NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin059
Hip pain, intra-articular injections of corticosteroids

Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: March 2024

This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Where MCAS services are in place the patient needs to be seen in a Musculoskeletal Clinical Assessment (MCAS) service before referral to a consultant.

1.2 Intra-articular corticosteroid injections for hip pain are not routinely commissioned unless the following criteria are satisfied:

- other pharmacological interventions for osteoarthritis are ineffective or unsuitable

OR

- the use of corticosteroid injections would support the patient to undertake therapeutic exercise **AND**
- the patient is aware that only short-term relief is provided by the injections (between 2 and 10 weeks) **AND**
- the procedure is conducted under imaging guidance.

1.3 Intra-articular injection of any other pharmacological agent (apart from corticosteroid) is not routinely commissioned.

2. Exclusion

2.1 Intra-articular injection of corticosteroid is still permitted when used as a diagnostic agent.

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme. https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 This policy is based primarily on the national NICE guidelines NG226, Osteoarthritis in over 16s: diagnosis and management, which recommend that corticosteroid injections are considered in those where other pharmacological interventions have not been effective or suitable, or to support patients to undertake therapeutic exercise. The patient should be informed of the short-term nature of the benefits of the injections.

5. Summary of evidence review and references

5.1 Osteoarthritis is a syndrome which consists of joint pain accompanied by varying degrees of functional limitation and reduced quality-of-life. The most commonly affected peripheral joints are the knees, hips, hands and feet.[1] Progressive loss of a particular cartilage may result and there is no curative treatment.[2] Available therapies include physiotherapy, weight loss, lifestyle changes, steroid injections and intra-articular hyaluronic acid. The knee is the leading cause of disability in older adults and more than a third of people aged over 60 years have radiographic evidence of knee osteoarthritis.[3]

5.2 Hip pain is very common with radiographic evidence of hip osteoarthritis affecting up to 27% of adults above the age of 45. The estimated lifetime risk of an eventual total hip replacement is 10% and this is preceded by a progressive loss of articular cartilage, subchondral cysts, osteophyte formation and synovial inflammation.[4] According to the Royal College of Surgeons, 450 patients per 100, 000 population present to primary care with hip pain each year. Of these, over a third will improve at 12 months.[5]

5.3 To date, the basis of nonsurgical management of hip pain includes both non-pharmacological and pharmacological interventions. One aspect of pharmacological interventions has been the use of therapeutic hip joint injection with corticosteroids, hyaluronic acid or plasma rich platelets. This frequently involves image guidance to minimise patient discomfort and to ensure patient safety.[4] Whilst some have questioned whether such radiological guidance is required for these intra-articular injections, one author concluded that certain hip injections can be performed without this requirement. However, caveats were applied such as using experienced surgeons only and operating on patients with normal BMIs.[6] Additionally, within the NICE NG226 evidence review (provided within Section J) it was noted that whilst image guidance is not routinely required for all joint injections, image guidance may be essential for injections used in the treatment of hip osteoarthritis.[1]

5.4 A 2021 systematic review investigated the effectiveness of various intra-articular injections for patients with hip osteoarthritis. This concluded that platelet rich plasma decreased pain in the short term and was superior to hyaluronic acid.[7] Similarly, intra-articular corticosteroid injection alone has been shown to be effective for up to 12 weeks.[8] This short-term effectiveness of intra-articular corticosteroid in reducing pain (but not function) has previously been confirmed.[1] In contrast, a 2nd systematic review recommended against the use of platelet rich plasma.[9] In a randomised, double-blind study, ketorolac was found to be equivalent to triamcinolone.[10] Finally, perhaps the most telling piece of efficacy data is the 2021 systematic review and network meta-analysis of various agents (hyaluronic acid, corticosteroids & platelet rich plasma) which concluded that none of these agents provided significant improvements in pain or function when compared to placebo (saline) at short-term follow-up.[11]

5.5 From an adverse effects point of view, it has long been held there are potentially serious side effects associated with corticosteroid injection such as an increased risk of avascular necrosis, subchondral insufficiency fracture, femoral head collapse and osteoarthritis progression. However, these effects have been challenged.[12,13]

5.6 Hip injections have also been used as a diagnostic test to detect the presence of intra-articular hip pathology particularly in patients with vague complaints of pain in the hip region. Used in this way, this test is said to have good specificity and positive predictive values.[14]

5.7 In terms of national guidelines, the clinical guideline from NICE (NG226) makes recommendations on the diagnosis and management of osteoarthritis in adults. It recommends that injections of corticosteroids are considered for adults for whom other pharmacological treatments for osteoarthritis have been ineffective or are unsuitable. They should also be considered for adults with osteoarthritis if used to support therapeutic exercise. In all instances, the patient should be made aware of the short-term nature of the relief provided by corticosteroid injections (2-10 weeks).[1] Additionally, NICE firmly recommend against the use of hyaluronan injections. The guideline also recommends that there should be further research conducted into the clinical and cost-effectiveness of both intra-articular corticosteroids and intra-articular stem-cell injections for the management of osteoarthritis, although the latter are not recommended at this time.[1]

5.8 Additionally, the Royal College of Surgeons commissioning guide on pain arising from the hip in adults, recommends the use of image – guided intra-articular steroids for very elderly patients (unsuitable for surgery) with moderate symptoms.[5] Affected patients are likely to obtain benefit for up to 3 months.

5.9 The most comprehensive guidance on the management of osteoarthritis of the hip is provided by the American Academy of Orthopaedic Surgeons' evidence-based clinical practice guideline.[15] This strongly recommends the use of intra-articular glucocorticoid injection for hip osteoarthritis and this should be performed under imaging guidance. The Academy also strongly recommends *against* injections of hyaluronic acid (which doesn't perform any better than placebo), platelet rich plasma, stem cell injection, tumour necrosis factor inhibitors and interleukin 1 receptor antagonists.

5.10 In summary, hip pain is very common and the most likely cause is hip-related osteoarthritis. Many pharmacological agents have been used as intra-articular injections and corticosteroid injections are probably most frequently used. At best, the effect is short term (in the order of weeks) but there is a strong suspicion that the mode of action could be a placebo effect. The American Academy of orthopaedic surgeons recommends against the use of all intra-articular agents except for corticosteroid which should be administered under imaging guidance. The Royal College of surgeons recommends limited use of intra-articular corticosteroid in very elderly patients with moderate symptoms and who are unsuitable for surgery. NICE recommend the use of intra-articular corticosteroids in all adults if other pharmacological therapies are ineffective or unsuitable, or to allow participation in therapeutic exercise, recognising the short-term nature of this intervention (2-10 weeks).

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6. Advice and Guidance

6.1 Aim and Objectives

- This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

- This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

- This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

- At the time of publication, the evidence presented per procedure/treatment was the most current available.

- The main objective for having healthcare commissioning policies is to ensure that:
  - Patients receive appropriate health treatments

- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

- Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms 'men' and 'women' are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

- Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

  - Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
  - Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
  - Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
  - Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
  - Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
  - Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
  - Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

- If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

- The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

- Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

- Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

- A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

6.5 Diagnostic Procedures

- Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

- Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 Clinical Trials

- The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

9.1 Data are unavailable for this intervention.

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