

Greater Manchester EUR Policy Statement on:

Ganglion Cyst Removal

GM Ref: GM025

Version: 3.0 (17 Jan 2018)

DRAFT



Commissioning Statement

Ganglion Cyst Removal	
Policy Exclusions	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	<p>Ganglion cyst surgery is <u>not</u> routinely commissioned.</p> <p><u>Surgery is only commissioned for</u> ganglion of the flexor tendon sheaths where grip is affected. NOTE: Needle puncture of the 'sheath' should be considered first (where suitable facilities are available) as less than half recur after this.</p> <p>Where indicated, and where suitable facilities are available, aspiration can be done in primary care for all ganglion as an aid reassurance (for all grades):</p> <p>Mild</p> <ul style="list-style-type: none"> an asymptomatic lump <p>Treatment: Reassurance and observation.</p> <p>Moderate</p> <ul style="list-style-type: none"> symptomatic lump with a long duration of symptoms occult ganglion <p>Severe</p> <ul style="list-style-type: none"> severe pain restriction of activities of daily living concern over the diagnosis <p>Treatment: As most ganglions will resolve spontaneously, and as a high proportion will recur after surgery, the routine treatment for all should be reassurance and observation, with aspiration in primary care for reassurance. Refer for ultrasound / MRI if there are concerns about the diagnosis.</p> <p>Funding Mechanism</p> <p>Monitored approval: Referrals may be made in line with the criteria for <u>flexor sheath ganglion</u> without seeking funding. NOTE: May be the subject of contract challenges and/or audit of cases against commissioned criteria.</p>
Clinical Exceptionality	<p>Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality.</p> <p>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:</p> <ul style="list-style-type: none"> 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.

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Policy Statement

Greater Manchester Shared Services (GMSS) 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 GMSS/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

GMSS/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. GMSS/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, GMSS/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 GMSS 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 GMSS 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 Association Governing Group (GMAGG) 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

Management of ganglia is considered to be a procedure of low clinical value. Ganglia are benign lesions that often spontaneously resolve and which only rarely cause functional problems. This policy has been developed to ensure that resources are used in the most effective way possible and targeted at those with the greatest need.

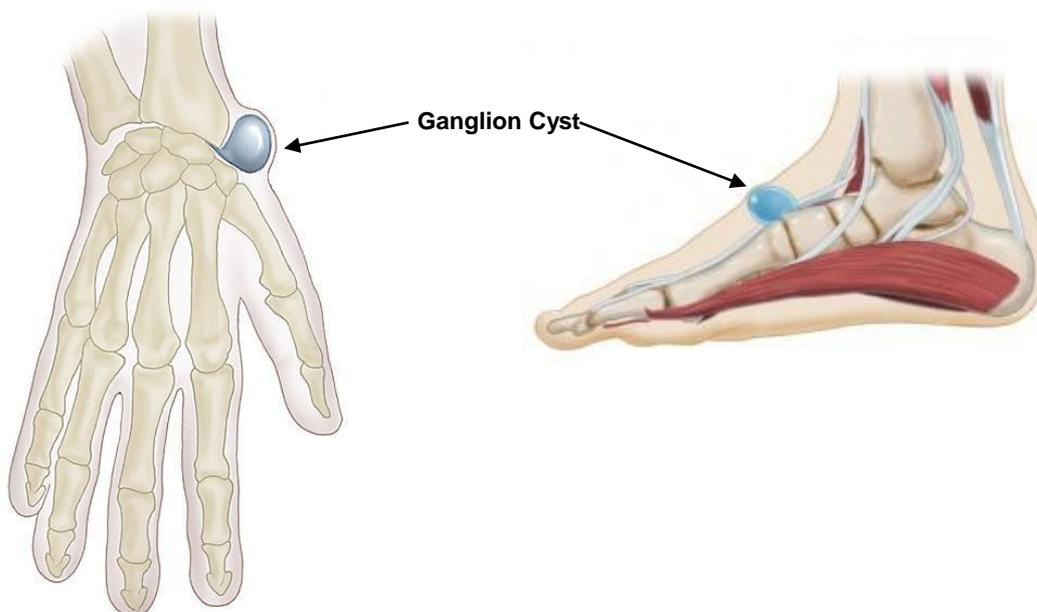
Treatment / Procedure

Ganglion cysts look and feel like a smooth, soft lump under the skin. Ganglia are the commonest soft tissue tumours of the hand and wrist. Wrist ganglia may be found either on the dorsal or palmar - commonly radial - aspects of the wrist. Dorsally they usually arise singly and originate from the scapho-lunate joint. On the volar wrist surface, they usually arise from the radio-carpal or scapho-trapezial joints.

Ganglia have been reported to occur in almost every joint in the hand and wrist. Two other common clinical entities are flexor sheath ganglia and “mucous” cysts associated with the distal inter-phalangeal joint.

Ganglia may also be found on the dorsal of the foot.

Histologically they are composed of a thin connective tissue capsule made up of compressed collagen fibres lined with flattened cells. There is no evidence of a synovial or epithelial lining. Cyst contents consist of a hyaluronic acid-rich mucin-filled uni- or multi-loculated cystic cavities with glucosamine, globulin and albumin. They may disappear without treatment, although this can take a number of years and they may recur in the future. Malignant degeneration has never been reported.



Epidemiology and Need

Population prevalence is unknown as many people live comfortably with their ganglia with no recourse to medical referral. Historical evidence would suggest incidences of between 25-43/100,000 population (Janzon 1981). In one study MRI scans were performed on 103 healthy asymptomatic volunteers and wrist ganglia were found in 53 (Lowden 2005). Ganglia are more prevalent in females (Barnes 1964) and occur most commonly in the second to fourth decades of life (Minotti 2002). They are also common in the paediatric and elderly population although in children the majority resolve in less than 1 year (Calif 2005, Coffey 2008). Ganglia are the second commonest cause for referral to hand units with one UK centre showing a rise from 43.9 per 100,000 per year in 1989/90 to 55 per 100,000 per year in 2000 (Burke 2003).

Source = BSSH Evidence for surgical treatment: Wrist Ganglia

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

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
Albumin	A simple form of protein that is soluble in water and coagulable (capable of changing from a fluid to a solid or semi-solid state) and becoming thick when heated.
Aspiration	A medical procedure that removes something from an area of the body. These substances can be air, body fluids, or bone fragments.
Asymptomatic	Producing or showing no symptoms (symptoms = a physical or mental feature which is regarded as indicating a condition of disease).
Collagen	The main structural protein found in animal connective tissue.
Dorsal (Dorsum)	The back of the wrist (posterior when standing with hands by your side palms forward).
Flexor sheath	A tendon sheath acts as a covering for the synovial tissue over a tendon. The tendon sheath guards the tendon from wear and destruction in physical movements. Flexor sheath relates to a tendon that flexes a joint (flexes =bends).
Globulin	Any of a group of simple proteins soluble in salt solutions and forming a large fraction of blood serum protein.

Glucosamine	A crystalline compound which occurs widely in connective tissue.
Mucin-filled uni- or multi-loculated cystic cavities	See mucous cysts. Multiloculated = Having many small cavities.
Mucous cysts	Mucous = a slimy substance, typically not miscible with water, secreted by the mucous membranes and glands for lubrication, protection, etc. Cysts = a membranous sac or cavity of abnormal character in the body, containing fluid.
Palmar	Pertaining to the palm of the hand.
Phobic	Suffering from irrational fears.
Radial	The side of the wrist relating to the radius (bone) – on the inside when standing with hands by your side palms forward.
Synovial or Epithelial Lining	Relating to or denoting a type of joint which is surrounded by a thick flexible membrane (epithelial lining) forming a sac into which is secreted a viscous fluid that lubricates the joint.
Tumour	A swelling of a part of the body, generally without inflammation, caused by an abnormal growth of tissue, whether benign or malignant.
Volar	Pertaining to the palm of the hand or the sole of the foot.

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
Bury Clinical Commissioning Group	04/03/2015
Bolton Clinical Commissioning Group	27/03/2015
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

Ganglion Cyst Removal GM025

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	<ul style="list-style-type: none">• NHS Choices website – Ganglion Cyst• Best Bets: Best Evidence Topics: Is surgery more effective than aspiration with or without steroid injection in the management of ganglion cysts? (Web based database developed by MRI as a repository for evidence based medicine reviews)• The British Society for Surgery of the Hand (BSSH), Evidence for Surgical Treatment: Wrist Ganglion (found in initial search – see below for Jan 18 review finding)
BMJ Best Practice	BMJ Best Practice Guidance: Ganglion Cyst
General Search (Google)	Patient.co.uk leaflet (not cited below)
Other	Interim Clinical Commissioning Policy: Ganglion Cyst Removal, Prepared by Armed Forces Commissioning Policy Task and Finish Group, NHS England (Added at review: Jan 2016)
Royal College Website	<ul style="list-style-type: none">• RCS – access to journal articles only (not cited below)• The British Society for Surgery of the Hand (BSSH) website: Ganglion Cysts (Added at Jan 18 review – significant changes from original so added to evidence)

Summary of the evidence

Management of ganglia is considered to be a procedure of low clinical value the evidence suggests that aspiration is useful for reassurance and where there is diagnostic uncertainty. Injection into the ganglion does not have any advantage over aspiration alone. Surgery is the treatment of choice for ganglion of the flexor tendon sheaths where grip is affected. The complication and recurrence rate for other types of ganglion and the fact that most will resolve naturally mean surgery is not the treatment of choice for these.

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: SYSTEMATIC REVIEW

The British Society for Surgery of the Hand (BSSH), Evidence for Surgical Treatment: Wrist Ganglion

NOTE: This has been updated with significant changes at Jan 18 review - see 5 below for up to date guidance.

Extract on treatment:

Conservative and “Non-operative” Treatment

Reassurance

A 6 year prospective study showed that 33% of dorsal and 45% of volar ganglia will resolve spontaneously (Dias 2007). Furthermore an internal audit in Derby, with 10 year follow up, showed these figures increase to 51% and 63% respectively (Burke 2003). Therefore, in asymptomatic ganglia, reassurance can be reasonably employed.

Aspiration with or without injection

There is evidence that aspiration of a ganglion may alleviate symptoms for a varying amount of time (Nield 1986, Oni 1992). There is however some reluctance to aspirate volar wrist ganglia because of the proximity of the radial artery and a theoretical risk of damage to it (Burke 2007). At present there is no evidence for this. Single aspiration yields a recurrence rate of 59-88% (Nield 1986, Burke 2003). This can be improved by three serial aspirations to 12-15% (Zubowicz 1987, Oni 1992). Aspiration has also been employed as a tool for reassurance in the 28% of patients who presented with concerns that their ganglion was a malignant lesion (Westbrook 2000, Stephen 1999).

- There is no clear evidence to suggest that aspiration coupled with instillation of steroid affects recurrence rate (Varley 1997). There is some evidence that injection of a combination of steroid and hyaluronidase may reduce recurrence rates further (Paul 1997). However, the recurrence rate after a single aspiration and injection of hyaluronidase has been shown to be inferior to surgical excision (Akkerhuis 2002).
- In both aspiration alone and aspiration with injection, it has been shown that only 25% of patients whose ganglia subsequently recurred after the first treatment requested surgical excision due to the confirmation of the benign nature of the lesion (Westbrook 2000).

Operative Treatment

- Surgical excision of the cyst with capsule and any attachments to the underlying wrist ligaments may be performed either by open surgery or arthroscopically (Kang 2008, Rocchi 2008).
- Published recurrence rates after excision vary dramatically from 1% - 40% (Clay 1988, Dias 2003 & 2007, Angelides 2005). Recurrence rate may depend on the surgical technique. Further investigation is needed to define what factors of the surgical technique are important in preventing recurrence.
- There is evidence that pre-operative pain persists, after excision, in up to 27% of patients (Clay 1988), even though this study reported only a 3% recurrence rate (Clay 1988).
- Two large studies looked independently at treatments for volar and dorsal wrist ganglia over 5 and 6 years respectively. No significant difference was identified between the groups that had received reassurance, aspiration or surgery. Patient satisfaction was higher in the group that received surgical intervention (Dias 2003 & 2007).
- Treatment for symptomatic ganglia therefore remains controversial.

British Society for Surgery of the Hand recommendations for Treatment

Mild

- Reassure / Observe.

Moderate

- Reassure / Observe.

- Aspiration for cancer reassurance.
- Refer for ultrasound / MRI if concerns re diagnosis.

Severe

- Refer for surgery.

Treatments without evidence:

No effect is demonstrated for the following treatments which are Not Recommended:

- Aspiration with simultaneous injection of steroid (Varley 1997)
- Aspiration and multiple wall puncture (Richman 1987)

Links to cited studies can be found in the original document on the website.

2. LEVEL 1: SYSTEMATIC REVIEW

Best Bets: Best Evidence Topics: Is surgery more effective than aspiration with or without steroid injection in the management of ganglion cysts? (Web based database developed by MRI as a repository for evidence based medicine reviews)

The use of steroid at the time of aspiration has not proved to be beneficial and in fact, its success seems to be no better than aspiration alone (Varley, 1997). Many reasons such as pain, fear of malignancy and cosmetic concern lead patients to seek medical advice. Surgery offers higher success rates in most series, but is associated with increased morbidity – wound infection, delayed healing, keloid formation, joint stiffness and damage to cutaneous nerves. Higher rates of recurrence have been attributed to inadequate dissection and incomplete operative excision (Gude, 2008). Meticulous dissection and wide excision could explain the relatively low recurrence rates reported in some studies. A number of factors needs to be taken into consideration, such as, patients' symptoms, occupation (time off work post-operatively), cosmetic reasons, patient perceptions [25% fear cancer (Westbrook, 2000)]. Prior to selecting treatment, the advantages and disadvantages of each modality should be explained to patients and their expectations explored. Ultimately, the decision to operate has to be carefully weighed and should involve patients who are fully informed.

Clinical Bottom Line

Based on current evidence, surgery is the most successful form of treatment when considering only the cure rate. Other references: Gude, W. & Morelli, V. (2008). Ganglion cysts of the wrists: pathophysiology, clinical picture and management. *Curr Rev Musculoskelet Med*, 1, 205-211. Varley, G.W., Neidoff, M., Davis, T.R.C, Clay, N.R. (1997). Conservative management of wrist ganglia: aspiration versus steroid infiltration. *Journal of Hand Surgery*, 22(5), 636–7. Westbrook, A.P., Stephen, A.B., Oni, J. & Davis, T.R.C. (2000). Ganglia: the patient's perception. *Journal of Hand Surgery*, 25B, 566-67.

References

1. Wright, T.W., Cooney, W.P. & Ilstrup, D.M. Anterior wrist ganglion. *The Journal of Hand Surgery* 2004;19(6), 954-8.
2. Bittner, J., Kang, R. & Stern, P. Management of flexor tendon sheath ganglions: A cost analysis. *The Journal of Hand Surgery* 2002; 27(4), 586–590.
3. Dias, J.J., Dhukarma, V. & Kumar, P. The natural history of untreated dorsal wrist ganglia and patient reported outcome 6 years after intervention. *The Journal of Hand Surgery European Volume* 2007;32(5),502–508.
4. Limpaphayom, N. & Wilairatana, V. Randomized controlled trial between surgery and aspiration combined with methylprednisolone acetate injection plus wrist immobilization in the treatment of dorsal carpal ganglion. *Journal of the Medical Association of Thailand* 2004;87(12),1513-7.
5. Kliman, M.E. & Freiberg, A. Ganglia of the foot and ankle. *Foot & Ankle* 1982;3(1), 45-6.
6. Pontious, J., Good, J. & Maxian, S.H. Ganglions of the foot and ankle. A retrospective analysis of 63 procedures. *Journal of the American Podiatric Medical Association* 1999;89(4),163-8.

3. LEVEL: N/A BMJ Best Practice Guidance: Ganglion Cyst

Summary

- Most common benign lesion of the hand/wrist.
- Typically, insidious onset with no predisposing conditions.
- Usually only a cosmetic problem but neurovascular compression may occur.
- Conservative management usually suffices if no neurovascular compromise.
- Aspiration of dorsal cysts can be therapeutic and diagnostic.
- Surgical excision has a higher rate of resolution but recurrence is possible.
- No reported malignant transformation.

4. LEVEL: N/A Interim Clinical Commissioning Policy: Ganglion Cyst Removal, Prepared by Armed Forces Commissioning Policy Task and Finish Group, NHS England (Added at review: Jan 2016)

NHS England will only fund surgery in the following circumstances:

- A. Ganglion on wrist with evidence of neurovascular compromise or significant pain
- B. Seed ganglia at base of digits with significant pain
- C. Mucoid cysts at DIP joint which has disrupted the nail growth and is causing functional impairment or pain, or there are cysts that tend to discharge.

5. LEVEL N/A: EXPERT EVIDENCE BASED GUIDELINES The British Society for Surgery of the Hand (BSSH) website: Ganglion Cysts (Added at Jan 18 review)

What is the treatment? Ganglion cysts are harmless and can safely be left alone. Many disappear spontaneously and many others cause little trouble. There are no long term consequences from leaving the ganglion untreated.

For ganglion cysts in general, the possibilities for treatment:

1. Explanation, reassurance and wait to see if the cyst disappears spontaneously
2. Removal of the liquid contents of the cyst with a needle (aspiration) under local anaesthetic
3. Surgical removal of the cyst

For any individual cyst, the recommendations for treatment will depend on the location of the cyst and on the symptoms that it is causing.

Dorsal wrist ganglion cyst: Typically occurs in young adults and often disappears spontaneously. Aspiration can reduce the swelling but it often returns. The risk of recurrence after surgery is around 10%, and problems after surgery include persistent pain, loss of wrist movement and painful trapping of nerve branches in the scar.

Palmar wrist ganglion cyst: May occur in young adults, but also seen in association with wrist arthritis in older individuals. Aspiration may be useful, but care is needed as the cyst is often close to the artery at the wrist (where you can feel the pulse). The risk of recurrence after surgery is around 30%, and problems after surgery include persistent pain, loss of wrist movement and trapping of nerve branches in the scar. For these reasons, many surgeons advise against operation for these cysts.

Flexor tendon sheath ganglion cyst: Typically occurs in young adults, causing pain when gripping and feeling like a dried pea sitting on the tendon sheath at the base of the finger. Puncture of the cyst with a fine needle can disperse it – like puncturing a balloon - and fewer than half return. Persistent cysts can be removed surgically and the risk of recurrence is small.

Dorsal digital ganglion cyst: Usually in middle-aged or older people and associated with early osteoarthritis of the end joint of a finger. Pressure from the cyst may cause a furrow in the fingernail. Occasionally the cyst fluid leaks through the thin overlying skin from time to time. The risk of recurrence

after surgery is around 10% and problems after surgery include infection, stiffness and pain from the arthritic joint.

Appendix 2 – Diagnostic and Procedure Codes

Ganglion Cyst Removal GM025

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

GM025 - Ganglion Cyst Removal Policy	
Excision of ganglion of wrist	T59.1
Excision of ganglion of hand NEC	T59.2
Excision of ganglion of knee	T59.3
Excision of ganglion of foot	T59.4
Other specified excision of ganglion	T59.8
Unspecified excision of ganglion	T59.9
Re-excision of ganglion of wrist	T60.1
Re-excision of ganglion of hand NEC	T60.2
Re-excision of ganglion of knee	T60.3
Re-excision of ganglion of foot	T60.4
Other specified re-excision of ganglion	T60.8
Unspecified re-excision of ganglion	T60.9
With the following ICD-10 diagnosis code(s):	
Ganglion (<i>nothing to state that this is severe as per policy</i>)	M67.4

Appendix 3 – Version History

Ganglion Cyst Removal GM025

The latest version of this policy can be found here: [GM Ganglion Cyst Removal Policy](#)

Version	Date	Summary of Changes
0.1	28/04/2014	Initial draft
0.2	29/05/2014	Amendments made by GM EUR Steering Group on 21/05/2014: <ul style="list-style-type: none"> Removal of third bullet point stating “patient is cancer phobic” and the word “cancer” from the treatment sentence, both under the criteria for Moderate varicose veins. 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	<ul style="list-style-type: none"> Amendments made by GM EUR Steering Group on 17/09/2014 following a review of feedback from the consultation: Inclusion of a diagram of a ganglion on a foot and reference to foot in section 2, the definition. Separate severe pain with restriction of activities of daily living, into 2 separate bullet points under the severe section in the mandatory criteria, section 4.
	17/09/2014	Policy approved by GM EUR Steering Group subject to the above amendments.
0.4	08/07/2014	Branding Change following creation of North West CSU on 1/10/2014.
1.0	17/09/2014	Policy approved by GM EUR Steering Group – required amendments made.
1.1	27/03/2015 23/06/2015	Bolton CCG adopted funding mechanism of IPA. <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> The following paragraph added under Policy Exclusions: <i>‘Ganglion removal as part of an externally funded trial or a locally agreed pathway of care is excluded from this policy’</i> Wording for date of review changed. Evidence review updated following review.
2.1	05/04/2016 19/04/2016	<ul style="list-style-type: none"> 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. Funding mechanism for Bolton CCG changed from Individual Prior Approval to Monitored Approval – in line with the rest of GM.
3.0	17/01/2018	Policy reviewed by GM EUR Steering Group and the following changes were agreed: <ul style="list-style-type: none"> Policy moved to new template <u>Policy Inclusion Criteria:</u> <ul style="list-style-type: none"> First paragraph changed from: <i>‘Only those ganglion cysts graded as</i>

		<p><i>severe will be referred for surgery. Where indicated aspiration can be done in primary care, to aid reassurance, for all grades.'</i></p> <ul style="list-style-type: none"> ○ <i>To: Ganglion cyst surgery is <u>not</u> routinely commissioned. <u>Surgery is only commissioned for ganglion of the flexor tendon sheaths where grip is affected.</u></i> NOTE: <i>Needle puncture of the 'sheath' should be considered first (where suitable facilities are available) as less than half recur after this. Where indicated, and where suitable facilities are available, aspiration can be done in primary care for all ganglion as an aid reassurance (for all grades):</i> ○ <i>'Treatment' under 'Severe' changed from: 'Referral for surgical removal' to: 'As most ganglions will resolve spontaneously, and as a high proportion will recur after surgery, the routine treatment for all should be reassurance and observation, with aspiration in primary care for reassurance. Refer for ultrasound / MRI if there are concerns about the diagnosis'</i> ○ <i>Funding mechanism changed from: '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.'</i> to: <i>'Monitored approval: Referrals may be made in line with the criteria for <u>flexor sheath ganglion</u> without seeking funding. NOTE: May be the subject of contract challenges and/or audit of cases against commissioned criteria.'</i> ● Date of Review: <i>Standard wording on next review added to state '3 years'</i> ● Appendix 1: <i>Evidence review updated</i> <p>The GM EUR Steering Group considered the above changes to be material and requested that the policy go back out for a period of clinical engagement.</p>
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