therefore, these procedures are not restricted as Lower Clinical Priority procedures, but patients should be treated conservatively, as per the pathway in this policy, before they are considered for surgery.

NICE IPG162 states that 'current evidence suggests that there are no major safety concerns associated with mosaicplasty for knee cartilage defects. There is some evidence of short-term efficacy, but data on long-term efficacy are inadequate. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and audit or research[10].

Restricted use of MRI

MRI is a good diagnostic tool[11], but may be inaccurate when used by less experienced staff[12] and its use is, therefore, restricted to secondary care or MSK specialists for this indication.

Numbers of People Affected

In Cambridgeshire and Peterborough, the estimated 2016/17 rate (and cost) of procedures associated with knee arthroscopy is 848 (£2,081,949) per year, equating to approximately 0.11% of the local population.

References

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6. NICE Clinical Guideline 177. Osteoarthritis: Care and management in adults. 2014.
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8. Kettunen J A, Harilainen A, Sandelin J, Schlenzka D, Hietaniemi K, Seitsalo S, Malmivaara A and Kujala U M. Knee arthroscopy and exercise versus exercise only for chronic patellofemoral pain syndrome: a randomized controlled trial. BMC Medicine 2007;5:38.
9. Devitt B M, Bell S W, Websterb K E, Fellera J A, Whitehead T S. Surgical treatments of cartilage defects of the knee: Systematic review of randomised controlled trials. The Knee 24 (2017) 508–517.
10. NICE Interventional Procedure Guidance 162. Mosaicplasty for knee cartilage defects. 2006.
11. Crawford R, Walley G, Bridgman S, Maffulli N. Magnetic resonance imaging versus arthroscopy in the diagnosis of knee pathology, concentrating on meniscal lesions and ACL tears: a systematic review. *British medical bulletin* 2007;84:5-23.
12. Bryan S, Weatherburn G, Bungay H, Hatrick C, Salas C, Parry D, et al. The cost-effectiveness of magnetic resonance imaging for investigation of the knee joint. *Health Technol Assess* 2001;5(27):1-95.
13. NICE Technology Appraisal TA508. Autologous chondrocyte implantation using chondrosphere for treating symptomatic articular cartilage defects of the knee. 2018.

Glossary

Arthroscopy:	Key-hole surgery using an arthroscope (light source and video camera).
Articular cartilage:	The cartilage covering the articular surfaces of the bones participating in a synovial joint.
Autologous chondrocyte implantation:	Harvesting of tissue from the edge of the affected knee joint which is cultured and, in a second surgical procedure, implanted into damaged areas.
Chondroplasty:	Reparative surgery of cartilage.
Debridement:	Removal of dead, damaged, or infected tissue.
Lavage:	Cleaning or rinsing.

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