Greater Manchester EUR Policy Statement on:

Removal of Common Benign Eyelid Lesions

GM Ref: GM044
Version: 3.0 (18 September 2019)
Commissioning Statement

Removal of Common Benign Eyelid Lesions

Policy Exclusions (Alternative commissioning arrangements apply)

All suspected malignant lesions are excluded from this policy – these should be managed via the 2 week wait with the exception of Basal Cell Carcinoma (BCC should be referred through the usual pathway).

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 removal of common benign eyelid lesions for aesthetic reasons is not routinely commissioned.

Referral to secondary care for surgical intervention (or in the case of chalazia for injection with triamcinolone) where the benign lesion may not be the primary condition

Referrals for the treatment of common benign eyelid lesions can be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis and the lesion may not be benign in nature.

Examples of reasons for referral include (but are not exclusive) to:

- Significant pre-septal cellulitis / orbital cellulitis
- Atypical presentation, re-occurrence in same site, may require cancer exclusion
- Protrusion of the eye
- Rapidly growing
- Visual field affected
- Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye
- The lesion interferes with the protection of the eye by preventing complete closure of the eye
- New and unexpected visual problems (e.g. double vision)
- Reduced light reflexes or abnormal swinging light test
- Symptomatically unwell
- CNS symptoms or signs

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.

Referral to secondary care where the benign lesion is the primary condition

Where the eyelid lesion is symptomatic, referrals can be made for any one or more of the following criteria:

- Persistent (more than 6 months and not responded to conservative treatment)
- There is significant pain as a direct result of the lesion
- There is a confirmed history of recurrent infection / inflammation
- Significant redness of the eye in the absence of an obvious cause

**Funding Mechanism**

Individual prior approval provided the patient meets the above criteria. Requests must be submitted with all relevant supporting evidence.

<table>
<thead>
<tr>
<th>Clinical Exceptionality</th>
<th>Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. More information on determining clinical exceptionality can be found in the Greater Manchester (GM) Effective Use of Resources (EUR) Operational Policy. Link to GM EUR Operational Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness for Surgery</td>
<td>NOTE: All patients should be assessed as fit for surgery before going ahead with treatment, even though funding has been approved.</td>
</tr>
<tr>
<td>Best Practice Guidelines</td>
<td>All providers are expected to follow best practice guidelines (where available) in the management of these conditions.</td>
</tr>
</tbody>
</table>
Policy Statement

The GM 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 the GM EUR Steering Group has 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

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. 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, 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 GM 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 CCGs 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

The Greater Manchester Joint Commissioning Board has given delegated authority to the Greater Manchester Directors of Commissioning and Directors of Finance to approve GM EUR treatment policies for implementation. 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**

The vast majority of common benign eyelid lesions are harmless and although they may be unsightly there is no clinical reason for their removal. There are occasional circumstances in which the removal of these lesions are indicated and these circumstances are listed in this policy. The policy does not allow lesions to be removed for solely aesthetic reasons.

**Treatment / Procedure**

Benign lesions of the eyelid are those which do not affect the functioning of the eye or eyelids and will not develop into malignant disease. These include but are not limited to Chalazion (meibomian) cyst, dermatochelasis and xanthelasma.

The first step in the management of most lesions will be self-care in the form of enhanced eyelid hygiene. Individuals will be expected to self-fund the products needed for good hygiene e.g. Baby shampoo or blepharwipes.

**Epidemiology and Need**

The vast majority of eyelid lesions are harmless and self-limiting. Xanthelasma is often seen in people with high cholesterol or other fat (lipid) levels in the blood, and the lesions contain deposits that are high in fat (lipid-rich). Xanthelasma can occur in people of any race and of either sex. However, females seem to be more frequently affected than males. In addition, it is unusual for a child or teenager to develop xanthelasma; most individuals develop the condition in middle age. Approximately one half of patients with xanthelasma have high amounts of fats (lipids) in their blood, such as high cholesterol or high triglycerides.

Dermatochalasis is a common finding seen in elderly persons and occasionally in young adults. Gravity, loss of elastic tissue in the skin, and weakening of the connective tissues of the eyelid frequently contribute to this lax and redundant eyelid tissue. These findings are more common in the upper eyelids but can be seen in the lower eyelids as well. Genetic factors and family traits may play a role in some patients.

**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**

Five 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**

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astigmatism</td>
<td>A condition of unequal curvatures along the different meridians in one or more of the refractive surfaces (cornea, anterior or posterior surface of the lens) of the eye, in consequence of which the rays from a luminous point are not focused at a single point on the retina.</td>
</tr>
<tr>
<td>Benign</td>
<td>(Of a disease) not harmful in effect.</td>
</tr>
<tr>
<td>Chalazion</td>
<td>A chalazion is a small (2-8mm) fluid-filled swelling (cyst) in the eyelid. It is common and sometimes called a meibomian cyst or tarsal cyst. A chalazion is more common on the upper eyelid and can affect both eyes. It is not the same as a stye.</td>
</tr>
<tr>
<td>Canthus</td>
<td>The outer or inner corner of the eye, where the upper and lower lids meet</td>
</tr>
<tr>
<td>Dermatochelasis</td>
<td>Drooping of the eyelids.</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>A medical condition in which the skin becomes red, swollen, and sore, sometimes with small blisters.</td>
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<tr>
<td>Malignant</td>
<td>Unregulated cell growth. In cancer, cells divide and grow uncontrollably, forming malignant tumors, and invading nearby parts of the body.</td>
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<tr>
<td>Orbital septum</td>
<td>A fibrous membrane attached to the margin of the orbit and extending into the lids, containing the orbital fat and constituting in great part the posterior fascia of the orbicularis oculi muscle.</td>
</tr>
<tr>
<td>Preseptal</td>
<td>Infection involving the superficial tissue layers anterior to the orbital septum.</td>
</tr>
<tr>
<td>Xanthelasma</td>
<td>Xanthelasma (xanthelasma palpebrarum) is a skin condition that develops flat yellow growths on the eyelids. The appearance is of yellow flat plaques over the upper or lower eyelids, most often near the inner canthus.</td>
</tr>
</tbody>
</table>

**References**

1. GM EUR Operational Policy
2. Individual CCG referral criteria and policy statements.

**Governance Approvals**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester Effective Use of Resources Steering Group</td>
<td>20/05/2015</td>
</tr>
<tr>
<td>Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning</td>
<td>11/08/2015</td>
</tr>
<tr>
<td>Greater Manchester Association Governing Group</td>
<td>15/09/2015</td>
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<tr>
<td>Bolton Clinical Commissioning Group</td>
<td>23/10/2015</td>
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<tr>
<td>Bury Clinical Commissioning Group</td>
<td>07/10/2015</td>
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<tr>
<td>Clinical Commissioning Group</td>
<td>Date</td>
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<tr>
<td>Heywood, Middleton &amp; Rochdale Clinical Commissioning Group</td>
<td>20/11/2015</td>
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<tr>
<td>Manchester Clinical Commissioning Group</td>
<td>North: 21/10/2015</td>
</tr>
<tr>
<td></td>
<td>Central: 16/12/2015</td>
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<td></td>
<td>South: 01/10/2015</td>
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<tr>
<td>Oldham Clinical Commissioning Group</td>
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<td>Salford Clinical Commissioning Group</td>
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<tr>
<td>Stockport Clinical Commissioning Group</td>
<td>23/09/2015</td>
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<tr>
<td>Tameside &amp; Glossop Clinical Commissioning Group</td>
<td>25/10/2015</td>
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<tr>
<td>Trafford Clinical Commissioning Group</td>
<td>17/11/2015</td>
</tr>
<tr>
<td>Wigan Borough Clinical Commissioning Group</td>
<td>07/10/2015</td>
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</tbody>
</table>
Appendix 1 – Evidence Review

Removal of Common Benign Eyelid Lesions

GM044

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:

<table>
<thead>
<tr>
<th>Database</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE</td>
<td>Xanthelasma mentioned in CG71: Familial hypercholesterolaemia: identification and management (Not cited below)</td>
</tr>
<tr>
<td>NHS Evidence and NICE CKS</td>
<td>The College of Optometrists Clinical Management Guidelines: Chalazion (Meibomian cyst), Version 12, Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16 (Previous version replaced by updated version - Added at review: Sep 2016)</td>
</tr>
<tr>
<td></td>
<td>The College of Optometrists Clinical Management Guidelines: Hordeolum, Version 9, Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16 (Added at review: Sep 2016)</td>
</tr>
<tr>
<td></td>
<td>NICE CKS: Meibomian cyst (chalazion), Last revised: November 2015, (Previous version replaced by updated version added at review: Sep 2016)</td>
</tr>
<tr>
<td></td>
<td>NICE CKS: Styes (hordeola), Last revised: August 2015, (Previous version replaced by updated version added at review: Sep 2016)</td>
</tr>
<tr>
<td></td>
<td>BMJ Practice Summary: Stye and Chalazion (not cited below)</td>
</tr>
<tr>
<td></td>
<td>Modernisation Agency Plastic Surgery Guidelines (not cited below)</td>
</tr>
<tr>
<td>BMJ Best Practice</td>
<td>Stye and Chalazion section (Not cited below)</td>
</tr>
<tr>
<td></td>
<td>Nil specific found (reference in management of hypercholesterolaemia)</td>
</tr>
</tbody>
</table>

Summary of the evidence

The vast majority of benign skin lesions of the eyelid are harmless, many are self-limiting. Most removals are requested for aesthetic reasons; however, in some circumstances removal is indicated for clinical or functional reasons e.g.: where a:

- lesion is causing a reduction of the visual fields

OR

- should have resolved within 6 months and hasn’t
The evidence

Levels of evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Meta-analyses, systematic reviews of randomised controlled trials</td>
</tr>
<tr>
<td>Level 2</td>
<td>Randomised controlled trials</td>
</tr>
<tr>
<td>Level 3</td>
<td>Case-control or cohort studies</td>
</tr>
<tr>
<td>Level 4</td>
<td>Non-analytic studies e.g. case reports, case series</td>
</tr>
<tr>
<td>Level 5</td>
<td>Expert opinion</td>
</tr>
</tbody>
</table>

1. **LEVEL 3: PROSPECTIVE COHORT STUDY**

   **Abstract**

   **Aim:** To study prospectively the outcome of conservative and surgical treatment of chalazia provided by medical and nursing staff.

   **Methods:** During a 5 month recruitment period all patients attending a district general eye hospital for treatment of chalazion were included in the study. 129 patients (217 visits) with chalazia were seen by either a senior nurse or a trainee ophthalmologist (senior house officer, SHO) or both. Patients received either conservative treatment or eversion of the eyelid with incision and curettage. Patients were mailed a questionnaire asking them if their cyst had resolved and how they rated their treatment. Marginal cost analysis was used to determine the cost of treatment.

   **Results:** The outcome of treatment could be determined in 170 of the 217 visits. Conservative treatment was successful for 29% of cysts while surgical treatment was successful for 72%. There was no significant difference in treatment outcome between nurse and SHO groups. Patients found nurse treatment acceptable with a high level of patient satisfaction. The marginal cost of treatment by a nurse was 9.91 pounds sterling per cyst compared with 12.10 pounds sterling for SHOs. There were no surgical complications and no evidence of malignancy in six biopsies.

   **Conclusions:** Surgical treatment of chalazion is safe and effective and successfully treats approximately three quarters of selected cysts. With conservative treatment approximately one third of selected chalazia will resolve within 3 months. Nurse treatment of chalazion is safe, effective, and acceptable to patients.

2. **LEVEL: N/A**

   **NICE CKS: Styes (Hordeola), Last revised: August 2015**

   **MANAGEMENT**

   **How should I manage a stye in primary care?**

   - **Reassure the person that a stye is usually self-limiting and rarely causes serious complications.**
     - Symptoms typically rapidly resolve once the stye has spontaneously ruptured or has been drained.

   - **Advise the person:**
     - To apply a warm compress (for example, using a clean flannel that has been rinsed with hot water) to the affected eye for 5–10 minutes. Repeat several times a day until the stye drains or resolves.
     - They should not attempt to puncture the stye.
     - To avoid eye makeup or contact lens use until the area has healed.

   - **For a painful external stye, consider:**
Epilating the eyelash from the infected follicle (to facilitate drainage).
Incising and draining the stye, using a fine sterile needle, if appropriate. This should only be undertaken by a healthcare professional with suitable expertise.

- **Do not prescribe a topical antibiotic** unless there is evidence of conjunctivitis. See the CKS topic on Conjunctivitis - infective for more information.
- **If the stye does not improve** or resolve with conservative treatment, consider referral for specialist assessment.
- **Manage any co-existing blepharitis** to reduce the risk of recurrence. See the CKS topic on Blepharitis for more information.

**Basis for recommendation**

**Self-management advice**
- The recommendation on applying a warm compress is based on expert opinion in the British Medical Journal (BMJ) review article *Eyelid lumps and lesions* [Gupta et al., 2014]. The recommendation to apply a warm compress several times a day is based on expert opinion in US clinical review articles [Greenberg, 2002; Mueller and McStay, 2008], and an Australian optometry guideline *Optometric management of hordeolum* [QUT, 2005]. A UK optometry review article *Hordeolum and chalazion treatment* recommends applying a warm compress 2–4 times daily [Skorin, 2002].
- The recommendation to avoid puncturing an external stye is based on 2 UK case reports. They highlighted the serious complications that can follow the puncture of a stye by the person themselves, causing periorbital cellulitis [Benton and Karkanevatos, 2007] and periorbital necrotizing fasciitis (which can be potentially life-threatening) [Raja et al, 2008].
- The recommendation to avoid eye makeup or contact lenses is based on a Canadian patient information resource, *Styes and Chalazia* [HealthLink BC, 2014].

**Procedures for symptomatic relief of external styes**
- The recommendations for epilating the affected hair follicle or incising an external stye are supported by expert opinion in a US review article *The red eye: evaluation and management* [Sethuraman and Kamat, 2009a] and the College of Optometrists guideline *Hordeolum* [The College of Optometrists, 2015].

**Topical antibiotics not recommended**
- A Cochrane systematic review (search date July 2012) found no relevant trials on interventions for an acute internal stye [Lindsley et al, 2013].
- Expert opinion on the use of topical antibiotics for the treatment of styes differs:
  - A US review article *The red eye: evaluation and management* suggests that topical antibiotics do not affect the course of an external stye [Sethuraman and Kamat, 2009b]. A second US review article *Ocular Infection and Inflammation* states that the use of topical antibiotics for preventing complications is controversial [Mueller and McStay, 2008].
  - A British Medical Journal (BMJ) clinical review article *Eyelid lumps and lesions* states that the role of topical antibiotics is debatable [Gupta et al, 2014].
  - A UK optometry review article *Hordeolum and chalazion treatment* recommends the use a topical antibiotic for the treatment of an external stye (not internal because the infection is deep within the lid and therefore topical application is ineffective) [Skorin, 2002]. However, an Australian optometry guideline *Optometric management of hordeolum* recommends the use of a topical antibiotic for the treatment of both an external and internal stye [QUT, 2005].
- Given the lack of a consensus in the literature and the self-limiting nature of the condition, CKS does not recommend topical antibiotics for the routine treatment of a stye. This recommendation is supported by a consensus of expert opinion from previous external reviewers of this CKS topic.

**Referral if non-resolution**
- The recommendation to consider referral to an ophthalmologist if a stye is not improving with conservative management is based on a clinical review article published in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014].

**Management of co-existing blepharitis**
• The recommendation on managing co-existing blepharitis to reduce the risk of recurrence is based on expert opinion in the guideline *Clinical management guidelines for hordeolum* published by the College of Optometrists [The College of Optometrists, 2015].

**REFERRAL**

When should I refer a person with a stye?

• Admit the person to hospital if:
  - There are signs of significant periorbital or orbital cellulitis.

• Arrange a 2-week wait referral if a malignant eyelid tumour is suspected — for example, if the stye has an atypical appearance (for example distortion of the eyelid margin, loss of eyelashes, ulceration, or bleeding) or a suspected stye recurs in the same location.

• Refer the person to an ophthalmologist for possible incision and drainage if:
  - The stye is persistent and has not discharged following conservative treatment.
  - An internal stye is particularly large and painful.

**Basis for recommendation**

**Admission**

• The recommendation to admit a person with either periorbital or orbital cellulitis is based on expert opinion in a clinical review article *Guidelines for the management of periorbital cellulitis/abscess* [Howe and Jones, 2004].

**2-week wait referral for suspected cancer**

• The recommendation to urgently refer a person if cancer is suspected is based on expert opinion in a clinical review article in the British Medical Journal (BMJ), *Eyelid lumps and lesions* [Gupta et al, 2014].

**Referral to an ophthalmologist for possible incision and drainage**

• The recommendation to refer a person with a persistent stye or a large, painful internal stye is based on expert opinion in a clinical review article in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014]

3. LEVEL: N/A

NICE CKS: Meibomian cyst (chalazion), Last revised: November 2015

**MANAGEMENT**

How should I manage a meibomian cyst in primary care?

• Reassure the person that a meibomian cyst is usually self-limiting and rarely causes serious complications.
  - Meibomian cysts usually resolve spontaneously or with conservative treatment.

• Advise the person:
  - To apply a warm compress (for example, using a clean flannel that has been rinsed with warm water) to the affected eye for 5–10 minutes at least twice a day.
    - Explain that this will help to liquefy the lipid content of the cyst, thus encouraging drainage of the cyst contents.
    - Avoid excessively hot compresses (to avoid scalding).
  - Gently massage the meibomian cyst after application of the warm compress (to aid expression of the cyst contents).
    - This should be done in the direction of the eyelashes using clean fingers or a cotton bud.

• Do not prescribe topical or oral antibiotics.

• If the meibomian cyst does not improve or resolve after 4 weeks with conservative treatment, offer the following options (depending on clinical judgement and the person's preference):
  - No treatment — for example, if the meibomian cyst is small and asymptomatic.
  - Referral to an ophthalmologist.

• Manage any co-existing risk factors to reduce the risk of recurrent episodes.
  - Chronic blepharitis. See the CKS topic on Blepharitis for more information.
- Seborrhoeic dermatitis. See the CKS topic on Seborrhoeic dermatitis for more information.
- Acne rosacea. See the CKS on Rosacea for more information.

**Basis for recommendation**

**Self-management advice**
- The recommendation on applying a warm compress is based on expert opinion in the British Medical Journal (BMJ) review article *Eyelid lumps and lesions* [Gupta et al, 2014].
- The recommendation to apply heat and massage at least twice a day is based on expert opinion in the British Medical Journal (BMJ) review article *Chalazion* [Arbabi et al, 2010].

**Antibiotics not recommended**
- Meibomian cysts are generally sterile in nature. Consequently, treatment with antibiotics (topical or oral) is not recommended [Arbabi et al, 2010].

**Treatment options if the cyst is unresponsive to conservative treatment**
- CKS recommends that no treatment or referral are considered as options if there is no improvement after 4 weeks. Meibomian cysts may resolve spontaneously and only rarely cause serious complications.
  - The recommendation to apply conservative treatment for up to 4 weeks is based on expert opinion and evidence from published trials [Olson, 1991; Lederman and Miller, 1999].

**Management of co-existing risk factors**
- The recommendation to manage risk factors in order to reduce the risk of future episodes is based on expert opinion in the BMJ review article *Chalazion* [Arbabi et al, 2010] and The College of Optometrists Clinical Management guidelines of Chalazion (meibomian cyst) [The College of Optometrists, 2015].
  - This is also supported by the Department of Health's 18-Week Commissioning Pathway guideline which recommends 2–3 weeks of conservative treatment [DH, 2008].

**REFERRAL**

**When should I admit or refer a person with a meibomian cyst?**
- **Admit the person to hospital if:**
  - There are symptoms or signs of significant periorbital or orbital cellulitis.
- **Arrange a 2-week wait referral if a malignant eyelid tumour is suspected** — for example, if the meibomian cyst has an atypical appearance (for example distortion of the eyelid margin, loss of eyelashes, ulceration, or bleeding) or a suspected meibomian cyst recurs in the same location.
- **Refer the person to an ophthalmologist** for specialist treatment if:
  - The meibomian cyst is affecting vision or causing discomfort.
  - The meibomian cyst does not respond to conservative treatment.
    - Large and persistent meibomian cysts (those lasting more than 6 months) are likely to require specialist treatment.
  - There is uncertainty about the diagnosis.

**SPECIALIST TREATMENT**

**Incision and curettage**
- This is generally carried out under local anaesthetic.
- The eyelid may remain swollen and inflamed for up to 1 week after the procedure.
- Complications are uncommon, but include haemorrhage, infection, and (more rarely) canalicular trauma and globe perforation. The meibomian cyst may recur (particularly if the drainage was inadequate).

**Intralesional corticosteroid injection**
- Triamcinolone acetonide is injected directly into the cyst; either subcutaneously or via the trans-conjunctival route. More than one injection may be required (particularly for large cysts).
- Reported success rates are 75–84%. Resolution typically occurs 1–2 weeks after injection.
• Adverse effects include depigmentation of the eyelid at the injection site, temporary skin atrophy, subcutaneous white deposits, and a potential increase in intraocular pressure. [Arbabi et al, 2010; Ben Simon et al, 2011; The College of Optometrists, 2015]

**Basis for recommendation**

**Arranging admission**

• The recommendation to admit a person with either significant periorbital or orbital cellulitis is based on expert opinion in the clinical review article *Guidelines for the management of periorbital cellulitis/abscess* [Howe and Jones, 2004].

**Arranging a 2-week wait referral for suspected cancer**

• The recommendation to urgently refer a person if cancer is suspected is based on expert opinion in a clinical review article published in the British Medical Journal (BMJ), *Eyelid lumps and lesions* [Gupta et al, 2014]; an Australian review article [Gilchrist, 2009]; and a US review article [Papier et al, 2007].

**Routine referral to an ophthalmologist**

• The recommendation to refer a person with a meibomian cyst, which is large and causing visual disturbance is based on The College of Optometrists *Clinical management guidelines of Chalazion (Meibomian cyst)* [The College of Optometrists, 2015].

• The recommendation to refer a person with a persistent meibomian cyst is based on expert opinion in a clinical review article published in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014].

• The recommendation to refer the person if there is any doubt regarding the diagnosis is based on what CKS considers to be good clinical practice.

4. **LEVEL: N/A**

**The College of Optometrists Clinical Management Guidelines: Chalazion (Meibomian cyst), Version 12, Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16**

<table>
<thead>
<tr>
<th>Aetiology</th>
<th>Blockage of Meibomian gland duct with retention and stagnation of secretion May occur spontaneously or follow an acute hordeolum (internal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predisposing factors</td>
<td>Chronic blepharitis Rosacea Seborrhoeic dermatitis Pregnancy Diabetes mellitus</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Painless lid lump Usually single; sometimes multiple May be recurrent May rupture through the skin (Sometimes) blurred vision from induced astigmatism</td>
</tr>
<tr>
<td>Signs</td>
<td>Well-defined, 2-8mm diameter subcutaneous nodule in tarsal plate Lid eversion may show external conjunctival granuloma Induced astigmatism may cause change in refraction May be associated blepharitis</td>
</tr>
<tr>
<td>Differential diagnosis</td>
<td>Hordeolum (external or internal) Sebaceous cyst of skin Sebaceous (Meibomian gland) Carcinoma (consider if lesion recurrent)</td>
</tr>
<tr>
<td>Management by Optometrist</td>
<td>Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere Non pharmacological</td>
</tr>
</tbody>
</table>
management by ophthalmologist
Regular lid hygiene for blepharitis (see Clinical Management Guideline on Blepharitis)
(GRADE*: Level of evidence=low; Strength of recommendation=strong)

<table>
<thead>
<tr>
<th>Pharmacological</th>
<th>None (but see Clinical Management Guideline on Hordeolum [internal])</th>
</tr>
</thead>
</table>
| Management Category | **B2:** alleviation/palliation: normally no referral  
**B1:** routine referral to Ophthalmologist if persistent or recurrent, if causing  
significant astigmatism or if cosmetically unacceptable |

### Possible management by Ophthalmologist

- Incision and curettage where appropriate
- Intra-lesion injection of steroid (may be preferred in children)

Trials have shown that intralesional triamcinolone injection may be as effective as incision and curettage in primary chalazia (see evidence base)

#### Evidence base

*GRADE: Grading of Recommendations Assessment, Development and Evaluation (see http://www.gradeworkinggroup.org/index.htm)

**Sources of evidence**


Perry HD, Serniuk RA. Conservative treatment of chalazia Ophthalmology 1980;87(3):218-21

**Lay Summary:** A chalazion, also known as a Meibomian cyst, is a common condition of the eyelid caused by blockage of the openings of the oil-producing Meibomian glands. It is usually felt as a small firm lump in the upper or lower eyelid. The condition usually gets better without treatment. However if it does not settle on its own, it can be treated by a steroid injection or the cyst can be removed by a minor operation.

### 5. LEVEL: N/A

The College of Optometrists Clinical Management Guidelines: Hordeolum, Version 9, Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16

#### Aetiology

There are two types:
- external hordeolum (stye) – acute bacterial infection of the lash follicle and its associated gland of Zeis or Moll
- internal hordeolum – acute bacterial infection of Meibomian gland

These infections are usually staphylococcal

#### Predisposing factors

Chronic blepharitis

#### Symptoms

- Tender lump in eyelid
- Epiphora
- Local redness of eye and lid

#### Signs

**External hordeolum**

Tender inflamed swelling of the lid margin. May point anteriorly through the skin
Occasionally, multiple abscesses involve entire eyelid

**Internal hordeolum**

Tender inflamed swelling within the tarsal plate. More painful than a stye. May
| **Differential diagnosis** | Preseptal cellulitis  
| Haematoma of eyelid  
| Acute dacryocystitis  
| Chalazion (blockage of Meibomian gland with cyst formation)  
| Sebaceous cell carcinoma |

**Management by Optometrist**

Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere

**Non pharmacological**

Most resolve spontaneously or discharge, followed by resolution

In the case of external hordeola, it may help to remove the lash associated with the infected follicle

Traditional remedies such as hot spoon bathing and/or warm compresses may relieve symptoms

Manage associated blepharitis with lid hygiene (see Clinical Management Guideline on Blepharitis)

Rarely, refer for incision in cases that do not discharge (commoner with internal hordeolum)

An internal hordeolum may evolve into a chalazion (see Clinical Management Guideline on Chalazion)

Advise patient to return/seek further help if symptoms persist

(GRADE*: Level of evidence=low; Strength of recommendation=strong)

**Pharmacological**

Consider course of antibiotic drops or ointment (e.g. chloramphenicol) in the presence of copious muco-purulent discharge

In severe or recurrent cases, consider management with systemic antibiotics (possible co-management with GP)

(GRADE*: Level of evidence=low; Strength of recommendation=strong)

**Management Category**  
**B2:** Alleviation/palliation: normally no referral

**Possible management by Ophthalmologist**

Possible incision, but surgery rarely performed in presence of acute infection

See also Clinical Management Guidelines on Chalazion, Pre-septal Cellulitis

**Evidence base**

*GRADE: Grading of Recommendations Assessment, Development and Evaluation (see http://www.gradeworkinggroup.org/index.htm)

Sources of evidence


**Lay Summary:** A hordeolum is an acute bacterial infection of the glands of the eyelid. An internal hordeolum affects the Meibomian (oil) glands within the eyelids whereas an external hordeolum (commonly referred to as a stye) affects the glands associated with the eyelashes. Both conditions cause red and tender swellings of the eyelid. Traditional remedies such as hot spoon bathing and/or warm compresses may relieve symptoms. In some cases, treatment with antibiotic drops or ointment is needed to speed up resolution. In the case of a severe infection, antibiotic tablets may be required.
6. LEVEL n/a : NHS England – Evidence Based Intervention (EBI) guidance


The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery.

Updated clinical criteria

<table>
<thead>
<tr>
<th>Summary of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of CCG interventions in 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,026</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:</td>
</tr>
<tr>
<td>• Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks</td>
</tr>
<tr>
<td>• Interferes significantly with vision</td>
</tr>
<tr>
<td>• Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy</td>
</tr>
<tr>
<td>• Is a source of infection that has required medical attention twice or more within a six month time frame</td>
</tr>
<tr>
<td>• Is a source of infection causing an abscess which requires drainage</td>
</tr>
<tr>
<td>• If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale for recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used.</td>
</tr>
<tr>
<td>Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does</td>
</tr>
</tbody>
</table>

7. LEVEL n/a NICE Clinical Knowledge Summary (CKS)

Updated NICE CKS on Meibomian cyst (chalazion) – last revised March 2019 - Next planned review by December 2024
How should I manage a meibomian cyst in primary care?

- If there are signs and symptoms of associated orbital cellulitis, arrange urgent hospital admission for assessment and management.
- If there are red flag signs or symptoms to suggest malignancy, arrange urgent referral for specialist assessment, biopsy (where appropriate), and any required management.
- If the meibomium cyst is persistent, recurrent, causing significant astigmatism, cosmetically unacceptable, or there is uncertainty about the diagnosis, refer the person to an ophthalmologist for further management.
  - An ophthalmologist may consider incision and curettage where appropriate, or intra-lesion injection of steroid (may be preferred in children). For recurrent lesions, biopsy may be indicated to rule out meibomium gland carcinoma.
- Otherwise, if the person is being managed in primary care, reassure them that a meibomian cyst is usually self-limiting and rarely causes serious complications. Advise the person to:
  - Apply a warm compress (for example, a clean flannel that has been rinsed with warm water) to the affected eye for 10–15 minutes up to five times a day. Explain that this will encourage drainage of the cyst contents.
  - Gently massage the meibomian cyst after application of the warm compress (to aid expression of the cyst contents). This should be done in the direction of the eyelashes using clean fingers or a cotton bud.
- Do not prescribe topical or oral antibiotics.
- If the meibomian cyst does not improve or resolve after four weeks of conservative treatment, offer the following options (depending on clinical judgement and the person's preference):
  - No treatment — for example, if the meibomian cyst is small and asymptomatic.
  - Referral to an ophthalmologist.
- Manage any co-existing risk factors to reduce the risk of recurrent episodes, such as:
  - Chronic blepharitis. See the CKS topic on Blepharitis for more information.
  - Seborrhoeic dermatitis. See the CKS topic on Seborrhoeic dermatitis for more information.
  - Acne rosacea. See the CKS on Rosacea - acne for more information.

Basis for recommendation

The information on management of a person with meibomian cyst is largely based on expert opinion in the College of Optometrists guideline Chalazion (meibomian cyst) [College of Optometrists, 2018], the BMJ Best Practice Guideline Styes and Chalazion [BMJ Best Practice, 2018], the BMJ 10 Minute Consultation review article Eyelid Lumps and Lesions [Gupta et al, 2014], and the American Family Physician review article Differential Diagnosis of the Swollen Red Eyelid [Carlisle and Digiovanni, 2015].

Orbital cellulitis

- The recommendation to seek urgent hospital admission for people with signs and symptoms of associated orbital cellulitis is pragmatic, based on information about the potential severity of the condition [Carlisle and Digiovanni, 2015] and the fact that clinical signs often do not correlate with severity. Additionally, for peri-orbital cellulitis, CT scanning of the face or orbits may be indicated to exclude orbital cellulitis and for orbital cellulitis to identify extension of disease, and exclude the potential of abscess formation. IV antibiotics may also be indicated [BMJ Best Practice, 2018].

Suspected malignancy

- The recommendation to refer urgently if malignancy is suspected is based on expert opinion that for suspicious lesions, biopsy to exclude carcinoma is warranted [BMJ Best Practice, 2018]. Suspected cancer referral guidelines from the National Institute of Health and Care Excellence (NICE) recommend a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that may be a squamous cell carcinoma. For suspected basal cell carcinoma (BCC), clinicians are generally advised by NICE to consider routine referral and only consider a suspected cancer pathway referral (for an appointment within 2 weeks) if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size [NICE, 2017]. CKS
pragmatically suggests that clinical judgement is exercised, bearing in mind that removal of a BCC from the eyelid may be more complicated than from other sites.

**Treatment options if the cyst is unresponsive to conservative treatment**

- The recommendation that no treatment or referral are considered as options if there is no improvement after 4 weeks is pragmatic, based on what CKS considers to be good clinical practice. Meibomian cysts may resolve spontaneously and only rarely cause serious complications [BMJ Best Practice, 2018].
- The recommendation to advise conservative treatment for up to 4 weeks is based on expert opinion and evidence from published trials [Olson, 1991; Lederman, 1999] and is also broadly supported by a Department of Health 18-Week Commissioning Pathway guideline which recommends 2–3 weeks of conservative treatment [DH, 2008].

**Management of co-existing risk factors**

The recommendation to manage risk factors in order to reduce the risk of future episodes is based on expert opinion in the BMJ review article Chalazion [Arbabi, 2010] and is also pragmatic, based on what CKS considers to be good clinical practice
Appendix 2 – Diagnostic and Procedure Codes
Removal of Common Benign Eyelid Lesions
GM044

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

<table>
<thead>
<tr>
<th>GM044 - Common Benign Skin Lesion of the Eyelid Policy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excision of lesion of canthus</td>
<td>C11.1</td>
</tr>
<tr>
<td>Destruction of lesion of canthus</td>
<td>C11.2</td>
</tr>
<tr>
<td>Excision of lesion of eyelid NEC</td>
<td>C12.1</td>
</tr>
<tr>
<td>Cauterisation of lesion of eyelid</td>
<td>C12.2</td>
</tr>
<tr>
<td>Cryotherapy to lesion of eyelid</td>
<td>C12.3</td>
</tr>
<tr>
<td>Curettage of lesion of eyelid</td>
<td>C12.4</td>
</tr>
<tr>
<td>Destruction of lesion of eyelid NEC</td>
<td>C12.5</td>
</tr>
<tr>
<td>Wedge excision of lesion of eyelid</td>
<td>C12.6</td>
</tr>
<tr>
<td>Other specified excision of lesion of eyelid</td>
<td>C12.8</td>
</tr>
<tr>
<td>Unspecified excision of lesion of eyelid</td>
<td>C12.9</td>
</tr>
</tbody>
</table>

With the following ICD-10 diagnosis code(s):

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chalazion</td>
<td>H00.1</td>
</tr>
<tr>
<td>Xanthelasma of eyelid</td>
<td>H02.6</td>
</tr>
<tr>
<td>Melanocytic naevi of eyelid, including canthus</td>
<td>D22.1</td>
</tr>
<tr>
<td>Other benign neoplasms of skin of eyelid, including canthus</td>
<td>D23.1</td>
</tr>
</tbody>
</table>

Exceptions (ICD-10); the following in a primary or secondary diagnostic position:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other malignant neoplasms of skin of eyelid, including canthus</td>
<td>C44.1</td>
</tr>
<tr>
<td>Malignant melanoma of unspecified eyelid, including canthus</td>
<td>C43.10</td>
</tr>
<tr>
<td>Malignant melanoma of right eyelid, including canthus</td>
<td>C43.11</td>
</tr>
<tr>
<td>Malignant melanoma of left eyelid, including canthus</td>
<td>C42.12</td>
</tr>
<tr>
<td>Melanoma in situ of right eyelid, including canthus</td>
<td>D03.11</td>
</tr>
<tr>
<td>Melanoma in situ of left eyelid, including canthus</td>
<td>D03.12</td>
</tr>
<tr>
<td>Squamous cell carcinoma of skin of unspecified eyelid, including canthus</td>
<td>C44.121</td>
</tr>
<tr>
<td>Squamous cell carcinoma of skin of right eyelid, including canthus</td>
<td>C44.122</td>
</tr>
<tr>
<td>Squamous cell carcinoma of skin of left eyelid, including canthus</td>
<td>C44.129</td>
</tr>
<tr>
<td>Basal cell carcinoma of skin of unspecified eyelid, including canthus</td>
<td>C44.111</td>
</tr>
<tr>
<td>Basal cell carcinoma of skin of right eyelid, including canthus</td>
<td>C44.112</td>
</tr>
</tbody>
</table>
## Appendix 3 – Version History

### Removal of Common Benign Eyelid Lesions

**GM044**

The latest version of this policy can be found here: [GM Removal of Common Benign Eyelid Lesions policy](#).

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>19/09/2014</td>
<td>Initial draft</td>
</tr>
<tr>
<td>0.2</td>
<td>10/10/2014</td>
<td>Branding changed following creation of North West CSU on 1/10/2014</td>
</tr>
<tr>
<td>0.3</td>
<td>21/11/2014</td>
<td>Amendments made following discussion of the Consultation feedback by the Greater Manchester EUR Steering Group on 19/11/2014:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 2: Definition: Detailed definition taken out and shorter definition added.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 4: Criteria for Commissioning:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sentence added stating: ‘The removal of common benign eyelid lesions for aesthetic reasons is not commissioned.’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Titles ‘Urgent referral’ and ‘Routine referral’ taken out and replaced by: ‘A: Referrals for the treatment of common benign eyelid lesions may be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis and the lesion may not be benign in nature. Examples of reasons for referral include but are not exclusive to:’ and ‘B: The following criteria will require prior approval via the IFR route:’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ‘Lid swelling and/or protrusion of the eye’ changed to ‘protrusion of the eye’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Bullet point added stating ‘New and unexpected visual problems (e.g. double vision)’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Bullet point starting ‘Ocular symptoms…’ clarified to read ‘an underlying condition or the potential for serious damage to the eye’ and ‘significant redness:’ moved to a separate bullet point to read ‘Significant redness in the absence of an obvious cause’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Additional criteria for Dermatocheliasis and Xanthelasma Palpebrum removed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 5: Description of Epidemiology and Need: Section reworded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 9: Mechanism for funding: Changed to monitored approval if meeting criteria for A and prior approval if meeting criteria for B.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 14: Glossary: Chalazion and Xanthelasma added.</td>
</tr>
<tr>
<td>0.4</td>
<td>21/01/2015</td>
<td>Approved by GM EUR Steering Group to go out to Consultation</td>
</tr>
<tr>
<td>1.0</td>
<td>25/06/2015</td>
<td>Changes made following the GM EUR Steering Group meeting on 20/05/2015 post Consultation:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 2 – Definition: The following paragraph added: ‘The first step in the management of most lesions will be self-care in the form of enhanced eyelid hygiene. Individuals will be expected to self-fund the products needed for good hygiene e.g. Baby shampoo or blepharwipes.’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Section 4 - Commissioning Criteria:</td>
</tr>
</tbody>
</table>
|         |            |     - The bullet points ‘Rapidly growing’, ‘visual field affected’ and ‘Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye’ moved from ‘B’ to ‘A’ }
Policy agreed by Greater Manchester EUR Steering on 20th May 2015 subject to the above changes being made.

1.1 07/04/2016
- 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 Manchester Shared Services.
- Wording for date of review amended to read ‘One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)’ on ‘Policy Statement’ and Section 13: Date of Review.

1.2 13/06/2016
- Wigan CCG changed funding mechanism to Individual Prior Approval (IPA) for all requests (both 4A and 4B) – to be adopted from 1 August 2016.

2.0 21/09/2016
The policy was reviewed in August 2016 and two new papers were found, an updated version of a review and a new review, however these did not affect the existing policy. Following GM EUR Steering Group on 21 September 2016 it was agreed that no changes would be made to main body of policy and the following updates be made:
- Review date added to cover page and ‘Policy Statement’
- The ‘Date of Review’ on ‘Policy Statement’ and in body of report changed to ‘Three years from the date of last review unless new evidence warrants earlier review’
- Appendix 1: Evidence Review’ updated to include the 2 new papers found

2.1 01/08/2017
- Wigan CCG changed funding mechanism to monitored approval in line with other GM CCGs.

2.2 16/05/2018
The GM EUR Steering Group requested the following amendment:
- **Policy Exclusions:** ‘with the exception of Basal Cell Carcinoma (BCC should be referred through the usual pathway),’ added to end of first paragraph
Other amendments made due to policy being put onto the new format:
- **Commissioning Statement:**
  - Section for ‘Fitness for Surgery’ added.
  - Titles added to the ‘Policy Inclusion Criteria’ section and wording amended slightly for clarity
- **Appendix 1:** Working clarified in ‘Summary of Evidence’ section.

06/06/2018
- **Appendix 2:** Following ICD-10 codes added to Exceptions:
  - C44.1 Other malignant neoplasms of skin of eyelid, including canthus
  - C43.10 Malignant melanoma of unspecified eyelid, including canthus
  - C43.11 Malignant melanoma of right eyelid, including canthus
  - C43.12 Malignant melanoma of left eyelid, including canthus
  - D03.11 Melanoma in situ of right eyelid, including canthus
  - D03.12 Melanoma in situ of left eyelid, including canthus
  - C44.121 Squamous cell carcinoma of skin of unspecified eyelid, including canthus
  - C44.122 Squamous cell carcinoma of skin of right eyelid, including canthus
<table>
<thead>
<tr>
<th>2.3</th>
<th>10/10/2018</th>
</tr>
</thead>
</table>
| **Policy Inclusion Criteria:** | *any one or more* of added for clarification to the first sentence under the sub heading ‘Referral to secondary care where the benign lesion is the primary condition’  
Brandling changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning. |

<table>
<thead>
<tr>
<th>2.4</th>
<th>25/01/2019</th>
</tr>
</thead>
</table>
| **Links updated as documents have all moved to a new EUR web address.**  
**Commissioning Statement:** | *Fitness for Surgery* section moved to bottom of *Commissioning Statement*  
*Best Practice Guideline* section added |

<table>
<thead>
<tr>
<th>2.5</th>
<th>20/03/2019</th>
</tr>
</thead>
</table>
| GM EUR Steering Group approved the following changes to the policy:-  
**Policy Inclusion Criteria** – The words in bold added to title *Referral to secondary care for surgical intervention (or in the case of chalazia for injection with triamcinolone)* where the benign lesion may not be the primary condition  
The following bullet point added to examples of reasons for referral |  
*The lesion interferes with the protection of the eye by preventing complete closure of the eye* |

<table>
<thead>
<tr>
<th>2.6</th>
<th>01/08/2019</th>
</tr>
</thead>
</table>
| **Clinical Exceptionality Section** updated to read: *Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. More information on determining clinical exceptionality can be found in the Greater Manchester (GM) Effective Use of Resources (EUR) Operational Policy.*  
Link to [GM EUR Operational Policy](#) | |

<table>
<thead>
<tr>
<th>3.0</th>
<th>18/09/2019</th>
</tr>
</thead>
</table>
| The GM EUR Steering Group reviewed the policy. The usual evidence review was carried out in August 2019. No changes were necessary to the policy as a result of the review other than to add the new evidence found.  
Policy to be reviewed again in five years unless new evidence warrants earlier review. |