Derby and Derbyshire
Clinical Commissioning Group

CLINICAL POLICY ADVISORY GROUP (CPAG)

Meibomian Cyst (Chalazion) Policy

This procedure requires prior approval. Prior approval must be sought through Blueteq.

Criteria:
Black – criteria required to be met prior to referral
Blue – criteria to be met prior to procedure

Statement

Derby and Derbyshire CCG, in line with its principles for procedures of limited clinical value has deemed the Incision and Curettage OR Intra-Lesion Steroid Injection of a Meibomian Cyst should not be routinely commissioned unless **TWO OR MORE** of the following criteria have been met:

- Has been present for more than six months
- Has been managed conservatively with warm compresses, lid cleaning and massage for at least **FOUR weeks**
- Vision is significantly impaired
- Lid closure is affected, thereby compromising eye protection
- Where it is a source of infection, creating an abscess
- It has been a source of infection, requiring medical attention on two or more episodes in the last six months.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the CCG.

1. Background

A meibomian cyst (chalazion) is a sterile, inflammatory granuloma caused by the obstruction of the meibomian gland. The gland normally produces lipid secretions which provide the lipid layer of the tear film. However, the obstruction of the gland duct causes the gland to enlarge and rupture, releasing the accumulated lipid contents into the surrounding eyelid soft tissue. This triggers an inflammatory reaction against the lipid content, which subsides with time. Eventually, the meibomian cyst often becomes painless and non-tender.

A meibomian cyst may develop acutely with an oedematous, erythematous eyelid or arise insidiously as a firm, painless nodule. Most meibomian cysts resolve spontaneously or with conservative management, although this may take weeks or months.

2. Recommendation

This procedure requires prior approval. Prior approval must be sought through Blueteq. Criteria:

Black – criteria required to be met prior to referral
Blue – criteria to be met prior to procedure

Incision and Curettage OR Intra-Lesion Steroid Injection of a Meibomian Cyst should only be undertaken if **TWO OR MORE** of the following criteria have been met:

- Has been present for more than six months
- Has been managed conservatively with warm compresses, lid cleaning and massage for at least FOUR weeks
- Vision is significantly impaired
- Lid closure is affected, thereby compromising eye protection
- Where it is a source of infection, creating an abscess
- It has been a source of infection, requiring medical attention on two or more episodes in the last six months.

Exclusion Criteria:
- Where malignancy is suspected
  - Referral for specialist opinion may be sought (under 2WW as deemed appropriate)
- Presence of a red eye may indicate blepharokeratoconjunctivitis (BKC)
  - Referral to ophthalmology is advised

3. Rationale for Recommendation

Incision and curettage is not recommended as first line treatment unless the criteria listed above are met as:
- Warm compresses followed by gentle massage of the meibomian cyst is first line treatment
  - Many chalazia will spontaneously resolve within a few weeks, and within a six-month period in the majority of cases without the need of surgery.
- After incision and drainage, the cyst may take some weeks to completely disappear, and may also return in some cases.
- Surgery carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedures performed on the eyelids.

4. Useful Resources

- NICE Clinical Knowledge Summaries. Meibomian Cyst (Chalazion). https://cks.nice.org.uk/topics/meibomian-cyst-chalazion/
- Moorfields Eye Hospital NHS Foundation Trust: Chalazion https://www.moorfields.nhs.uk/condition/chalazion-0

5. References

- NHS Evidence-Based Interventions: Academy of Medical Royal Colleges. https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/ebi-statutory-guidance.pdf
- NICE Clinical Knowledge Summaries. Meibomian Cyst (Chalazion). https://cks.nice.org.uk/topics/meibomian-cyst-chalazion/

6. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Consultant Ophthalmologist, UHDBFT	March 2022
Consultant Ophthalmologist, CRHFT	March 2022
Clinical Policy Advisory Group (CPAG)	April 2022
Clinical and Lay Commissioning Committee (CLCC)	May 2022

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 5.0 Policy has been re-worded and reformatted to reflect the DDCCG clinical policies format. This includes the addition of background information, useful resources, references and consultation.	April 2022

Appendix 3 - PLCV Form

Derby and Derbyshire Clinical Commissioning Group

Derbyshire PLCV Referral Form
Meibomian (Chalazion) cyst removal

THIS FORM MUST BE COMPLETED IN FULL AND ATTACHED WITH THE APPROPRIATE CLINICAL INFORMATION TO THE E-REFERRAL SERVICE

"PLCV: - DERBYSHIRE PRIOR APPROVAL PROCESS: Ophthalmology_RAS"

REFERRALS WITHOUT FORMS WILL BE REJECTED

Patient details	**Referring GP details**
Surname	**Referring GP**
Forename(s)	**Practice name**
Address **Post code**	**Practice address**
Date of birth	**Telephone number**
NHS Number	**GP practice code**

Patient Consent	
	Mark or tick boxes below to confirm
I confirm the patient has consented to sharing personal and clinical information contained within this referral form. The Derbyshire Prior Approval Team will process this information, clarify data and communicate with the patient and the GP on the outcome.	☐
By submitting this request you are confirming that you have reviewed this request against relevant policy and believe the patient meets the relevant threshold criteria and therefore you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	☐

Please confirm that you have given PLCV patient leaflet to the patient	☐

Part A - PLCV criteria	
Incision and curettage of chalazia should only be undertaken if TWO or more of the following criteria have been met:	
	At least <u>TWO</u> of the following criteria must apply
• The chalazion/ chalazia have been present for more than six months	☐
• The chalazion/ chalazia has/ have been managed conservatively with warm compresses, lid cleaning and massage for at least FOUR weeks	☐
• Vision is significantly impaired	☐
• Lid closure is affected, therefore compromising eye protection	☐
• The chalazion/ chalazia is/ are infected and creating an abscess	☐
• The chalazion/ chalazia is/ are infected, requiring medical attention on two or more episodes in the last six months.	☐
Exclusion Criteria – Where malignancy is suspected referral for specialist opinion may be sought (under 2ww as deemed appropriate). Presence of a red eye may indicate blepharokeratoconjunctivitis (BKC) – Referral to ophthalmology is advised.	

Additional clinical information that may have a bearing on the application

Additional Patient Information	**BOTH must apply**
This patient is willing to undergo a surgical procedure should it be offered.	☐
I have discussed with the patient the fact they will be referred for a possible procedure but there is no guarantee that a surgical intervention will be the required outcome following the consultation with the secondary care specialist.	☐

Prior Approval No	

Patient Choice of Provider	
First Choice:	[Manually enter provider name]
Second Choice:	[Manually enter provider name]

I confirm that the patient meets the current clinical guideline/policy for referral for the procedure.

Name of referrer: _____ Date: _____

Part B – Reason for referral	
Salutations: Preamble/context:	Dear colleague, ${Current_Consultation} Thank you, ${Referring_doctor}

Problems

${Major_Active_Problems}

${Minor_Active_Problems}

Relevant SH & FH:

Date	${Todays_date}
Smoking status Alcohol Occupation Ethnicity Veteran?	${RC_XE0og} ${RC_Ub0lD} ${RC_0….} ${RC_ XaJQu} ${RC_ XaX3N}
Detail which might assist timely discharge:	

Medication – ${Todays_date}
${Current_Acute_Issues}

Allergies – ${Todays_date}
${Allergies}

Useful values:

BP ${RC_246..} **Systolic BP** ${RC_2469.} **Diastolic BP** ${RC_246A.} ${Todays_date}	**Pulse rate** ${RC_242..}	**Height** ${RC_229..}	**Weight** ${RC_22A..}	**BMI** ${RC_22K..}	**HbA1C** ${RC_X772q} ${Todays_date}

Please embed any attached items here.

Please note any individual patient requirements here (e.g. Wheelchair user).

Appendix 4 - Blueteq Form

Click here to access the guidelines/NICE algorithm

Click to view Southern Derbyshire CCG Policies

Prior Approval Form - Prior Approval Form - PLCV Meibomian Cyst (Chalazion)

PATIENT CONSENT	
I confirm the patient has consented to sharing personal and clinical information contained within this referral form. The Derbyshire Prior Approval Team will process this information, clarify data and communicate with the patient and the GP on the outcome.	☐ Yes ☐ No
By submitting this request you are confirming that you have reviewed this request against relevant policy and believe the patient meets the relevant threshold criteria and therefore you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	☐ Yes ☐ No
Please confirm that you have given PLCV patient leaflet to the patient	☐ Yes ☐ No

APPLICANT DETAILS			
Clinician Making Request:		**Trust:**	
Clinician Full Name:	*	**Telephone:**	*
Contact Email (nhs.net):	*		

PATIENT DETAILS			
Patient Name:		**GP Practice Name:**	
NHS Number:		**GP Practice Code:**	
Patient DOB:		Is the patient a smoker:	☐ Yes ☐ No
Primary Care Prior Approval Number:			

PROCEDURE CRITERIA	
1. Derby and Derbyshire CCG, in line with its principles for procedures of limited clinical value has deemed the incision and curettage of chalazia should be routinely commissioned only if the patient meets TWO or MORE of the following criteria: - Meibomian/Chalazia cyst has/have been present for more than six months -The cyst has been managed consecutively with warm compress, lid cleaning and massage or at least FOUR weeks. - Vision is significantly impaired. - Lid closure is affected, thereby compromising eye protection. - Where it is a source of infection, creating an abscess. The Cyst has been a source of infection, requiring medical attention on two or more episodes in the last six months. **Exclusion Criteria - Where malignancy is suspected referral for specialist opinion may be sought (under 2ww as deemed appropriate). Presence of a red eye may indicate blepharokeratoconjunctivitis (BKC) - Referral to ophthalmology is advised.**	☐ Yes ☐ No * Required

ADDITIONAL INFORMATION
Please provide any additional clinical information that may have a bearing on the application in the text box below.

SUBMISSION DECLARATION
I confirm that the above information is complete and accurately describes the patient's condition.
Submitting User * Date *