NHS
Cheshire and Merseyside

Clinical Commissioning Policies

Rhinophyma, surgical management

Category 1 Intervention - Not routinely commissioned -

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Date:	**Version Number:**	**Section and Description of Change**
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1. Introduction

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

1.2 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 in Appendix 1.

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

2. Purpose

2.1 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.

3. Policy statement

3.1 Surgical management of rhinophyma is not routinely commissioned.

4. Exclusions

4.1 None

5. Rationale

5.1 The underpinning evidence to support surgical management of rhinophyma is regarded by the British Association of Dermatologists to be weak.

6. Underpinning evidence

6.1 First described in 1856[1], ***rhinophyma*** is considered to be a cosmetically disfiguring disease of the external nose which most frequently affects elderly males. Although there is an associated derangement of the nasal airway patency, the disease is widely believed to represent the final stage in a continuum of acne rosacea.[2] It is a disfiguring disease characterised by sebaceous gland hypertrophy and proliferation of blood vessels and connective tissue. The phymatous changes (thickening of the skin due to hyperplasia of sebaceous glands) are considered to be the end-stage of acne rosacea and classically affects the lower two thirds of the nose. Clinically, it appears as a bulbous nasal overgrowth with coarsened texture, expanded pores and telangiectasias.[3] Unsurprisingly, there is significant psychological morbidity associated with this disease.[4]

6.2 Whilst the prevalence of rosacea has been estimated to be 5.46%, prevalence of rhinophyma is uncertain.[4] As stated above, the condition mainly affects elderly men particularly in their 50s and 70s.[1] The estimated male: female ratio ranges from 5:1 to 30:1 and is probably mediated by increased androgen activity in men.

6.3 Available treatments for rosacea include topical agents (metronidazole, azelaic acid, benzoyl peroxide & retinoids) and oral ones (tetracyclines, metronidazole, macrolides & isotretinoin).[5] For rhinophyma, however, surgery seems to be the most accepted method of treatment.[2] Common methods are scalpel excision, resection with heated knives, dermabrasion, electrosurgery and lasers (CO_2 and YAG).[3] Whilst there is no accepted gold standard of treatment [2,3,6,7], one author recommended cold blade excision and trichloroacetic acid or CO_2 laser for mild rhinophyma, continuous and pulsed CO_2 laser for moderate and monopolar diathermy knife for severe disease.[6] Postsurgical complications include scarring and hypopigmentation.[3,7]

6.4 There are few (if any) national guidelines on the management of rhinophyma. The British Association of Dermatologists produced guidelines (2021) for the management of people with rosacea.[8] The only relevant recommendation was for clinicians to "consider" nasal debulking by laser ablation or surgical intervention (dependent on local expertise) in people with significant rhinophyma. However, the Association recognised that the underpinning evidence was weak.

6.5 In summary, rhinophyma is considered to be a cosmetically disfiguring disease of the external nose which is most common in men in their 50s and 70s. In the majority of cases, the condition has progressed from long-standing rosacea. Although there is no cure, treatment can be effective in improving the appearance and possibly prevent deterioration. The British Association of Dermatologists recognise that surgical treatments are not routinely commissioned in the NHS and recurrence can occur. Cheshire and Mersey CCGs' policies are exactly the same.

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7. Force

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.

8. Coding

8.1 **Office of Population Censuses and Surveys (OPCS)**
In primary position
S09.1 Laser destruction of lesion of skin of head or neck
S09.2 Laser destruction of lesion of skin NEC
S09.3 Photodestruction of lesion of skin of head or neck NEC
S09.4 Infrared photocoagulation of lesion of skin of head or neck
S09.5 Infrared photocoagulation of lesion of skin NEC
S09.8 Other specified
S09.9 Unspecified

8.2 **International classification of diseases (ICD-10)**
Must include the following
L71.1 Rhinophyma

9. Monitoring And Review

9.1 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

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

10. Quality and Equality Analysis

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

Appendix 1 - Core Objectives and Principles

Objectives

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.

Principles

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.

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.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

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 wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

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

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.

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.

Clinical Exceptionality

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.