NHS

Buckinghamshire Clinical Commissioning Group

Procedure that requires prior approval

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. TVPC 48 **Elective surgical hernia repair in adults**

Recommendation made by the Priorities Committee: **September 2016/ Updated January 2019**[1]

Date of issue: **June 2019**

The Thames Valley Priorities Committee has considered the evidence for elective surgical hernia repair 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

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[2]. Long-term complications include chronic pain and mesh infection.

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

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[1] Reference to patient decision aid (which is no longer available) and citations to the scientific literature have been removed; no other changes have been made.
[2] http://www.britishherniasociety.org/for-patients/what-are-the-risks-of-surgery/

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, eg, from NICE.
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/

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