Carpal Tunnel Syndrome Commissioning Policy

Intervention	**Treatment for Carpal tunnel syndrome may be called carpal tunnel release (CTR) or carpal tunnel decompression surgery.**
For the treatment of	**Carpal tunnel syndrome**
Commissioning position	Nerve conduction studies (NCS) are NOT available from primary care (see commissioning statement). The need for NCS to confirm and predict positive surgical outcome in specific cases is a matter for surgeons and neurophysiologists consideration. NHS Scarborough & Ryedale and Vale of York CCGs will commission surgical decompression under local anaesthetic, for the treatment of carpal tunnel syndrome only in the following circumstances. For classification of symptoms of CTS, please see Appendix 1. **Moderate symptoms** Patients are experiencing symptoms that are interfering with activities of daily living **AND** all of the following have been tried: • The patient has not responded to a minimum of 6 months of conservative management, including at least 8 weeks of night time use of well-fitting wrist splints **and** • Appropriate analgesia has been tried **and** • Corticosteroid injections (given at least once prior to referral, unless clinically contraindicated) **and** • Lifestyle/workplace modification e.g. weight loss, if appropriate **OR** **Severe symptoms** • Patient is experiencing advanced or severe, neurological symptoms of Carpal Tunnel Syndrome such as constant pins and needles, numbness, muscle wasting and prominent pain **or** • Sudden or traumatic in origin Surgery should only be undertaken under local anaesthetic. Fear of the procedure, or patient choice are **not** adequate reasons for requesting surgery under GA, unless supporting mitigating factors are submitted to the IFR panel by the requesting clinician. **Patients who do not meet the criteria outlined above, can be considered on an individual basis where their GP or Consultant believes there is an exceptional clinical need that justifies deviation from this policy. In those instances an application should be made to the IFR panel.** In all cases the patient should have been informed about the shared decision making tool for Carpal Tunnel Syndrome available here http://www.valeofyorkccg.nhs.uk/rss/data/uploads/shared-decision-making/sdm-carpal-tunnel-syndrome.pdf

	Both splinting and steroid injection produce improvement in the majority of patients at least temporarily and should both be tried for patients with less severe symptoms and findings who are likely to include the 35% of patients who will not need further intervention.
Summary of evidence / rationale	Overall, patients whose CTS symptoms are significantly troublesome and who have mild or moderate impairment of the median nerve function should be offered splinting and local steroid injection. Patients failing such conservative management and those who present at a later stage with objective neurological signs or delayed motor conduction on nerve conduction systems should be offered the option of surgical decompression. All should be advised of the potential risks of the different treatments. An estimated 35% of patients with carpal tunnel syndrome will improve without surgical intervention. This is more likely when the patient is younger, when the symptoms are unilateral and/or of shorter duration or when Phalen's test is negative. A survey of over 4,000 patients having surgery under usual NHS circumstances found that about two years after surgery, only 75% considered the operation an unqualified success and 8% thought that they were worse off.
Date effective from	22nd February 2020
Review Date	2022

References:

1. NICE CKS Carpal tunnel syndrome
2. Clinical Evidence – Carpal Tunnel Syndrome updated August 2014
3. Bland JDP. Carpal tunnel syndrome. Curr Opin Neurol 2005;18:581-5. [PubMed]
4. Bland J (2007) Clinical Review: Carpal tunnel syndrome. BMJ 2007;335;p343- 346
5. BSSH Evidence for Surgical Treatment 1 - CTS 2010
6. Royal College of Surgeons Commissioning Guide: Treatment of painful tingling fingers (November 2013)
7. NHS Choices – Carpal tunnel syndrome – Treatment
8. Evidence Based Intervention Policy – NHSE – published November 2018

Version	Created /actioned by	Nature of Amendment	Approved by	Date
FINAL	Senior Service Improvement Manager	Approval of threshold	SRCCG Business Committee VoY Clinical Executive	14.01.20 Dec 2019

Appendix 1 – Classification of Carpal Tunnel Syndrome (CTS) Symptoms

CTS is a condition that involves pain and tingling in the first three or four fingers of one or both hands, which usually occurs at night. It is caused by pressure on the median nerve as it passes under the strong ligament that lies across the front of the wrist. Mild or moderate symptoms often resolve within 6 months.

There are a variety of treatment options which may be applied to the syndrome, depending on the severity of symptoms which can be mild, moderate or severe. An indication of each classification is detailed below:-

Assessment and Management in Primary Care		
	Symptoms	**Treatment**
Mild CTS	The sensory symptoms occur: ➢ No more than once during the day ➢ Once or twice a week during the night ➢ Lasting for up to 10 minutes ➢ Pain is not present	Explanation of condition and that it may improve spontaneously Lifestyle advice
Moderate CTS	The sensory symptoms occur: ➢ Two or three times during the day ➢ Once most nights ➢ Last for more than 10 minutes ➢ Pain may be present	Lifestyle advice Well fitted nocturnal wrists splints if waking at night is troublesome Appropriate analgesia Corticosteroid injection
Severe CTS	The sensory symptoms occur: ➢ Frequently each day and can last for more than an hour at a time ➢ Can be continuous ➢ Sleep is disturbed with more than two wakings every night ➢ Pain can be prominent ➢ Wasting and weakness of the thenar muscles may be present, together with sensory loss in the median supplied digits.	Consider early or immediate referral for surgery