NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Morton's Neuroma, surgical treatment

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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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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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 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 referral for Morton's neuroma is not routinely commissioned unless the patient is currently suffering from pain which impacts on daily life.

AND

3.2 The patient has tried (without effect) conservative treatments which may include:
- 3.2.1 Careful selection of footwear.
- 3.2.2 A trial of nonsteroidal anti-inflammatory drugs (if appropriate).
- 3.2.3 Metatarsal pads.

3.3 If symptoms persist after trying 3 of footwear modification and using metatarsal pads

THEN

3.4 Refer to an orthotist for a metatarsal dome orthotic.

3.5 If symptoms persist after a trial of the orthotic device (or referral to orthotics is unavailable locally)

THEN

3.6 Refer to a specialist surgeon for a surgical opinion.

3.7 The specialist surgeon may consider injections (e.g. corticosteroid), ablative therapy or surgical management.

4 Exclusions

4.4 None

5 Rationale

5.1 A variety of treatments is available to treat this condition, and these include conservative measures, injections, and surgery.

5.2 Current evidence doesn't support any particular pathway of care, but it is generally accepted that conservative management is an appropriate initial course of action. The policy statement, therefore, directs treatment accordingly.

6 Underpinning evidence

6.1 Morton's neuroma is a common cause of pain which typically radiates between the 3rd and 4th metatarsals (toes) and causes symptoms or sensations of burning, sharp pain or numbness in the forefoot.[1] This paroxysmal neuralgia is often so debilitating a patient may become anxious about walking or even putting their foot to the ground. The source of the problem is associated with the plantar digital nerve although the precise cause is unclear.[2] The mean age of presentation is between 45 – 50 years with a much higher proportion of females than males. It is frequently described as a tumour whereas, more correctly, it is caused by a fibrosis of the nerve. [3] This creates scar tissue, resulting in compression of the interdigital nerve.[4] The diagnosis is mainly clinical and currently there are no reliable instrumental diagnostics.[5]

6.2 Conservative treatments include: activity modification, orthosis application, local injections of corticosteroids, alcohol, phenol, or capsaicin. Other treatments include radiofrequency ablation, extracorporeal shockwave therapy, cryoablation and laser therapy. Surgery is indicated when the long-term conservative treatments fail. Surgical management may involve either removal of the affected interdigital nerve (neurectomy) or decompression of the entrapped nerve. Currently, most surgeons prefer the former.[6] However, initial management is usually rest, anti-inflammatories, using an orthosis in the shoe or wearing a different type of shoe.[4]

6.3 A systematic review (2021) considered all forms of treatment of Morton's neuroma in a total of 2,998 patients. It concluded that neurolysis (i.e. release of the nerve from the intramuscular fibrosis and fascial slips crossing the nerve) or neurectomy trended towards better pain relief compared to injection treatment (i.e. injection of alcohol, hyaluronic acid, corticosteroid). All procedures demonstrated favourable complication rates. [7] An earlier review (based on 2015 data) had demonstrated better outcomes with surgical procedures (as opposed to more conservative, non-invasive methods).[8] A third systematic review (2020) examined nonsurgical management (which included injections, extracorporeal shockwave therapy, radiofrequency ablation, cryoablation & laser therapy) and concluded that corticosteroid injections should be recommended based on a statistically significant reduction in pain score with at least 50% success at 12 months. Alcohol showed promising short-term pain relief only and radiofrequency ablation & cryoablation required more well-designed RCTs.[9] However, although corticosteroid injections are useful, up to 30% eventually require additional surgical management [10] and their efficacy is thought to be inferior to surgical excision.[11]

6.4 It has been estimated that up to 80% of patients will require surgical excision for symptom relief. Even though between 50% – 85% of patients obtain pain relief after primary excision, symptoms may recur because of an incorrect diagnosis, inadequate resection or adherence of pressure on a nerve stump neuroma. Symptom relief rate on reoperation is similar to that of a primary excision.[12] Whilst minimally invasive neurectomy is considered to be safe and effective as other operative procedures[13], minimally invasive nerve decompression may not be as effective as previously seen.[14]

6.5 A 2004 Cochrane review examined the data on effectiveness for all types of intervention in Morton's neuroma and concluded there was insufficient evidence for both surgical and nonsurgical options.[2] Finally, the only published cost effectiveness study considered the treatment pathway for symptomatic Morton's neuromas which had failed conservative management. The study concluded that a trial of ultrasound-guided injection therapy is a cost-effective strategy and should be preferred before progressing to surgical neurectomy.[15]

6.6 In summary, Morton's neuroma is a common cause of pain which typically (but not always) occurs between the 3rd and 4th toes and is caused by a fibrosis of the plantar digital nerve. Symptoms may come and go but can be so debilitating that the patient struggles to walk. A variety of treatments is available which range from conservative management (such as footwear modification, pads or massage), injections (e.g. corticosteroids, alcohol, phenol or capsaicin), ablative therapy or surgery (neurectomy or release of the entrapped nerve). Whilst it is generally accepted that conservative management is an appropriate measure initially, current evidence doesn't support any particular pathway of care. Whichever treatment is chosen, the likelihood is that the condition will re-occur.

6.7 Regarding neighbouring CCGs, Mersey and North Staffordshire CCGs are similar to the current Cheshire policy whereas Shropshire and Greater Manchester have no stated policies.

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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
A61.1 Excision of lesion of peripheral nerve

With
Z12.4 Plantar nerve or
Z12.5 Digital nerve of toe

8.2 **International classification of diseases (ICD-10)**
Within any position
G57.6 Lesion of plantar nerve

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.