**The effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome: 24-month follow-up of a randomised trial**

1. Claire Burton PhD ([c.burton@keele.ac.uk](mailto:c.burton@keele.ac.uk)), corresponding author. 0044 1782 734879. ORCID ID **0000-0003-4688-3075**

1. Trishna Rathod-Mistry PhD ([t.rathod@keele.ac.uk](mailto:t.rathod@keele.ac.uk))

1 Steven Blackburn PhD (s.blackburn@keele.ac.uk)

1. Milica Blagojevic-Bucknall PhD ([m.bucknall@keele.ac.uk](mailto:m.bucknall@keele.ac.uk))

1. Linda Chesterton PhD [l.chesterton1@gmail.com](mailto:l.chesterton1@gmail.com)

1. Graham Davenport BM davenport5959@gmail.com

1. Krysia Dziedzic PhD ([k.s.dziedzic@keele.ac.uk](mailto:k.s.dziedzic@keele.ac.uk))

1.4 Adele Higginbottom (a.higginbottom@keele.ac.uk)

2. Sue Jowett PhD (S.Jowett@bham.ac.uk)

1. Helen Myers PhD ([h.l.myers@keele.ac.uk](mailto:h.l.myers@keele.ac.uk))

2. Raymond Oppong PhD ([R.A.Oppong@bham.ac.uk](mailto:R.A.Oppong@bham.ac.uk))

1. Danielle van der Windt PhD (d.van.der.windt@keele.ac.uk)

1. Elaine Hay MD ([e.m.hay@keele.ac.uk](mailto:e.m.hay@keele.ac.uk))

1,3. Edward Roddy DM ([e.roddy@keele.ac.uk](mailto:e.roddy@keele.ac.uk))

1. School of Medicine and Primary Care Centre Versus Arthritis. Keele University. Staffordshire. ST5 3BG

2. Institute of Applied Health Research. University of Birmingham. B15 2TT

3. Haywood Academic Rheumatology Centre, Midlands Partnership NHS Foundation Trust, Stoke-on- Trent, ST6 7AG

4 Patient and public involvement and engagement coordinator

**KEYWORDS**

**Carpal tunnel syndrome |clinical trial |primary care**

**Word count = 3369**

**Objectives**

This follow-up study of the INSTinCTS (INjection versus SplinTing in Carpal Tunnel Syndrome) trial compared the effects of corticosteroid injection (CSI) and night splinting (NS) for the initial management of mild-to-moderate carpal tunnel syndrome (CTS) on symptoms, resource use, and carpal tunnel surgery, over 24 months.

**Methods**

Adults with mild-to-moderate CTS were randomised 1:1 to a local corticosteroid injection or a night splint worn for 6 weeks. Outcomes at 12 and 24 months included the Boston Carpal Tunnel Questionnaire (BCTQ), hand/wrist pain intensity numeric rating scale (NRS), the number of patients referred for and undergoing CTS surgery, and healthcare utilisation. A cost-utility analysis was conducted.

**Results**

116 participants received a CSI and 118 a NS. The response rate at 24 months was 73% in the CSI arm and 71% in the NS arm. By 24 months, a greater proportion of the CSI group had been referred for (28% vs 20%) and undergone (22% vs 16%) CTS surgery compared with the NS group. There were no statistically significant between-group differences in BCTQ score or pain NRS at 12 or 24 months. CSI was more costly (mean difference £68⋅59 (95% CI: -120⋅84, 291⋅24)) with fewer quality-adjusted life-years (QALYs) than NS over 24 months (mean difference -0⋅022 (95% CI: (-0·093, 0·045)).

**Conclusion**

Over 24 months, surgical intervention rates were low in both groups, but less frequent in the NS group. Whilst there were no differences in the clinical effectiveness of CSI and NS, initial treatment with CSI may not be cost-effective in the long-term compared with NS.

**INTRODUCTION**

Carpal tunnel syndrome (CTS) is a symptomatic compression neuropathy of the median nerve at the wrist.1 Clinical symptoms include localised pain and/or discomfort, paraesthesia, and functional loss. CTS is the most common peripheral entrapment neuropathy2 with 36 patients per 10,000 person years consulting with CTS in primary care in 2013.3

Management options are surgical or conservative (non-surgical). Surgical carpal tunnel decompression is usually offered to those with severe CTS or those not improving with conservative management. Conservative treatment options include local corticosteroid injections (CSI) and night splinting (NS), which are the most used conservative interventions and are recommended in national care pathways and guidelines.4, 5 In one systematic review, 57-66% of affected people initially treated with a conservative approach, were reported to eventually have required surgery.6

Cochrane and other systematic reviews of randomised and quasi-randomised trials have evaluated the effectiveness of NS7 and CSI for CTS.8, 9 They found limited evidence that NS is more effective than no treatment in the short term (less than 3 months), however concerns were raised about allocation concealment and blinding.7 There was evidence of short-term benefit from CSI compared with placebo injection or other conservative treatment options.8 Evidence of longer-term benefit was insufficient, and reviews concluded that more research was needed.

We investigated the clinical and cost-effectiveness of corticosteroid injection versus night splints for CTS in the INSTinCTS (INjection versus SplinTing in Carpal Tunnel Syndrome) trial.10, 11 We found significantly greater improvements in pain and function at 6 weeks with CSI than NS, although there were no significant between-group differences at 6 months. CSI was also cost effective over 6 months when compared with NS.10 The aim of long-term trial follow-up was to compare the effect of CSI and NS on hand and wrist pain and function, the number of participants referred for and undergoing CTS surgery, and health care resource use, over 24 months.11

**METHODS**

*Study design*

INSTinCTS was a pragmatic, two-arm parallel group, open-label, randomised controlled trial conducted within the National Health Service (NHS). The trial was approved by the National Research Ethics Service Committee North West—Liverpool (UK; reference 13/NW/0280) and the Medicines and Healthcare products Regulatory Agency (European Clinical Trials Database, number 2013-001435-8). The trial protocol detailing the methods used, and the 6-week and 6-month findings have been published previously.10, 11

**Setting**

Participants were recruited from 25 primary and community musculoskeletal clinics and services in England and Wales.

**Eligibility criteria**

Patients were eligible if they were aged 18 years or over and presented with mild to moderate CTS, 12 diagnosed according to agreed standardised criteria.13 Exclusion criteria included having severe CTS requiring urgent consideration of surgery or having received a CSI or NS for CTS within the preceding 6 months.11 Written, informed consent was obtained from eligible participants who were interested in participating.11

**Randomisation, blinding and procedures**

Participants were randomly allocated on a 1:1 basis using permutated blocks of sizes two and four, pre-stratified by research site to either:

1. One injection of 20 mg methylprednisolone acetate (as 20 mg of Depo-Medrone from 40 mg/mL; Pfizer Manufacturing Belgium NV; Puurs, Belgium)
2. Resting night splint set at a neutral angle (0-20 degrees) (Beta Wrist Brace with CE marking; Promedics Orthopaedic; Port Glasgow, UK), to be worn at night for 6 weeks.

Participants with bilateral CTS had their most severely affected wrist treated and reported as part of the trial. The contralateral wrist could be treated as per local protocol.

Randomisation was completed by sites using Keele University Clinical Trial Unit’s (CTU) web randomisation service. The allocation sequence was not available to research team members. Neither clinicians nor patients could be blinded to treatment allocation. Treatment group allocation was masked up to the 6-week primary analysis.

**Sample size**

In order to detect a 15% greater improvement at the primary end-point of 6 weeks, measured by the BCTQ, in the CSI group compared to NS (0.45 points, such as a 0.9-point (30%) reduction in the CSI group versus a 0.45-point (15%) reduction in the NS group, with pooled SD of 0.1), complete data was needed for 200 participants (100 in each treatment group), given 80% power and 5% two-tailed significance. By adopting an initial sample size that would allow for 15% lost-to-follow-up, 240 participants (120 participants in each treatment group) were needed.11 A post hoc sample size calculation was not conducted for long-term analysis.

**Data collection**

Baseline data were collected from a self-completed questionnaire immediately before randomisation. Subsequent postal questionnaires were mailed to participants at 6 weeks and 6, 12, and 24 months post-randomisation. At each time point, two reminders were sent after 2 and 4 weeks to non-responders, thereafter minimum data collection of the primary outcome measure and surgery for CTS by phone and/or post was obtained. Deceased participants or those who withdrew consent were no longer followed-up, however their data up to that time point were used in the analysis.

Incident adverse events from either intervention were reported and assessed with clinical case report forms, participant self-report in follow-up questionnaires or directly to the CTU, or to their GP.

**Outcomes**

The primary outcome measure was the overall mean total score for hand and wrist symptom and function measured by the Boston Carpal Tunnel Questionnaire (BCTQ) (1-5 scale, higher scores indicating more severe symptoms and functional impairment).14 Other secondary outcome measures included hand/wrist pain intensity (numeric rating scale 0–10 (NRS)); referral for CTS surgery; undergoing CTS surgery; health-related quality of life (EuroQoL:EQ-5D-5L);15 employment status; work performance (NRS); work absence (self-reported days absent from work due to CTS); healthcare utilisation (primary and secondary care consultations, investigations and treatments, over-the-counter or prescribed medications, use of private healthcare due to CTS); and patient incurred costs due to CTS.11

**Analysis**

Using data from the four follow-up points (6 weeks, 6, 12, and 24 months) a longitudinal mixed effect linear regression model examined the overall mean difference in outcome (BCTQ score and pain intensity) in the two treatment groups over the whole follow-up period adjusting for baseline outcome score and time point. The model then included an interaction term between treatment and time point to assess treatment effect at each time point. The treatment effect at each time point was estimated by summing the coefficients from the treatment effect and the interaction term. The models were further adjusted for age, gender, and duration of symptoms. Patients with relevant outcomes reported on at least one follow-up time point, with available data for baseline adjustment factors, were eligible for corresponding analysis.

This approach was conducted to optimise use of the data for the repeated measure analysis and mitigate the influence of any further study attrition. The issue of treatment contamination over the course of the observed period remains, so results present the outcomes of patients initially treated with either corticosteroid injection or night splints.

The cumulative number (%) of participants requiring additional wrist splints or injections, referred for CTS surgery or undergoing CTS surgery were examined by treatment group. Only the first referral to surgery/surgical episode was taken into consideration.

Point estimates were accompanied by associated 95% confidence intervals and all *p* values <0·05 were considered to indicate statistical significance.

**Economic evaluation**

A cost-utility analysis was conducted from an NHS perspective, to determine the cost-effectiveness of night splints versus corticosteroid injection at 6, 12 and 24 months. Health-care resource use data were obtained from self-report questionnaires at 6, 12 and 24 months and valued using unit cost data obtained from standard UK sources.16-18 We also estimated the cost of delivering both interventions.

All costs were valued at 2016–17 prices. Outcomes were measured in quality-adjusted life-years (QALYs) which were estimated at 6, 12 and 24 months for each study participant, using EQ-5D-5L scores and the area under the curve approach. Imbalances in baseline utility (EQ-5D-5L) scores between the study arms were controlled for with a regression approach. Missing costs and EQ-5D-5L scores were accounted for using multiple imputation methodology. Twenty-five datasets were imputed using chained equations with predictive mean matching to ensure that imputed values do not go out of the plausible range.The coefficients were then pooled across the multiply imputed datasets using the Rubin’s rule to obtain single estimates of the corresponding population parameters.19, 20 Cost and health outcomes (QALYs) at 24 months were discounted using the recommended discount rates of 3·5%.

An incremental analysis was undertaken, with differences in costs and QALYs expressed as an incremental cost-effectiveness ratio (ICER) of cost per additional QALY gained. Bootstrapping was used to quantify overall uncertainty, and 5000 paired estimates of mean differential costs and QALYs were estimated to construct cost-effectiveness acceptability curves. These show the probability of injection being cost-effective across a range of possible values of willingness to pay for an additional QALY at 6, 12 and 24 months. All analyses were performed using STATA v15.

**Patient and Public Involvement**

Ten public contributors with lived experience of CTS were involved throughout this study (Supplementary File 1). Their input and contributions shaped the delivery of the study and helped us consider how the findings should be disseminated to the wider public. One public contributor (AH) co-authored this paper and one sat on the Trial Steering Committee.

**RESULTS**

Between April 17th 2014 and December 31st 2016, 750 patients were assessed for eligibility at either their general practice or community musculoskeletal clinic (Figure 1). Two hundred and thirty-four participants (58% of the 405 eligible patients) gave informed consent to participate. One hundred and sixteen participants were randomly assigned to CSI and 118 to NS. As previously reported, demographics were similar between participants and eligible non-participants and between the CSI and NS groups.10 The response rates at all time-points were similar between the treatment arms. The 24-month response rate was 73% in the CSI arm and 71% in the NS arm.

Expected adverse reactions reported in the 6-week follow-up questionnaire or directly from participating sites have been reported previously.10 There were seven serious adverse events after 6 months, three in the CSI group (two deaths from cryptogenic organising pneumonia and heart failure respectively, and one participant hospitalised for patella resurfacing) and four in the NS group (four participants hospitalised for myocardial infarction, fractured finger, total hip replacement and total knee replacement respectively). All were considered unrelated to treatment.

Mean BCTQ and hand/wrist pain intensity scores decreased over time in both intervention groups (Table 1, Figure 2). Overall, there was no difference in improvement of mean BCTQ score between treatment groups over the 24-month period (adjusted mean difference -0·10 (95% CI: -0.25, 0·04)). The interaction term once added to the model suggested the treatment effect changed over time. Greater improvement in BCTQ score in the CSI arm compared to the NS arm was observed at 6 weeks (-0·34 (-0·53, -0·14)), but the effect diminished and lost significance at 6 months (0·03 (-0·17, 0·24)), 12 months (-0·09 (-0·30, 0·12)), and 24 months (0·06 (-0·16, 0·28)).

Table 1 Treatment effect at each time point

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Splint** | **Injection** |  |  |
| **\*Boston Carpal Tunnel Questionnaire** | Number analysed  Mean (SD) | Number analysed  Mean (SD) | (Unadjusted)  Treatment effect adjusted for time and baseline score  Mean difference (95% CI) | (Adjusted)  Treatment effect adjusted for time, baseline score, age, sex and duration of symptoms  Mean difference (95% CI) |
| Overall treatment effect at 24 months\*\*\* |  |  | -0·10 (-0·24, 0·05)  P=0·178 | -0·10 (-0·25, 0·04)  P=0·162 |
| Baseline | N=105  2·64 (0·64) | N=100  2·65 (0·72) | - | - |
| 6 weeks | N=102  2·30 (0·77) | N=95  1·95 (0·82) | -0·33 (-0·53, -0·14)  p=0·001 | -0·34 (-0·53, -0·14)  p =0·001 |
| 6 months | N=92  2·04 (0·72) | N=83  2·08 (0·79) | 0·04 (-0·16, 0·24)  p =0·702 | 0·03 (-0·17, 0·24)  p =0·744 |
| 12 months | N=78  2·05 (0·80) | N=78  1·98 (0·88) | -0·09 (-0·30, 0·13)  p=0·429 | -0·09 (-0·30, 0·12)  p =0·406 |
| 24 months | N=73  1·73 (0·76) | N=70  1·79 (0·79) | 0·07 (-0·15, 0·29)  p =0·552 | 0·06 (-0·16, 0·28)  p =0·578 |
| **\*\*Hand/wrist pain intensity score** |  |  |  |  |
| Overall treatment effect at 24 months\*\*\* |  |  | -0·05 (-0·58, 0·47)  p=0·841 | -0·02 (-0·55, 0·50)  p=0·926 |
| Baseline | N=108  6·12 (2·21) | N=108  6·30 (2·01) | - | - |
| 6 weeks | N=106  4·28 (2·62) | N=105  3·33 (2·67) | -1·02 (-1·76, -0·28)  p=0·007 | -0·98 (-1·72, -0·24)  p =0·009 |
| 6 months | N=94  3·29 (2·74) | N=92  4·11 (3·01) | 0·73 (-0·05, 1·51)  p=0·068 | 0·76 (-0·02, 1·54)  p=0·058 |
| 12 months | N=85  3·14 (2·74) | N=83  3·17 (2·93) | -0·02 (-0·84, 0·80)  p=0·960 | 0·03 (-0·79, 0·85)  p=0·947 |
| 24 months | N=77  2·40 (2·83) | N=75  2·81 (3·19) | 0·39 (-0·46, 1·25)  p=0·369 | 0·41 (-0·45, 1·26)  p=0·350 |

\*Boston Carpal Tunnel Questionnaire: higher scores indicating more severe symptoms and functional impairment.

\*\*Hand/wrist pain intensity: higher scores indicate more pain.

\*\*\* The overall treatment effect of injection compared with splint at 24 months, not considering the time interaction term

Similarly, there was little overall difference in improvement of hand/wrist pain intensity score between the two treatment groups over the 24-month period (adjusted mean difference -0·02 (95% CI: -0·55, 0·50)). Comparative treatment effect changed over time; greater reduction in pain in the CSI arm compared to NS arm was observed at 6 weeks (-0·98 (-1·72, -0·24)), however the difference diminished and lost significance at 6 months (0·76 (-0·02, 1·54)), 12 months (0·03 (-0·79, 0·85)), and 24 months (0·41 (-0·45, 1·26)).

During the 24-month follow-up period, 56 participants were referred for and 44 underwent carpal tunnel surgery. More participants in the CSI group than in the NS group were referred for (28% vs. 20%) and underwent (22% vs 16%) carpal tunnel surgery (Table 2).

Table 2 Number of participants referred for surgery and undergoing had carpal tunnel surgery

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Injection**  **N=116** | | **Splint**  **N=118** | |
| N (%) | Cumulative  N (%) | N (%) | Cumulative  N (%) |
| ***Referral for carpal tunnel surgery*** | | | | |
| 6 weeks | 2 (1·72) | 2 (1·72) | 3 (2·54) | 3 (2·54) |
| 6 months | 15 (12·93) | 17 (14·66) | 8 (6·78) | 11 (9·32) |
| 12 months | 9 (7·76) | 26 (22·41) | 5 (4·24) | 16 (13·56) |
| 24 months | 6 (5·17) | 32 (27·59) | 8 (6·78) | 24 (20·34) |
| ***Underwent carpal tunnel surgery*** | | | | |
| 6 weeks | 1 (0·86%) | 1 (0·86%) | 1 (0·85%) | 1 (0·85%) |
| 6 months | 9 (7·76%) | 10 (8·62%) | 5 (4·24%) | 6 (5·08%) |
| 12 months | 7 (6·03%) | 17 (14·66%) | 3 (2·54%) | 9 (7·63%) |
| 24 months | 8 (6·90%) | 25 (21·55%) | 10 (8·47%) | 19 (16·10%) |

In the presence of missing data it was assumed referral to surgery/surgery did not occur.

Use of additional wrist splints and injections reduced over the 24-month period (Table 3). Over the 24-month period, in the CSI group 13% wore a splint and 28% reported having a further corticosteroid injection; in the NS group 25% continued using splints and 18% subsequently had an injection.

Table 3 Number of additional wrist splints and wrist injections recorded by participants at follow-up beyond 6 weeks

|  |  |  |
| --- | --- | --- |
|  | **Injection** | **Splint** |
| \*Treatments in the last 6 months recorded in the 6 month questionnaire |  |  |
| Splint | 7/77 (9·09%) | 19/79 (24·05%) |
| Injection | 20/77 (25·97%) | 13/79 (16·46%) |
| Treatments in the last 6 months recorded in the 12 month questionnaire |  |  |
| Splint | 7/68 (10·29%) | 6/65 (9·23%) |
| Injection | 13/68 (19·12%) | 3/65 (4·62%) |
| Treatments in the last 12 months recorded in the 24 month questionnaire |  |  |
| Splint | 2/56 (3·57%) | 1/61 (1·64%) |
| Injection | 2/56 (3·57%) | 4/61 (6·56%) |
| \*\*Cumulative total over 24 months |  |  |
| Splint | 12/90 (13·33%) | 23/90 (25·56%) |
| Injection | 26/90 (28·89%) | 17/90 (18·89%) |

\* may include the randomised treatment

\*\*denominator is based on providing this data in at least one follow-up questionnaire

With the exception of visits to a physiotherapist which were higher in the CSI group, all other visits to health professionals were higher in the NS group (Table 4). Costs related to surgery, blood tests, MRI scans and wrist exercises were higher in the injection group. QALY scores at 24 months were higher in the NS than the CSI group (Supplementary table 1).

Table 4 Mean (SD) NHS costs over 24 months (£) (Complete case analysis)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Injection**  **N=95** | **Splint**  **N=96** | **Difference (95% confidence interval)** |
| **Health Professionals** | | |
| GP visits | 24·42 (39·98) | 29·60 (46·66) | -5·18 (-17·12, 7·55) |
| Nurse visits | 2·84 (14·45) | 3·38 (14·38) | -0·53 (-4·55, 3·81) |
| Physiotherapist visits | 13·26 (67·54) | 11·72 (44·88) | 1·54 (-12·18, 19·85) |
| Surgeon visit | 28·74 (58·99) | 30·47 (72·41) | -1·73 (-20·28, 17·11) |
| Rheumatologist visit | 9·47 (56·42) | 11·25 (39·72) | -1·78 (-14·41, 13·74) |
| Acupuncturist visit | - | 1·88 (18·37) | -1·88 (-6·75, 0·00) |
| Occupational therapist visit | 3·54 (14·58) | 7·44 (33·93) | -3·90 (-11·64, 2·51) |
| Other health professionals | 4·74 (23·13) | 3·41 (16·65) | 1·33 (-4·01, 7·71) |
|  | **Investigations and interventions** | | |
| X-ray | 1·81 (9·24) | 3·59 (13·69) | -1·78 (-5·43, 1·18) |
| Blood test | 1·26 (8·88) | 1·18 (5·05) | 0·08 (-1·46, 2·78) |
| Ultrasound | 1·15 (7·94) | 1·72 (12·49) | -0·56 (-4·29, 1·79) |
| MRI scan | 12·08 (72·72) | 3·42 (23·55) | 8·67 (-2·51, 28·99) |
| Carpal tunnel surgery | 415·22 (760·37) | 354·86 (718·13) | 60·36 (-140·66, 280·37) |
| \*Night splint during follow-up | 4·29 (15·91) | 8·14 (17·95) | -3·85 (-8·52, 0·81) |
| \*Carpal tunnel injection during follow-up | 18·08 (29·54) | 18·14 (43·64) | -0·06 (-11·92,8·83) |
| Wrist exercises | 15·63 (139·05) | 1·41 (13·78) | 14·23 (-2·57, 57·44) |
| Nerve conduction studies | 36·47 (93·77) | 30·93 (90·57) | 5·54 (-20·35, 33·17) |
| Prescribed medication | 5·05 (24·58) | 20·03 (137·30) | -14·99 (-57·53, 2·41) |

\*Participants were asked ‘*in the last 6 months have you had any investigations or treatments in the NHS, privately or tried yourself.’* The number of wrist splints and injections recorded by participants in each arm of the trial over each 6-month period of follow-up, are summarised in Table 3

From an NHS perspective, CSI was more costly and was associated with lower QALYs than NS at both 12 months (cost difference £113·15 (95% CI: -37·09, 279·21), QALY difference -0·003 (95% CI: -0·034, 0·027) and 24 months (cost difference £68·59 (95% CI: -120⋅84, 291⋅24), QALY difference -0·022 (95% CI: -0·093, 0·045) (Supplementary table 1, Supplementary table 2, Supplementary figure 1, Supplementary figure 2, Supplementary table 4). The 12- and 24-month probability of CSI being cost-effective compared with NS at the £20,000 per QALY threshold was 30% and 22% respectively.(Supplementary figure 3, Supplementary figure 4). Therefore, NS may be more cost-effective at 12 and 24 months. There were no significant between group differences regarding time off work, work performance or overall productivity (Supplementary table 3).

**DISCUSSION**

**Summary of findings**

In this randomised trial, we found no differences in pain and function at 12- and 24-month follow-up between corticosteroid injection and night splinting used in the initial treatment of mild to moderate carpal tunnel syndrome. We have previously reported greater improvement in pain and function in the CSI group at 6 weeks that had attenuated by 6 months.10 There was continued symptomatic improvement in both the CSI and NS groups over 24 months*.* Surgical rates were low (one in four) over all but slightly higher in the CSI group compared to the NS group. Whilst CSI was cost-effective from both an NHS and societal perspective over the first 6 months, 10 the long-term results of this trial show that over 24 months NS may be more cost-effective.

The continued improvement over the 24-month observed period of symptoms and pain extended well beyond the active life of a single methylprednisolone injection or the expected effect of 6 weeks of NS. Therefore, a CSI may give more effective relief from symptoms in the short term, however either treatment is likely to be clinically effective in the longer term. There were few expected adverse reactions and no related serious adverse events, supporting the safety profile of both interventions.

**Comparison to existing literature**

Three other RCTs have compared the effectiveness of CSI and NS over varying periods of time. 21-23 Sevim et al evaluated the effectiveness of CSI and NS in mild and moderate CTS, randomising 120 patients with electrophysiologically confirmed CTS to either night splinting or beclomethasone injection. The trial excluded patients who were non-adherent with splinting but suggested that the adherent cohort showed significant clinical and electrophysiological improvements at one year whilst the injection groups did not.23 Ucan compared the use of splinting, splinting plus local steroid injection, and open carpal tunnel release in patients with mild to moderate CTS with symptoms (and an electrophysiological diagnosis) for at least 6 months. At 3 months, all treatment modalities demonstrated improvement in patient reported and electrophysiological outcomes, however at 6 months both measures deteriorated in the CSI and CSI with splinting group, whilst the CTR group continued to improve (BCTQ functional score *P*=0.03).21 So et al also compared the efficacy of CSI with NS in 50 patients with CTS. At 4 weeks, both the CSI and NS groups showed an improvement in the BCTQ symptom severity scale, however only the CSI group showed improvement in function and patient satisfaction.22

These trials were relatively small and set in a secondary care environment using case definitions which included electrophysiological criteria. It is therefore unlikely that these trials present robust evidence of the effectiveness of splinting versus corticosteroid injection generalisable to the primary care population, where patients can be assumed to present in the earlier stages of the condition. To our knowledge, our trial is the largest and longest randomised comparison of the effectiveness of corticosteroid injection versus night splints for the treatment of mild to moderate CTS. It is also the first trial of its kind to be conducted in a primary care setting, where most patients with CTS symptoms are initially managed.

Our trial protocol dissuaded additional treatment, including referral for surgery, in the initial 6 weeks. After this time point, clinicians were encouraged to treat participants with ongoing symptoms as per usual care. The protocol itself should not therefore have impacted on referrals in the longer term. In total, 44 (18%) participants in our trial had undergone carpal tunnel surgery by 24 months. This proportion is similar to an observational study set in primary care electronic health records, which reported 27% of patients presenting in UK primary care had carpal tunnel surgery within 3 years of their initial presentation.3 These surgical intervention rates from primary care and interface services are substantially lower than those reported in studies based in secondary care.6 PALMS, a recent observational study, reported 64% of participants recruited from secondary care outpatient sites in England had carpal tunnel surgery by 18 months.24

The discrepancies in the proportion of patients receiving surgery after initial conservative management is likely to be different between those treated in primary and secondary care for several reasons. One conclusion may be that those treated earlier have a better outcome, however consistent evidence for this is lacking.25 A further assumption may be that treatment setting may dictate eventual surgical treatment, over clinical need. Again, evidence for this is lacking. Importantly, it is not possible to compare directly the patient reported outcome for each treatment option between these different types of studies, which would be required to make a definitive conclusion about overall patient benefit from CTS treatment.

**Strengths and limitations**

Strengths of this trial include collecting long-term outcomes with low attrition and a further full long-term health economic analysis. Limitations of the trial remain the absence of a no-treatment control group and no group receiving both interventions. The potential competing effect of a surgical intervention or further conservative management (e.g. a repeat corticosteroid injection or longer-term splint wearing), was not considered, given the small proportion of participants receiving further treatment and likely risk of confounding by indication. Further research should consider the additional participant reported benefit of combined CSI and NS, repeat CSI, longer term use of splints, and surgery.

**Implications for clinical practice**

More rapid initial improvement following corticosteroid injection led to it being more cost-effective from both an NHS and societal perspective at 6 weeks. 12- and 24-month results further add to the preceding evidence of only short-term comparative effectiveness of CSI versus NS but that continuing improvement beyond 12 months can still be observed with either initial intervention. This is in line with many other studies of the effectiveness of local steroid injections;26 with short-term benefit but no long-term gain. This gives patients a clear choice, CSI is the treatment of choice if short-term benefit is required, but the patient needs to be counselled that it is unlikely to alter the overall course of the condition.

The idea of a one-off injection may seem preferable compared with wearing a NS for 6 weeks. Likewise, those who may be needle-phobic or for whom CSI are contraindicated, may opt for NS. Patient choice must therefore be strongly advocated.

**CONCLUSION**

Over 24 months, whilst there were no differences in the clinical effectiveness of corticosteroid injection compared with night splinting, surgical intervention was slightly more frequent in the CSI group, and NS may be cost-effective when compared with CSI. Overall, surgical referral and intervention rates were low, however we cannot comment on the reasons for and outcomes of the surgical intervention. Patients receiving conservative treatment in a primary care setting for mild to moderate CTS can be reassured that fewer than 1 in 4 of them will need surgery over the next 2 years. Patients can be informed that symptoms are likely to improve over time and patient choice between CSI or NS can be encouraged in initial management decisions.

**KEY MESSAGES**

*1.* Corticosteroid injection and night splinting are safe and effective treatment options for mild-to-moderate carpal tunnel syndrome.

*2.* Clinical effectiveness did not differ over 24-months, but night splinting may be more cost effective.

*3.* Patient choice between a corticosteroid injection or night splinting can be encouraged in initial management decisions.

**CONTRIBUTORSHIP STATEMENT**

All authors contributed to study design, interpretation of data, and critical revision of the report; approved the final version of the report; and agree to be accountable for all aspects of the work. KSD, DAvdW, LSC, EMH, and GD conceived the study. KSD, DAvdW, LSC, GD, HLM, EMH, and ER contributed to acquisition of data. TR-M and MB-B accessed and verified the data, and analysed the clinical outcomes, and RO and SJ did the health economic analysis. SB and AH provided a patient and public involvement perspective. CB wrote the first draft of the report with input from TR-M, RO, and ER.

**DECLARATION OF INTERESTS**

KSD is a member of the NICE Advisor of Fellows and Scholars Programme and UKRI REF Impact Assessor. Keele University receives royalties from a Rheumatology Book for Allied Health Profressionals, for which KSD was a contributor, and a conference fee waiver for Guidelines International, at which KSD was a plenary speaker.

**DATA AVAILABILITY STATEMENT**

Data for this study will be made available to others in the scientific community upon request after publication. Data will be made available for scientific purposes for researchers whose proposed use of the data has been approved by a publication committee. Data and documentation will be made available through a secure file exchange platform after approval of proposal and a data transfer agreement is signed (which defines obligations that the data requester must adhere to with regard to privacy and data handling). Partially deidentified participant data limited to the data used for this work will be made available. For data access, please contact the corresponding author.

**ACKNOWLEDGEMENTS AND AFFILIATIONS**

The findings of this study were presented remotely at the British Society of Rheumatology 2020 Conference: <https://academic.oup.com/rheumatology/article/59/Supplement_2/keaa111.138/5822293>

This work presents independent research funded by a Versus Arthritis Grant (Grant Number 20105) and Centre of Excellence Grant. The funder had no role in the design or conduct of the study, or in the writing of the manuscript. EMH and KSD are National Institute for Health Research (NIHR) Senior Investigators. KSD was funded by a Knowledge Mobilisation Research Fellowship (KNRF-2012-03-002) from the NIHR and the NIHR Applied Research Collaboration (ARC) West Midlands. CB is an NIHR Clinical Lecturer. SB was funded by the NIHR Research Design Service. The views expressed in this paper are those of the authors and not necessarily those of the National Health Service, the NIHR or the Department of Health and Social Care. There has been no payment for the writing of this manuscript. Authors have not been precluded from accessing data in the study and accept responsibility to submit for publication.

Figure 1 Consort flow diagram over 24 months



Figure 2 Mean BCTQ (95% CI) over time

Supplementary table 1 Health-related quality of life outcomes over 24 months (EQ-5D-5L) – crosswalk tariff

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Injection**  **N=116** | **Splint**  **N=118** | **Difference (95% confidence interval) (Injection – Splint)** |
| **EQ-5D (mean (SD)** | | | |
| EQ-5D baseline | 0·652 (0·221) | 0·671 (0·208) | -0·019 (-0·074, 0·034) |
| EQ-5D 6 weeks | 0·703 (0·227) | 0·695 (0·202) | 0·008 (-0·040, 0·062) |
| EQ-5D 6 months | 0·732 (0·180) | 0·749 (0·193) | -0·016 (-0·060, 0·032) |
| EQ-5D 12 months | 0·742 (0·186) | 0·768 (0·174) | -0·026 (-0·073, 0·019) |
| EQ-5D 24 months | 0·733 (0·178) | 0·755 (0·201) | -0·022 (-0·074, 0·024) |
| **QALYs (mean (SD)** | | | |
| QALYs 6 months | 0·354 (0·093) | 0·356 (0·087) | - |
| QALYs 12 months | 0·723 (0·163) | 0·736 (0·156) | - |
| QALYs 24 months | 1·461 (0·311) | 1·497 (0·301) | - |
| \*QALYs 6 months | 0·357 | 0·354 | 0·004 (-0·011, 0·020) |
| \*QALYs 12 months | 0·727 | 0·731 | -0·003 (-0·034, 0·027) |
| \*QALYs 24 months | 1·468 | 1·490 | -0·022 (-0·093, 0·045) |

\* Adjusted for baseline utility

Supplementary table 2 Total costs over 24 months (NHS perspective)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Injection**  **N=116** | **Splint**  **N=118** | **Difference (95% confidence interval) (Injection – Night splint)** |
| **Total costs** | | | |
| 6 months | 346·78 (467·97) | 313·24 (480·84) | 33·54 (-94·57, 145·59) |
| 12 months | 508·69 (657·48) | 395·54 (596·47) | 113·15 (-37·09, 279·21) |
| 24 months | 667.01 (824.78) | 598.42 (805.15) | 68.59 (-120·84, 291·24) |

Supplementary table 3 Sensitivity analysis: time off work· Mean (SD) per patient

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Injection**  **N=95** | **Splint**  **N=96** | **Difference (95% confidence interval)** |
|  | **Broader societal costs** | | |
| **\*Performance at work 12 months** | 0·88 (1·69) | 0·81 (1·69) | 0·07 (-0·43, 0·50) |
| **\*Performance at work 24 months** | 0·58 (1·61) | 0·40 (1·14) | 0·18 (-0·20, 0·60) |
| **\*\*Days off-work over 12 months** | 1·03 (5·09) | 1·92 (8·96) | -0·89 (-3·29, 0·84) |
| **\*\*Days off-work over 24 months** | 1·33 (5·70) | 2·36 (9·85) | -1·03 (-3·64, 1·04) |
| **Productivity costs** | 178·10 (850·82) | 181·13 (781·31) | -3·03 (-228·95, 227·24) |

\*Mean performance at work on a scale of 0 to 10 where 0 indicates work performance not affected

\*\*Day off work measured over the time period

Supplementary table 4 Cost-utility analysis NHS perspective (corticosteroid injection versus night splinting, using cross walk tariff)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Injection**  **(n=116)** | **Splint**  **(n=118)** | **Difference** | **Incremental cost-effectiveness ratio** |
| **Cost-effectiveness 12 months** | | | | |
| Mean costs (SD) | 508·69 (657·48) | 395·54 (596·47) | 113·15 | Injection dominated by splinting |
| \*Mean QALYs | 0·727 | 0·731 | -0·003 |
| **Cost-effectiveness 24 months** | | | | |
| Mean costs (SD) | 667.01 (824.78) | 598.42 (805.15) | 68.59 | Injection dominated by splinting |
| \*Mean QALYs | 1·468 | 1·490 | -0·022 |

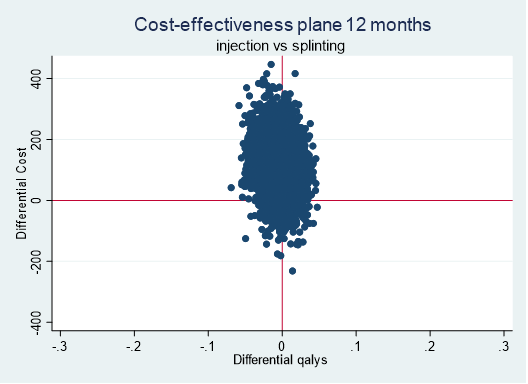
\* Adjusted for baseline utility



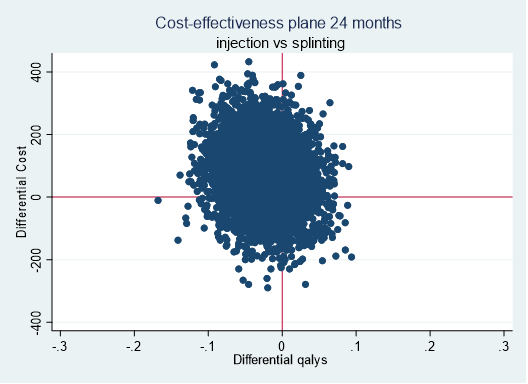
Supplementary figure 1 Cost-effectiveness acceptability curve 12-month analysis (NHS perspective)



Supplementary figure 2 Cost-effectiveness acceptability curve 24-months (NHS perspective)



Supplementary figure 3 Cost-effectiveness plane 12 months



Supplementary figure 4 Cost-effectiveness plane 24 months

**REFERENCES**

1 Keith MW, Masear V, Chung K, et al. Diagnosis of carpal tunnel syndrome. *J Am Acad Orthop Surg* 2009;17:389-96.

2 Padua L, Coraci D, Erra C, et al. Carpal tunnel syndrome: clinical features, diagnosis, and management*. Lancet Neurol* 2016;15:1273-84 doi:S1474-4422(16)30231-9 [pii].

3 Burton CL, Chen Y, Chesterton LS, et al. Trends in the prevalence, incidence and surgical management of carpal tunnel syndrome between 1993 and 2013: an observational analysis of UK primary care records*. BMJ Open* 2018;8:e020166-020166 doi:10.1136/bmjopen-2017-020166 [doi].

4 Carpal Tunnel Syndrome. Available at: <http://cks.nice.org.uk/carpal-tunnel-syndrome#!scenariorecommendation:1>. Accessed 05/14, 2013.

5 Royal College of Surgeons. Commissioning Guide: Treatment of Carpal Tunnel Syndrome 2016.

6 Burton CL, Chesterton LS, Chen Y, et al. Clinical Course and Prognostic Factors in Conservatively Managed Carpal Tunnel Syndrome: A Systematic Review*. Arch Phys Med Rehabil* 2016;97:836,852.e1 doi:10.1016/j.apmr.2015.09.013 [doi].

7 Page MJ, Massy-Westropp N, O'Connor D, et al. Splinting for carpal tunnel syndrome. *Cochrane database of systematic reviews (Online)* 2012;7:010003.

8 Marshall SC, Tardif G, Ashworth NL. Local corticosteroid injection for carpal tunnel syndrome*. Cochrane Database of Systematic Reviews* 2007:CD001554-NaN.

9 Huisstede BM. Hoogvliet P. Randsdorp Glerum S. Van Middelkoop M. Koes, B. W. Carpal Tunnel Syndrome. Part I: Effectiveness of nonsurgical treatments - a systematic review*. Archives of Physical Medicine and Rehabilitation 2010* 1004;Jul;91:981.

10 Chesterton LS, Blagojevic-Bucknall M, Burton C, et al. The clinical and cost-effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (INSTINCTS trial): an open-label, parallel group, randomised controlled trial. *Lancet* 2018;392:1423-33.

11 Chesterton LS, Dziedzic KS, van der Windt, D. A., et al. The clinical and cost effectiveness of steroid injection compared with night splints for carpal tunnel syndrome: the INSTINCTS randomised clinical trial study protocol*. BMC Musculoskelet Disord* 2016;17:415-8 doi:415.

12 BSSH Evidence for Surgical Treatment 1 Carpal Tunnel Syndrome. Available at: <http://www.bssh.ac.uk/education/guidelines/carpal_tunnel_syndrome.pdf>. Accessed 22/10/, 2012.

13 Burton C, Chesterton LS, Davenport G. Diagnosing and managing carpal tunnel syndrome in primary care*. British Journal of General Practice* 2014;64:262-3 doi:10.3399/bjgp14X679903.

14 Levine DW, Simmons BP, Koris MJ, et al. A self-administered questionnaire for the assessment of severity of symptoms and functional status in carpal tunnel syndrome. *Journal of Bone and Joint Surgery - Series A* 1993;75:1585-92.

15 Herdman M, Gudex C, Lloyd A, et al. Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L)*. Qual Life Res* 2011;20:1727-36 doi:10.1007/s11136-011-9903-x [doi].

16 NHS reference cost 2015/2016. Available at: <https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016>. Accessed 30/11/, 2021.

17 BMJ Group and RPS Publishing. British National Formulary (BNF) 74. London: BMJ Group and RPS Publishing 2017.

18 Curtis LA, Burns A. Unit costs of health and social care 2017, Personal Social Services Research Unit 2017.

19 White IR, Royston P, Wood AM. Multiple imputation using chained equations: Issues and guidance for practice*. Stat Med* 2011;30:377-99 doi:10.1002/sim.4067 [doi].

20 Rubin DB. Multiple Imputation for  
Nonresponse in Surveys. New York, NY: John Willey & Sons 1987.

21 Ucan H, Yagci I, Yilmaz L, et al. Comparison of splinting, splinting plus local steroid injection and open carpal tunnel release outcomes in idiopathic carpal tunnel syndrome. *Rheumatol Int* 2006;27:45-51.

22 So H, Chung VCH, Cheng JCK, et al. Local steroid injection versus wrist splinting for carpal tunnel syndrome: A randomized clinical trial*. Int J Rheum Dis* 2018;21:102-7 doi:10.1111/1756-185X.13162.

23 Sevim S, Dogu O, Camdeviren H, et al. Long-term effectiveness of steroid injections and splinting in mild and moderate carpal tunnel syndrome. *Neurological Sciences* 2004;25:48-52.

24 Jerosch-Herold C, Shepstone L, Houghton J, et al. Prognostic factors for response to treatment by corticosteroid injection or surgery in carpal tunnel syndrome (palms study): A prospective multicenter cohort study*. Muscle Nerve* 2019;60:32-40 doi:10.1002/mus.26459.

25 Burton CL, Chesterton LS, Chen Y, et al. Clinical Course and Prognostic Factors in Conservatively Managed Carpal Tunnel Syndrome: A Systematic Review*. Archives of Physical Medicine and Rehabilitation* 2016;97:836,852.e1 doi:<https://doi.org/10.1016/j.apmr.2015.09.013>.

26 Paskins Z, Bromley K, Lewis M, et al. O04 Clinical and cost-effectiveness of ultrasound-guided intra-articular corticosteroid and local anaesthetic injection for hip OA: a randomised controlled trial (HIT)*. Rheumatology (Oxford)* 2020;59 doi:10.1093/rheumatology/keaa110.003.

stylefix