*Extract from the below named document for ICS Implementation purposes;* [*Microsoft Word - EBI consultation response statutory guidance 11 Jan 2019 FINAL v2.0 CLEAN + cover sheet.docx (aomrc.org.uk)*](https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/ebi-statutory-guidance.pdf)

­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carpal tunnel syndrome release

Updated description of the intervention

Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time. Splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. Surgical treatment of carpal tunnel should only be offered under the criteria included below.

Updated clinical criteria

|  |
| --- |
| Summary of intervention |
| Open or endoscopic surgical procedure to release median nerve from carpal tunnel. |
| Number of CCG interventions in 2017/18 |
| 44,497 |
| Recommendation |
| Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)ornight splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks;orThere is either:a permanent (ever-present) reduction in sensation in the median nerve distribution;ormuscle wasting or weakness of thenar abduction (moving the thumb away from the hand). Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain. |

|  |
| --- |
| Rationale for recommendation |
| Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical effectiveness and long term benefit) should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%. |
| References |
| Atroshi I, Flondell M, Hofer M, Ranstam J. Methylprednisolone injections for the carpal tunnel syndrome: a randomized, placebo-controlled trial. Annals of internal medicine. 2013;159(5):309-17.Chesterton LS, Blagojevic-Bucknall M, Burton C et al. The clinical and cost- effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (instincts trial): An open-label, parallel group, randomised controlled trial. Lancet. 2018, 392: 1423-33.Gerritsen AA, de Vet HC, Scholten RJ, Bertelsmann FW, de Krom MC, Bouter LM. Splinting vs surgery in the treatment of carpal tunnel syndrome: A randomized controlled trial. JAMA. 2002, 288: 1245-51.Korthals-de Bos IB, Gerritsen AA, van Tulder MW et al. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: Results of an economic evaluation alongside a randomized controlled trial. BMC Musculoskelet Disord. 2006, 7: 86.Louie D , Earp B & Philip Blazar P Long-term outcomes of carpal tunnel release: a critical review of the literature HAND (2012) 7:242–246Marshall S, Tardif G, Ashworth N. Local corticosteroid injection for carpal tunnel syndrome. Cochrane Database Syst Rev. 2007(2):CD001554.Page MJ, Massy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel syndrome. Cochrane Database Syst Rev. 2012(7):CD010003.Shi Q, MacDermid JC. Is surgical intervention more effective than non- surgical treatment for carpal tunnel syndrome? A systematic review. J Orthop Surg Res. 2011;6:17.Stark H, Amirfeyz R. Cochrane corner: local corticosteroid injection for carpal tunnel syndrome. J Hand Surg Eur Vol. 2013;38(8):911-4.Royal College of Surgeons: https://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2017.28Verdugo RJ, Salinas RA, Castillo JL, Cea JG. Surgical versus non-surgical treatment for carpal tunnel syndrome. Cochrane Database Syst Rev. 2008(4):CD001552. |

*Evidence-Based Interventions: Guidance for CCGs*

*Published by NHS England in partnership with NHS Clinical Commissioners, the Academy of Medical Royal Colleges, NHS Improvement and the National Institute for Health and Care Excellence*

*Version number: 1*

*First published: 28 November 2018*

*Prepared by: NHS England Medical directorate and Strategy and Innovation directorate*

*Classification: OFFICIAL*

*NHS England Publications Gateway Reference: 08659*