NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Policy title	**Hip replacement surgery for treatment of osteoarthritis in adults (primary hip replacement)** **v3.0**
Policy position	**Criteria Based Access**
Date of Forum recommendation	**February 2019, updated June 2021**
Date of ICB recommendation	**July 2023**

The most common indication for elective primary total hip replacement (THR) is degenerative arthritis (osteoarthritis) of the joint. It is the most common type of arthritis and is most often seen in older people. Osteoarthritis (OA) causes pain, stiffness and problems moving the joint.

Symptoms of OA may be mild, or more severe and affect everyday life. Symptoms can vary between joints and over time, and do not always get worse. Sometimes they flare up and settle back down again.

The aims of THR are the relief of pain and improvement in function, and this operation can be very successful for appropriate patients. A small number of patients who have elective THR require a second replacement operation within their lifetime which is a much more complex procedure. Therefore, patients should not be considered for joint replacement until their condition has become chronic and conservative methods have failed.

Cemented hip replacements are recommended for patients over the age of 65[1,2]. This will be at the discretion of the surgeon.

Imaging[3]

Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment. Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip.

The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who:

- Are 45 or over AND
- Have activity-related joint pain AND
- Have either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

It is important to exclude other diagnoses, especially when red flags are present.

Management[4]
Initial management should take place within primary and community care. Recommended core treatments may include therapeutic exercise, weight reduction (if appropriate) and adequate doses of analgesics including topical non-steroidal anti-inflammatory drugs (NSAIDs). Walking aids such as walking sticks may also be considered.

People should be advised that doing regular and consistent exercise, even though this may initially cause pain or discomfort, will be beneficial for their joints, and that long-term adherence to an exercise plan increases its benefits by reducing pain and increasing functioning and quality of life.

People with osteoarthritis who are overweight or obese should be advised that weight loss is likely to improve their quality of life, physical function and reduce pain. Health professionals should support people to choose a weight loss goal and explain that any amount of weight loss is likely to be beneficial. However, for example losing 10% of their body weight is likely to have more benefit than a loss of 5%.

Do not routinely offer paracetamol or weak opioids unless they are only used infrequently for short-term pain relief and all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer glucosamine or strong opioids to people to manage osteoarthritis.

Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain that these only provide short-term relief (2 to 10 weeks).

Do not offer acupuncture for the management of osteoarthritis.

Referral for consideration of hip replacement surgery will be supported where there is:

- Persistent pain not adequately relieved by at least 3 months of core treatments (therapeutic exercise, weight loss if relevant and appropriate analgesia)[5]

  AND

- Clinically significant functional limitation resulting in diminished quality of life

  AND

- Radiographic evidence of joint damage

For patients who are overweight or obese and/ or active smokers: Primary care and community services should refer patients for weight loss and smoking cessation support at the earliest opportunity and in any case at the same time as referral to secondary care.

For all patients[6,7]**:** Use of a quality assured decision support aid is encouraged to support discussion of the risks, benefits and consequences of the treatment options available in the context of each person's life and what matters to them.

Guidance for secondary care on thresholds for hip replacement surgery

Hip joint replacement surgery is funded for the following:[1,8-10]

1. Where the patient complains of
   a. severe joint pain *(please refer to the Appendix 1. for a detailed definition)*
   b. **AND** has severe functional limitation *(please refer to the Appendix 1. for a detailed definition)* irrespective of whether conservative management has been trialled.
   c. **OR** has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

2. Where the patient complains of
   a. Mild to moderate joint pain *(please refer to the Appendix 1. for a detailed definition)*
   b. **AND** has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.
   c. **AND** is assessed to be at low surgical risk *(please refer to the Appendix 1. for a detailed definition)*

Evidence suggests that the following patients would be inappropriate candidates for hip joint replacement surgery[8,9]

1. Where the patient complains of
   a. Mild joint pain
   b. **AND** has minor or moderate functional limitation

2. Where the patient complains of
   a. Moderate to severe joint pain
   b. **AND** has minor functional limitation
   c. **AND** has **not** previously had an adequate trial of conservative management as described above

Patients who do not meet the above criteria for hip replacement surgery should not be listed for surgery. Patients who partially fulfil the criteria for appropriate hip joint replacement surgery *may* benefit from the operation and a decision will need to be taken on an individual basis.

For all patients who fulfil all the criteria for surgery as indicated above, or only partially fulfil the appropriate criteria for surgery, clinicians are required to document in the medical record that they have fully informed the patient of the risks and benefits of the procedure, and have offered a patient information leaflet prior to listing the patient for surgery. A quality assured decision support aid may be helpful in this process[6,7].

A range of resources are available to support patients prepare for surgery, these are listed on the My Hospital Journey website.

Metal on metal hip replacement prostheses

The Medicines and Healthcare products Regulatory Agency (MHRA) monitors the safety of devices used in clinical practice. In June 2010, the MHRA issued an alert on all metal on metal (MoM) hip replacement prostheses (both THR and resurfacing arthroplasty) after reports of soft tissue reactions that may be associated with pain. In June 2012, the MHRA released an updated alert noting that MoM prostheses (THR and resurfacing arthroplasty) may wear at an accelerated rate. The MHRA stated that people with MoM prostheses may develop soft tissue damage caused by wear debris from these prostheses. It advised annual monitoring of the hip using imaging and measurement of metal levels in the blood to determine whether a revision is needed in people with MoM hip replacement prostheses who have symptoms, or who have a certain type of MoM hip replacement, including stemmed MoM THRs with a larger femoral head (36 mm diameter or more) or the recalled DePuy ASR hip replacements (THR and resurfacing arthroplasty).

Annual monitoring is to be undertaken by the patient's GP.

NOTE:

- This policy will be reviewed in the light of new evidence or new national guidance e.g. from NICE
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process

References:

1. National Institute of Clinical Excellence (NICE) TA304: Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip. Published February 2014.
2. Getting it Right First Time. A national review of adult elective orthopaedic services in England. Published March 2015.
3. Academy of Medical Royal Colleges. Evidence-Based Interventions List 2 Guidance. Published 2020.
4. NICE NG226: Osteoarthritis in over 16s: diagnosis and management. Published October 2022.
5. NICE QS87: Osteoarthritis in over 16s. Published 2015; updated October 2022.
6. NICE NG197: Shared decision making. Published June 2021.
7. NHS England. Decision support tools: making a decision about hip osteoarthritis. Published July 2022. https://www.england.nhs.uk/publication/decision-support-tools-making-a-decision-about-a-health-condition/
8. Quintana, JM et al. Evaluation of explicit criteria for total hip joint replacement. Journal of Clinical Epidemiology, 2000;53: 1200-1208
9. Quintana J et al. Health-related Quality of Life and Appropriateness of hip or knee Joint Replacement. Archives of Internal Medicine. 2006; 166: 220-226
10. Royal College of Surgeons. Commissioning Guide: Pain Arising from the Hip in Adults. London: Royal College of Surgeons. Published 2017.

Clinical coding:

Age range: ≥19 years

ICD10 Coding:
M16.: Coxarthrosis

Primary OPCS:
W37.1: Primary total prosthetic replacement of hip joint using cement
W37.9: Unspecified total prosthetic replacement of hip joint using cement
W38.1: Primary total prosthetic replacement of hip joint not using cement
W38.9: Unspecified total prosthetic replacement of hip joint not using cement
W39.1: Primary total prosthetic replacement of hip joint NEC
W39.9: Unspecified other total prosthetic replacement of hip joint
W93.1: Primary hybrid prosthetic replacement of hip joint using cemented acetabular component
W93.9: Unspecified hybrid prosthetic replacement of hip joint using cemented acetabular component
W94.1: Primary hybrid prosthetic replacement of hip joint using cemented femoral component
W94.9: Unspecified hybrid prosthetic replacement of hip joint using cemented femoral component
W95.1: Primary hybrid prosthetic replacement of hip joint using cement NEC
W95.9: Unspecified hybrid prosthetic replacement of hip joint using cement

Key words: Hip replacement.

Policy update record	
V2.0 22.6.2021 BLMK 3CF meeting	Addition of Evidence Based Interventions phase 2 recommendation on imaging in primary care: section 'Imaging'.
July 2023	Policy has been updated in line with new NICE guidance, NG226: Osteoarthritis in over 16s: diagnosis and management. Links to shared decision aids and other resources have also been added.

Appendix 1: Definitions of pain level, functional limitations and surgical risk

Variable	Definition
Pain Level[11]	
- Mild	Pain interferes minimally on an intermittent basis with usual daily activities Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
- Moderate	Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
- Severe	Pain is constant and interferes with most activities of daily living Pain at rest or interferes with sleep Pain not controlled by appropriate analgesics
Functional Limitations[12]	
- Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
- Moderate	Functional capacity adequate to perform only a few or none of the normal activities and self-care Walking capacity of about one half hour Aids such as a cane are needed
- Severe	Largely or wholly incapacitated Walking capacity of less than half hour or unable to walk or bedridden Aids such as a cane, a walker or a wheelchair are required

Surgical risk divided into; Low (ASA 1 to 3); High (ASA 4)[13]

References:

11. Lequesne M. Indices of severity and disease activity for osteoarthritis. Seminars in Arthritis Research, 1991;20:48-54
12. Hochberg et al. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. Arthritis Rheum, 1992;35:498-502
13. Schneider AJL. Assessment of risk factors and surgical outcome. Surgical Clinics of North America, 1983; 63:1113-26