Policy for Asymptomatic and Symptomatic Bunions
The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community;
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decisions are considered within the wider constraints of the CCG’s legally responsibility to remain fiscally responsible.
Bunions

Hallux valgus is the deviation of the big toe (the hallux) away from the mid-line towards the lesser toes. The metatarsal head drifts towards the midline and this together with its overlying bursa and inflamed soft tissue is known as the bunion, which causes pain and rubbing on shoes.

Hallux rigidus is the development of arthritic changes within the joint causing stiffness, pain and deformity. Hallux valgus and rigidus are frequently accompanied by lesser toe changes such as hammer or claw toes and abnormal weight distribution under the lesser toes which can be painful (metatarsalgia).

Hallux valgus (deviation of the big toe) is often accompanied with, or mistaken for, hallux interphalangeus, where the tip of the big toe is deviated laterally (moved to one side), although symptoms may be similar. Deformity may contribute to impaired balance, which can increase the incidence of falls.

Untreated hallux valgus deformity in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even below knee amputation.

Bunions are common, and more so in advanced age and in females. Prevalence has been estimated at 23% in adults aged 18-65 years and 35.7% in those aged over 65 years. Footwear often contributes to this problem. Patients with hallux valgus and rigidus have worse pain than the general population. Surgery can improve the quality of life in this group.

Overall satisfaction rates following surgery are good (more than 80% in most studies), but studies are small and follow up short.

The exact cause of bunions is unknown, but they tend to run in families. Wearing badly fitting shoes is thought to make bunions worse. It's also thought that bunions are more likely to occur in people with unusually flexible joints, which is why bunions sometimes occur in children. In some cases, certain health conditions, such as rheumatoid arthritis and gout, may also be responsible.

There are a number of treatment options for hallux vagus (bunions). Non-surgical treatments include painkillers, orthotics (insoles) and bunion pads.
While surgery is usually effective (symptoms are improved in 85% of cases), bunions can sometimes return. Complications occur after bunion surgery. These will depend on the type of surgery the patient has had and can include:

- stiffness in the toe joints
- a delay or failure of the bone to heal or the bone healing in the wrong position
- pain under the ball of the foot
- damage to the nerves in the foot
- prolonged swelling and continued pain
- the need for further surgery

The best way to reduce the patient’s chances of developing bunions is to wear shoes that fit properly. Shoes that are too tight or have high heels can force the patient’s toes together.

Primary Care Assessment

- The diagnosis of a bunion is usually based on clinical findings. Not all people with bunions have symptoms.
- Examine the person both sitting down and standing (standing up may exaggerate the deformity). Look for:
  - Lateral deviation of the first toe at the metatarsophalangeal (MTP) joint.
  - Movement of the first toe towards the second toe.
  - Prominence of the first metatarsal head.
  - Medial bursitis over the first MTP joint (as a result of irritation from shoes).
- Rule out alternative diagnoses, such as:
  - Hallux rigidus (arthritis of the metatarsophalangeal joint).
  - Gout.
  - Sesamoiditis.
  - Fractures.
  - Rheumatological disease.
  - Neurological pain (may be related to diabetes).
  - Infection.

Assessment

- Establish the reason for consultation.
  - The person may:
    - Require symptomatic relief only.
    - Have difficulty in fitting into footwear (resulting in skin trauma).
    - Have no symptoms but dislike the look of their foot or the type of footwear that must be worn to accommodate the foot.
Assess the severity of the bunion(s).
- Ask about: The duration of pain and the presence of paraesthesia (not all people with bunions are symptomatic). The patient may report medial first metatarsophalangeal (MTP) joint or plantar foot pain, which is often worse when wearing shoes, may occur on weight bearing, and may be described as deep and aching if associated with joint degeneration. The effect of symptoms on the patient's lifestyle and activities.

Assess the degree of deformity.
- This depends on the extent of lateral deviation of the proximal phalanx from the first metatarsal (this can be formally measured using weight-bearing X-ray images, usually done in secondary care if referral is necessary). Also check for involvement of the second toe (may be at risk of dislocation).

Assess for degenerative joint disease (which may develop in people with long-standing or severe bunions).
- Ask the person to stand on tiptoe if they are able (stiffness of the first MTP joint may indicate osteoarthritis).

Enquire about a medical history of diabetes, vascular disease, or neuropathy, and check for:
- Skin quality (foot ulceration can occur if there are areas of skin breakdown).
- Calluses or corns (indicate points of overload).
- Pulses and sensation.

Assess footwear, and ask what types of shoes are normally worn and whether there has been any recent change in footwear.

Enquire about treatments that have already been tried, such as bunion pads or over-the-counter analgesics

Management

- Advise patients presenting with bunions that:
  - They should wear low-heeled, wide shoes with a soft sole.
  - Bunions can be progressive.
  - Non-surgical treatments (for example medication, bunion pads, orthoses) may relieve symptoms but do not limit progression.
- If the patient is symptomatic:
  - Offer oral analgesia (for example paracetamol or a nonsteroidal anti-inflammatory drug, such as ibuprofen).
  - Advise self-care treatments for symptomatic relief, such as bunion pads (available over-the-counter) or ice packs.
Consider referral to podiatry for footwear advice or consideration of a night splint or orthosis.

- Offer written information, i.e. CCG patient information leaflet.
- If analgesia and self-care measures are not effective, consider referral.
  - Advise the person that:
    - Referral for bunion surgery is indicated for symptomatic bunions (see eligibility criteria below) and is not routinely commissioned for cosmetic purposes.
    - Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery.
  - Refer for orthopaedic or podiatric surgery consultation according to local policy and service provision. Situations where referral may be of benefit include if:
    - The deformity is painful and worsening.
    - The second toe is involved.
    - The person has difficulty obtaining suitable shoes.
    - There is significant disruption to lifestyle or activities.
  - If the patient is referred for consideration of surgery, advise that:
    - Surgery is usually done as a day case.
    - Bunion surgery is one of the most commonly-performed foot and ankle procedures. It may help relieve pain and improve the alignment of the toe in most people (85%–90%); however, there is no guarantee that the foot will be perfectly straight or pain-free after surgery.
    - Complications after bunion surgery may include infection, joint stiffness, transfer pain (pain under the ball of the foot), hallux varus (overcorrection), bunion recurrence, damage to the nerves, and continued long-term pain.
  - Refer to a diabetic foot protection service if the person has diabetes.
Intermediate Care – Community Foot Health Service

- Commissioned services must be integrated into a multidisciplinary network and include the skills for example:
  - Musculoskeletal (MSK) physiotherapy
  - Podiatry (non-surgical and surgical)
  - Orthotics
  - Rheumatology
  - Orthopaedic surgery

Assessment:
- History - as above
- Examination: As above
  - Examine for metatarsalgia
  - Lesser toe deformity
  - Overall lower leg alignment
  - Presence of tibialis posterior dysfunction
  - Investigation - weight bearing X-rays (only if indicated, such as to guide injection; if to be undertaken include: Weight bearing X-rays Anteroposterior (AP), Lateral & Oblique)

Management:
- Providers must adopt a shared decision making model, define treatment goals and take into account personal circumstances.
- Patient information should be provided.
- Footwear assessment and provision of offloading orthotics as appropriate.
- Physiotherapy:
  - Balance, proprioception, and core stability, calf muscle stretches, and to treat features of tibialis posterior tendon dysfunction.
- Injections:
  - Only indicated if inflammation or arthritis is suspected or if patient unfit for surgery.
  - Contraindicated if infection is suspected.
- Radiographs (X-rays - Weight bearing X-rays - Anteroposterior (AP), Lateral & Oblique) should be performed prior to procedure.
Refer for surgery:

- Deteriorating symptoms.
- Failure of appropriate conservative measures after three months.
- Persistent pain and disability not responding to up to 12 weeks of non-surgical treatments; this time to include any treatment received in primary care.
- Patient must be prepared to undergo surgery understanding that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks (2 weeks if left foot and driving automatic car).
- Age, gender, smoking, obesity and co-morbidity should not be barriers to referral.
- Patients with significant co-morbidities [systemic or local] should have treatment which optimises these before referral.
- For clarification, co-morbidities must be managed through a shared decision making process with the patient, enabling patients to make joint decisions on referral and treatment.
- Patients who are not suitable for surgery should be referred for a complex care package.
Secondary Care Assessment:
- History - as above, diagnosis confirmed.
- Examination - as above, other pathologies excluded.

Investigations:
- Weight bearing X-rays - Anteroposterior (AP), Lateral & Oblique and;
- Further imaging (e.g.: Ultrasound, MRI) as indicated.

Management:
- Providers must adopt a shared decision making model, define treatment goals and take into account personal circumstances, all alternatives MUST be discussed.
- Patient information should be provided.

Surgery:
Criteria for intervention are the same as the criteria for referral.
- MUST NOT be undertaken for prophylactic or cosmetic reasons.
- Should be undertaken by orthopaedic surgeons trained in foot and ankle surgery or Health and Care Professions Council registered podiatric surgeons (CCPST), integrated into a multi-disciplinary network.
- Is usually day case or 23-hour admission, unless clinical or social circumstances dictate otherwise.
- A minimum of 3 outpatient follow up appointments by appropriately experienced foot and ankle clinicians.
- Review of standing radiographs within 8 weeks by surgeon.
- It is recommended that PROM (Patient Reported Outcome Measures) scores be recorded at least 12 months following surgical episode.
- There are a number of surgical options. The procedure selected will depend on: patient symptoms/signs and patient choice having considered with the surgeon the risk and benefits of each. These require appropriate facilities. There is no conclusive evidence for the superiority of one operation over another.
- Surgery is simpler and more successful in the earlier stages of deformity.
- Recurrence of deformity after bunion surgery occurs in 8 - 15% of patients.
- Non-union of fusion for hallux rigidus occurs in up to 10% of cases.
- Complex surgery (e.g. complex revision infection with bone loss avascular necrosis and neurological deformity) must be undertaken by surgeons with a recorded interest in complex foot and ankle surgery working in high volume centre with appropriate facilities.
- Minimal access techniques must only be undertaken as part of a research project or where special arrangements for audit are in place (NICE IPG 332).
- In cases of post-operative complications, primary care should ideally be able to refer the patient back to the same surgical team, should the patient want this.

Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery does not exclude them from having surgery at a future time point.
Eligibility Criteria:

**Surgery for Asymptomatic Hallux Valgus (Bunions) is not routinely commissioned.**

If the patient has diagnosed diabetes and presents with an asymptomatic bunion the patient should be referred to a community foot health service.

**Surgery for Symptomatic Hallux Valgus (Bunions) will be funded in the following circumstances:**

- The patient has a confirmed diagnosis of a bunion AND
- The patient has deteriorating symptoms AND
- ALL Conservative measures have failed after three months AND
- The patient is experiencing persistent pain and disability due to the hallux valgus, which is causing functional impairment and has not responded following 12 weeks of conservative measures AND
- The patient must be prepared to undergo surgery, understanding that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks (2 weeks if left foot and driving automatic car) AND
- Weight bearing X-rays - Anteroposterior (AP), Lateral & Oblique have been undertaken prior to surgery. AND
- The provider has adopted a shared decision making model, with defined treatment goals and has taken into account personal circumstances, with ALL alternatives discussed with the patient AND the procedure will be undertaken by orthopaedic surgeons trained in foot and ankle surgery or Health and Care Professions Council registered podiatric surgeons (CCPST), integrated into a multi-disciplinary network.

**Deteriorating symptoms** are defined for the purposes of this policy as the following:

- moderate or severe pain AND functional impairment AND redness/soreness OR
- Bigger demormation, 2nd toe affected/lifting OR
- Callus under 2nd MTPJ.

**Conservative measures** are defined for the purposes of this policy as the following:

- Ensure footwear is appropriate (lower heels; wider fitting shoes; moulded shoes) AND
- the patient has been advised on and has trialled patient directed approach (bunion pads, over the counter analgesia, ice to relieve pain and inflammation) AND
- the use of offloading orthotics has been exhausted AND
- the patient has been provided with the patient leaflet.

**Functional impairment** is defined as interfering with activities of daily living, i.e. sleeping; eating; walking.

**N.B.:** Current evidence on the efficacy of surgical correction of hallux valgus using minimal access techniques is limited and inconsistent. In addition, the evidence relates to a range of different surgical techniques. The evidence on
safety is inadequate. (NICE 2010). Therefore, surgical correction of hallux valgus using minimal access techniques is Not Routinely Commissioned in any circumstances. This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Information regarding clinical outcomes and patient reported outcome measures following surgery were submitted during the engagement period and demonstrated good outcomes at 1, 2, 4 and 9.5 years’ post–surgery.
Guidance:


*JBJS:* October 2000 - Volume 82 - Issue 10 - p 1373-1373


NICE 2010. Surgical correction of hallux valgus using minimal access techniques. Interventional procedures guidance. IPG332. nice.org.uk/guidance/ipg332


