Procedure that requires prior approval

Bedfordshire, Hertfordshire, West Essex, Luton and Milton Keynes Priorities Forum statement

Number	**25**
Subject	**Management of Abdominal Hernias in adults**
Date of decision	**August 2017**
Date review due	**August 2019**

GUIDANCE

Policy Summary

This policy covers the management of abdominal hernias including inguinal, femoral, umbilical, and incisional hernias, with criteria for referrals/treatment. The term 'ventral hernia' is a non- specific term which could include umbilical, epigastric or incisional hernias, and therefore the more specific term must be used. Epigastric hernias need to be clearly differentiated from divarication of the recti, which is a widening of the linea alba without a defect in the fascia (see guidance 63 for divarication of the recti management).

The evidence for elective surgical hernia repair has been considered and recommends immediate referral for surgical opinion for patients with the following conditions:

- diagnosis of femoral hernia
- diagnosis of Spigelian hernia, following ultrasound confirmation,
- diagnosis of an inguino-scrotal hernia

For other abdominal/ventral hernias, including inguinal, umbilical, para-umbilical, epigastric and incisional, referral may be considered only if **at least one** of the following criteria are met:

- Documented history of incarceration of, or real difficulty in reducing, the hernia
- Documented pain or discomfort significantly interfering with activities of daily living. Details of nature and extent of impact must be provided at referral
- Increase in size month to month
- Work-related issues (includes domestic duties and unpaid caring):
    - has become restricted to light duties because of hernia
    - off work/missed work/unable to work because of hernia

AND

As patients have a right to be fully informed about this procedure, as part of this process, clinicians should engage the patients (or their carers) in shared decision making about alternative management and the risks and benefits of surgery.

Bilateral groin hernia repair will be funded if one or both of the hernias fulfil the above criteria.

The risk/benefit of elective surgical hernia repair requires careful consideration.
In general abdominal hernia repair short-term complications include bleeding, bruising, infection, seroma, deep vein thrombosis and pulmonary embolism[1]. 30 day reoperation and readmission rates are reported at 0.3 to 2.2% and 5.9 to 13.3% respectively[2]. Long- term complications include chronic pain reported in up to 30% (3% debilitating)[3] and mesh infection. Recurrence rates vary according to hernia type and size, patient specific factors and surgical technique, and are reportedly up to 29%[4]. Mortality rates are 0.2 to 0.5%[2].

In groin hernia repair it is suggested that the rate of chronic pain is up to 5%[1] and mesh infection at 0.2%[1]. Recurrence rates have been reported at 0.5%[1] to 2-5%[5]. Mortality rate is estimated at 0.5%[6].

Human Rights and Equality Legislation has been considered in the formation of this policy

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g., from NICE.

OPCS Procedure codes

T19: Simple excision of inguinal hernia sac (herniotomy)
T20: Primary repair of inguinal hernia.
T21: Repair of recurrent inguinal hernia.
T22: Primary repair of femoral hernia.
T23: Repair of recurrent femoral hernia.
T24: Primary repair of umbilical hernia. T25:
Primary repair of incisional hernia. T26:
Repair of recurrent incisional hernia.
T27: Repair of other hernia of abdominal wall.
T28: Other repair of anterior abdominal wall.
T97: Repair of recurrent umbilical hernia.
T98: Repair of recurrent other hernia of abdominal wall

[1] http://www.britishherniasociety.org/for-patients/what-are-the-risks-of-surgery/
[2] Helgstrand F et al. (2013). Outcomes after emergency versus elective ventral hernia repair: a prospective nationwide study. World J Surg (2013) 37:2273–2279 http://www.ncbi.nlm.nih.gov/pubmed/23756775
[3] O'Dwyer P et al. (2005) Groin Hernia Repair: Postherniorrhaphy Pain. World J. Surg. (2005) 29: 1062.
[4] Ballem N, Parikh R, Berber E, Siperstein A. Laparoscopic versus open ventral hernia repairs: 5 year recurrence rates. Surgical endoscopy. Sep 2008;22(9):1935-1940.
[5] The Society for Surgery of the Alimentary Tract (USA): Patient Care Guidelines, Surgical Repair of Groin Hernias (2013) http://www.ssat.com/cgi-bin/hernia6.cgi
[6] Van den heuvel et al. (2011). Is surgical repair of an asymptomatic groin hernia appropriate? A review. Hernia (2011) 15:251–259 http://link.springer.com/article/10.1007%2Fs10029-011-0796-y