# SHIP8 Clinical Commissioning Groups Priorities Committee

**No. 50**

**Policy Recommendation: Primary joint replacement for hip and knee osteoarthritis**

**Date of issue: 20th March 2019**

The committee have considered the current thresholds for operative interventions for primary joint replacement of hips and knees. It heard from a variety of orthopaedic consultants, both directly and by message as well as an in-depth evidence review. The committee makes the following recommendations:

- **Obesity** is an important factor in the aetiology of joint disease as well as being detrimental to the outcomes. Consequently, the committee recommends that weight management has an important role throughout the patient's life, and this should be reflected in prevention strategies
- There is clear evidence that there are poorer outcomes for patients with increased body mass index. The committee therefore recommends that primary replacement should be reserved for patients with a BMI below 35.
- **Patients with a BMI of 35 or above: Separate prior approval criteria** are in place to manage access to surgery for patients with a BMI of 35 and above, namely under the following conditions prior approval may be granted:
  - In patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk;
  - In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure;
  - Referral should also have been made for referral to the commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.
- **Smoking** is the most important factor for the development of postoperative cardiopulmonary and wound-related complications in elective surgery and the most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement.
- Stopping smoking should be encouraged for at least 8 weeks prior to operation and patients should be referred to a structured smoking cessation programme prior to or at time of referral for surgical assessment or there should be documented informed dissent.
- With reference to **Policy Statement 21**: Smoking and Non-Urgent Surgery (July 2017);
  - Prescribing smoking cessation medication outside of supported programmes is low priority;
  - All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact;
  - Use of e-cigarettes is less harmful and is preferable to cigarette smoking.
- **Shared decision making** was seen to be helpful and effective at improving outcomes and should be started in Primary Care or in the Community based MSK service using resources such as the Joint replacement Decision Aid (https://www.cimauk.org/science-update/national-joint-registry-patient-decision-supp)

**There should be a period of 3 months** for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.