GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester EUR Policy Statement on:

Bunion (Hallux Valgus) Surgery

GM Ref: GM052

Version: 3.2 (24 January 2019)

Commissioning Statement

Bunion (Hallux Valgus) Surgery	
Policy Exclusions **(Alternative commissioning arrangements apply)**	Hallux Rigidus is excluded from this policy. Patients may be referred for assessment as clinically appropriate. 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	The presence of a bunion does not indicate a need for surgery. The decision to refer a patient for surgery should be based on pain, disability, and functional impairment. In line with the British Orthopaedic Association's Commissioning Guide: Painful Deformed Great Toe In Adults, patients may be referred for surgery when: • There are repeated episodes of ulceration / infection necessitating surgery **OR** • If there are associated problems with hammer toes or pain under the ball of the foot (suggesting excessive foot strain as big toe is not functional) **NOTE:** • Most bunions can be alleviated by modifying activities and / or shoes • Surgery has a LONG recovery time (up to six months for full recovery) • Surgery carries a risk of complications, some of which may require further surgery • Treatment for bunions is not affected by 'severity' so a 'before it gets worse' approach is not necessary **Funding Mechanism** Monitored approval: Referrals may be made in line with the criteria without seeking funding. **NOTE:** May be the subject of contract challenges and/or audit of cases against commissioned criteria. Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. 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

Due to the prevalence of bunions, the range of impact of the condition on a patient's quality of life, and the inconsistent evidence base there is a need for clear surgical criteria.

Referral should be based on patient's pain and functional impairment post conservative management. Assessment and conservative measures should occur in a primary care setting, a referral to intermediate care should occur with deteriorating symptoms, functional impairment, and inability to wear suitable shoes, pain under the ball of the foot. Referral to intermediate care prior to secondary care will distinguish between those patients who would benefit most from surgery, how urgently they need to be seen and those who would be better served through non-surgical intervention. Therefore, the above criteria are to be used.

Treatment / Procedure

Bunion is the lay term for hallux valgus, where the hallux (great toe) moves towards the second toe, overlying it in severe cases. This movement away from the midline of the body is accompanied by some rotation of the toe so the nail faces the midline of the body. As a result of this movement and consequent rotation the metatarsal head becomes more prominent. The bunion is the prominent and often inflamed metatarsal head overlying the bursa.

Radiological criteria for hallux valgus vary, a commonly accepted criterion is to measure the angle formed between the metatarsal and the abducted hallux. This is called the metatarsophalangeal joint angle or hallux abductus angle, it is considered abnormal when it is greater than 14.5°.

Bunions can be asymptomatic or symptomatic. Symptomatic bunions cause pain, functional impairment and problems wearing normal shoes.

There are numerous different surgical treatments for hallux valgus including fusion of the joint, (arthrodesis), simple excision of the joint (Keller's procedure), osteotomy and joint replacement with an artificial implant.

Epidemiology and Need

Bunions are a common foot deformity and the most common chronic foot complaint presenting to foot and ankle specialists. Bunions can lead to functional disability, foot pain, impaired gait patters, poor balance and falls in older people. For patients with diabetes, untreated bunions can lead to ulceration, deep infection and possible below knee amputation.

Determining the causes of bunions is difficult due to a limited evidence base however possible causes include:

- genetics (family history)
- arthritis, particularly rheumatoid arthritis, gout and psoriatic arthritis
- other conditions, for example, conditions associated with loose ligaments, flexible joints and low muscle tone, neuromuscular conditions (such as cerebral palsy) and connective tissue disorders (such as Marfans syndrome)
- poorly fitting shoes, this also contributes to the progression of hallux valgus

Prevalence studies estimate that 2% of children aged 9-10 years old have a bunion. In the adult population prevalence is estimated at between 23% and 28%. Prevalence increases with age and is higher in females than males.

Adherence to NICE Guidance

There is no NICE Clinical Guidance available.

Audit Requirements

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

Date of Review

3 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
Hallux	'Great toe' also referred as the 'big toe'
IPG	Interventional Procedure Guidance
Osteotomy	Surgical procedure to realign or remove a segment of bone

References

1. GM EUR Operational Policy

Governance Approvals

Name	Date Approved
Greater Manchester Effective Use of Resources Steering Group	17/09/2014
Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning	15/11/2014
Greater Manchester Association Governing Group	29/12/2014
Bolton Clinical Commissioning Group	27/03/2015
Bury Clinical Commissioning Group	04/03/2015
Heywood, Middleton & Rochdale Clinical Commissioning Group	16/01/2015

Manchester Clinical Commissioning Group	North: 11/03/2015 Central: 05/03/2015 South: 14/01/2015
Oldham Clinical Commissioning Group	29/12/2014
Salford Clinical Commissioning Group	29/12/2014
Stockport Clinical Commissioning Group	25/02/2015
Tameside & Glossop Clinical Commissioning Group	27/05/2015
Trafford Clinical Commissioning Group	17/03/2015
Wigan Borough Clinical Commissioning Group	04/03/2015

Appendix 1 – Evidence Review

Bunion (Hallux Valgus) Surgery
GM052

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
NICE	NICE CG177: Osteoarthritis: Care and management in adults (February 2014) (not cited here)
	NICE IPG332: Surgical Correction of hallux valgus using minimal access techniques (February 2012)
	NICE IPG140: Metatarsophalangeal joint replacement of the hallux (November 2005)
NHS Evidence and NICE CKS	Ferrari, J. (2009) *Clinical Evidence, Bunions*, 2009;03;1112
	NICE Clinical Knowledge Summary: Bunions (Added at review: Jan 2016)
Cochrane	Interventions for treating hallux valgus (abductovalgus) and bunions (Review), Ferrari, J. Higgins, JPT. Prior, TD, (2009), 10.1002/14651858.CD000964.pub3 (Withdrawn as of Issue 2, 2009)
	Interventions for treating hallux valgus (abductovalgus) and bunions, Ferrari, J. Higgins, JPT. Prior, TD, (2004), DOI: 10.1002/14651858.CD000964.pub2
BMJ Clinical Evidence	Ferrari, J. (2009) *Clinical Evidence, Bunions*, 2009;03;1112, (as sourced by NHS Evidence)
General Search (Google)	NHS Choices webpage: Bunions (not cited here)
	Commissioning Guide: Painful deformed great toe in adults, British Orthopaedic Foot and Ankle Society, British Orthopaedic Association, Royal College of Surgeons of England, (2013), (Superceded in Nov 2017 - see below)
	Commissioning Guide: Painful Deformed Great Toe In Adults, British Orthopaedic Foot & Ankle Society, British Orthopaedic Association (BOA), Royal College of Surgeons of England (RCSEng), Version 2.1: Published in November 2017 (Added at Review: Jan 2018)
Other	Interim Clinical Commissioning Policy: Bunion Surgery, Ref: N-SC/007, NHS England, November 2013

Summary of the evidence

There is a small, robust evidence base about the efficacy of surgical interventions for the treatment of bunions. A wider evidence base supports conservative treatments such as the effectiveness of custom foot orthotics; this includes a 2012 Health Technology Assessment.

The NICE Clinical Guideline, Osteoarthritis: Care and management in adults, Clinical Guideline 177 published in February 2014 includes bunion surgery within the recommendation '*treating common presentations of osteoarthritis for which there is little evidence'.* NICE recommend further research on the effectiveness of treatments.

Of the evidence published, Ferrari's (2009) *Clinical effectiveness Systematic Review of Bunions* provides a robust summary of the effectiveness of the evidence. For surgical treatments, effectiveness was unknown for arthrodesis, chevron osteotomy, different methods of bone fixation, Keller's arthroplasty. Keller-Lelievre arthroplasty, Phalangeal osteotomy plus distal chevron and proximal chevron osteotomy. However, distal chevron osteotomy was likely to be beneficial and more effective than no treatment or orthoses. However, there was insufficient evidence to compare with other distal osteotomies, proximal osteotomies, or arthrodesis. This conclusion was supported by Ferrari's et al's (2004) Cochrane Collaboration Review, *Interventions for treating hallux valgus (abductovalgus) and bunions.*

NICE have published two interventional procedure guidance (IPG) concerning hallux valgus. IPG 140 supports the metatarsophalangeal joint replacement of the hallux, whereas IPG 332 stresses caution for the implementation of surgical correction of hallux valgus using minimal access techniques.

There are two commissioning guides, both published in November 2013, which are considered in the development of this commissioning policy. Firstly, NHS England's *Interim Clinical Commissioning Policy: Bunion Surgery* which was published in November 2013. This policy sets down clear criteria for the removal of symptomatic or painful bunions, this includes:

- when conservative methods have failed
- severe deformity causing significant impairment or
- severe pain causing significant functional impairment

NHS England stresses that referral for surgery should not be offered for cosmetic reasons.

The second commissioning guide is The British Orthopaedic Foot and Ankle Society, British Orthopaedic Association, Royal College of Surgeons of England, (2013), *Commissioning guide: Painful deformed great toe in adults.* The most relevant and up-to-date studies are referenced and the guidance presents a high value care pathway for *painful deformed great toe* with criteria for Primary Care, Intermediate Care and Secondary Care. The guide states that referral to Secondary Care should **not** occur for prophylactic or cosmetic reasons. The guide makes no preference for type of surgical intervention and states that procedure selection will depend on patient symptoms/signs and patient choice.

This commissioning guide is NICE accredited and has been developed using the same process as NICE use to develop their guidance.

The evidence reviewed does not include reference to the cost-effectiveness of surgical interventions.

Commissioning guide: Painful deformed great toe in adults, British Orthopaedic Foot and Ankle Society, British Orthopaedic Association, Royal College of Surgeons of England, (2013) was updated in 2017 and moved to Royal College of Surgeons commissioning guides.

The relevant section has changed from:

'The surgical referral criteria are;

- *the patient experiences deteriorating symptoms.*
- *failure of appropriate conservative measures after three months.*
- *persistent pain and disability not responsive to up to 12 weeks of evidence based non-surgical treatments.*

- *patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car).*

*This guidance stresses that patients should **not** be referred for surgery for prophylactic or cosmetic reasons for asymptomatic hallux valgus.'*

To:

'Refer to specialist provider:

- *Deteriorating symptoms*
- *Functional impairment*
- *Inability to wear suitable shoes*
- *Any pain under the ball of the foot*
- ***DO NOT refer for prophylactic or cosmetic reasons'***

The guidance in this document has been used to amend the commissioning criteria.

Furthermore, there are no clear measurement criteria for the affected joint, for example, angle of the toe or size of the bunion to qualify for referral the impact on the individual and the degree of disability are the measures used. Finally the presence of a bunion on one or both feet is not identified in the evidence as a criterion for surgical intervention.

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 1: EXPERT OPINION

Commissioning Guide: Painful deformed great toe in adults, British Orthopaedic Foot and Ankle Society, British Orthopaedic Association, Royal College of Surgeons of England, (2013), (Superceded in Nov 2017 - see below)

The Commissioning guide is NICE accredited and has been developed using the same process as NICE develop their guidance. A systematic evidence review was completed and is referenced in the Commissioning guide. The most relevant and up-to-date studies are referenced.

The surgical referral criteria are;

- the patient experiences deteriorating symptoms.
- failure of appropriate conservative measures after three months.
- persistent pain and disability not responsive to up to 12 weeks of evidence based non-surgical treatments.
- patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car).

This guidance stresses that patients should **not** be referred for surgery for prophylactic or cosmetic reasons for asymptomatic hallux valgus.

2. LEVEL 1: SYSTEMATIC REVIEW

Interventions for treating hallux valgus (abductovalgus) and bunions (Review), Ferrari, J. Higgins, JPT. Prior, TD, (2009), 10.1002/14651858.CD000964.pub3 (Withdrawn as of Issue 2, 2009)

This systematic review aimed to answer three questions: what are the effects of conservative treatments for bunions? What are the effects of surgery for bunions? What are the effects of postoperative care of bunions?

Ferrari, (2009) has produced a comprehensive and robust systematic review of the treatment and management of bunions.

The different interventions were reviewed against 12 outcome criteria including pain, functional assessment, improvement in joint angle, healing and adverse effects. The cost-effectiveness of the intervention was not considered.

The systematic review concluded that for conservative treatment, effectiveness was unknown. Interventions reviewed included: antipronatory orthoses in children, night splints and orthoses to treat hallux valgus in adults.

For surgical treatments, effectiveness was unknown for arthrodesis, chevron osteotomy, different methods of bone fixation, Keller's arthroplasty. Keller-Lelievre arthroplasty, Phalangeal osteotomy plus distal chevron and proximal chevron osteotomy. Distal chevron osteotomy was likely to be beneficial. This treatment was shown to be more effective than no treatment or orthoses, but there was insufficient evidence to compare with other distal osteotomies, proximal osteotomies, or arthrodesis.

For postoperative care, the effectiveness of early weight bearing and slipper casts was unknown.

Physiotherapy and joint distraction were not included in this review.

3. LEVEL 5: EXPERT OPINION

NICE IPG140: Metatarsophalangeal joint replacement of the hallux (November 2005)

This NICE IPG states that the current evidence on the safety and efficacy of metatarsophalangeal joint replacement of the hallux appears adequate to support the use of this procedure.

NICE identify the delivery of conservative treatments including: exercise, physiotherapy, analgesics, non-steroidal anti-inflammatory tablets or cream, and steroid injections into the joint. Surgery may be required in patients with severe symptoms that do not respond to conservative measures. The main surgical options NICE list are fusion of the joint, (arthrodesis), simple excision of the joint (Keller's procedure) and joint replacement with an artificial implant.

The IPG measures efficacy of the joint replacement procedure using pain relief and patient satisfaction. Seven studies are cited as reporting high levels of pain relief. Four studies reported between 74% and 88% of patients being satisfied with the procedure. The guidance does identify issues of safety including the formation of osteophytes, fractures and removal of the implants.

Cost effectiveness is not discussed in this interventional procedure guidance, however, NICE do considered this in their recommendations, therefore cost effectiveness can be assumed.

4. LEVEL 1: SYSTEMATIC REVIEW

Interventions for treating hallux valgus (abductovalgus) and bunions, Ferrari, J. Higgins, JPT. Prior, TD, (2004), DOI: 10.1002/14651858.CD000964.pub2

The objectives of this systematic review were to identify and evaluate the evidence from randomised trials of interventions used to correct hallux valgus. This is a robust systematic review which included electronic database and hand searches for evidence. This review was published in 2004; a second updated Cochrane review with the same objective by the same review group was published in 2009 and subsequently withdrawn.

Ferrari et al, (2004) concluded that the quality of RCTs was poor and trial sizes small. They concluded that surgery (chevron osteotomy) was shown to be beneficial compared to orthoses or no treatment. When osteotomies were compared no technique was shown to be more superior. Cost-effectiveness was not considered in the review.

5. LEVEL 5: EXPERT OPINION

NICE IPG332: Surgical Correction of hallux valgus using minimal access techniques (February 2012)

This IPG states that the efficacy of surgical correction of hallux valgus using minimal access techniques is limited and inconsistent. The evidence available relates to a range of different surgical techniques and the evidence on safety is inadequate. Case series reports are the main source of evidence underpinning this IPG.

NICE advise clinicians wishing to undertake this surgery to inform clinical governance leads audit and review clinical outcomes and ensure that patients understand the uncertainty about the procedure's safety and efficacy.

6. LEVEL 5: EXPERT OPINION

Interim Clinical Commissioning Policy: Bunion Surgery, November 2013, Ref: N-SC/007, NHS England

NHS England's *Interim Clinical Commissioning Policy: Bunion Surgery* was published in November 2013. This is a brief policy; there is no description of the development process. In reference to the evidence base this policy states that the procedure is considered to be of limited clinical value.

NHS England sets down clear criteria for the removal of symptomatic or painful bunions, this includes:

- when conservative methods have failed,
- severe deformity (overriding toes) causing significant impairment,
- severe pain causing significant functional impairment.

NHS England stresses that referral for surgery should not be offered for cosmetic reasons.

7. LEVEL N/A: NICE CLINICAL KNOWLEDGE SUMMARY

NICE Clinical Knowledge Summary: Bunions

Extract of relevant section: Age from 18 years onwards

Assessment

How should I assess someone with bunions?

- Establish the reason for consultation. The person may:
  - Require symptomatic relief only.
  - Have difficulty in fitting into footwear (resulting in skin trauma).
  - Have no symptoms but dislike the look of their foot or the type of footwear that must be worn to accommodate the foot.
- Assess for severity:
  - Ask about the location and duration of pain and the presence of paraesthesia (not all people with bunions are symptomatic).
  - Ask how the symptoms are affecting the person's lifestyle.
- Assess the degree of deformity: mild, moderate, or severe (weight-bearing X-rays are not done in primary care).
- Assess for degenerative joint disease (which may develop in people with long-standing or severe bunions).
  - Assess for coexisting osteoarthritis (more likely in people with long-standing or severe bunions).
- Rule out alternative diagnoses, such as gout or sesamoiditis*.
- Enquire about a medical history of diabetes, vascular disease, or neuropathy.
- Assess footwear, and ask what types of shoes are normally worn and whether there has been any recent change in footwear.

- Enquire about treatments that have already been tried, such as bunion pads or over-the-counter analgesics.

Basis for recommendation

- These recommendations are based on practical advice, two reviews [Ferrari, 2006; Easley and Trnka, 2007], and a guideline on the diagnosis and treatment of bunions [Vanore et al, 2003].
- Establishing the reason for consultation at assessment is important so that the clinician can decide whether successful treatment can be provided [Ferrari, 2006]. Significant deformities may be asymptomatic, and reassurance and advice on footwear may be all that is required [Vanore et al, 2003].
- People with diabetes require specialist management. For more information, see the CKS topic on Diabetes - type 2.

Management

How should I manage bunions?

- Advise people presenting with bunions that:
  - They should wear low-heeled, wide shoes.
    - It is preferable for the shoe to have laces or an adjustable strap.
    - If they also have osteoarthritis of the foot, this is another good reason not to wear tightly fitting shoes.
  - Bunions are progressive.
  - Non-surgical treatments (e.g. medication, bunion pads, orthoses) may relieve symptoms but do not limit progression.
- Advise the person that referral for bunion surgery is indicated only for pain and is not routinely performed for cosmetic purposes.
  - Surgery can be done under local or general anaesthetic and is usually done as a day case.
  - Bunion surgery may help relieve pain and improve the alignment of the toe in the majority of people (85%–90%); however, there is no guarantee that the foot will be perfectly straight or pain-free after surgery.
  - Some people (less than 10%) may have complications after bunion surgery (infection, joint stiffness, transfer pain [pain under the ball of the foot], bunion recurrence, damage to the nerves, and continued long-term pain).
  - The person will need to wear sensible, wide-fitting, low-heeled shoes for 6 months or more after surgery.
- If the person is symptomatic:
  - Prescribe oral analgesia (e.g. paracetamol or a nonsteroidal anti-inflammatory drug, such as ibuprofen).
  - Advise self-care treatments for symptomatic relief, such as bunion pads (available over-the-counter) or ice packs.
  - Consider referral for an orthosis.
  - Symptomatic treatment is most effective when there is inflammation or when the symptoms are of short duration.
- If the person has diabetes, refer to diabetic foot care services.

*Sesamoiditis is a common ailment of the plantar forefoot, causing pain in the ball of the foot specifically under the big toe joint. The sesamoid bones are very small bones which are located under the big toe joint within the tendons that run to the big toe.

8. LEVEL 5: EXPERT OPINION

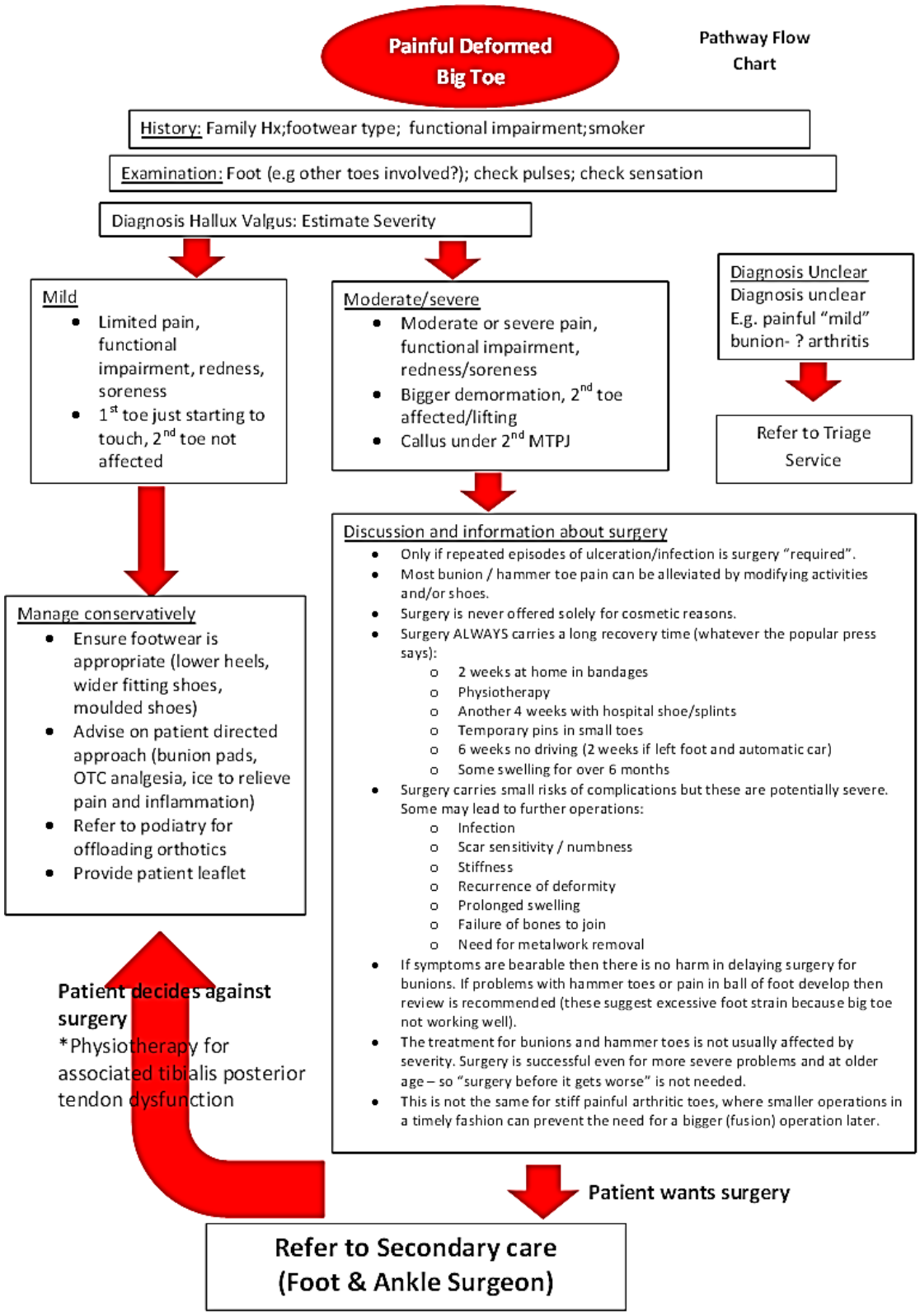
Commissioning Guide: Painful Deformed Great Toe In Adults, British Orthopaedic Foot & Ankle Society, British Orthopaedic Association (BOA), Royal College of Surgeons of England (RCSEng), Version 2.1: Published in November 2017

The relevant section has changed to:

Refer to specialist provider:

- Deteriorating symptoms
- Functional impairment
- Inability to wear suitable shoes
- Any pain under the ball of the foot
- **DO NOT refer for prophylactic or cosmetic reasons'**

The update also includes the following flowchart:



Appendix 2 – Diagnostic and Procedure Codes

Bunion (Hallux Valgus) Surgery
GM052

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

GM052 - Bunion Removal Policy	
Biosseus angulation periarticular osteotomy and internal fixation HFQ	W12.1
Angulation periarticular osteotomy and internal fixation NEC	W12.2
Biosseus angulation periarticular osteotomy and external fixation HFQ	W12.3
Angulation periarticular osteotomy and external fixation NEC	W12.4
Biosseus angulation periarticular osteotomy NEC	W12.5
Other specified angulation periarticular division of bone	W12.8
Unspecified angulation periarticular division of bone	W12.9
Rotation periarticular osteotomy	W13.1
Displacement osteotomy	W13.2
Cuneiform osteotomy NEC	W13.3
Relocation and derotation osteotomy	W13.4
Other specified other periarticular division of bone	W13.8
Unspecified other periarticular division of bone	W13.9
Angulation diaphyseal osteotomy and internal fixation HFQ	W14.1
Angulation diaphyseal osteotomy and external fixation HFQ	W14.2
Angulation diaphyseal osteotomy NEC	W14.3
Rotation diaphyseal osteotomy and internal fixation HFQ	W14.4
Rotation diaphyseal osteotomy and external fixation HFQ	W14.5
Rotation diaphyseal osteotomy NEC	W14.6
Other specified diaphyseal division of bone	W14.8
Unspecified diaphyseal division of bone	W14.9
Osteotomy of neck of first metatarsal bone	W15.1
Osteotomy of base of first metatarsal bone	W15.2
Osteotomy of first metatarsal bone NEC	W15.3
Osteotomy of head of metatarsal bone	W15.4
Osteotomy of midfoot tarsal bone	W15.5
Cuneiform osteotomy of proximal phalanx with resection of head of first metatarsal	W15.6

Other specified division of bone of foot	W15.8
Unspecified division of bone of foot	W15.9
Fusion of first metatarsophalangeal joint and replacement of lesser metatarsophalangeal joint	W59.1
Fusion of first metatarsophalangeal joint and excision of lesser metatarsophalangeal joint	W59.2
Fusion of first metatarsophalangeal joint NEC	W59.3
Fusion of interphalangeal joint of great toe	W59.4
Fusion of interphalangeal joint of toe NEC	W59.5
Revision of fusion of joint of toe	W59.6
Other specified fusion of joint of toe	W59.8
Unspecified fusion of joint of toe	W59.9
Periarticular osteotomy for stabilisation of joint	W77.5
Soft tissue correction of hallux valgus	W79.1
Excision of bunion NEC	W79.2
Other specified soft tissue operations on joint of toe	W79.8
Unspecified soft tissue operations on joint of toe	W79.9
With the following ICD-10 diagnosis code(s):	
Hallux valgus (acquired)	M20.1

Appendix 3 – Version History

Bunion (Hallux Valgus) Surgery
GM052

The latest version of this policy can be found here GM Bunion (Hallux Valgus) Surgery policy

Version	Date	Summary of Changes
0.1	14/05/2014	Initial draft from Greater Manchester EUR Steering Group
0.2	06/06/2014	Amendments agreed by Greater Manchester EUR Steering Group on 21/05/2014: • Under the Mandatory criteria 'AND' should follow each bullet point to make it clear that patients must meet ALL criteria. • Bullet point 1 to state 'the patient experiences persistent pain and functional impairment that is interfering with the activities of daily living'. • Bullet point 2 and 3 merged and examples included. • A further bullet point added to state that patients with diabetes, where there is a higher risk of ulceration or other complications, e.g. neuropathy, should be referred for an early assessment. • Hallux Rigidus to be included as an exclusion to the policy. • Funding mechanism agreed as Monitored approval. • Draft policy approved for consultation following the above amendments. • Policy published for consultation from 09/07/2014 to 03/09/2014.
0.3	25/09/2014 17/09/2014	Amendments made following a review of the feedback from the consultation by the GM EUR Steering Group on 17/09/2014: • Inclusion of the word 'significant' under section 4, mandatory criteria, i.e. 'the patient experiences persistent significant pain….' • Numbering of the 2 separate criteria for commissioning to make it clearer to read. Policy approved by GM EUR Steering Group subject to above amendments.
0.4	08/10/2014	Branding change following creation of North West CSU on 01/10/2014.
1.0	17/09/2014	Policy approved by GM EUR Steering Group - required amendments have been made.
1.1	27/03/2015 23/06/2015	Bolton CCG adopted funding mechanism of IPA. • Variance column removed and funding mechanism column added to table. • Format of funding mechanism changed.
2.0	20/01/2016	Policy reviewed by GM EUR Steering Group no material changes necessary to the policy. • Paragraph added under Policy Exclusions: '*Bunion surgery as part of an externally funded trial or a locally agreed pathway of care is excluded from this policy'* • Wording for date of review changed. • Evidence review updated following review.
2.1	05/04/2016	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

	19/04/2016	Manchester Shared Services. Funding mechanism for Bolton CCG changed from Individual Prior Approval to Monitored Approval – in line with the rest of GM.
2.2	13/06/2016	Wigan CCG changed funding mechanism to Individual Prior Approval (IPA) – to be adopted from 1st August 2016.
2.3	01/08/2017	Wigan CCG changed funding mechanism to monitored approval in line with other GM CCGs.
3.0	17/01/2018	Policy reviewed by GM EUR Steering Group: • Policy moved to new template • Policy Inclusion Criteria: Criteria re-written to be in line with the British Orthopaedic Association's Commissioning Guide: Painful Deformed Great Toe In Adults • Date of Review: Standard wording on next review added to state '3 years' • Appendix 1 – Evidence Review updated The changes were not considered to be material and therefore it was not necessary for the revised policy to go back through the governance process again.
3.1	06/06/2018	Appendix 2: Removed Exceptions for ICD-10 code M20.2 Hallux rigidus
3.2	24/01/2019	• 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 • Commissioning Statement: o *'(Alternative commissioning arrangements apply)'* added after Policy Exclusions o *'Fitness for Surgery'* section added o *'Best Practice Guideline'* section added