NHS
Dorset
Clinical Commissioning Group

NHS England / NHS Dorset Clinical Commissioning Group

Excision of Chalazion

Criteria Based Access Protocol



Supporting people in Dorset to lead healthier lives

NHS DORSET CLINICAL COMMISSIONING GROUP

EXCISION OF CHALAZION
CRITERIA BASED ACCESS PROTOCOL

1. INTRODUCTION AND SCOPE

This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Many but not all resolve within six months with regular application of warm compresses and massage.

1.1 A meibomian cyst (also known as a chalazion) is a sterile, chronic, inflammatory granuloma of the eyelid, caused by the obstruction of a meibomian gland.

1.2 Meibomian cysts can occur in all age groups and are the most common cause of lumps on the eyelid. Cysts can occur spontaneously, may develop following an internal stye (or hordeolum), or may be due to dysfunction of the meibomian glands.

1.3 A meibomian cyst typically presents as a firm, localized eyelid swelling that develops slowly over several weeks. There may be initial discomfort, but this usually settles, and pain and tenderness are usually absent:

- Cysts are more common on the upper eyelid;
- They are usually 2–8 mm in diameter;
- One or both eyes can be affected;
- More than one meibomian cyst may be present;
- When the eyelid is everted, there is a discrete, immobile, round, yellowish lump (lipogranuloma), which may be red, inflamed, and tender;
- **A 2-week wait referral should be made if a malignant eyelid tumour is suspected (for example if the meibomian cyst has an atypical appearance or recurs in the same location).**

1.4 This protocol is applied in accordance with the Policy for Individual Patient Treatments.

2. DEFINITIONS

2.1 Any definitions related to this Criteria Based Access Protocol (CBAP) are included as a Glossary at Appendix B.

3. ACCESS CRITERIA

3.1 NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop of ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used.

3.2 Where there is significant inflammation of the chalazion a drop of ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.

3.3 Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm. However, there are a small number which are persistent, very large, or can cause other problems such as distortion of vision.

3.4 In these cases surgery can remove the contents from a chalazion. However, all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back. The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding.

3.5 Some trials comparing the two treatments suggest that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction but less pain and patient inconvenience. However, this is controversial and other studies show that steroid injection is less effective than surgery. Therefore, both options can be considered for suitable patients.

3.6 Approval for incision and curettage should only be taken where **One** of the following criteria is met:

- Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
- Interferes significantly with vision
- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection that has required medical attention twice or more within a six month time frame
- Is a source of infection causing an abscess which requires drainage

3.7 If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

3.8 Where there is recurrence of chalazion at the same site then biopsy is supported.

4. EXCLUSIONS

4.1 There are no exclusions.

5. CASES FOR INDIVIDUAL CONSIDERATION

5.1 NHS Dorset Clinical Commissioning Group recognises that there will be occasions when patients may have good clinical reasons for being treated as exceptions to the above. The Individual Patient Treatment Policy is available on the NHS Dorset Clinical Commissioning Group website or upon request. In such cases the requesting clinician must provide further information to support the case for being considered as an exception.

5.2 The fact that treatment is likely to be effective for a patient is not, in itself a basis for exceptional circumstances. In order for funding to be agreed there must be some unusual or unique clinical factor in respect of the patient that suggests that they are:

- significantly different to the general population of patients with the particular condition; **and**
- they are likely to gain significantly more benefits from the intervention than might be expected for the average patient with the condition

5.3 In these circumstances, please refer to the Individual Patient Treatment Team at the address below:

First Floor West
Vespasian House
Barrack Road
Dorchester
DT1 1TG
Telephone no: 01305 368936
Email: individual.requests@dorsetccg.nhs.uk

6. REFERRALS

6.1 Patients referred for treatment, or referred for consideration of treatment, using the criteria detailed in the previous version of this CBAP (V3.1, dated October 2017) should continue to be treated, or considered for treatment, in accordance with the arrangements previously outlined in that CBAP until 1st April 2019.

7. CONSULTATION

7.1 Prior to approval from NHS Dorset CCG's Clinical Reference Group this Protocol was reviewed within the local NHS including input from commissioners, clinicians and other relevant stakeholders.

7.2 An Equality Impact Assessment for this Criteria Based Access Protocol is available on request.

8. RECOMMENDATION AND APPROVAL PROCESS

8.1 This access protocol has been approved on behalf of the Clinical Commissioning Committee in line with processes agreed by the CCG's Governing Body.

9. COMMUNICATION/DISSEMINATION

9.1 Following approval of Criteria Based Access Protocols at Clinical Reference Group each Protocol will be uploaded to the CCG's Intranet, Internet and added to the next GP Bulletin.

10. IMPLEMENTATION

10.1 There is no requirement for a formal implementation plan but GPs and provider clinicians communicated with that the criteria for acceptance is worded differently. As the previous version of the protocol was brought in line with neighbouring CCGs there will be a need to confirm they have likewise changed to the NHSE recommendations.

11. DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

11.1 This Criteria Based Access Protocol requires a review every three years, or in the event of any changes to national guidance or when new guidance is issued.

FREQUENTLY ASKED QUESTIONS

N/A

APPENDIX B

GLOSSARY

N/A

A	DOCUMENT DETAILS
Procedural Document Number	119
Author (Name and Job Title)	Tracey Hall, Head of Service, Elective Care
Recommending group	NHSE
Date of recommendation	January 2019
Date of approval	1st April 2019
Version	4.0
Review frequency	3 yearly
Review date	January 2022

B	CONSULTATION PROCESS		
Version No	**Review Date**	**Author and Job Title**	**Level of Consultation**
3.0	April 2017	Jenny Jones, Programme Officer	IPT Panel, CCC. Circulated for comment through the Medical Directors of the three Dorset acute Trusts. IPT Panel includes; GP, Consultant, Public Health, and Patient / Public representation.
4.0	February 2019	Tracey Hall, Head of Service, Elective Care	NHSE Consultation July 2018 to November 2018. Verified by Dorset acute clinicians March 2019.

C	VERSION CONTROL				
Date of recommendation	**Version No**	**Review date**	**Nature of change**	**Approval date**	**Approval Committee**
January 2014	2.0	January 2017	Adoption of document previously developed by PCTs	January 2014	CCC
December 2016	3.0	July 2020	Changes to the access criteria to bring in line with neighbouring CCG policies	July 2017	CCC
January 2019	4.0	February 2022	Updated in line with national policy (January 2019)	April 2019	n/a NHSE requirement

D	ASSOCIATED DOCUMENTS

- NHS England Policy for Evidence Based Interventions, January 2019
- Policy for individual patient treatment, NHS Dorset Clinical Commissioning Group
- Making sense of Local Access Based Protocols, NHS Dorset Clinical Commissioning Group

E	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES

Evidence	Hyperlink (if available)	Date
NHS Health Conditions	https://www.nhs.uk/conditions/eyelid-problems/	
NICE Clinical Knowledge Summaries	https://cks.nice.org.uk/meibomian-cyst-chalazion2#Search?q=chalazia	

F	DISTRIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
✓	✓	✓	✓