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NHS
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Clinical Commissioning Group

Clinical Commissioning Policy

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Clinical Commissioning Policy

Abdominal Wall Hernia Management and Repair in Adults

Prepared by NHS England and adopted by Sheffield CCG

Policy Statement

Sheffield CCG will commission treatments for Abdominal Wall Hernia Management and Repair in Adults in accordance with the criteria outlined in this document.

In creating this policy Sheffield CCG 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 patients where Sheffield CCG directly commissions this service.

Equality Statement

Sheffield 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. Sheffield 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, sex (gender) or sexual orientation. In carrying out its functions, Sheffield CCG will have due regard to the different needs of protected equality 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.

Plain Language Summary

A hernia is where an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall, usually appearing as a lump on the body.

1. Introduction

Abdominal Wall Hernia Repair is regarded as a procedure of low clinical priority and therefore not routinely funded by the commissioner.

NB: All suspected femoral hernias do not require prior approval to be sought - Please refer patients direct to secondary care.

Evidence and Background

A hernia is defined as a protrusion of a sac of peritoneum, often containing intestine or other abdominal contents, from its proper cavity through a weakness in the abdominal wall. They usually present as a lump, and patients often experience pain or discomfort that can limit daily activities.[1,2] In addition, hernias can present as a surgical emergency should the bowel strangulate or become obstructed due to the hernia.

There are many different types of hernia; those that are covered in this policy include inguinal, femoral, umbilical ventral and incisional hernias.

2. Criteria for commissioning

This policy covers the management of inguinal, femoral, umbilical, ventral and incisional hernias, with criteria for referrals/treatment.

Initial management of patients with hernia

Patients with BMI >35: the decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient, but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered.

Patients who smoke should be warned of clinical advice that hernia recurrence rates are 3 times higher in smokers than non-smokers. All patients who smoke should be encouraged to stop and offered information on local cessation support services.

Inguinal:

For asymptomatic or minimally symptomatic hernias, the commissioner advocates a watchful waiting approach including providing reassurance, pain management etc. under informed consent.

Surgical treatment will only be approved when one of the following criteria is met:

- symptomatic i.e. symptoms are such that they cause significant functional impairment **OR**
- the hernia is difficult or impossible to reduce***, [i.e. history of incarceration or real difficulty reducing the hernia confirmed by ultrasound]*** **OR**
- Inguino-scrotal hernia, **OR**
- The hernia increases in size month on month.

Umbilical:

Surgical treatment will only be approved when one of the following criteria is met:

- pain/discomfort that causes significant functional impairment **OR**
- increase in size month on month **OR**
- to avoid incarceration or strangulation of bowel

Incisional:

Surgical treatment will only be approved when **both** of the following criteria are met:

- Pain/discomfort that causes significant functional impairment **AND**

- Appropriate conservative management has been tried first e.g. weight reduction where appropriate

Femoral:

All suspected femoral hernias are approved for a referral to secondary care due to the increased risk of incarceration/strangulation and do not require prior approval to be sought.

Impalpable hernia and groin pain

Hernia surgery is not commissioned in patients with groin pain, but no visible external swelling.

Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair.

Management of persistent groin pain that has not resolved after a period of watchful waiting, should be based on individual clinical assessment. Where groin pain is severe and persistent with diagnostic uncertainty, options include referral for musculoskeletal assessment or imaging. Ultrasound should not be routinely requested in the early management of groin pain.

The clinician proposing this intervention will make the decision to treat based on the criteria set out above. If the patient does not fully meet this criteria the clinician may submit an application for exceptional funding (Individual funding request policy)

3. Evidence Base

1. http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 6th June 2011)
2. NICE guidelines: TA83 (Sept 2004) – Laparoscopic surgery for hernia
3. McIntosh, Hutchinson, Roberts, Withers (2000). Evidence based management of groin hernia in primary care - a systematic review. Family Practice; 17:442-447
4. Friedrich, Muller-Riemenschneider, Roll, Kulp, Vauth, Greiner, Willich and von der Schulenbury (2008). Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. GMS Health Technology Assessment ; 7/4: Doc 01
5. Dabbas (2011) Frequency of abdominal wall hernias: is classical teaching out of date. JRSM Short Reports: 2/5; 5
6. Fitzgibbons (2006); Watchful waiting versus repair of inguinal hernia in minimally symptomatic men, a randomised controlled trial. JAMA: 295; 285-292
7. Flum (2006) : The asymptomatic hernia: If it's not broken don't fix it. JAMA: 295; 249
8. BMJ clinical evidence on Inguinal Hernias; Chos, Purkayastha, Anthanasiou, Tekkis and Darzi.
9. Rosenberg (2011). Danish hernia database recommendations for management of inguinal and femoral hernias in adults. Danish Medical Bulletin; 58/2: C4243
10. Simons et al. European hernia society guidelines: Treatment of inguinal hernia in adult patients. Hernia, 2009: 13(4): 343–403.
11. Primatesta, Goldacre. Inguinal Hernia repair: incidence of elective and emergency surgery, readmission and mortality (1996). International Journal of Epidemiology; 25/4: 835-839
12. Courtney, Lee, Wilson and O'Dwyer (2003). Ventral hernia repair: a study of current practice. Hernia; 7:44-46
13. Surgery for Society on the Alimentary tract patient care guidelines (2004). Surgical repair of incisional hernia. Journal of Gastrointestinal surgery; 8/3: 369-70