

Greater Manchester EUR Policy Statement

Title/Topic: Removal of Common Benign Eyelid Lesions

Reference: GM044

Version: 2.1 (August 2017)



VERSION CONTROL

Version	Date	Details	Page number
0.1	19/09/2014	Initial draft	N/A
0.2	10/10/2014	Branding changed following creation of North West CSU on 1/10/2014	All
0.3	21/11/2014	<p>Amendments made following discussion of the Consultation feedback by the Greater Manchester EUR Steering Group on 19/11/2014:</p> <p>Section 2 “Definition” – Detailed definition taken out and shorter definition added.</p> <p>Section 4 “Criteria for Commissioning”</p> <ul style="list-style-type: none"> • Sentence added stating: “The removal of common benign eyelid lesions for aesthetic reasons is not commissioned”. • The titles “Urgent referral” and “Routine referral” have been taken out and replaced by: <ul style="list-style-type: none"> ○ A: “Referrals for the treatment of common benign eyelid lesions may be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis and the lesion may not be benign in nature. Examples of reasons for referral include but are not exclusive to:” ○ B: “The following criteria will require prior approval via the IFR route:” • “Lid swelling and/or protrusion of the eye” changed to read “protrusion of the eye” • Bullet point added “New and unexpected visual problems (e.g. double vision)” • Bullet point starting ‘Ocular symptoms...’ has been clarified to refer to “an underlying condition or the potential for serious damage to the eye” and “significant redness: has been moved to a separate bullet point to read “Significant redness in the absence of an obvious cause” • The additional criteria for Dermatocheliiasis and Xanthelasma Palpebrum removed. <p>Section 5 “Description of Epidemiology and Need” section reworded.</p> <p>Section 9 “Mechanism for funding” changed to monitored approval if meeting criteria for A and prior approval if meeting criteria for B.</p> <p>Section 14 “Glossary” – Chalazion and Xanthelasma added.</p>	<p style="text-align: center;">7</p> <p style="text-align: center;">8</p> <p style="text-align: center;">9</p> <p style="text-align: center;">9/10</p>

0.4	21/01/2015	Approved by GM EUR Steering Group to go out to Consultation	N/A
1.0	25/06/2015	<p>Changes made following the GM EUR Steering Group meeting on 20/05/2015 post Consultation:</p> <p>Section 2 - Definition the following paragraph added</p> <p>'The first step in the management of most lesions will be self-care in the form of enhanced eyelid hygiene. Individuals will be expected to self-fund the products needed for good hygiene e.g. Baby shampoo or blepharwipes.'</p> <p>Section 4 - Commissioning Criteria</p> <ul style="list-style-type: none"> • Rapidly growing • Visual field affected • Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye <p>The above moved from 'B' to 'A'</p> <p>'B' clarified to read 'Where the eyelid lesion is symptomatic referrals can be made using the prior approval through IFR route for the following criteria:</p> <p>The last bullet point in 'B' amended to read Significant redness of the eye in the absence of an obvious cause</p> <p>Policy agreed by Greater Manchester EUR Steering on 20th May 2015 subject to the above changes being made.</p>	<p>8</p> <p>8</p> <p>8</p> <p>9</p>
1.1	07/04/2016	<p>List of diagnostic and procedure codes in relation to this policy added as Appendix 2.</p> <p>Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services.</p> <p>Wording for date of review amended to read <i>"One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)"</i> on 'Policy Statement' and section '13. Date of Review'.</p>	<p>16</p> <p>N/A</p> <p>4 & 10</p>
1.2	13/06/2016	Wigan CCG changed funding mechanism to Individual Prior Approval (IPA) for <u>all</u> requests (both 4A and 4B) – to be adopted from 1 st August 2016.	5 & 10
2.0	21/09/2016	The policy was reviewed in August 2016 and two new papers were found, an updated version of a review and a new review, however these did not affect the existing policy. Following GM EUR Steering Group on 21 September 2016 it was agreed that no changes would be made to main body of policy and the following updates be made:	

		<ul style="list-style-type: none"> • Review date added to cover page and 'Policy Statement' • The 'Date of Review' on 'Policy Statement' and in body of report changed to <i>"Three years from the date of last review unless new evidence warrants earlier review"</i> • 'Appendix 1: Evidence Review' updated to include the 2 new papers found 	<p>1 & 4</p> <p>4 & 12</p> <p>14, 17-19</p>
2.1	01/08/2017	Wigan CCG changed funding mechanism to monitored approval in line with other GM CCGs.	5 & 10

POLICY STATEMENT

Title/Topic:	Removal of Common Benign Eyelid Lesions
Issue Date:	September 2015
Reviewed:	September 2016
Commissioning Recommendation:	<p>The removal of common benign eyelid lesions for aesthetic reasons is not commissioned.</p> <p><i>All suspected malignant lesions are excluded from this policy – these should be managed via the 2 week wait.</i></p> <p>See Section 4: Criteria for Commissioning</p>
Date of Review:	Three years from the date of last review unless new evidence warrants earlier review.
Prepared By:	Greater Manchester Shared Services Effective Use of Resources Policy Team

Approved By	Date Approved	Funding Mechanism
Greater Manchester Effective Use of Resources Steering Group	20/05/2015	<p>GM EUR Steering Group recommended funding mechanism:</p> <p>Funding will be via monitored approval for referrals made and accepted in line with the criteria detailed in section <u>4 A</u>).</p> <p>Referrals in line with section <u>4 B</u>) will be via the EUR route for individual prior approval.</p>
Greater Manchester Chief Finance Officers / Greater Manchester Heads of Commissioning	11/08/2015	N/A
Greater Manchester Association Governing Group	15/09/2015	N/A
Bury Clinical Commissioning Group	07/10/2015	Recommended mechanism above
Bolton Clinical Commissioning Group	23/10/2015	Recommended mechanism above
Heywood, Middleton & Rochdale Clinical Commissioning Group	20/11/2015	Recommended mechanism above
Central Manchester Clinical Commissioning Group	16/12/2015	Recommended mechanism above

North Manchester Clinical Commissioning Group	21/10/2015	Recommended mechanism above
Oldham Clinical Commissioning Group	15/09/2015	Recommended mechanism above
Salford Clinical Commissioning Group	15/09/2015	Recommended mechanism above
South Manchester Clinical Commissioning Group	01/10/2015	Recommended mechanism above
Stockport Clinical Commissioning Group	23/09/2015	Recommended mechanism above
Tameside & Glossop Clinical Commissioning Group	25/10/2015	Recommended mechanism above
Trafford Clinical Commissioning Group	17/11/2015	Recommended mechanism above
Wigan Borough Clinical Commissioning Group	07/10/2015	Recommended mechanism above

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Policy Statement

The Greater Manchester Shared Services (GMSS) has developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission the removal of common benign eyelid lesions in accordance with the criteria outlined in this document.

In creating this policy the GMSS has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

Equality & Equity Statement

The GMSS/CCG has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. The GMSS/CCG is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, the GMSS/CCG will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMSS Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMSS evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Association Governing Group (AGG) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the Greater Manchester EUR Operational Policy.

1. Introduction

This commissioning policy has been produced in order to provide and ensure equity, consistency and clarity in the commissioning of the removal of common benign eyelid lesions by Clinical Commissioning Groups in Greater Manchester. When this policy is reviewed all available additional data on outcomes will be included in the review and the policy updated accordingly.

2. Definition

Benign lesions of the eyelid are those which do not affect the functioning of the eye or eyelids and will not develop into malignant disease. These include but are not limited to Chalazion (meibomian) cyst, dermatochelasis and xanthelasma.

The first step in the management of most lesions will be self-care in the form of enhanced eyelid hygiene. Individuals will be expected to self-fund the products needed for good hygiene e.g. Baby shampoo or blepharwipes.

3. Aims and Objectives

Aim

This policy document aims to specify the conditions under which removal of common benign eyelid lesions will be routinely commissioned by Clinical Commissioning Groups in Greater Manchester.

Objectives

- To reduce the variation in access to the removal of common benign eyelid lesions.
- To ensure that removal of common benign eyelid lesions is commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- To reduce unacceptable variation in the commissioning of the removal of common benign eyelid lesions across Greater Manchester.
- To promote the cost-effective use of healthcare resources.

4. Criteria for Commissioning

Mandatory Criteria

The removal of common benign eyelid lesions for aesthetic reasons is not commissioned.

- A) Referrals for the treatment of common benign eyelid lesions may be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis and the lesion may not be benign in nature. Examples of reasons for referral include but are not exclusive to:
- Significant preseptal cellulitis / orbital cellulitis
 - Atypical presentation, re-occurrence in same site, may require cancer exclusion
 - Protrusion of the eye
 - Rapidly growing
 - Visual field affected
 - Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye
 - New and unexpected visual problems (e.g. double vision)
 - Reduced light reflexes or abnormal swinging light test
 - Symptomatically unwell
 - CNS symptoms or signs
- B) Where the eyelid lesion is symptomatic referrals can be made using the prior approval through IFR route for the following criteria:
- Persistent (more than 6 months and not responded to conservative treatment)
 - There is significant pain as a direct result of the lesion

- There is a confirmed history of recurrent infection / inflammation
- Significant redness of the eye in the absence of an obvious cause

Policy Exclusions

All suspected malignant lesions are excluded from this policy – these should be managed via the 2 week wait.

The removal of common benign eyelid lesions for cosmetic reasons or outside of the criteria detailed above are not routinely commissioned. Funding may be considered on an individual patient basis, if there is evidence of clinical exceptional circumstances.

Clinicians can submit an Individual Funding Request (IFR) if they feel there is a good case for exceptionality in line with the procedures described in the Greater Manchester EUR Operational Policy

Exceptionality means ‘a person to which the general rule is not applicable’. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is:

- Significantly different to the general population of patients with the condition in question.

and as a result of that difference

- They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

5. Description of Epidemiology and Need

The vast majority of eyelid lesions are harmless and self-limiting. Xanthelasma is often seen in people with high cholesterol or other fat (lipid) levels in the blood, and the lesions contain deposits that are high in fat (lipid-rich). Xanthelasma can occur in people of any race and of either sex. However, females seem to be more frequently affected than males. In addition, it is unusual for a child or teenager to develop xanthelasma; most individuals develop the condition in middle age. Approximately one half of patients with xanthelasma have high amounts of fats (lipids) in their blood, such as high cholesterol or high triglycerides.

Dermatochalasis is a common finding seen in elderly persons and occasionally in young adults. Gravity, loss of elastic tissue in the skin, and weakening of the connective tissues of the eyelid frequently contribute to this lax and redundant eyelid tissue. These findings are more common in the upper eyelids but can be seen in the lower eyelids as well. Genetic factors and family traits may play a role in some patients.

6. Evidence Summary

The vast majority of common benign eyelid lesions are harmless and self-limiting. Most removals are requested for aesthetic reasons; however, in some circumstances (see criteria above) removal is indicated for clinical or functional reasons. Full details of the Evidence Review are contained with Appendix 1.

7. Rationale behind the Policy Statement

The vast majority of common benign eyelid lesions are harmless and although they may be unsightly there is no clinical reason for their removal. There are occasional circumstances in which the removal of a these lesions are indicated and these circumstances are listed in this policy. The policy does not allow lesions to be removed for solely aesthetic reasons.

8. Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

9. Mechanism for Funding

Clinical Commissioning Group	Funding Mechanism
Bolton Bury Heywood, Middleton & Rochdale Manchester Central Manchester North Manchester South Oldham Salford Stockport Tameside & Glossop Trafford Wigan	Funding will be via monitored approval for referrals made and accepted in line with the criteria detailed in section <u>4A</u> . Referrals in line with section <u>4B</u>) will be via the EUR route for individual prior approval.

10. Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

11. Documents which have informed this Policy

- Individual CCG referral criteria and policy statements.
- Greater Manchester EUR Operational Policy.

12. Links to other Policies

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

- Greater Manchester EUR Policy Statement - GM047 - Correction of Eyelid Ptosis

13. Date of Review

Three years from the date of last review unless new evidence warrants earlier review.

14. Glossary

Term	Meaning
Astigmatism	A condition of unequal curvatures along the different meridians in one or more of the refractive surfaces (cornea, anterior or posterior surface of the lens) of the eye, in consequence of which the rays from a luminous point are not focused at a single point on the retina.
Benign	(Of a disease) not harmful in effect.

Chalazion	A chalazion is a small (2-8mm) fluid-filled swelling (cyst) in the eyelid. It is common and sometimes called a meibomian cyst or tarsal cyst . A chalazion is more common on the upper eyelid and can affect both eyes. It is not the same as a sty.
Canthus	The outer or inner corner of the eye, where the upper and lower lids meet
Dermatochalasis	Drooping of the eyelids.
Dermatitis	A medical condition in which the skin becomes red, swollen, and sore, sometimes with small blisters.
Malignant	Unregulated cell growth. In cancer, cells divide and grow uncontrollably, forming malignant tumors, and invading nearby parts of the body.
Orbital septum	A fibrous membrane attached to the margin of the orbit and extending into the lids, containing the orbital fat and constituting in great part the posterior fascia of the orbicularis oculi muscle.
Preseptal	Infection involving the superficial tissue layers anterior to the orbital septum.
Xanthelasma	Xanthelasma (xanthelasma palpebrarum) is a skin condition that develops flat yellow growths on the eyelids. The appearance is of yellow flat plaques over the upper or lower eyelids, most often near the inner canthus.

References

N/A

Appendix 1 – Evidence Review

Title/Topic: Removal of Common Benign Eyelid Lesions
Ref: GM044

Search Strategy

A search was undertaken for **Chalazion (meibomian cyst or tarsal cyst)**, **Xanthelasma** and **Dermatocheliiasis**. Most studies related to comparison of therapies and techniques and not reviewing the need for removal.

Database	Result
NICE	Xanthelasma mentioned in CG71 (managing familial hypercholesterolaemia) Not cited below
NHS Evidence and NICE CKS	<ul style="list-style-type: none"> • The College of Optometrists Clinical Management Guidelines: Chalazion (Meibomian cyst) Version 12, Page 1 of 2 Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16 (Previous version replaced by updated version added at review: Sep 2016) • The College of Optometrists Clinical Management Guidelines: Hordeolum Version 9, Page 1 of 2 Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16 (Added at review: Sep 2016) • NICE CKS: Meibomian cyst (chalazion) Last revised: November 2015 (Previous version replaced by updated version added at review: Sep 2016) • NICE CKS: Styes (hordeola) Last revised: August 2015 (Previous version replaced by updated version added at review: Sep 2016) • BMJ Practice Summary: Stye and Chalazion (not cited below) • Modernisation Agency Plastic Surgery Guidelines (not cited below)
SIGN	Nil found
Cochrane	Nil found
York	A prospective study of cost, patient satisfaction, and outcome of treatment of chalazion by medical and nursing staff Jackson TL, Beun L. Br J Ophthalmol. 2000 Jul;84(7):782-5
BMJ Clinical Evidence	Nil found
BMJ Best Practice	<ul style="list-style-type: none"> • Stye and Chalazion section (Not cited below) • Nil specific found (reference in management of hypercholesterolaemia)

General Search (Google)	<ul style="list-style-type: none"> • Various websites including NHS choices, patient.co.uk, and clinic sites • Patient.co.uk guidance on Xanthelasma (Not cited below)
Royal College of Ophthalmologists	Nil found

Summary of the evidence

The vast majority of benign skin lesions of the eyelid are harmless, many are self-limiting. Most removals are requested for aesthetic reasons however were a:

- lesion is causing a reduction of the visual fields

OR

- should have resolved within 6 months and hasn't

These are considered indication for removal.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

1. LEVEL 3: PROSPECTIVE COHORT STUDY

A prospective study of cost, patient satisfaction, and outcome of treatment of chalazion by medical and nursing staff

Jackson TL, Beun L.

Br J Ophthalmol. 2000 Jul;84(7):782-5.Abstract

Aim: To study prospectively the outcome of conservative and surgical treatment of chalazia provided by medical and nursing staff.

Methods: During a 5 month recruitment period all patients attending a district general eye hospital for treatment of chalazion were included in the study. 129 patients (217 visits) with chalazia were seen by either a senior nurse or a trainee ophthalmologist (senior house officer, SHO) or both. Patients received either conservative treatment or eversion of the eyelid with incision and curettage. Patients were mailed a questionnaire asking them if their cyst had resolved and how they rated their treatment. Marginal cost analysis was used to determine the cost of treatment.

Results: The outcome of treatment could be determined in 170 of the 217 visits. Conservative treatment was successful for 29% of cysts while surgical treatment was successful for 72%. There was no significant difference in treatment outcome between nurse and SHO groups. Patients found nurse treatment acceptable with a high level of patient satisfaction. The marginal cost of treatment by a nurse

was 9.91 pounds sterling per cyst compared with 12.10 pounds sterling for SHOs. There were no surgical complications and no evidence of malignancy in six biopsies.

Conclusions: Surgical treatment of chalazion is safe and effective and successfully treats approximately three quarters of selected cysts. With conservative treatment approximately one third of selected chalazia will resolve within 3 months. Nurse treatment of chalazion is safe, effective, and acceptable to patients.

2. LEVEL N/A
NICE CKS: Styes (hordeola)
Last revised: August 2015

MANAGEMENT

How should I manage a stye in primary care?

- **Reassure the person that a stye is usually self-limiting and rarely causes serious complications.**
 - Symptoms typically rapidly resolve once the stye has spontaneously ruptured or has been drained.
- **Advise the person:**
 - To apply a warm compress (for example, using a clean flannel that has been rinsed with hot water) to the affected eye for 5–10 minutes. Repeat several times a day until the stye drains or resolves.
 - They should not attempt to puncture the stye.
 - To avoid eye makeup or contact lens use until the area has healed.
- **For a painful external stye, consider:**
 - Epilating the eyelash from the infected follicle (to facilitate drainage).
 - Incising and draining the stye, using a fine sterile needle, if appropriate. This should only be undertaken by a healthcare professional with suitable expertise.
- **Do not prescribe a topical antibiotic** unless there is evidence of conjunctivitis. See the CKS topic on Conjunctivitis - infective for more information.
- **If the stye does not improve** or resolve with conservative treatment, consider referral for specialist assessment.
- **Manage any co-existing blepharitis** to reduce the risk of recurrence. See the CKS topic on Blepharitis for more information.

Basis for recommendation

Self-management advice

- The recommendation on applying a warm compress is based on expert opinion in the British Medical Journal (BMJ) review article *Eyelid lumps and lesions* [Gupta et al, 2014]. The recommendation to apply a warm compress several times a day is based on expert opinion in US clinical review articles [Greenberg, 2002; Mueller and McStay, 2008], and an Australian optometry guideline *Optometric management of hordeolum* [QUT, 2005]. A UK optometry review article *Hordeolum and chalazion treatment* recommends applying a warm compress 2–4 times daily [Skorin, 2002].
- The recommendation to avoid puncturing an external stye is based on 2 UK case reports. They highlighted the serious complications that can follow the puncture of a stye by the person themselves, causing periorbital cellulitis [Benton and Karkanavatos, 2007] and periorbital necrotizing fasciitis (which can be potentially life-threatening) [Raja et al, 2008].

- The recommendation to avoid eye makeup or contact lenses is based on a Canadian patient information resource, *Styes and Chalazia* [HealthLink BC, 2014].

Procedures for symptomatic relief of external styes

- The recommendations for epilating the affected hair follicle or incising an external stye are supported by expert opinion in a US review article *The red eye: evaluation and management* [Sethuraman and Kamat, 2009a] and the College of Optometrists guideline *Hordeolum* [The College of Optometrists, 2015].

Topical antibiotics not recommended

- A Cochrane systematic review (search date July 2012) found no relevant trials on interventions for an acute internal stye [Lindsley et al, 2013].
- Expert opinion on the use of topical antibiotics for the treatment of styes differs:
 - A US review article *The red eye: evaluation and management* suggests that topical antibiotics do not affect the course of an external stye [Sethuraman and Kamat, 2009b]. A second US review article *Ocular Infection and Inflammation* states that the use of topical antibiotics for preventing complications is controversial [Mueller and McStay, 2008].
 - A British Medical Journal (BMJ) clinical review article *Eyelid lumps and lesions* states that the role of topical antibiotics is debatable [Gupta et al, 2014].
 - A UK optometry review article *Hordeolum and chalazion treatment* recommends the use a topical antibiotic for the treatment of an external stye (not internal because the infection is deep within the lid and therefore topical application is ineffective) [Skorin, 2002]. However, an Australian optometry guideline *Optometric management of hordeolum* recommends the use of a topical antibiotic for the treatment of both an external and internal stye [QUT, 2005].
- Given the lack of a consensus in the literature and the self-limiting nature of the condition, CKS does not recommend topical antibiotics for the routine treatment of a stye. This recommendation is supported by a consensus of expert opinion from previous external reviewers of this CKS topic.

Referral if non-resolution

- The recommendation to consider referral to an ophthalmologist if a stye is not improving with conservative management is based on a clinical review article published in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014].

Management of co-existing blepharitis

- The recommendation on managing co-existing blepharitis to reduce the risk of recurrence is based on expert opinion in the guideline *Clinical management guidelines for hordeolum* published by the College of Optometrists [The College of Optometrists, 2015].

REFERRAL

When should I refer a person with a stye?

- **Admit the person to hospital if:**
 - There are signs of significant periorbital or orbital cellulitis.
- **Arrange a 2-week wait referral if a malignant eyelid tumour is suspected** — for example, if the stye has an atypical appearance (for example distortion of the eyelid margin, loss of eyelashes, ulceration, or bleeding) or a suspected stye recurs in the same location.
- **Refer the person to an ophthalmologist for possible incision and drainage if:**
 - The stye is persistent and has not discharged following conservative treatment.
 - An internal stye is particularly large and painful.

Basis for recommendation

Admission

- The recommendation to admit a person with either periorbital or orbital cellulitis is based on expert opinion in a clinical review article *Guidelines for the management of periorbital cellulitis/abscess* [Howe and Jones, 2004].

2-week wait referral for suspected cancer

- The recommendation to urgently refer a person if cancer is suspected is based on expert opinion in a clinical review article in the British Medical Journal (BMJ), *Eyelid lumps and lesions* [Gupta et al, 2014].

Referral to an ophthalmologist for possible incision and drainage

- The recommendation to refer a person with a persistent stye or a large, painful internal stye is based on expert opinion in a clinical review article in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014]

3. LEVEL N/A

NICE CKS: Meibomian cyst (chalazion)

Last revised: November 2015

MANAGEMENT

How should I manage a meibomian cyst in primary care?

- **Reassure the person that a meibomian cyst is usually self-limiting and rarely causes serious complications.**
 - Meibomian cysts usually resolve spontaneously or with conservative treatment.
- **Advise the person:**
 - To apply a warm compress (for example, using a clean flannel that has been rinsed with warm water) to the affected eye for 5–10 minutes at least twice a day.
 - Explain that this will help to liquefy the lipid content of the cyst, thus encouraging drainage of the cyst contents.
 - Avoid excessively hot compresses (to avoid scalding).
 - Gently massage the meibomian cyst after application of the warm compress (to aid expression of the cyst contents).
 - This should be done in the direction of the eyelashes using clean fingers or a cotton bud.
- **Do not prescribe** topical or oral antibiotics.
- **If the meibomian cyst does not improve or resolve after 4 weeks with conservative treatment,** offer the following options (depending on clinical judgement and the person's preference):
 - No treatment — for example, if the meibomian cyst is small and asymptomatic.
 - Referral to an ophthalmologist.
- **Manage any co-existing risk factors** to reduce the risk of recurrent episodes.
 - Chronic blepharitis. See the CKS topic on Blepharitis for more information.
 - Seborrhoeic dermatitis. See the CKS topic on Seborrhoeic dermatitis for more information.
 - Acne rosacea. See the CKS on Rosacea for more information.

Basis for recommendation

Self-management advice

- The recommendation on applying a warm compress is based on expert opinion in the British Medical Journal (BMJ) review article *Eyelid lumps and lesions* [Gupta et al, 2014].
- The recommendation to apply heat and massage at least twice a day is based on expert opinion in the British Medical Journal (BMJ) review article *Chalazion* [Arbabi et al, 2010].

Antibiotics not recommended

- Meibomian cysts are generally sterile in nature. Consequently, treatment with antibiotics (topical or oral) is not recommended [Arbabi et al, 2010].

Treatment options if the cyst is unresponsive to conservative treatment

- CKS recommends that no treatment or referral are considered as options if there is no improvement after 4 weeks. Meibomian cysts may resolve spontaneously and only rarely cause serious complications.
 - The recommendation to apply conservative treatment for up to 4 weeks is based on expert opinion and evidence from published trials [Olson, 1991; Lederman and Miller, 1999].

Management of co-existing risk factors

- The recommendation to manage risk factors in order to reduce the risk of future episodes is based on expert opinion in the BMJ review article *Chalazion* [Arbabi et al, 2010] and The College of Optometrists *Clinical Management guidelines of Chalazion (meibomian cyst)* [The College of Optometrists, 2015].
- This is also supported by the Department of Health's 18-Week Commissioning Pathway guideline which recommends 2–3 weeks of conservative treatment [DH, 2008].

REFERRAL

When should I admit or refer a person with a meibomian cyst?

- **Admit the person to hospital if:**
 - There are symptoms or signs of significant periorbital or orbital cellulitis.
- **Arrange a 2-week wait referral if a malignant eyelid tumour is suspected** — for example, if the meibomian cyst has an atypical appearance (for example distortion of the eyelid margin, loss of eyelashes, ulceration, or bleeding) or a suspected meibomian cyst recurs in the same location.
- **Refer the person to an ophthalmologist** for specialist treatment if:
 - The meibomian cyst is affecting vision or causing discomfort.
 - The meibomian cyst does not respond to conservative treatment.
 - Large and persistent meibomian cysts (those lasting more than 6 months) are likely to require specialist treatment.
 - There is uncertainty about the diagnosis.

SPECIALIST TREATMENT

Incision and curettage

- This is generally carried out under local anaesthetic.
- The eyelid may remain swollen and inflamed for up to 1 week after the procedure.
- Complications are uncommon, but include haemorrhage, infection, and (more rarely) canalicular trauma and globe perforation. The meibomian cyst may recur (particularly if the drainage was inadequate).

Intralesional corticosteroid injection

- Triamcinolone acetonide is injected directly into the cyst; either subcutaneously or via the trans-conjunctival route. More than one injection may be required (particularly for large cysts).
- Reported success rates are 75–84%. Resolution typically occurs 1–2 weeks after injection.
- Adverse effects include depigmentation of the eyelid at the injection site, temporary skin atrophy, subcutaneous white deposits, and a potential increase in intraocular pressure. [Arbabi et al, 2010; Ben Simon et al, 2011; The College of Optometrists, 2015]

Basis for recommendation

Arranging admission

- The recommendation to admit a person with either significant periorbital or orbital cellulitis is based on expert opinion in the clinical review article *Guidelines for the management of periorbital cellulitis/abscess* [Howe and Jones, 2004].

Arranging a 2-week wait referral for suspected cancer

- The recommendation to urgently refer a person if cancer is suspected is based on expert opinion in a clinical review article published in the British Medical Journal (BMJ), *Eyelid lumps and lesions* [Gupta et al, 2014]; an Australian review article [Gilchrist, 2009]; and a US review article [Papier et al, 2007].

Routine referral to an ophthalmologist

- The recommendation to refer a person with a meibomian cyst, which is large and causing visual disturbance is based on The College of Optometrists *Clinical management guidelines of Chalazion (Meibomian cyst)* [The College of Optometrists, 2015].
- The recommendation to refer a person with a persistent meibomian cyst is based on expert opinion in a clinical review article published in the BMJ, *Eyelid lumps and lesions* [Gupta et al, 2014].
- The recommendation to refer the person if there is any doubt regarding the diagnosis is based on what CKS considers to be good clinical practice.

4. LEVEL: N/A

The College of Optometrists Clinical Management Guidelines: Chalazion (Meibomian cyst)

Version 12, Page 1 of 2 Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16

Aetiology	Blockage of Meibomian gland duct with retention and stagnation of secretion May occur spontaneously or follow an acute hordeolum (internal)
Predisposing factors	Chronic blepharitis Rosacea Seborrhoeic dermatitis Pregnancy Diabetes mellitus
Symptoms	Painless lid lump Usually single; sometimes multiple May be recurrent May rupture through the skin (Sometimes) blurred vision from induced astigmatism
Signs	Well-defined, 2-8mm diameter subcutaneous nodule in tarsal plate Lid eversion may show external conjunctival granuloma Induced astigmatism may cause change in refraction

	May be associated blepharitis
Differential diagnosis	Hordeolum (external or internal) Sebaceous cyst of skin Sebaceous (Meibomian gland) Carcinoma (consider if lesion recurrent)
Management by Optometrist	
Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere	
Non pharmacological	Usually (up to 80%) resolves spontaneously (may take weeks or months) If persistent, large, recurrent or causing corneal distortion then refer for management by ophthalmologist Regular lid hygiene for blepharitis (see Clinical Management Guideline on Blepharitis) (GRADE*: Level of evidence=low; Strength of recommendation=strong)
Pharmacological	None (but see Clinical Management Guideline on Hordeolum [internal])
Management Category	B2: alleviation/palliation: normally no referral B1: routine referral to Ophthalmologist if persistent or recurrent, if causing significant astigmatism or if cosmetically unacceptable
Possible management by Ophthalmologist	
Incision and curettage where appropriate Intra-lesion injection of steroid (may be preferred in children) Trials have shown that intralesional triamcinolone injection may be as effective as incision and curettage in primary chalazia (see evidence base)	
Evidence base	
*GRADE: Grading of Recommendations Assessment, Development and Evaluation (see http://www.gradeworkinggroup.org/index.htm)	
<i>Sources of evidence</i> Ben Simon GJ, Rosen N, Rosner M, Spierer A. Intralesional triamcinolone acetonide injection versus incision and curettage for primary chalazia: a prospective, randomized study. Am J Ophthalmol. 2011;151(4):714-718 Goawalla A, Lee V. A prospective randomized treatment study comparing three treatment options for chalazia: triamcinolone acetonide injections, incision and curettage and treatment with hot compresses. Clin Exp Ophthalmol. 2007;35(8):706-12 Perry HD, Serniuk RA. Conservative treatment of chalazia Ophthalmology 1980;87(3):218-21	

Lay Summary

A chalazion, also known as a Meibomian cyst, is a common condition of the eyelid caused by blockage of the openings of the oil-producing Meibomian glands. It is usually felt as a small firm lump in the upper or lower eyelid. The condition usually gets better without treatment. However if it does not settle on its own, it can be treated by a steroid injection or the cyst can be removed by a minor operation.

5. LEVEL: N/A

The College of Optometrists Clinical Management Guidelines: Hordeolum

Version 9, Page 1 of 2 Date of search 13.09.14; Date of revision 16.12.14; Date of publication 16.02.15; Date for review 12.09.16

Aetiology	<p>There are two types:</p> <ul style="list-style-type: none"> external hordeolum (stye) – acute bacterial infection of the lash follicle and its associated gland of Zeis or Moll internal hordeolum – acute bacterial infection of Meibomian gland <p>These infections are usually staphylococcal</p>
Predisposing factors	Chronic blepharitis
Symptoms	<p>Tender lump in eyelid Epiphora Local redness of eye and lid</p>
Signs	<p>External hordeolum Tender inflamed swelling of the lid margin. May point anteriorly through the skin Occasionally, multiple abscesses involve entire eyelid</p> <p>Internal hordeolum Tender inflamed swelling within the tarsal plate. More painful than a stye. May point anteriorly through the skin or posteriorly through the conjunctiva</p>
Differential diagnosis	<p>Preseptal cellulitis Haematoma of eyelid Acute dacryocystitis Chalazion (blockage of Meibomian gland with cyst formation) Sebaceous cell carcinoma</p>
Management by Optometrist	
Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere	
Non pharmacological	<p>Most resolve spontaneously or discharge, followed by resolution In the case of external hordeola, it may help to remove the lash associated with the infected follicle Traditional remedies such as hot spoon bathing and/or warm compresses may relieve symptoms Manage associated blepharitis with lid hygiene (see Clinical Management Guideline on Blepharitis) Rarely, refer for incision in cases that do not discharge (commoner with internal hordeolum) An internal hordeolum may evolve into a chalazion (see Clinical Management Guideline on Chalazion) Advise patient to return/seek further help if symptoms persist (GRADE*: Level of evidence=low; Strength of recommendation=strong)</p>
Pharmacological	<p>Consider course of antibiotic drops or ointment (e.g. chloramphenicol) in the presence of copious muco-purulent discharge In severe or recurrent cases, consider management with systemic antibiotics (possible co-management with GP) (GRADE*: Level of evidence=low; Strength of recommendation=strong)</p>
Management Category	B2: Alleviation/palliation: normally no referral
Possible management by Ophthalmologist	

Possible incision, but surgery rarely performed in presence of acute infection
See also Clinical Management Guidelines on Chalazion, Pre-septal Cellulitis

Evidence base

*GRADE: Grading of Recommendations Assessment, Development and Evaluation (see <http://www.gradeworkinggroup.org/index.htm>)

Sources of evidence

Lindsley K, Nichols JJ, Dickersin K. Interventions for acute internal hordeolum. Cochrane Database of Systematic Reviews 2013, Issue 4. Art. No.: CD007742. DOI: 10.1002/14651858.CD007742.pub3

Lay Summary

A hordeolum is an acute bacterial infection of the glands of the eyelid. An internal hordeolum affects the Meibomian (oil) glands within the eyelids whereas an external hordeolum (commonly referred to as a sty) affects the glands associated with the eyelashes. Both conditions cause red and tender swellings of the eyelid. Traditional remedies such as hot spoon bathing and/or warm compresses may relieve symptoms. In some cases, treatment with antibiotic drops or ointment is needed to speed up resolution. In the case of a severe infection, antibiotic tablets may be required.

Appendix 2 – Diagnostic and Procedure Codes

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM044 - Common Benign Skin Lesion of the Eyelid Policy	
Excision of lesion of canthus	C11.1
Destruction of lesion of canthus	C11.2
Excision of lesion of eyelid NEC	C12.1
Cauterisation of lesion of eyelid	C12.2
Cryotherapy to lesion of eyelid	C12.3
Curettage of lesion of eyelid	C12.4
Destruction of lesion of eyelid NEC	C12.5
Wedge excision of lesion of eyelid	C12.6
Other specified excision of lesion of eyelid	C12.8
Unspecified excision of lesion of eyelid	C12.9
With the following ICD-10 diagnosis code(s):	
Chalazion	H00.1
Xanthelasma of eyelid	H02.6
Melanocytic naevi of eyelid, including canthus	D22.1
Other benign neoplasms of skin of eyelid, including canthus	D23.1
Exceptions (ICD-10); the following in a primary or secondary diagnostic position:	
Malignant melanoma of eyelid, including canthus	C43.1