NHS Vale of York Clinical Commissioning Group

22. Hernia Repair Commissioning Statement

Treatment	Hernia repair - inguinal (in men), umbilical, incisional
Background	Hernia repair refers to a surgical operation for the correction of a hernia (a bulging of internal organs or tissues through the wall that contains it.) Hernias can occur in many places, including the abdomen, groin, diaphragm, brain, and at the site of a previous operation. **This statement covers surgical treatment of inguinal hernias in adult men, and umbilical or incisional hernias in all adults** **It EXCLUDES suspected femoral hernias, inguinal hernias in women, and any irreducible hernias.**
Commissioning position	**Repair of suspected femoral hernias, inguinal hernias in women, or any irreducible hernias is commissioned and should be referred urgently due to the increased risk of incarceration/strangulation** **Hernia repair for cosmetic reasons or for asymptomatic or minimally symptomatic hernias in adults is NOT routinely commissioned.** An approach of watchful waiting is recommended for small painless hernias and supported by the evidence base; delaying repair is considered safe. Conservative management should be encouraged first e.g. to lose weight or try support from surgical appliances or suitable underwear. **Surgical treatment should only be offered when one of the following criteria are met:** • Pain/discomfort interfering significantly with activities of daily living **OR** • The hernia is difficult to reduce **OR** • Comorbidity which does not make the patient unfit for surgery at present but is like to significantly increase the risks associated with future surgery **AND** Where patients are willing to undergo surgery and are aware of the risks and benefits of surgery. To meet professional standard expectations[14] and ensure patients are fully informed about options for treatment it is recommended that the RightCare inguinal-hernia shared decision-making aid[4] is discussed with patients prior to surgery. **For referral please use the referral form** NHS Vale of York CCG does NOT routinely commission elective interventions on patients who have a BMI of 30 or above (classified as obese) or patients who are recorded as a current smoker – see commissioning statement 01. Optimising Outcomes from All Elective Surgery **Treatment in all other circumstances is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request Panel.** Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes

	there is an exceptional clinical need that justifies deviation from the rule of this policy. Individual cases will be considered by the individual funding request panel. • Patient information leaflets – general NHS hernia advice; inguinal hernias inguinal hernias; NHS inguinal hernia repair inguinal hernia repair • RightCare shared decision-making aid RightCare inguinal-hernia
Summary of evidence / rationale	Watchful waiting (WW) is regarded as an acceptable option for men with minimally symptomatic or asymptomatic inguinal hernias by the *European Hernia Society guidelines on the treatment of inguinal hernia in adult patients*[1] (Level 1B evidence) and by a number of RCTs, concluding that it is an acceptable option for men with minimally symptomatic inguinal hernias[2]. Delaying surgical repair until symptoms increase is safe because acute hernia incarcerations occur rarely. More recently, the European Hernia Society has developed World Guidelines for Hernia Management which also supports this approach[3]. The RightCare shared decision-making aid for surgical repair of inguinal hernia[4] states that 1. Most people with inguinal hernia are free of symptoms by two weeks after surgical repair. But about **30% continue to feel pain and discomfort** at the site of the repair. 2. The main short-term possible complications of surgical repair are bruising, swelling and numbness, difficulty passing urine and infection of the wound. Just over **22% of people get complications after surgery**. 3. The main long-term possible health problems are: chronic pain that may last for several years, and recurrence of the hernia. 4. Quality of life after surgical repair depends on whether or not symptoms persist. People left with chronic pain and discomfort report a lower quality of life than those who are symptom-free. 5. Both types of surgery for inguinal hernia can be done as day surgery without needing to stay overnight in hospital. People who have complications may need to stay longer. It can take between three and four weeks to recover completely. 6. People usually need about seven days off work and 14 days before they can return to strenuous leisure activities. About 7% of people can't return to work and 17% can't go back to strenuous leisure activities after 30 days either because of pain or problems with the wound. NICE CKS guidance[5] (last revised in February 2010) states that, although European guidelines on the treatment of inguinal hernia in adults recommend that repair is not necessary for men with asymptomatic and reducible inguinal hernias, they recommend referral for repair where the hernia extends into the scrotum and the person is medically fit on the basis that: ○ The risk of strangulation for all inguinal hernias is estimated to be 0.3–3.0% per year ○ If an inguinal hernia extends into the scrotum, it is almost always indirect The risk of strangulation is thought to be 10 times higher for indirect hernias than for direct inguinal hernias

- An emergency operation to treat a strangulated inguinal hernia has a higher mortality (higher than 5%) compared with an elective operation for a non-strangulated inguinal hernia (lower than 0.5%)
- Repair is recommended in a narrative review for people with asym ptomatic inguinal hernia if they are medically fit

The Royal College of Surgeons 2013 - High Value Care Pathway for groin hernia[6] (which includes a useful flow chart) states that GPs should refer:

- all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity **AND** do not want to have surgical repair (after appropriate information provided)[7, 8]
- irreducible and partially reducible inguinal hernias, and all hernias in women as '**urgent referrals**'[9, 10]
- patients with suspected strangulated or obstructed inguinal hernia as '**emergency referrals**'[9, 10]
- all children <18 years with inguinal hernia to a paediatric surgical provider

Analysis of 336 patients randomised to watchful waiting in the American College of Surgeons Watchful Waiting Hernia Trial found readily identifiable patient characteristics can predict those patients with minimally symptomatic inguinal hernia who are likely to "fail" watchful waiting hernia management[11]. These included pain with strenuous activities, chronic constipation and prostatism. Higher levels of activity reduced the risk of this combined outcome but there is no mention of BMI, although appropriate weight reduction is likely to help. Consideration of these factors will allow surgeons to tailor hernia management optimally.

Another study found that with follow up over 10 years, a total of 68% of men had had elective surgery, more commonly men older than 65 years, with pain[12]. They conclude that, although WW is a reasonable and safe strategy, symptoms are likely to progress and an operation will be needed eventually.

More recently a study concluded that a commissioning policy restricting funding for elective hernia repairs (but notably across all types) had led to a significant increase in emergency hernia repairs[13]. They carried out a retrospective cohort study on around 2550 patients who underwent repair of inguinal, umbilical, incisional, femoral or ventral hernias over a 3 year period.

The number of elective hernia repairs reduced from 857 over 12 months before the funding restrictions to 606 in the same period afterwards ($p < 0.001$). Over the same time period, however, a significant rise in total emergency hernia repairs was demonstrated, increasing from 98 to 150 ($p < 0.001$). 30-day readmission rates also increased from 5.1 % before the policy introduction to 8.5 % afterwards ($p = 0.006$). They concluded that the funding restrictions introduced in 2011 were followed by a statistically significant and unintended increase in emergency hernia repairs in their trust, with associated increased risks to patient safety.

A "watchful waiting" approach is also supported by other CCGs, including the

	Leeds CCGs. Their clinical guidelines commissioning position is that hernia repair is **not routinely commissioned** for: Men with an asymptomatic or a minimally symptomatic inguinal hernia (discomfort or pain that does not restrict daily activity - adopt watchful waiting) Men with groin pain and an ultrasound detected, but clinically impalpable, hernia (consider musculo-skeletal referral) Post-operative follow up for low risk cases (eg no evidence of clinically significant haematoma, injury to the bowel or major blood vessels, deep infection, ischaemic orchitis, recurrence) is not required.
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Author	Dr Alison Forrester, Healthcare public health advisor, VOYCCG
Approved by	Clinical Research and Effectiveness Committee 07.03.17 / Clinical Executive 27.04.17
Responsible officer	Shaun O'Connell GP Lead valeofyork.contactus@nhs.net

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