NICE news in the annals

Recent NICE Guidance of interest to surgeons

Sally Hamilton and Bruce Campbell

Interventional Procedures

Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis (August 2007)

Arthroscopic surgery is commonly used in the management of symptomatic osteoarthritis of the knee. Lavage may be done alone or in conjunction with debridement. However, there is uncertainty about whether simply washing out the knee joint is an effective treatment. There is also debate about which patients might benefit most from this procedure. One randomised controlled trial (RCT) which compared washout alone, washout with debridement and a sham procedure showed no differences in pain or knee function. Another RCT, which compared washout alone with washout and debridement, found that washout alone was not as effective for reducing pain as the combined procedure. Based on lack of efficacy, NICE recommended that washout alone should not be used in the treatment of osteoarthritis of the knee. When done as part of an arthroscopic debridement procedure, the evidence was adequate to recommend use with normal governance, consent and audit arrangements.

Laparoscopic deroofing of simple renal cysts (July 2007)

Since most renal cysts do not require treatment, NICE highlighted the importance of patient selection for this procedure. The evidence base included five case series of 155 patients in total, with symptomatic simple renal cysts. At follow-up, 91–100% of patients were free of symptoms (such as pain, urinary tract infections and haematuria). Specialist advisers pointed out that cyst recurrence was a potential problem and this was reported in small percentages of patients in most of the studies. The highest rate of cyst recurrence was 19% (among 36 patients after 67 months of follow-up). Overall, the evidence was considered adequate to support the use of this procedure with normal arrangements for governance, consent and audit. However, it was recommended that clinicians should assess the effect of aspirating cysts to predict whether deroofing is likely to relieve symptoms before performing the procedure.

Magnetic resonance image-guided transcatheter focused ultrasound ablation for uterine fibroids (September 2007)

Symptoms of uterine fibroids that do not respond to medical therapy are commonly treated by myomectomy or hysterectomy. However, many women would prefer less radical treatment and, in particular, an option which allows them to retain their womb. In MRI-guided transcatheter focused ultrasound ablation, high-power ultrasound is directed at the centre of the fibroid through the skin while the patient is under conscious sedation. Reports of the procedure describe facilities for the patient to inform the operator if they experience unacceptable pain so that ultrasound parameters can be altered. Pain relating to the ultrasound occurred in about 25% of participants in one study. The evidence on this procedure was based on limited numbers of patients and short-term follow-up. About 30% of patients required alternative treatments within a few months. These considerations led NICE to publish cautious guidance, recommending that the procedure should only be performed with special arrangements for consent and for audit or research.

Laparoscopic repair of abdominal aortic aneurysm (August 2007)

Open surgical repair or endovascular stent grafting are now the usual treatment options for large, unruptured abdominal aneurysms. Laparoscopic aneurysm repair, either by totally laparoscopic surgery or hand-assisted laparoscopic surgery, was recently notified to NICE and reviewed. This procedure presents particular technical challenges and has the potential for serious complications. NICE, therefore, recommended that the laparoscopic approach should only be performed with special arrangements for audit or research. The guidance stipulated a need for training in advanced laparoscopic surgical techniques and for mentoring. It also recommended that patients should be warned of the possible need for conversion to open operation.

Serial transverse enteroplasty procedure (STEP) for bowel lengthening in parenteral nutrition dependent children (September 2007)

In this procedure, an endoscopic stapler is passed through the mesentery and used to staple and dissect the bowel simultaneously (perpendicular to its long axis) on alternate sides leaving a zig-zag appearance. This decreases the width of the bowel and increases its length, so optimising the surface area for absorption. Data were available on the use of the STEP procedure in 53 children. These case series did not highlight any major safety concerns and reported efficacy outcomes which compared favourably with those of other (more complex) surgical procedures. However, due to the small patient numbers, NICE recommended special attention to consent and also submission of all patients to an international register based in the US.

Clinical Guidelines

None.

Other Guidance

Between July and September 2007, NICE published further guidance of relevance to surgery (listed below) which could not be summarised here. Please refer to the NICE website (<www.nice.org.uk>) for details.

Interventional Procedures guidance

- Corneal implants for keratoconus
- Corneal implants for the correction of refractive error
- Insertion of extra-urethral (non-circumferential) retropubic adjustable compression device for stress urinary incontinence in men
- Laparoscopic cerclage for prevention of recurrent pregnancy loss due to cervical incompetence.

Technology appraisals

- Haemorrhoid – stapled haemorrhoidopexy (please also see the article below for more information).

NICE technology appraisal on stapled haemorrhoidopexy for the treatment of haemorrhoids

Helen Tucker, Elisabeth George, David Barnett, Carole Longson

This article outlines the recommendations, the clinical and cost-effectiveness evidence and the Appraisal Committee's considerations for the recently published NICE technology appraisal on stapled haemorrhoidopexy for the treatment of haemorrhoids.¹

Estimates of the proportion of the UK population affected by haemorrhoids range from 4.4–24.5%. In 2004–2005, approximately 23,000 procedures listed as 'main operations on haemorrhoids' were performed in England and Wales.

Haemorrhoids are classified as 'first-degree' if they bleed but do not prolapse; second-degree haemorrhoids prolapse during bowel movements, and reduce spontaneously; third-degree haemorrhoids prolapse on straining and require manual reduction; fourth-degree haemorrhoids prolapse and cannot be manually reduced. Surgery is the usual treatment for third and fourth degree haemorrhoids that have not responded to non-surgical interventions and for full circumferential second degree haemorrhoids.

The most commonly conducted surgical techniques are the Milligan–Morgan or Ferguson haemorrhoidectomy. The Milligan–Morgan procedure involves dissection of the haemorrhoid and ligation of the vascular pedicle with the wounds being left open to heal naturally. Healing is frequently delayed, which may result in discomfort and prolonged postoperative morbidity. The Ferguson procedure is a modified version of the Milligan–Morgan technique, in which the wound is closed with a continuous suture to promote healing. Another, less frequently used procedure is the Parks submucosal haemorrhoidectomy, which uses intra-anal incisions directly over each haemorrhoid, with the underlying haemorrhoidal tissue excised.

Stapled haemorrhoidopexy is a technique that reduces the prolapse of haemorrhoidal tissue by excising a band of the prolapsed anal mucosal membrane above the dentate line, using a specially designed circular stapling device. This interrupts the blood supply to the haemorrhoids and reduces the potential for available rectal mucosa to prolapse. Stapled