Carpal Tunnel Syndrome Surgery

Referrals for carpal tunnel surgery will be funded if at least one of following criteria are met:

1. Patient has severe symptoms, interfering with activities of daily living that persist after conservative therapy with either local corticosteroid injection and/or nocturnal splinting
2. Moderate to severe symptoms persist after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks).
3. There is neurological deficit e.g. sensory blunting, muscle wasting or weakness of thenar abduction.

Note: Patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith and Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG and NHS West London CCG).

Background

Carpal tunnel syndrome causes pain, numbness and tingling in the hand and forearm. It is due to entrapment of the median nerve in the wrist.

Evidence Base

The benefits of conservative therapy are seen early after treatment and then decrease, while the benefits of surgery take longer to be fully realised. Local corticosteroid injection for carpal tunnel syndrome provides greater clinical improvement in symptoms one month after injection compared to placebo but significant symptom relief beyond one month has not been demonstrated.

Current evidence shows significant short-term benefit from oral steroids, splinting, ultrasound, yoga and carpal bone mobilisation. Other non-surgical treatments do not produce significant benefit.

Surgical treatment of carpal tunnel syndrome relieves symptoms significantly better than splinting both in the short and long term. Further research is needed to discover whether this conclusion applies to people with mild symptoms and whether surgical treatment is better than steroid injection.

There is no strong evidence supporting the need for replacement of standard open carpal tunnel release by existing alternative surgical procedures for the treatment of carpal tunnel syndrome. The pooled estimate indicated that a significant proportion of medically treated people required surgery while the risk of re-operation in the surgically treated people is low.

Latest version of the policy is available at:
http://www.hounslowccg.nhs.uk/what-we-do/individual-funding-requests.aspx
Version 4 (April 2016)
Patient information
http://www.nhs.uk/conditions/carpal-tunnel-syndrome/Pages/WhatIsIt.aspx

References