GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester EUR Policy Statement on:

Surgical Revision of Scarring

GM Ref: GM066

Version: 2.2 (28 January 2019)

Commissioning Statement

Surgical Revision of Scarring	
Policy Exclusions **(Alternative commissioning arrangements apply)**	Treatment of burn scars and surgical revision of scars post operatively for clinical reasons are not covered by this policy. Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).

Policy Inclusion Criteria	Scar revision, which is not part of a reconstruction process post trauma or cancer treatment, is considered to be mostly cosmetic and is therefore a procedure of low clinical value and not routinely commissioned.
	
	Funding of surgical revision of scarring will only be considered for scars that have been present for a minimum of 18 months post injury/surgery, and where the scar is causing a functional problem that is likely to be resolved with surgery.
	
	Requests made by clinicians will be considered under clinical exceptionality. Where exceptionality is claimed the following standard set of information will need to be provided in addition to the individual clinical exceptional circumstances:
	• Date of the original injury
	• Exact anatomical location of the scar
	• A detailed description of the functional impairment caused to the patient
	• A list of all treatments used to minimise the scarring, including:
	  ○ Date each treatment used
	  ○ Details of whether or not there was any improvement
	• Expectations of the outcome of the revision (e.g. full restoration of functionality or the degree of improvement expected)
	• Non-identifiable photographs, if possible showing the functional issues and preferably medical illustrations if available, will be requested, to support the decision making process, but will not form the sole basis of the decision. It is not mandatory for photographs to be provided by a patient.
	
	Funding Mechanism
	Individual funding request (exceptional case) approval: Requests must be submitted with all relevant supporting evidence.

Clinical Exceptionality	Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is: • Significantly different to the general population of patients with the condition in question. ***and as a result of that difference***

	• They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.
Fitness for Surgery	**NOTE:** All patients should be assessed as fit for surgery before going ahead with treatment, even though funding has been approved.
Best Practice Guidelines	All providers are expected to follow best practice guidelines (where available) in the management of these conditions.

Contents

Policy Statement

Greater Manchester Health and Care Commissioning (GMHCC) Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy GMHCC/GM EUR Steering Group have reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

GMHCC/CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. GMHCC/CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, GMHCC/CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMHCC EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMHCC evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Joint Commissioning Board (GMJCB) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.

- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

Rationale behind the policy statement

Surgical revision of scarring is rarely indicated for clinical reasons unless it is a necessary part of the pathway of care following an initial injury /operation e.g. reconstruction following trauma, cancer etc.

Scar revision, which is not part of a clinical pathway, is usually carried out for aesthetic reasons and is therefore considered a procedure of low clinical value. This type of surgery is only commissioned where function, e.g. movement of a joint, is restricted by the scar.

Treatment / Procedure

Most procedures are carried out for aesthetic reasons and are not curative. In the case of keloid scars these may recur and in some cases be worse than before the revision.

Every time the skin is cut or damaged through its full thickness it will heal with a scar. Scars which lie in the lines of skin tension tend to heal better than ones that run across them. Surgeons will try and choose a good site and direction, but if the scar is due to an injury, there is no choice. Scar revision will not 'cure' scarring; however, a better scar can be achieved.

Time is the best healer as eventually normal scars and hypertrophic scars will mature and become pale.

Non-surgical treatment of scarring involves the use of pressure bandages, silicone sheets and steroid injections.

There is a whole range of scars but at the poor end there is the hypertrophic scar which occurs when the wound heals to become red, raised and itchy for a few months but will then resolve to become flat and pale.

A keloid scar is similar but the scar continues to grow encroaching upon normal tissue and may need specific treatment. In a true keloid scar there is a high likelihood of recurrence and a strictly adhered to post-operative regimen is necessary for the best result.

Epidemiology and Need

Individuals of all ethnic backgrounds can form keloids and hypertrophic scars. Keloids are seen with greater frequency in those ethnic groups with more highly pigmented skin – in these groups it can be as high as 16% of scars, and a familial predisposition is believed to exist. Keloid formation is approximately 15 times greater in the more highly pigmented ethnic groups than white Caucasians.

Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

Date of Review

Three years from the date of the last review, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

Term	Meaning
Fibrous tissue	Tissue consisting of or containing fibers (threads or filaments from which a tissue is formed).
Hypertrophic	Enlargement or overgrowth of an organ or part of the body due to increased size of the constituent cells.
Keloid	A keloid is the formation of a type of scar which, depending on its maturity, is composed mainly of either type III or type I collagen. It is a result of an overgrowth of granulation tissue at the site of a healed skin injury which is then slowly replaced by collagen type 1.
Pressure bandages	A thick pad of gauze or other material placed over a wound and attached firmly so that it will exert pressure.
Scar/Scarring	A mark left on the skin or within body tissue where a wound, burn, or sore has not healed completely and fibrous connective tissue has developed.
Silicone sheets	Silicone scar sheets are a type of treatment used to prevent the formation of new scars and to reduce the appearance of existing scars. The scar sheet is lined on one side with silicone gel.
Steroid injections	Injections that may help relieve pain and inflammation in a specific area of the body.

References

1. GM EUR Operational Policy
2. The British Association of Aesthetic and Plastic Surgeons (BAAPS) website: Scars and Keloids information sheet [accessed 31/08/2014]

Governance Approvals

Name	Date Approved
Greater Manchester Effective Use of Resources Steering Group	19/11/2014
Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning	May 2015
Greater Manchester Association Governing Group	02/06/2015
Bolton Clinical Commissioning Group	26/06/2015
Bury Clinical Commissioning Group	01/07/2015

Heywood, Middleton & Rochdale Clinical Commissioning Group	17/07/2015
Manchester Clinical Commissioning Group	North: 08/07/2015 Central: 30/07/2015 South: 24/06/2015
Oldham Clinical Commissioning Group	02/06/2015
Salford Clinical Commissioning Group	02/06/2015
Stockport Clinical Commissioning Group	24/06/2015
Tameside & Glossop Clinical Commissioning Group	22/07/2015
Trafford Clinical Commissioning Group	21/07/2015
Wigan Borough Clinical Commissioning Group	30/06/2015

Appendix 1 – Evidence Review

Surgical Revision of Scarring
GM066

Search Strategy

The following databases are routinely searched: NICE Clinical Guidance and full website search; NHS Evidence and NICE CKS; SIGN; Cochrane; York; and the relevant Royal College and any other relevant bespoke sites. A Medline / Open Athens search is undertaken where indicated and a general google search for key terms may also be undertaken. The results from these and any other sources are included in the table below. If nothing is found on a particular website it will not appear in the table below:

Database	Result
NHS Evidence and NICE CKS	Cochrane review (see below)
Cochrane	2 reviews in development
BMJ Clinical Evidence	Treatment of Keloids and Hypertrophic Scars A Meta-analysis and Review of the Literature , Douglas Leventhal, MD; Maxwell Furr, BS; David Reiter, MD, DMD, *Arch Facial Plast Surg.* 2006;8(6):362-368.
	Management of Keloids and Hypertrophic Scars, GREGORY JUCKETT, MD, MPH, and HOLLY HARTMAN-ADAMS, MD, West Virginia University, Morgantown, West Virginia, *Am Fam Physician*. 2009 Aug 1;80(3):253-260.
General Search (Google)	Provider websites
Medline / Open Athens	Not done
Other	Royal College websites searched: The British Association of Aesthetic and Plastic Surgeons (BAAPS) website: Scars and Keloids information sheet [accessed 31/08/2014]

Summary of the evidence

Most scarring will improve over time with raised red scars becoming flat and pale. There are a number of non-surgical and surgical interventions for scarring but none are curative and all are aimed at improving the appearance of the scar. Keloid scars are best managed by non-surgical treatments as they are very likely to recur after surgical revision.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

1. LEVEL 5: EXPERT OPINION

The British Association of Aesthetic and Plastic Surgeons website: Scars and Keloids information sheet [accessed 31/08/2014]

The treatment of active scars

Time is the best healer as eventually normal scars and hypertrophic scars will mature and become pale. We tend however, to try and treat the severer hypertrophic scars and keloids.

We use:

- **Pressure** which can be from a bandage or a pressure garment which would be made of some sort of stretchy material such as Lycra or Tubigrip. This pressure should be applied day and night for many months or even years.
- **The application of silicone.** Usually in sheet form directly to the wound is thought by many to speed up maturation of the scar.
- **Steroids.** The simplest is the application of a steroid containing tape (Haelan tape) which is worn day and night for extended periods. Strong steroids such as Triamcinalone can be injected into the scar itself. It is usually given

Scar revisions

These are usually done under local anaesthesia when it is felt that a scar can be improved because of particular circumstances or complications of healing in the first instance, or because the procedure is likely to be carried out in a better manner. The old scar is removed by one of several plastic surgery techniques and is repaired. Post-operative pain is usually minimal. Sutures are usually removed in 4 to 6 days from the face and 7 to 10 days from other parts of the body. However, dissolving sutures are frequently used on the trunk and limbs to avoid stitch marks. Stitch marks are much less likely to appear on the face as the stitches are removed early. All new scars will initially be red. Fading occurs within 6 to 24 months depending on the scar's location and the patient's skin type.

Additional procedures

A Z-plasty is used to reduce the tightness or contracture of the scar making it more comfortable and less conspicuous. It may also be used to change the position of a scar and by reducing tightness improve healing. A Z-plasty is performed by raising two adjacent skin flaps and transposing the flaps (putting each flap where the other one was). Dermabrasion and laser surgery can also be used to blur the edges of the scar and minimise surface irregularities.

2. LEVEL 1: SYSTEMATIC REVIEW

Treatment of Keloids and Hypertrophic Scars A Meta-analysis and Review of the Literature
Douglas Leventhal, MD; Maxwell Furr, BS; David Reiter, MD, DMD
***Arch Facial Plast Surg.* 2006;8(6):362-368.**

Management of hypertrophic scars and keloids has advanced from crude, invasive methods such as gross excision and radiation to intralesional or topical agents that act on a cellular level. There is no universally accepted treatment regimen and no evidence-based literature to guide management. Our objectives are to present a list of available treatment regimens, their proposed mechanisms of action, and supporting evidence and to perform a meta-analysis of clinical trials to identify treatments with a better-than-even likelihood of improvement. We conducted a PubMed search through October 2005, identifying clinical studies of various treatments for hypertrophic scars and keloids. We graded the quality of each study, delineated the results into favorable vs non-favorable, and calculated the statistical significance of the findings. The meta-analysis of 70 treatment series for various clinical measures showed a 70% chance of improvement with treatment; however, the mean amount of improvement to be expected was around 60%. There was no statistically significant difference between treatments. Most treatments for keloidal and hypertrophic scarring offer minimal likelihood of improvement. The magnitude of likely permanent improvement in any sign or symptom may be clinically meaningful but far short of cure. Novel therapies deserve further investigation but remain without proven benefit to date.

3. LEVEL 5: EXPERT OPINION

Management of Keloids and Hypertrophic Scars, GREGORY JUCKETT, MD, MPH, and HOLLY HARTMAN-ADAMS, MD, West Virginia University, Morgantown, West Virginia, *Am Fam Physician.* 2009 Aug 1;80(3):253-260.

Keloids and hypertrophic scars represent an exuberant healing response that poses a challenge for physicians. Patients at high risk of keloids are usually younger than 30 years and have darker skin. Sternal skin, shoulders and upper arms, earlobes, and cheeks are most susceptible to developing keloids and hypertrophic scars. High-risk trauma includes burns, ear piercing, and any factor that prolongs wound healing. Keloid formation often can be prevented if anticipated with immediate silicone elastomer sheeting, taping to reduce skin tension, or corticosteroid injections. Once established, however, keloids are difficult to treat, with a high recurrence rate regardless of therapy. Evidence supports silicone sheeting, pressure dressings, and corticosteroid injections as first-line treatments. Cryotherapy may be useful, but should be reserved for smaller lesions. Surgical removal of keloids poses a high recurrence risk unless combined with one or several of these standard therapies. Alternative postsurgical options for refractory scars include pulsed dye laser, radiation, and possibly imiquimod cream. Intralesional verapamil, fluorouracil, bleomycin, and interferon alfa-2b injections appear to be beneficial for treatment of established keloids. Despite the popularity of over-the counter herb-based creams, the evidence for their use is mixed, and there is little evidence that vitamin E is helpful.

Appendix 2 – Diagnostic and Procedure Codes

Surgical Revision of Scarring
GM066

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM066 - Surgical Revision of Scarring Policy	
Shave excision of lesion of skin of head or neck	S06.3
Shave excision of lesion of skin NEC	S06.4
Excision of lesion of skin of head or neck NEC	S06.5
Re-excision of skin margins of head or neck	S06.6
Re-excision of skin margins NEC	S06.7
Other specified other excision of lesion of skin	S06.8
Laser destruction of lesion of skin NEC	S09.2
Cauterisation of lesion of skin of head or neck NEC	S10.1
Cryotherapy to lesion of skin of head or neck	S10.2
Other specified other destruction of lesion of skin of head or neck	S10.8
Cryotherapy to lesion of skin NEC	S11.2
Refashioning of scar NEC	S60.4
Excision of scar tissue NOC	Y06.4
With the following ICD-10 diagnosis code(s) *(nothing to show demonstrable functional problem, as per policy)*:	
Scar conditions and fibrosis of skin	L90.5
Hypertrophic scar	L91.0
Other hypertrophic disorder of the skin	L91.8
Exceptions (ICD-10); the following in a secondary diagnostic position to either L90.5 or L91.0:	
Sequelae of burn, corrosion and frostbite of head and neck	T95.0
Sequelae of burn, corrosion and frostbite of trunk	T95.1
Sequelae of burn, corrosion and frostbite of upper limb	T95.2
Sequelae of burn, corrosion and frostbite of lower limb	T95.3
Sequelae of burn and corrosion classifiable only according to extent of body surface involved	T95.4
Sequelae of other specified burn, corrosion and frostbite	T95.8
Sequelae of unspecified burn, corrosion and frostbite	T95.9

Appendix 3 – Version History

Surgical Revision of Scarring
GM066

The latest version of this policy can be found here: GM Surgical Revision of Scarring policy

Version	Date	Summary of Changes
0.1	02/09/2014	Initial draft
0.2	25/09/2014	Amendments made following discussion by the Greater Manchester EUR Steering Group on 17/09/2014: • The mandatory criteria under section 4 amended to include a minimum period of time that the scar should have been present of 18 months. • The second bullet point under the mandatory criteria was also amended to include the word 'objectively', i.e. 'where the scar is **objectively** considered…..'
	17/09/2014	Policy approved for consultation by Greater Manchester EUR Steering Group, subject to agreed amendments.
0.3	01/10/2014	Branding changed following the creation of the North West CSU on 01/10/2014.
0.4	21/11/2014	Amendments made following discussion of the Consultation feedback by the Greater Manchester EUR Steering Group on 19/11/2014: • Mandatory criteria under section 4 amended to only commission for scars that have been present for a minimum of 18 months post injury/surgery, and where the scar is causing a functional problem that is likely to be resolved with surgery. • Standard set of information added if clinician applying on grounds of individual clinical exceptional circumstances.
	21/11/2014	• Definition re-formatted and an extra paragraph added around non-surgical treatment. • Sentence added under section 6 that keloid scars are best managed by non-surgical treatments as they are very likely to recur after surgical revision.
1.0	21/01/2015	Policy approved by GM EUR Steering Group
1.1	29/06/2015	• Variance column removed and funding mechanism column added to table. • Format of funding mechanism changed.
1.2	06/04/2016	• List of diagnostic and procedure codes in relation to this policy added as Appendix 2. • Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services. • Wording for date of review amended to read *'One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)'* on 'Policy Statement' and section '13. Date of Review'.
2.0	05/08/2016	Evidence reviewed June 2016 - no new studies or reviews were found. GM EUR Steering Group agreed: • No changes to policy other than the 'Date of Review' on 'Policy Statement' and in body of report changed to 'Three years from the date of last review

		unless new evidence warrants earlier review.' • Review date added to cover page and 'Policy Statement'.
2.1	06/06/2018	○ Policy moved to new format and some wording rearranged and clarified. ○ IDC-10 code L91.8 Other hypertrophic disorder of the skin has been added along with the following OPCS-4 codes in Appendix 2: ○ S06.6 Re-excision of skin margins of head or neck ○ S06.7 Re-excision of skin margins NEC ○ S06.8 Other specified other excision of lesion of skin ○ The following OPCS-4 codes have been removed from Appendix 2: ○ S08.1 Curettage and cauterisation of lesion of skin of head or neck ○ S08.2 Curettage and cauterisation of lesion of skin NEC ○ S09.1 Laser destruction of lesion of skin of head or neck ○ S10.9 Unspecified other destruction of lesion of skin of head or neck ○ S11.1 Cauterisation of lesion of skin NEC ○ S11.8 Other specified other destruction of lesion of skin of other site ○ S11.9 Unspecified other destruction of lesion of skin of other site ○ S12.2 Cryotherapy of lesion of skin NEC
2.2	28/01/2019	• Branding changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning. • Links updated as documents have all moved to a new EUR web address. • <u>Commissioning Statement:</u> ○ *'Fitness for Surgery'* section moved to bottom of *'Commissioning Statement'* ○ *'Best Practice Guideline'* section added