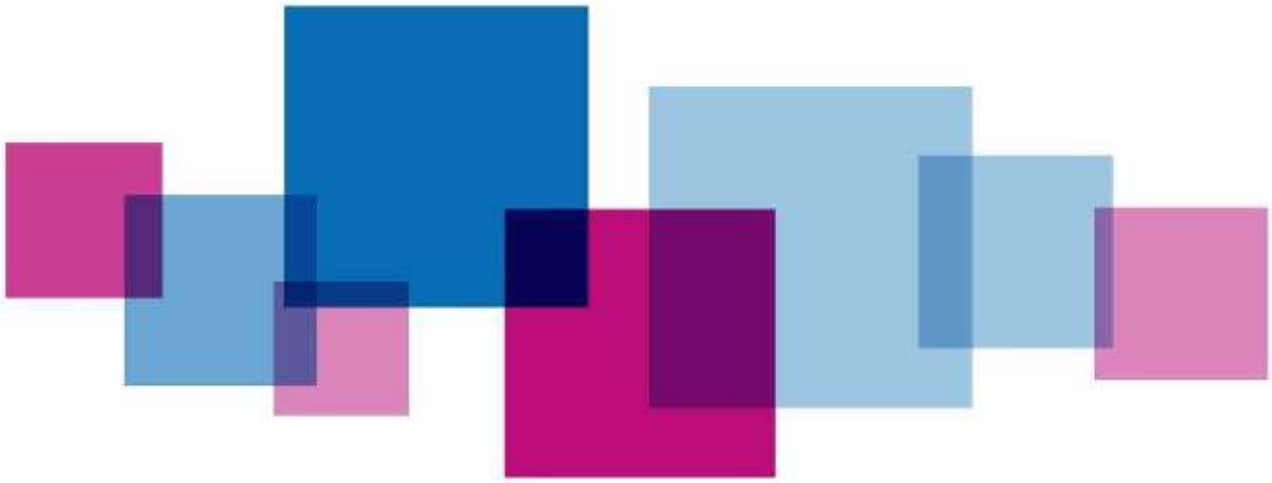
NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Commissioning Policy

Referral for Microsuction for Ear Wax, Discharge or Debris Removal

Criteria Based Access and Prior Approval



Date Adopted: 1st November 2019
Version: 1920.2.01

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Document Control

Title of document:	Referral for Microsuction for Ear Wax, Discharge or Debris Removal
Authors job title(s):	Commissioning Policy Development Manager
Document version:	v1920.2.01
Supersedes:	V1718.3.05
Clinical Engagement received from:	• ENT Consultants – UHB
Discussion and Approval by Commissioning Policy Review Group (CPRG):	20/08/2019
Discussion and Approval by ICB Commissioning Executive:	12/09/2019
Date of Adoption:	01/11/2019
Publication/issue date:	18/09/2019
Review due date:	Earliest of either NICE publication or three years from approval
Equality Impact Assessment Screening (date completed):	July 2019
Quality Impact Assessment Screening (date completed):	July 2019
PPI (date completed):	July 2019

Version Control

Version	Date	Reviewer	Comment
1718.3.0	27/09/2017	IFR Manager	Shared with CPRG
1718.3.01	27/09/2017	IFR Manager	Updated following CPRG feedback

1718.3.02	28/09/2017	IFR Co-ordinator	Ready for Board
1718.3.03	12/12/2017	IFR Co-ordinator	Updated to clarify referral routes
1718.3.04	07/03/2018	IFR Co-ordinator	Updated to include “syringing not available

			in Primary Care" criteria 2. f)
1718.3.05	28/03/2018	IFR Co-ordinator	Rebranded to BNSSG ICB
1920.2.00	04/7/2019	Commissioning Policy Development Manager	Updated to show 3 year clinical review. Removal of criteria 4f and amendment to wording in 2a to include secondary care records
1920.2.01	20/08/2019	Commissioning Policy Development Manager	Amended to split point 2 c in to C OR D

TREATMENT UNDER THIS POLICY IS EITHER SUBJECT TO CRITERIA BASED ACCESS (Criteria 1 and 2)
OR
REQUIRES PRIOR APPROVAL (Criteria 3 and 4)

THIS POLICY RELATES TO ALL PATIENTS

Referral for Microsuction for Ear Wax, Discharge or Debris Removal Policy

Ear wax, discharge and debris removal in Secondary Care is not routinely funded by the Commissioner and is subject to this restricted policy**.**

General Principles

Treatment should only be given in line with these general principles. Where patients are unable to meet these principles in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the ICB Exceptional Funding Request Panel.

1. Clinicians should assess the patients against the criteria within this policy prior to referring patients seeking treatment. Referring patients to secondary care that do not meet these criteria not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment.
2. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment and the EFR team should be approached for advice.
3. On limited occasions, the ICB may approve funding for a further assessment in secondary care only in order to confirm or obtain evidence demonstrating whether a patient meets the

criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.

4. Where funding approval is given by the Exceptional Funding Request Panel, it will be available for a specified period of time, normally one year.
5. Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015).
6. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing (ASH, 2016)
7. In applying this policy, all clinicians and those involved in making decisions affecting patient care will pay due regard to the need to eliminate unlawful discrimination, harassment, victimisation, etc., and will advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. In particular, due regard will be paid in relation to the following characteristics protected by the Equality Act 2010: age, disability, sex, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation.
8. Patients' (and carers' as appropriate) expectations of surgery, and the likely degree of additional benefit that may be obtained from surgery compared with continuing conservative management, must have been discussed by the referring clinician.

Background / Purpose and Scope

Ear Wax and Debris in Ears

Patients presenting with problems with ear wax is a common issue for healthcare providers with
around 4 million ears per annum being irrigated (Patient Info, 2016).

Although some people are asymptomatic, the most common symptom from impacted earwax is hearing loss. People may also complain of:

- Blocked ears
- Ear discomfort
- Earache
- Tinnitus (noises in the ear)
- Itchiness
- Vertigo (not all experts believe that wax is a cause of vertigo)
- Cough (rare and due to stimulation of the auricular branch of the vagus nerve by pressure from impacted ear wax)

Ear wax may be wet or dry and is a normal physiological substance that protects the ear canal. It has several functions including aiding removal of keratin from the ear canal (earwax naturally migrates out of the ear, aided by the movement of the jaw). It cleans, lubricates, and protects the lining of the ear canal, trapping dirt and repelling water.

Excessive build-up of ear wax can develop in some people, and the wax can become impacted. Although wax frequently obscures the view of the tympanic membrane it does not usually cause hearing impairment. It is only when the wax is impacted into the deeper canal against the tympanic membrane (often caused by attempts to clean out the ear with a cotton bud, or by the repeated insertion of a hearing aid mould) that it is likely to cause a hearing impairment.

Occasionally it may be inappropriate to treat a patient in Primary Care, or such treatment may be ineffective. These patients may therefore seek to access Microsuction of the Ear Canal in Secondary Care.
Broadly speaking, patients who wish/need to access Microsuction can be divided into three groups:

- Patients who have undergone modified radical mastoidectomy (mastoid cavities)
- Patients who require aural care for chronic or recurrent ear pathologies
- Patients who require dewaxing and cannot undergo syringing by Primary Care

Patients who have undergone modified radical mastoidectomy (mastoid cavities)

These patients have usually had surgery for cholesteatoma, which is a build-up of skin in the middle ear and/or mastoid. A modified radical mastoidectomy involves removal of the posterior ear canal wall and opening of the mastoid air cells, thereby joining the ear canal to the mastoid space, creating a ‘mastoid cavity’.

Although modern otological practice aims to avoid creation of a very large mastoid cavity, the nature of cholesteatoma disease means that it is sometimes unavoidable. In addition, modified radical mastoidectomy was for many years the standard option for cholesteatoma treatment and there is therefore a cohort of patients who were treated in this way.

A mastoid cavity will usually require cleaning on a regular basis. This is for several reasons:

- In many cases the natural migratory property of the skin lining the ear canal is lost, meaning that wax will tend to accumulate.
- The anatomy of the mastoid cavity, particularly if large, means that wax will tend to collect rather than self-clear.
- If wax is left in situ for any length of time, patients with mastoid cavities are more prone to infection due to the poorer aeration and anatomical shape of the cavity.
- Many patients with mastoid cavities require a hearing aid for which the cavity must be clean.

Syringing of a mastoid cavity **must be avoided**, because:

- In many patients the lateral semi-circular canal is exposed within the cavity and water entering the cavity will often lead to severe vertigo.
- The anatomy of the cavity means that water may become trapped, leading to infection.
- Wax in a cavity may be more difficult to soften prior to syringing than in the normal ear. In addition, the shape of the cavity means that syringing is less likely to clear wax than in the normal ear canal.

If cleaned regularly, most mastoid cavities will remain stable and dry. If infection does occur it can be more difficult to treat. Cleaning of wax is therefore recommended approximately once every 3 to 12 months, depending on the need of each individual patient. Many patients have a dry, stable, cavity most of the time but may intermittently require a period of more intense care to return to stability *(Thiel et al 2014).*

Patients who have undergone radical mastoidectomy surgery for cholesteatoma will be able to routinely access microsuction in Secondary Care aural clinics under Criteria Based Access rules.

Patients who require aural care for chronic or recurrent ear canal pathologies

A small proportion of patients need to be seen regularly in the aural care clinic to prevent the development of troublesome otitis externa – inflammation in the external auditory canal. In these cases, regular cleaning of wax and/or skin from the ear canal will prevent the development of otalgia and/or hearing loss as well as preventing progression to infective otitis externa (bacterial or fungal) that can be difficult to treat in these cases.

Examples of patients who fall into this category include:

- Patients prone to recurrent otitis externa. Despite keeping their ear dry and avoiding inappropriate instrumentation of the ear canal, some patients are prone to recurrent infection if wax or dry skin accumulates in their ear canal. In many patients there is no identifiable cause for their tendency to develop otitis, though in some cases there may be a systemic (e.g. diabetes, immune compromise) or local (e.g. skin disorder such as psoriasis) cause.
- Some patients with chronic otitis externa go on to develop a chronic inflammatory process that can lead to an acquired stenosis of the ear canal. This makes the ear more prone to blockage and infection and increases the need for regular cleaning.
- Patients with retracted tympanic membrane (retraction pocket). Some patients develop a retraction of their tympanic membrane, often secondary to Eustachian tube dysfunction. If the retraction affects a localised area of the tympanic membrane a ‘pocket’ can develop, in which skin can accumulate – cholesteatoma. In most cases this warrants surgical treatment to prevent complications. However, in some cases the disease is minimal and can be managed conservatively by regularly cleaning the retraction pocket with microsuction. Patients not fit for surgery can also be managed in this way.

- Patients with keratosis obturans. In this uncommon condition, the normal migration of skin from the ear canal fails, causing debris to build up deep in the ear canal. This leads to an inflammatory response, often with bony erosion and widening of the ear canal. Regular removal of the skin is crucial to prevent disease progression leading to otalgia and infection (Persaud et al 2004).

Patients with chronic or recurrent ear canal pathology will be able to routinely access microsuction in Secondary Care Aural clinics under Criteria Based Access rules.

Patients who require dewaxing and cannot undergo syringing in primary care

Approximately 2 to 6% of the UK population may suffer from wax (cerumen) impaction at any one time (Guest et al. 2004), though it is more common in the elderly and those with learning difficulties (Schwartz et al 2017;AAO-HNS Guideline). Wax removal is therefore, unsurprisingly, the most common ENT procedure performed in Primary Care.

Although wax is a normal physiological occurrence, and does not therefore need to be removed unless causing symptoms, wax accumulation can cause hearing loss, otalgia, dizziness, itching and tinnitus (Lesser and Robinson, 2009). Randomised controlled trials have shown improvement in all these symptoms in the majority of patients following wax clearance (Memel et al 2002). Wax removal may also be required to allow a full examination of the tympanic membrane in patients with otological symptoms.

The first line treatment for the majority of patients with wax build up is ceruminolytic drops followed by, when necessary, ear syringing in Primary Care. Evidence suggests that use of ear drops is effective, though there is no clear evidence to suggest that any particular drop is superior to another (or indeed to water) for wax softening/clearance (Wright 2014, Burton & Doree 2009, Clegg et al 2010).

Irrigation of the external auditory meatus or ‘ear syringing’ is a well-established technique for removal of wax that has accumulated and led to symptoms.

Where self-care, or management in the community or Primary Care, is inappropriate and patients meet the criteria within the policy, funding will be approved for up to a maximum of two treatments over the period of one year.

Referring Children for Microsuction of Ear Wax, Discharge or Debris Removal in Secondary Care

Children who have ear wax build up should be treated, in the first instance, in Primary Care in line with this policy. Ear drops should be used (unless clinically contraindicated) per instructions for a minimum of 14 days. If no improvement and/or irrigation is clinically contraindicated then funding should be sought for a referral to Secondary Care.

POLICY CRITERIA – COMMISSIONED

CRITERIA BASED ACCESS

Policy - Criteria to Access Treatment – CRITERIA BASED ACCESS

1. **Mastoid Cavities**

   Funding for Microsuction treatment will only be provided by the ICB for patients who have previously undergone surgery for cholesteatoma including radical mastoidectomy and require ongoing care and monitoring through ENT services.

Note:

Cleaning of wax is usually recommended approximately once every 3 to 12 months, depending on the need of each individual patient.

2. **Chronic or Recurrent Ear Canal Pathologies**

   Funding for Microsuction treatment will only be provided by the ICB for patients suffering from:

   a) recurrent otitis externa (more than 2 episodes in one year recorded in the patient's care records);

OR

   b) retracted tympanic membrane (retraction pocket) which is suitable for management with regular cleaning;

OR

   c) acquired stenosis of the ear canal following chronic otitis externa;

OR

   d) keratosis obturans.

Policy - Criteria to Access Treatment – PRIOR APPROVAL FUNDING REQUIRED

Funding approval for treatment will only be provided by the ICB for patients meeting the criteria set out below.

1. **There is a foreign body, including vegetable matter, in the ear canal that could swell during irrigation;**

OR

2. **The patient is suffering from significant symptoms due to ear wax build up, including hearing loss or pain, and the patient's condition warrants microsuction.**

AND one or more of a) to f):

a) The patient has previously undergone ear surgery (other than grommets insertion that have been extruded for at least 18 months);

OR

b) The patient has a recent* history of Otalgia and/or middle ear infection (*in the past 6 weeks);

OR

c) The patient has a current perforation

OR

d) The patient has a history of ear discharge in the past 12 months;

OR

e) The patient has had previous complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo;

OR

f) Two attempts at irrigation of the ear canal in primary care have been unsuccessful;

AND

3. **Patients must have used ear drops/olive oil (unless clinically contraindicated), as per instructions for a minimum of 14 days with no improvement and/or irrigation is clinically contraindicated.**

   NB: if funding approval is successful, patients are advised to continue with ear drops until their ENT assessment.

Patients who are suspected of suffering from malignancy should be referred under the 2 Week Wait cancer pathway which does not require prior approval.

Due Regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Commissioning Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the ICBs are responsible, including policy development and review.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the ICB's Exceptional Funding Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net .**

Connected Policies

N/A

This policy has been developed with the aid of the following references:

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Schwartz SR, M. A. (2017, January). *Clinical Practice Guideline (Update): Earwax (Cerumen Impaction)*. Retrieved July 31, 2019, from NCBI: https://www.ncbi.nlm.nih.gov/pubmed/28045591

Thelwall, S. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. *Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases*, vol. 21, no. 11, p. 1008.e1.

Thiel G, R. J. (2014, October). *The behavior of mastoidectomy cavities following modified radical mastoidectomy.* Retrieved July 31, 2019, from NCBI: https://www.ncbi.nlm.nih.gov/pubmed/24459037

Tony Wright, e. p. (2015). *Summaries of BMJ Clinical Evidence - Ear Wax*. Retrieved July 31, 2019, from The BMJ: https://www.bmj.com/content/351/bmj.h3601

OPCS Procedure codes

Must have any of (primary only):
D071, D072, D152