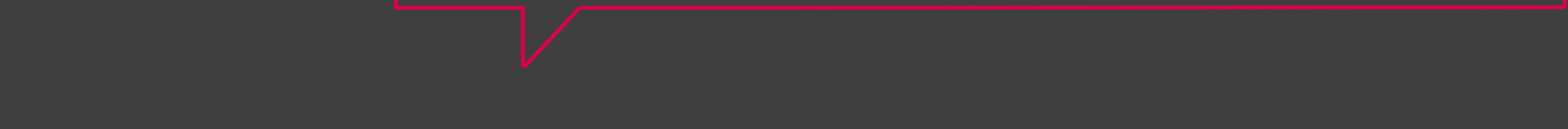


# Evidence-based Interventions – Wave two

## Surgery and devices

Introduction from Helen Stokes-Lampard, Chair of  
the AoMRC

Prof Martin Marshall  
Prof Sir Terence Stephenson  
Dr Aoife Molloy





## Patient empowerment and improving shared decision-making

National EBI guidance provides recommendations on gold-standard care, but this should still be tailored to individuals. Each patient should have an individual-level discussion with their doctor and supported in shared decision-making for their own treatment and care.

## Prioritisation of care to support COVID-19 recovery and reduce patient harm

EBI guidance is based on NICE and NICE-accredited guidance and makes up to date recommendations based on the best available evidence. Implementation of the EBI guidance can aid national plans for COVID-19 recovery by supporting decision-making.

## Access to evidence-based tests, treatments and procedures

Due to the increased pressures on the health and care system following the COVID-19 pandemic access to health and social care may be reduced, including for the interventions we are proposing and their alternatives (for example, physiotherapy and community based care). We are working with NICE, patients and clinicians to ensure the best available evidence is put into practice and patients have the best possible outcomes.

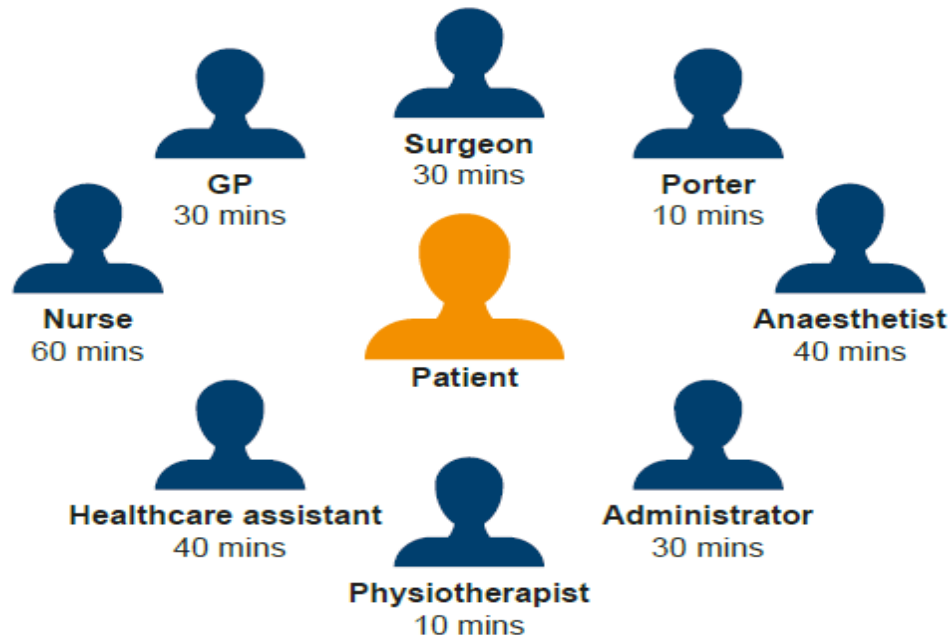
## Data analysis

Measuring uptake of guidance is always challenging. We are continuously improving our data analysis and feedback in collaboration with NHS Digital, GIRFT, HQIP and commissioners and CSUs and welcome any suggestions you can share with us.

---

# Knee arthroscopy for patients with osteoarthritis

**Knee arthroscopy should not be used as treatment for osteoarthritis because it is clinically ineffective**



Average NHS time taken for 1 procedure: **370mins** per patient  
In 2017/18 we carried out **3,432** procedures which amounts to **881 days**

A clinically-led Expert Advisory Committee was established in May 2019 to provide independent leadership, advice and guidance to the EBI programme.

## Committee membership

### Chairs

- Professor Sir Terence Stephenson, Chair of the Health Research Authority
- Professor Martin Marshall, Chair of the Royal College of General Practitioners

### Membership includes

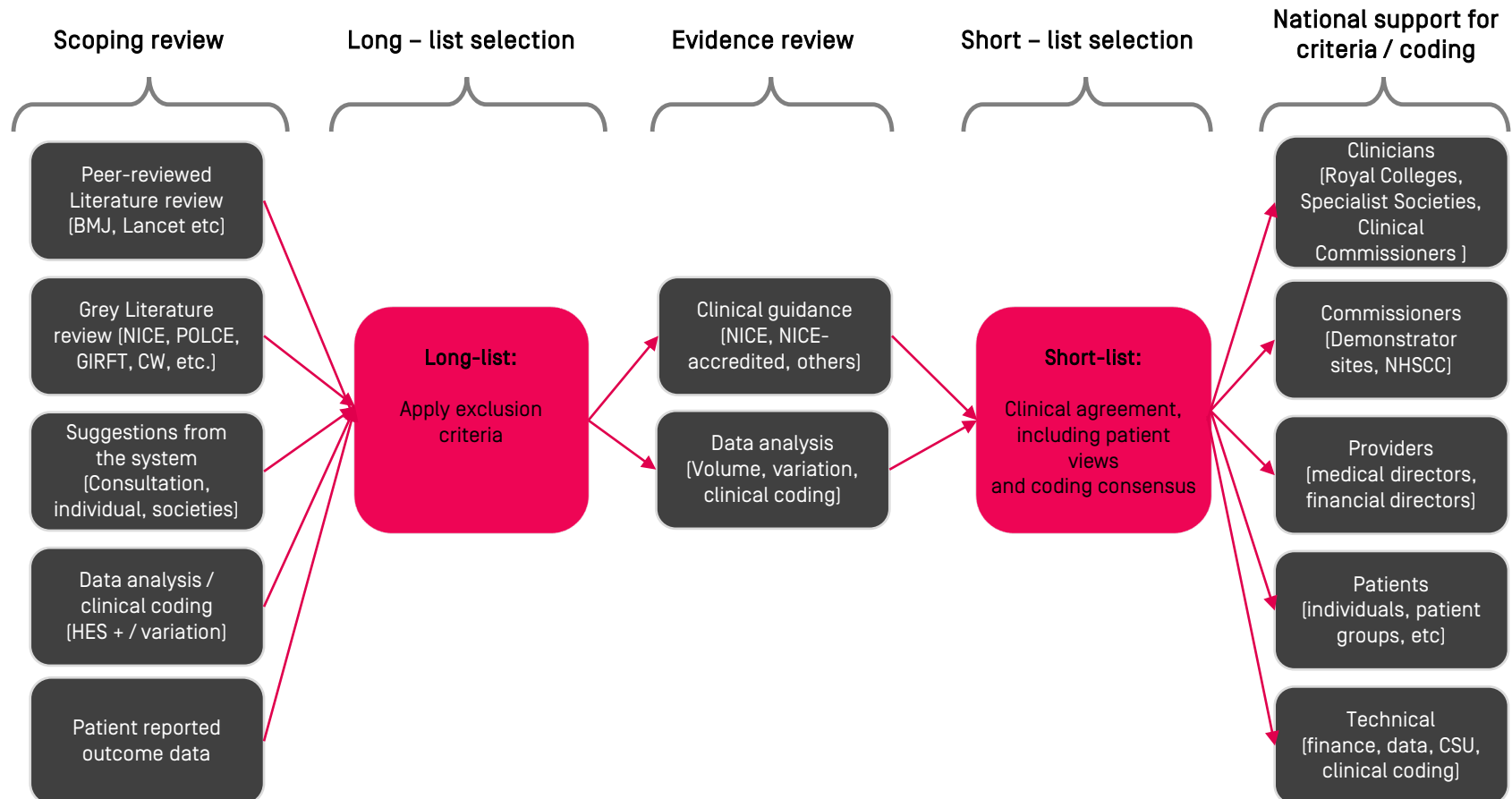
- Patient voices
- Senior clinicians
- Experts on public health
- Clinical commissioners
- Experts on value in healthcare
- Guideline producers

## Committee mandate

### The committee was asked to

- Recommend a list of interventions proven to be inappropriate based on clinical evidence
  - Draft clinical guidance based on rigorous evidence and stakeholder consensus
  - Lead engagement programme with relevant Medical Royal Colleges and sub-specialty groups, patient groups and the public
  - Maximise implementation of evidence-based guidance
-

## Process for shortlisting



We have worked with many clinical and patient stakeholder groups over the past year and would welcome continued feedback and input as we continue to develop the guidance now.

Medical Royal Colleges	Sub-speciality groups	Sub-speciality groups
Royal College of Anaesthetists	Association of Surgeons of Great Britain & Ireland	British Society of Cardiovascular Imaging and British Society of Cardiac Computed Tomography
Royal College of General Practitioners		
Royal College of Paediatrics & Child Health	Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland	British Society of Gastroenterologists
Royal College of Pathologists	British Association for Paediatric Otolaryngology	British Society of Gastrointestinal and Abdominal Radiology
Royal College of Physicians		
Royal College of Radiologists	British Association of Perinatal Medicine	British Society of Haematology
Royal College of Surgeons of England and Federation of Surgical Societies	British Association of Otorhinolaryngology [ENT UK]	British Society of Interventional Radiology
	British Association of Urological Surgeons	British Society of Thoracic Imaging
Patient organisations	British Blood Transfusion Society	Craniofacial Society of GB&I
Bladder Health UK	British Cardiology Society	Great Britain and Ireland Hepato Pancreato Biliary Association
Versus Arthritis	British Medical Ultrasound Society	Faculty of Pain Medicine
Prostate Cancer UK	British Orthopaedic Association inc.	Pancreatic Society of GB&I
GUTS UK	BASK, BASS, BESS, BHS	Society of British Neurological Surgeons
Chartered Society of Physiotherapists	British Society of Cardiovascular Imaging/ Cardiac Computed Tomography	
British Heart Foundation		

# Participate in the engagement and next steps

---

There will be several online events so the public can comment on the proposals. We would encourage you to attend any of interest to you.

## Engagement events

- Today is the first of three intervention-focused events looking at 13 proposals on surgery and devices

### The next intervention-focused events will be

- 11 August, radiology and cardiology
- 18 August, pathology and other investigative procedures

### Additionally there will be

- Data-focused event (19 August)
- Three patient-focused workshops led by the Patients Association (13, 18, 20 August)

Please get in touch at [ebi@aomrc.org.uk](mailto:ebi@aomrc.org.uk) if you would like to join any of these events or if you have any comments/ questions on the proposals.

## Next steps

- All responses to the engagement will be considered and analysed
  - A final recommendation will be submitted to the EBI programme partners by the Committee
-

The focus of today's webinar are surgical interventions and devices. You can still use Slido to choose the intervention(s) you would like to talk about more later.

- Diagnostic coronary angiography for low risk, stable chest pain
- **Repair of minimally symptomatic inguinal hernia**
- **Surgical intervention for chronic sinusitis**
- **Removal of adenoids**
- **Arthroscopic surgery for meniscal tears**
- Troponin test
- **Surgical removal of kidney stones**
- Cystoscopy for men with uncomplicated lower urinary tract symptoms
- **Surgical intervention for benign prostatic hyperplasia**
- **Discectomy**
- **Radiofrequency facet joint denervation**
- Exercise ECG for screening for coronary heart disease
- Upper GI endoscopy
- Appropriate colonoscopy
- Repeat Colonoscopy
- ERCP in acute gallstone pancreatitis without cholangitis
- **Cholecystectomy**
- **Appendicectomy without confirmation of appendicitis**
- Low back pain imaging
- Knee MRI when symptoms are suggestive of osteoarthritis
- Knee MRI for suspected meniscal tears
- **Vertebroplasty for painful osteoporotic vertebral fractures**
- Imaging for shoulder pain
- MRI scan of the hip for arthritis
- **Fusion surgery for mechanical axial low back pain**
- **Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children**
- Pre-operative chest x-ray
- Pre-operative ECG
- Prostate-specific antigen (PSA) test
- Liver function, creatinine kinase and lipid level tests – [Lipid lowering therapy]
- Blood transfusion



## Webinar One

### Surgery and devices

ENT

Orthopaedics: Knee

Urology

Orthopaedics: Back

Paediatrics

General surgery



ENT

# Surgery for sinusitis

Surgical intervention for chronic sinusitis is rarely indicated (Group A)

## Rationale

Endoscopic sinus surgery should only be considered where medical treatment has failed. Surgery carries some risks that include bleeding, infection, scar tissue formation, and very rarely orbital injuries or cerebrospinal fluid leak [with associated risk of meningitis]. There is also a risk of recurrent symptoms and ongoing medical treatment to maintain symptom improvement after endoscopic sinus surgery.

First-line treatment for sinusitis is with maximal medical therapy which should include intranasal steroids and nasal saline irrigation. In the case of chronic rhinosinusitis with Nasal Polyposis [CRSwNP] a trial of a short course of oral steroids should also be considered.

## Avoidable harms

Bleeding, infection, scar tissue formation, very rarely orbital injuries or cerebrospinal fluid leak. risks associated with sedation/anaesthetic

## Alternatives

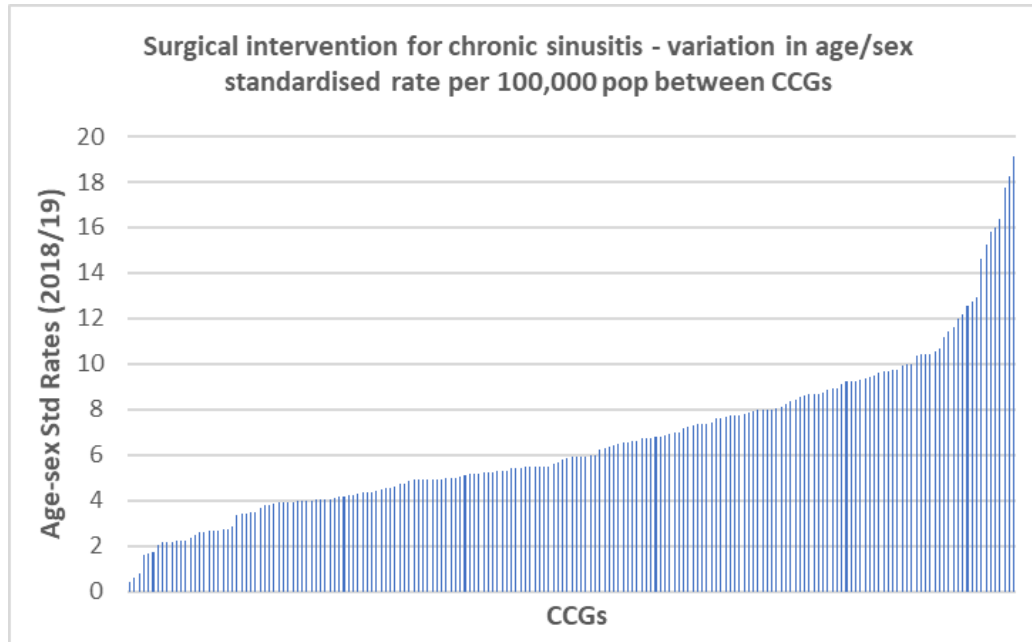
Medication

## Wider impacts

The majority of this surgery is performed by specialised ENT surgeons, therefore its important to work alongside ENT UK as well as referring GPs to raise awareness of evidence-based practice and ensure patients do not receive inappropriate treatment

# Surgery for sinusitis

Surgical intervention for chronic sinusitis is rarely indicated (Group A)



## Activity

- 3,914 episodes during 2018/19
- Age/sex std rate per 100,000 – 6.6
- Reduction opportunity: 1,568 [40%]  
based on 25<sup>th</sup> percentile of activity  
across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 3.9
  - 10<sup>th</sup> percentile – 2.7
  - 25<sup>th</sup> percentile – 4.2
  - 50<sup>th</sup> percentile – 5.9
  - 90<sup>th</sup> percentile – 10.4

# Further questions on ENT?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
  2. If you agree with the suggested thresholds and codes
  3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?
-

# Urology

# Surgical removal of kidney stones

Treatment for kidney stones should be offered according to evidence-based guidance [Group A]

## Rationale

The optimal management of kidney stones depends on the type, size and location of the stone as well as patient factors such as co-morbidity and pregnancy.

Some stones can be observed to see if they pass spontaneously. However, where intervention is indicated, shockwave lithotripsy [SWL] should be considered as first-line treatment unless contraindicated. SWL is non-invasive and therefore has fewer major adverse events than surgery. Where SWL is not appropriate or ineffective, surgical techniques such as ureteroscopy [URS] and percutaneous stone surgery can be considered.

## Avoidable harms

Varies depending on modality selected

## Alternatives

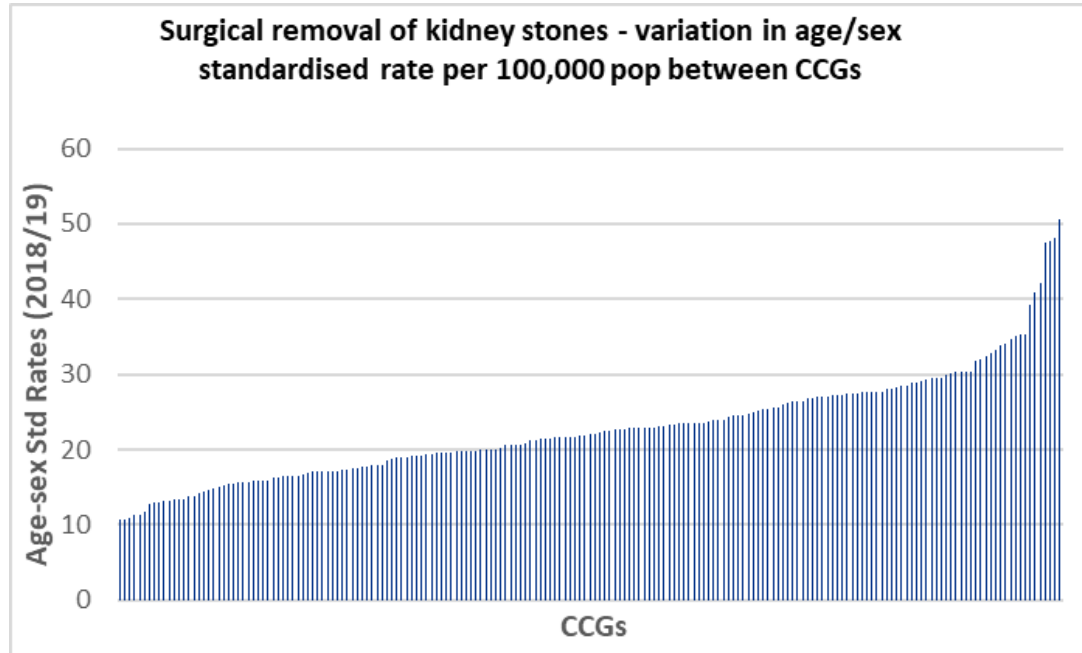
Watch and wait, non-invasive treatment

## Wider impacts

As identified by GIRFT, appropriate facilities and operating skills may not be available for SWL, therefore national recommendations must ensure specialists align and support training

# Surgical removal of kidney stones

Treatment for kidney stones should be offered according to evidence-based guidance [Group A]



## Activity

- 14,457 episodes during 2018/19
- Age/sex std rate per 100,000 – 24.3
- Reduction opportunity: 3,220 [22%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 2.1
  - 10<sup>th</sup> percentile – 14.8
  - 25<sup>th</sup> percentile – 17.6
  - 50<sup>th</sup> percentile – 22.0
  - 90<sup>th</sup> percentile – 30.4



# Surgical intervention for enlarged prostate

Surgical intervention for Benign Prostatic Hypertrophy should only be offered according to evidence-based guidance [Group A]

## Rationale

Surgery should only be offered to men with severe voiding symptoms, or in whom conservative management options and drug treatment have been unsuccessful. Complications of the intervention vary and include discomfort, bleeding, and rarely urinary incontinence.

Men considering surgical intervention should be counselled thoroughly regarding alternatives to and outcomes from surgery.

## Avoidable harms

Temporary discomfort, occasionally pain, haematuria, small risks of infection following catheter removal, risk of sexual dysfunction, risks associated with sedation/anaesthetic

## Alternatives

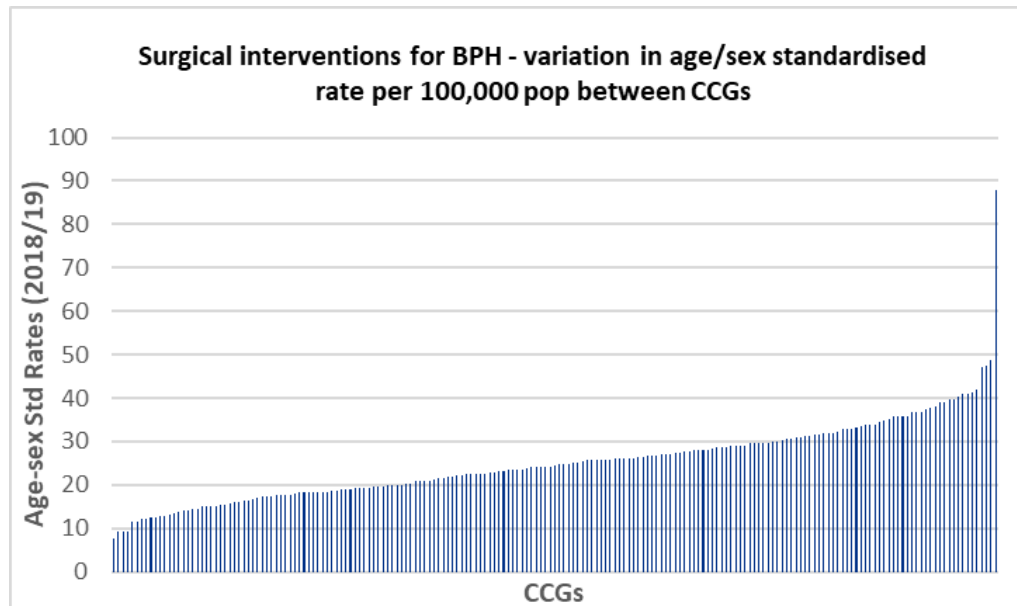
Lifestyle interventions, medication

## Wider impacts

It is important that we ensure continued awareness of men's health, therefore our messaging is aligned with Prostate Cancer UK and the national screening programme

# Surgical intervention for enlarged prostate

Surgical intervention for Benign Prostatic Hypertrophy should only be offered according to evidence-based guidance [Group A]



## Activity

- 14,562 episodes during 2018/19
- Age/sex std rate per 100,000 – 24.5
- Reduction opportunity: 4,096 [28%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 2.4
  - 10th percentile – 15.0
  - 25th percentile – 18.7
  - 50th percentile – 24.4
  - 90th percentile – 36.0

# Further questions on urology?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. If you agree with the suggested thresholds and codes
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?



# Paediatrics



---

# Removal of adenoids

Removal of the adenoids is rarely indicated [Group A]

## Rationale

NICE guidance recommends that adjuvant adenoidectomy should not be performed for the treatment of glue ear in the absence of persistent and/or frequent upper respiratory tract symptoms. The benefit in hearing compared to grommets alone is very limited. Risks of adenoidectomy include damage to teeth, lips or gums, bleeding (usually only minor and self-resolving), and rarely speech problems.

Adenoidectomy is indicated in some children as described in this guidance, for example where the child has persistent and/or frequent upper respiratory tract symptoms.

## Avoidable harms

Damage to teeth, lips or gums, bleeding (usually only minor and self-resolving), speech problems (rarely), risks associated with sedation/anaesthetic

## Alternatives

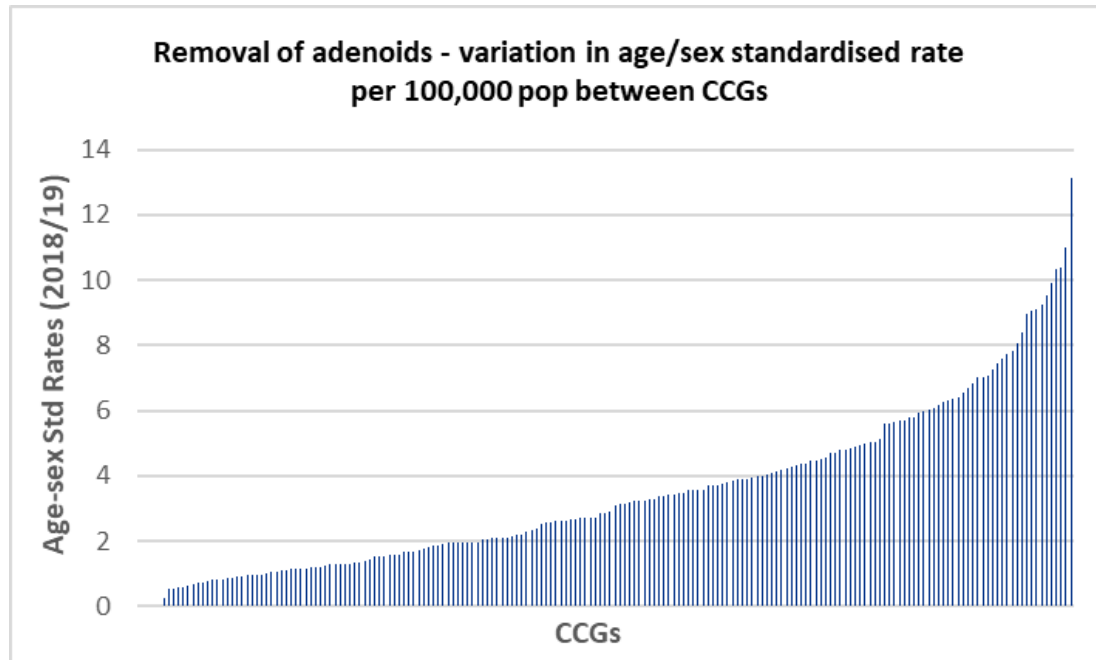
Watch and wait, medication

## Wider impacts

Potentially impacts a small group of children with hearing difficulty, therefore it's important to work with relevant specialists to ensure all children receive appropriate evidence-based care and none are disadvantaged by assessing the impact of implementation through data

# Removal of adenoids

Removal of the adenoids is rarely indicated [Group A]



## Activity

- 1,921 episodes during 2018/19
- Age/sex std rate per 100,000 – 3.2
- Reduction opportunity: 1,131 [59%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 8.0
  - 10th percentile – 0.9
  - 25th percentile – 1.5
  - 50th percentile – 2.9
  - 90th percentile – 7.0

# Helmet therapy to reshape flat heads in babies

Helmet therapy is not recommended in the treatment of non-synostotic/positional plagiocephaly and brachycephaly in babies (Group C)

## Rationale

Helmet therapy should not be used to reshape flat heads in babies because they are not proven to affect the natural course of skull growth. Helmet therapy may be associated with significant risks such as pain and pressure sores and may adversely affect the bond between baby and parents.

Instead, pressure can be reduced on the flattened head by changing baby's position while awake.

## Avoidable harms

Pain, pressure sores, parent/baby bonding

## Alternatives

Change sleeping position

## Wider impacts

Ensure guidance is communicated clearly and emphasise that this recommendation is addressing the shape of the skull and not addressing developmental delay in children

# Further questions on paediatrics?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
  2. If you agree with the suggested thresholds and codes
  3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?
-



# Orthopaedics: knee

# Surgery to treat knee problems

Arthroscopic surgery for meniscal tears should be performed following the published BASK clinical guidelines [Group A]

## Rationale

Most patients with a degenerate meniscal tear should not have arthroscopic meniscectomy as first-line treatment but should instead be treated non-operatively. Non-operative treatment is highly effective and may involve patient education, physiotherapy, weight-loss interventions and muscle strengthening exercises. Paracetamol and topical NSAIDs should be first-line pharmacological management strategies. Many patients treated this way will improve and do not require surgery.

However in the following situations arthroscopic meniscal surgery is indicated: patients with a repairable meniscal tear, patients with a locked knee, and patients with mechanical symptoms and a MRI proven unstable meniscal tear that does not respond to three months of non-operative treatment. Arthroscopic meniscectomy carries a small risk of serious complications including risk of infection and deep vein thrombosis.

## Avoidable harms

Infection, deep vein thrombosis, risks associated with sedation/anaesthetic

## Alternatives

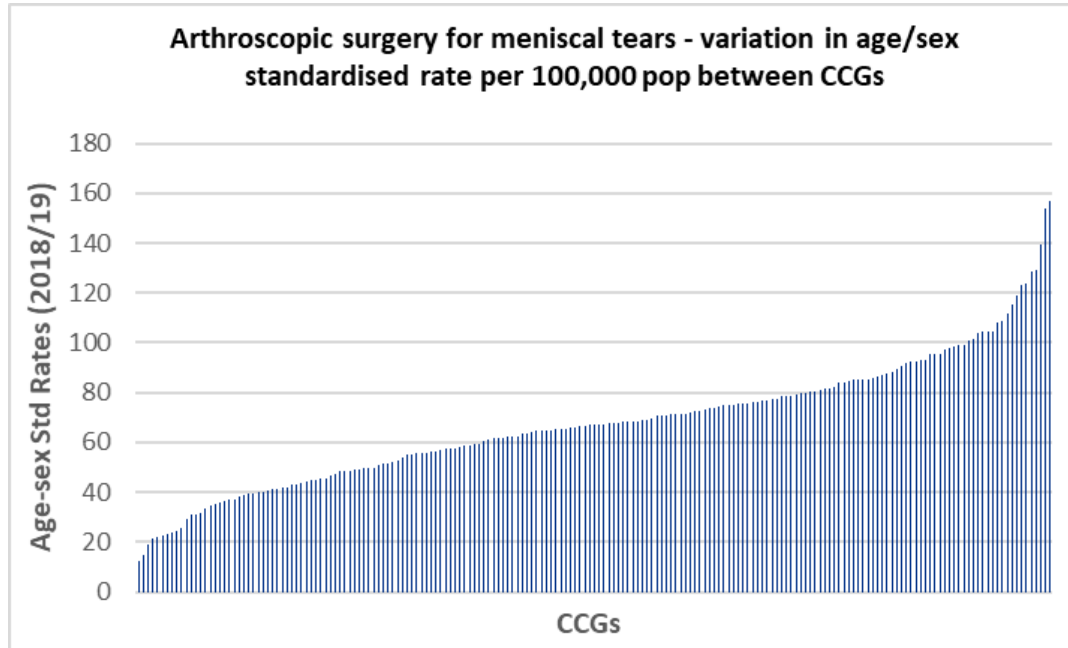
Lifestyle interventions, medication

## Wider impacts

This could cause increased pressure on primary care for those with chronic pain issues, however work with pain services, physiotherapy and other community services to reduce pressure

# Surgery to treat knee problems

Arthroscopic surgery for meniscal tears should be performed following the published BASK clinical guidelines [Group A]



## Activity

- 38,106 episodes during 2018/19
- Age/sex std rate per 100,000 – 64.1
- Reduction opportunity: 10,597 [28%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 2.7
  - 10th percentile – 36.8
  - 25th percentile – 49.7
  - 50th percentile – 67.0
  - 90th percentile – 99.0

# Further questions on knee interventions?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. If you agree with the suggested thresholds and codes
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

# Orthopaedics: back

# Spinal surgery for a slipped disc

Discectomy is only recommended in carefully selected patients according to evidence-based guidance [Group A]

## Rationale

Discectomy should only be offered to patients with compressive nerve root signs and symptoms lasting more than six weeks despite best efforts with non-operative management. Complications of discectomy include dural tear, nerve root damage, bleeding and infection. Generally, the symptoms of radiculopathy will settle with non-operative treatment.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, physiotherapy and screening patients who are high risk of developing chronic pain [i.e. STaRT Back].

## Avoidable harms

Dural tear, nerve root damage, bleeding, infection, risks associated with sedation/anaesthetic

## Alternatives

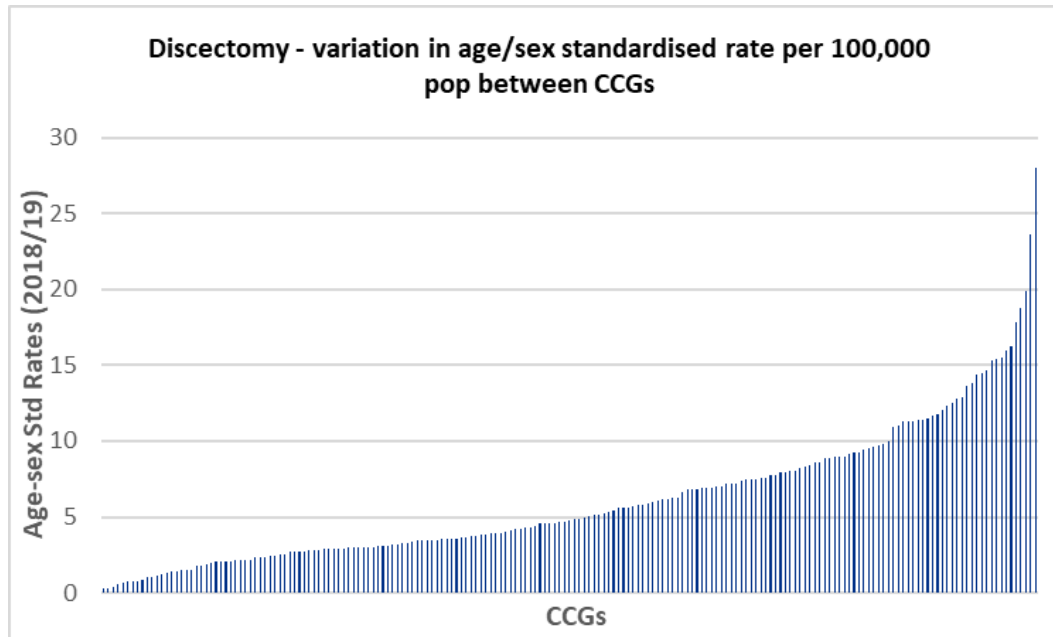
Lifestyle interventions, physiotherapy, medication

## Wider impacts

Back pain is a major factor in chronic pain, absence from work and health care utilisation, therefore its important to work with relevant specialists to treat back pain in line with the National Back Pain Pathway

# Spinal surgery for a slipped disc

Discectomy is only recommended in carefully selected patients according to evidence-based guidance (Group A)



## Activity

- 3,488 episodes during 2018/19
- Age/sex std rate per 100,000 – 5.9
- Reduction opportunity: 1,942 [56%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 6.7
  - 10th percentile – 1.8
  - 25th percentile – 2.9
  - 50th percentile – 4.8
  - 90th percentile – 12.1

# Surgery to fuse the bones in the back

Spinal fusion is not indicated for the treatment of non-specific, mechanical back pain (Group B)

## Rationale

Fusion of the spine is not recommended as treatment for mechanical axial back pain in the absence of a focal structural pathology and concordant mechanical or neurological symptoms. Complications of the intervention include infection, bleeding and sometimes pseudarthrosis where the fusion doesn't work and back pain returns.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, physiotherapy and screening patients who are high risk of developing chronic pain [i.e. STaRT Back].

## Avoidable harms

Infection, bleeding, return of pain, risks associated with sedation/anaesthetic

## Alternatives

Lifestyle interventions, physiotherapy, medication

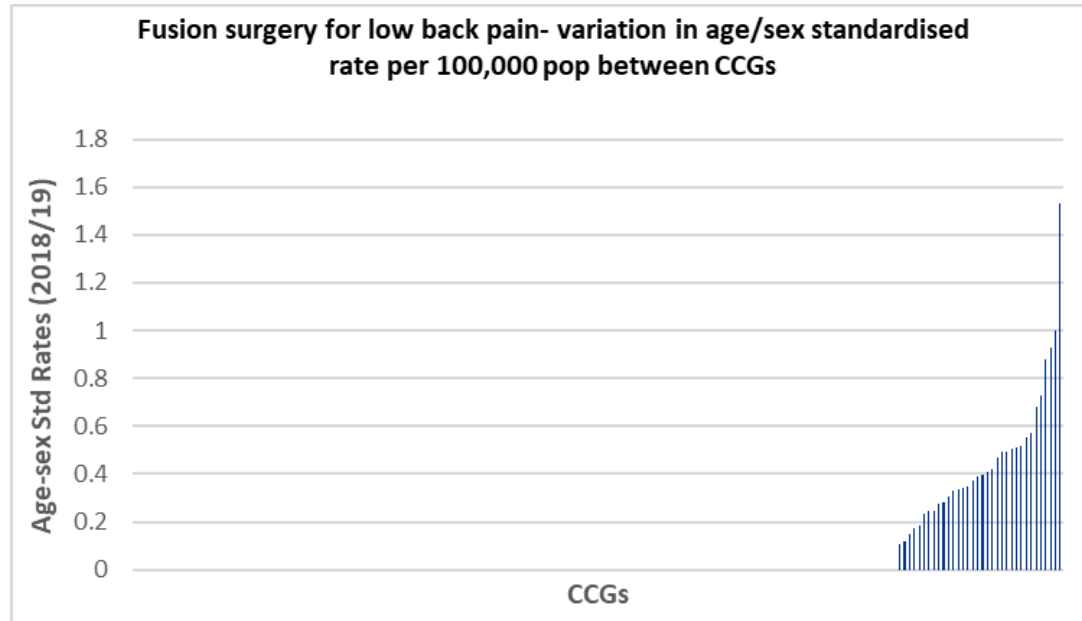
## Wider impacts

Bone pain is challenging and patient/clinicians will need to seek solutions, therefore the relevant specialists as well as primary and community care will need to ensure pain is managed appropriately



# Surgery to fuse the bones in the back

Spinal fusion is not indicated for the treatment of non-specific, mechanical back pain [Group B]



## Activity

- 41 episodes during 2018/19
- Reduction opportunity (if activity reduced to 25th percentile) – NA
- Age/sex std rate per 100,000 – 0.1

## Variation

- Variation [age/sex std rates]:
- N-fold – not calculated

# Radiofrequency facet joint denervation for low back pain

Radiofrequency facet joint denervation is rarely indicated [Group A]

## Rationale

Radiofrequency facet joint denervation is only recommended as an adjunct in the management of chronic lower back pain when non-operative treatment has failed, and the main source of pain is thought to arise from one or more degenerate facet joints. Risks of facet joint injections include bleeding and infection, or rarely nerve or spinal cord damage.

Physiotherapy, with appropriate psychological therapies where necessary, should be considered as an early intervention to support the individual.

## Avoidable harms

Bleeding, infection, nerve or spinal cord damage

## Alternatives

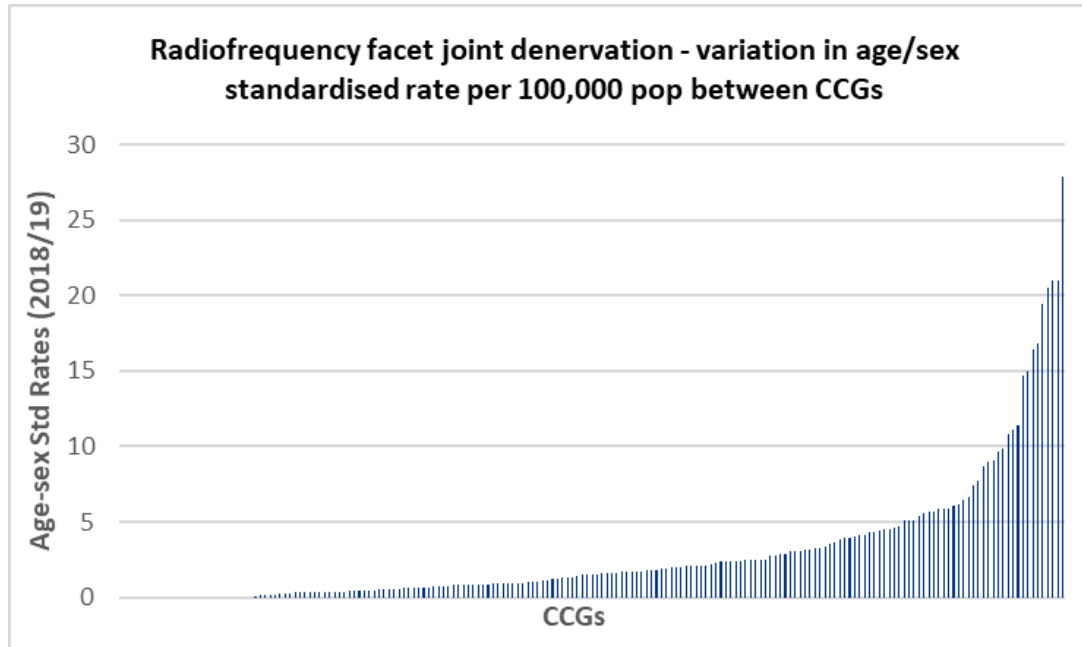
Physiotherapy, lifestyle interventions

## Wider impacts

Back pain is a major factor in chronic pain, absence from work and health care utilisation, therefore its important to work with relevant specialists to treat back pain in line with the National Back Pain Pathway

# Radiofrequency facet joint denervation for low back pain

Radiofrequency facet joint denervation is rarely indicated [Group A]



## Activity

- 1,618 episodes during 2018/19
- Age/sex std rate per 100,000 – 2.7
- Reduction opportunity: 1,247 [77%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 21.6
  - 10th percentile – 0.4
  - 25th percentile – 0.8
  - 50th percentile – 1.9
  - 90th percentile – 8.4

N.B. CCGs with zero activity were excluded in the n-fold calculation for this intervention

# Vertebroplasty to build up brittle spine bones

vertebroplasty should not be routinely offered for painful osteoporotic vertebral fractures (Group B)

## Rationale

Vertebroplasty should not be routinely offered as a treatment for painful osteoporotic vertebral fractures. Risks related to vertebroplasty include cement leakage which can cause pulmonary embolism, and nerve or cord compression. The procedure may be complicated by haemorrhage, infection, rib or sternal fracture or haemo- or pneumothorax.

Conservative management should instead be offered including pain relief, bracing, and physiotherapy and normal healing takes place over 2-12 weeks.

## Avoidable harms

Cement leakage, nerve/ cord compression, haemorrhage, infection, bleeding, fractures, haemo- or pneumothorax

## Alternatives

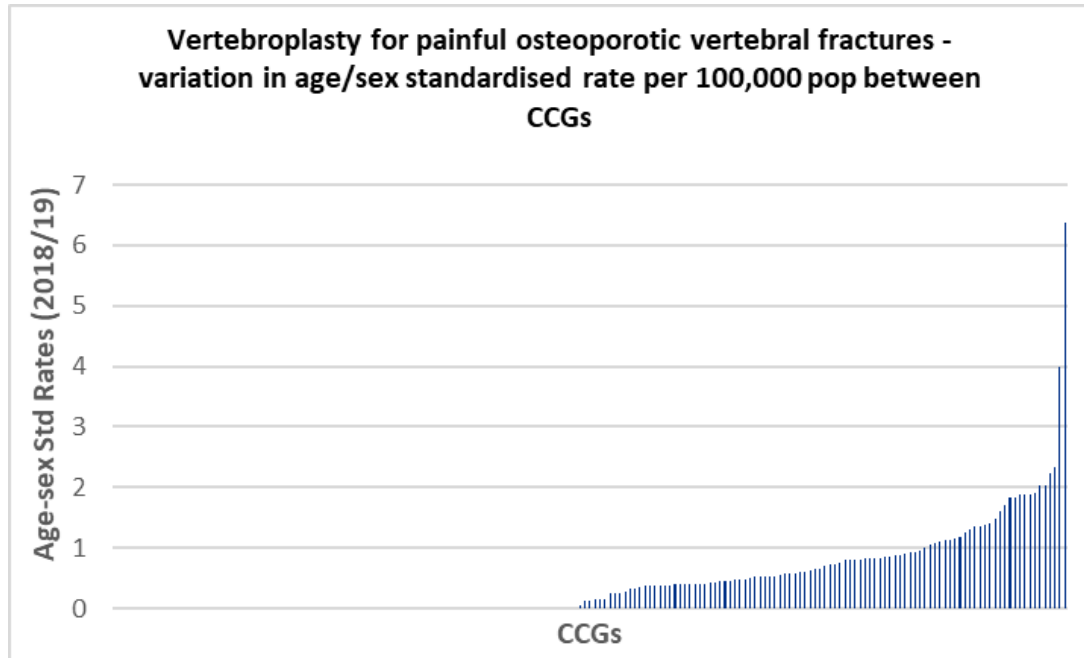
Lifestyle interventions, physiotherapy, medication

## Wider impacts

Bone pain is challenging and patient/clinicians will need to seek solutions, therefore the relevant specialists as well as primary and community care will need to ensure pain is managed appropriately

# Vertebroplasty to build up brittle spine bones

Vertebroplasty should not be routinely offered for painful osteoporotic vertebral fractures [Group B]



## Activity

- 304 episodes during 2018/19
- Age/sex std rate per 100,000 – 0.5
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated.

## Variation

- Variation [age/sex std rates]:
- N-fold – not calculated for interventions where the age-sex standardised rate in the 10th percentile is zero.

# Further questions on back interventions?



Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. If you agree with the suggested thresholds and codes
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?



# General surgery

# Removal of an inflamed gallbladder

Cholecystectomy should be considered on the same admission as acute cholecystitis or gallstone pancreatitis [Group B]

## Rationale

In patients with acute cholecystitis or gallstone pancreatitis, remove the gallbladder without discharging the patient. This reduces the rate of recurrent gallstone-related complications such as Gram-negative blood stream infections in patients with mild gallstone pancreatitis and carries a very low risk of cholecystectomy-related complications.

In patients with mild biliary pancreatitis, same-admission cholecystectomy reduces the rate of recurrent gallstone-related complications significantly from 17% to 5%.

## Avoidable harms

Bile leak, bleeding, infection, risks associated with sedation/anaesthetic

## Alternatives

Watch and wait

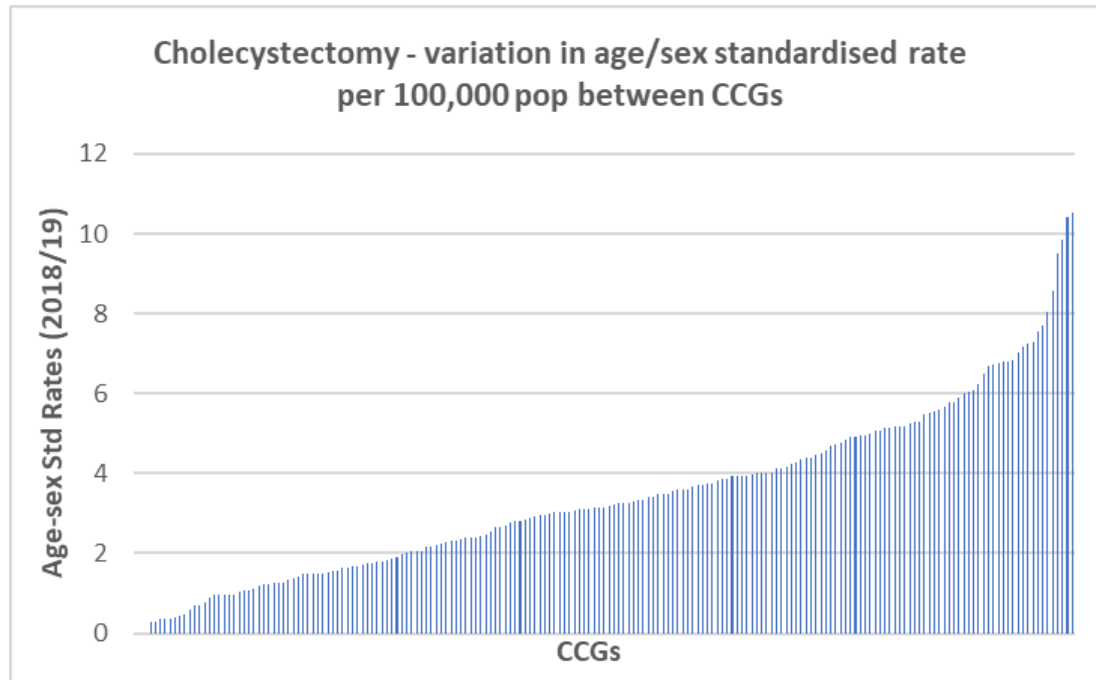
## Wider impacts

To ensure patient safety and to ensure highly trained surgeons supervise or carry out more complex surgery, the guidance should be implemented with the caveat that surgery should ideally be performed on the same admission but not necessarily as an out-of-hours emergency



# Removal of an inflamed gallbladder

Cholecystectomy should be considered on the same admission as acute cholecystitis or gallstone pancreatitis [Group B]



## Activity

- 2,085 episodes during 2018/19
- Age/sex std rate per 100,000 – 3.5
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated.

## Variation

Variation [age/sex std rates]:

- N-fold – 6.4
  - 10th percentile – 1.0
  - 25th percentile – 1.8
  - 50th percentile – 3.2
  - 90th percentile – 6.2

# Tests to confirm appendicitis

Appendicitis should be confirmed prior to appendicectomy (Group B)

## Rationale

Where patients present with symptoms of appendicitis, imaging should only be offered if appendicitis is not confirmed after clinical history, physical exam and blood analysis.

Where patients present with atypical or equivocal symptoms of appendicitis, imaging should be requested to confirm appendicitis. Ultrasound is preferred as first-line investigation, however CT may be more appropriate in older patients (who have a broader differential diagnosis) or patients with a high BMI (where ultrasound is not possible). MRI should be considered if CT is contraindicated and ultrasound is not possible. Appropriate imaging in line with this guidance can reduce unnecessary surgery and associated complications.

## Avoidable harms

Unnecessary radiation, unnecessary surgery, risks associated with sedation/anaesthetic

## Alternatives

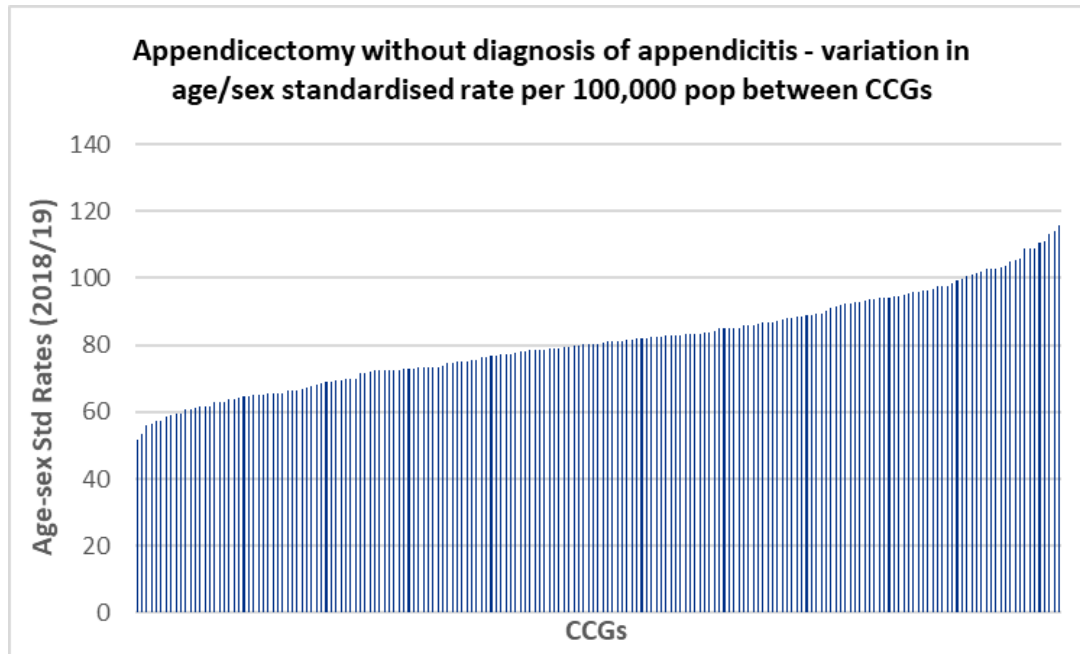
Clinical history, physical exam, blood tests before imaging in line with pathway

## Wider impacts

Often availability of out of hours CT scanning and interpretation is challenging. To ensure implementation of the guidance, we will work with RCR and GIRFT to ensure they are feasible

# Tests to confirm appendicitis

Appendicitis should be confirmed prior to appendicectomy (Group B)



## Activity

- 47,605 episodes during 2018/19
- Age/sex std rate per 100,000 – 80.1
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated.

## Variation

Variation [age/sex std rates]:

- N-fold – 1.6
  - 10th percentile – 63.7
  - 25th percentile – 71.7
  - 50th percentile – 80.4
  - 90th percentile – 100.7

# Surgery for inguinal hernia

Repair of minimally symptomatic inguinal hernia is not indicated [Group A]

## Rationale

Repair of minimally symptomatic hernia is not appropriate. Delaying surgical repair until symptoms increase is acceptable. Acute hernia incarcerations occur rarely and patients who develop symptoms have no greater risk of operative complications than those undergoing prophylactic hernia repair.

Watchful waiting is a safe option for people with minimally symptomatic inguinal hernias. Many people with an inguinal hernia are asymptomatic or minimally symptomatic and may never need surgery.

## Avoidable harms

Infection, bleeding, perforation, long-lasting significant pain after surgery, risks associated with sedation/anaesthetic

## Alternatives

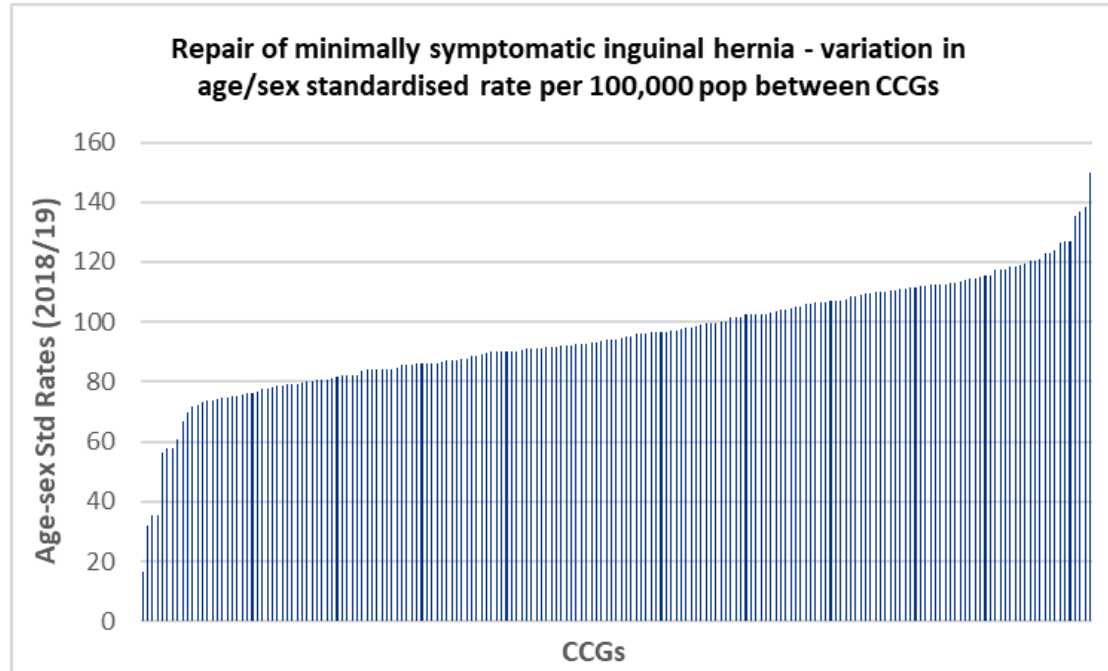
'Watch and wait', non-operative management

## Wider impacts

It is difficult to define 'symptomatic' with no validated scale, however patient decision aids may help to quantify symptoms and appropriateness of surgery

# Surgery for inguinal hernia

Repair of minimally symptomatic inguinal hernia is not indicated [Group A]



## Activity

- 56,457 episodes during 2018/19
- Age/sex std rate per 100,000: 95.0
- Reduction opportunity: 7,891 [14%] based on 25th percentile of activity across CCGs.

## Variation

Variation [age/sex std rates]:

- N-fold – 1.6
  - 10th percentile – 75.2
  - 25th percentile – 84.1
  - 50th percentile – 94.3
  - 90th percentile – 117.2

# Further questions on general surgery interventions?

---

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer.

We're especially interested to hear about:

1. Any suggested changes to the guidance
  2. If you agree with the suggested thresholds and codes
  3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?
-

## Share your views / ask questions

Let's talk about the interventions looking at the questions below – please use MS Teams chat function to send your questions or feedback.

Based on the slido results, people want to talk about some in more detail, so we'll focus on those but appreciate your comments and feedback on anything we have discussed today.

1. Do you have any suggested changes to the guidance?
2. Do you agree with the suggested thresholds and codes?
3. Do you think there will be a negative or positive impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

Thank you for your time, we would appreciate your feedback on the webinar [https://www.surveymonkey.co.uk/r/VM\\_MHM5S](https://www.surveymonkey.co.uk/r/VM_MHM5S)

Please share any further views or comments, including suggestions for future guidance

Email us [ebi@aomrc.org.uk](mailto:ebi@aomrc.org.uk) or complete the online survey available at [www.aomrc.org.uk/ebi](http://www.aomrc.org.uk/ebi)

