Buckinghamshire, Oxfordshire & Berkshire West
Integrated Care Board

BOB ICB and Frimley ICB Priorities Committee Clinical Commissioning Policy Statement

Policy Number/ Name	BOBFPC58 Hysterectomy – Indications for Surgery
Date of BOBFPC Recommendation	February 2024

The Buckinghamshire, Oxfordshire, and Berkshire West ICB and Frimley ICB Priorities Committee has considered the evidence and national guidance for hysterectomy surgery. Funding for hysterectomy will be considered for appropriate patients with a diagnosis of:

- **Severe and debilitating endometriosis or adenomyosis** that has been diagnosed and managed in accordance with NICE guideline 73 (See algorithm in Appendix 1) *
- **Uterine prolapse**, where non-surgical and non-hysterectomy surgery options are inappropriate or have failed to manage the woman's symptoms
- **Pelvic inflammatory disease** that has not responded to conventional treatment
- **Large fibroids** which are causing symptoms and other treatment options have failed or are contraindicated by the woman
- **Severe premenstrual syndrome** when all other available treatments have been trialled in a step-wise approach (see algorithm in Appendix 2) and the woman has shown response to a GnRH analogue as a test of cure and to ensure that HRT is tolerated

Hysterectomy is funded for cancer of the cervix / fallopian tubes / uterus and/or ovaries.

*Note that NHS England commissions specialised services for women with severe endometriosis or non-severe endometriosis refractory to treatment. NHS England define severe endometriosis as either deeply infiltrating endometriosis or recto-vaginal endometriosis. For the full service specification, see **https://www.england.nhs.uk/wp-content/uploads/2018/08/Complex-gynaecology-severe-endometriosis.pdf**

This policy should be read in conjunction with Management of Female Pelvic Organ Prolapse (BOBFPC59) in relation to uterine prolapse.

Hysterectomy is not normally funded for non-specific pelvic pain.

Hysterectomy will be commissioned for **Heavy Menstrual Bleeding (HMB)** as per NICE Clinical Guideline 44 only when:

- Other treatment options for heavy menstrual bleeding and/or dysmenorrhoea (with or without fibroids) have failed or are contraindicated;

AND

- There is a wish for amenorrhoea (absence of menstruation);

AND

- The woman no longer wishes to retain her uterus and fertility;

AND

- The woman (who has been fully informed) requests hysterectomy

All patients have a right to be fully informed about this procedure as part of this process. Clinicians should engage the patients (or their carers) in shared decision making about alternative management and the risks and benefits of surgery using a Patient Decision Aid for HMB available at: Heavy Menstrual Bleeding Patient Decision Aid

Using the decision aid, the referring clinician should:

- Have a full discussion of the implications of the surgery before a decision is made. The discussion should include: fertility impact; bladder function; need for further treatment; treatment complications; sexual feeling; the woman's expectations; alternative surgery; and psychological impact.

- Inform the woman about the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.

- Inform the woman about the potential risk of loss of ovarian function and the consequences of this, even if the ovaries are retained during hysterectomy.

OPCS codes:
Abdominal Hysterectomy Codes:
Q071 Abdominal hysterocolpectomy and excision of periuterine tissue.
Q072 Abdominal hysterectomy and excision of periuterine tissue NEC.
Q073 Abdominal hysterocolpectomy NEC.
Q074 Total abdominal hysterectomy NEC.
Q075 Subtotal abdominal hysterectomy.
Q078 Other specified abdominal excision of uterus.
Q079 Unspecified abdominal excision of uterus.

Laparoscopic Abdominal Hysterectomy Codes:
Any of Q071 to Q079; with addition of:
Y751 Laparoscopically assisted approach to abdominal cavity.
Y752 Laparoscopic approach to abdominal cavity NEC.

Vaginal Hysterectomy Codes:
Q081 Vaginal hysterocolpectomy and excision of periuterine tissue.
Q082 Vaginal hysterectomy and excision of periuterine tissue NEC.
Q083 Vaginal hysterocolpectomy NEC.
Q088 Other specified vaginal excision of uterus.

Q089 Unspecified vaginal excision of uterus.

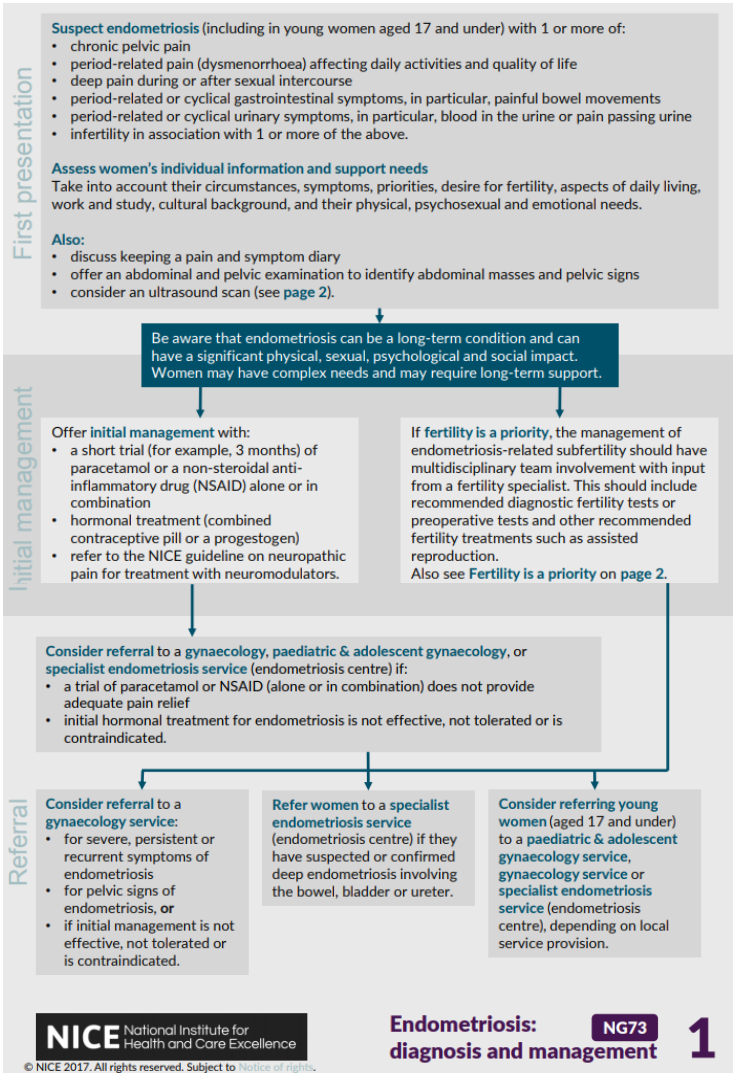
Laparoscopic Vaginal Hysterectomy Codes
Any of Q081 to Q089; with addition of:
Y751 Laparoscopically assisted approach to abdominal cavity.
Y752 Laparoscopic approach to abdominal cavity NEC.

Additional diagnostic code for hysterectomy for HMB
N920 - Excessive and frequent menstruation with regular cycle
N921 - Excessive and frequent menstruation with irregular cycle
N926 – irregular menstruation, unspecified
N938 - Other specified abnormal uterine and vaginal bleeding

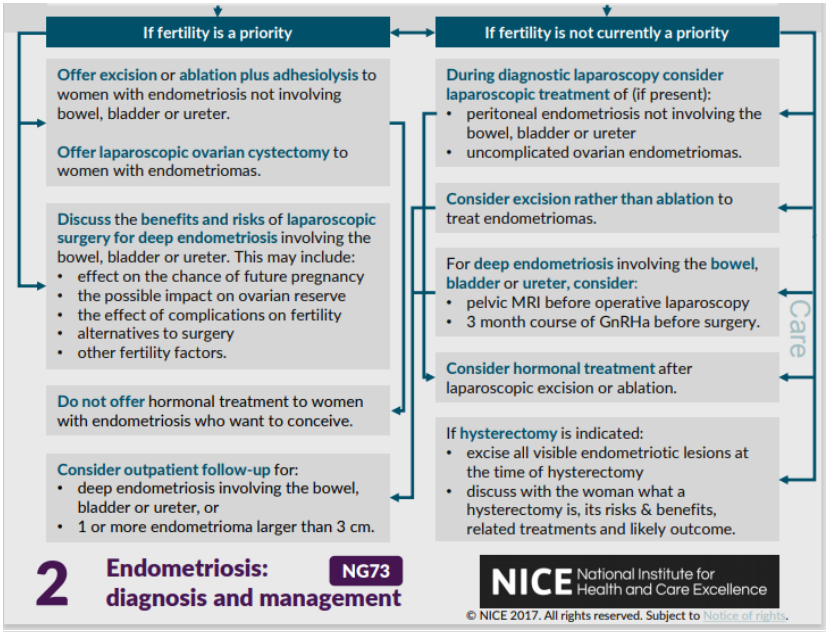
NOTES:

- Potentially exceptional circumstances may be considered by a patient's ICB where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy was developed and recommended by Thames Valley Priorities Committee which was the predecessor of Buckinghamshire, Oxfordshire, and Berkshire West ICB and Frimley ICB Priorities Committee.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g., from NICE.
- BOBFPC clinical policy statements can be viewed at Clinical Commissioning Policy Statements & IFRs | BOB ICB

Appendix 1: Endometriosis diagnosis and treatment algorithm (NICE Guideline 73[1])



[1] NICE guideline (NG 73) (2017): Endometriosis: diagnosis and management https://www.nice.org.uk/guidance/ng73


If fertility is a priority
If fertility is not currently a priority
Offer excision or ablation plus adhesiolysis to women with endometriosis not involving bowel, bladder or ureter.
Offer laparoscopic ovarian cystectomy to women with endometriomas.
Discuss the benefits and risks of laparoscopic surgery for deep endometriosis involving the bowel, bladder or ureter. This may include:
• effect on the chance of future pregnancy
• the possible impact on ovarian reserve
• the effect of complications on fertility
• alternatives to surgery
• other fertility factors.
Do not offer hormonal treatment to women with endometriosis who want to conceive.
Consider outpatient follow-up for:
• deep endometriosis involving the bowel, bladder or ureter, or
• 1 or more endometrioma larger than 3 cm.
During diagnostic laparoscopy consider laparoscopic treatment of (if present):
• peritoneal endometriosis not involving the bowel, bladder or ureter
• uncomplicated ovarian endometriomas.
Consider excision rather than ablation to treat endometriomas.
For deep endometriosis involving the bowel, bladder or ureter, consider:
• pelvic MRI before operative laparoscopy
• 3 month course of GnRHa before surgery.
Consider hormonal treatment after laparoscopic excision or ablation.
If hysterectomy is indicated:
• excise all visible endometriotic lesions at the time of hysterectomy
• discuss with the woman what a hysterectomy is, its risks & benefits, related treatments and likely outcome.
Care
2 Endometriosis: diagnosis and management NG73
NICE National Institute for Health and Care Excellence
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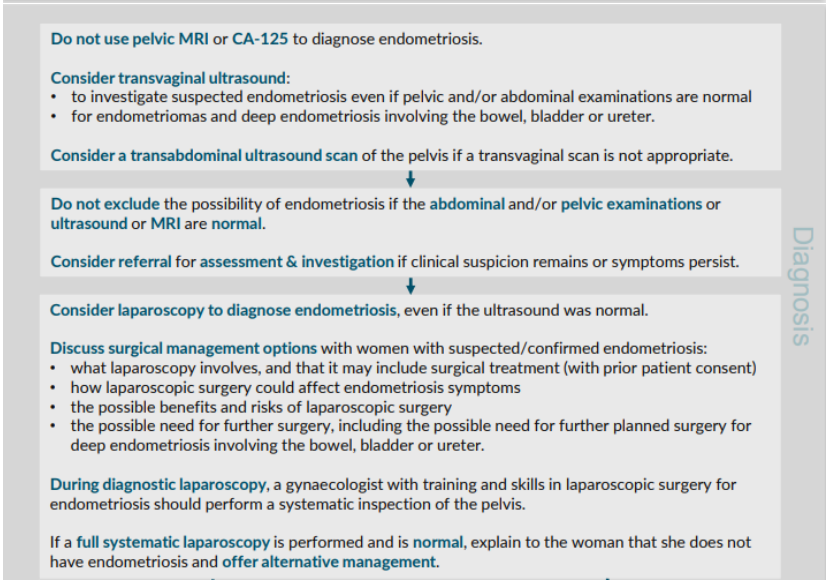
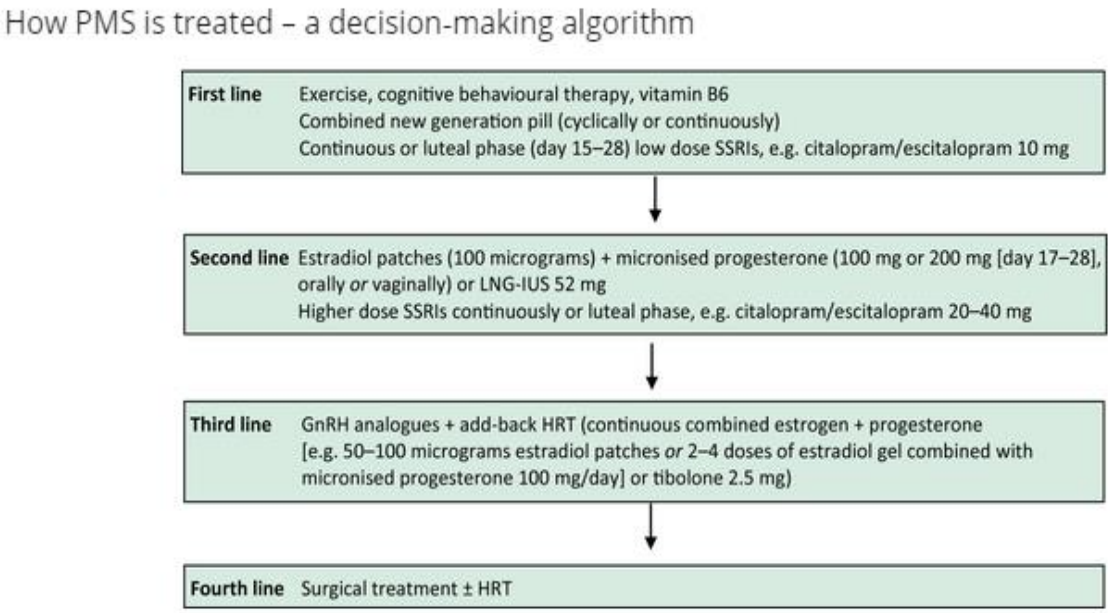

Do not use pelvic MRI or CA-125 to diagnose endometriosis.
Consider transvaginal ultrasound:
• to investigate suspected endometriosis even if pelvic and/or abdominal examinations are normal
• for endometriomas and deep endometriosis involving the bowel, bladder or ureter.
Consider a transabdominal ultrasound scan of the pelvis if a transvaginal scan is not appropriate.
Do not exclude the possibility of endometriosis if the abdominal and/or pelvic examinations or ultrasound or MRI are normal.
Consider referral for assessment & investigation if clinical suspicion remains or symptoms persist.
Consider laparoscopy to diagnose endometriosis, even if the ultrasound was normal.
Discuss surgical management options with women with suspected/confirmed endometriosis:
• what laparoscopy involves, and that it may include surgical treatment (with prior patient consent)
• how laparoscopic surgery could affect endometriosis symptoms
• the possible benefits and risks of laparoscopic surgery
• the possible need for further surgery, including the possible need for further planned surgery for deep endometriosis involving the bowel, bladder or ureter.
During diagnostic laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis.
If a full systematic laparoscopy is performed and is normal, explain to the woman that she does not have endometriosis and offer alternative management.
Diagnosis

Appendix 2: Royal College of Obstetricians and Gynaecologists Premenstrual Syndrome Treatment algorithm[2]



[2] Royal College of Obstetricians and Gynaecologists (2016) Management of Premenstrual Syndrome https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14260