# Commissioning Policy

## Hernia Repair in Adults

**July 2012**

This commissioning policy applies to patients within:

- South Worcestershire Clinical Commissioning Group (CCG)
- Redditch & Bromsgrove Clinical Commissioning Group (CCG)
- Wyre Forest Clinical Commissioning Group (CCG)

<table>
<thead>
<tr>
<th>Version:</th>
<th>V1.2</th>
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<tbody>
<tr>
<td>Ratified by (name of Committee):</td>
<td>Clinical Senate – February 2013</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; April 2013 – this policy was formally adopted by:</td>
<td>NHS South Worcestershire Clinical Commissioning Group</td>
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<td></td>
<td>NHS Redditch &amp; Bromsgrove Clinical Commissioning Group</td>
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<td></td>
<td>NHS Wyre Forest Clinical Commissioning Group</td>
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<tr>
<td>Date ratified:</td>
<td>February 2013</td>
</tr>
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<td>April 2013</td>
</tr>
<tr>
<td>Expiry date: (Document is not valid after this date)</td>
<td>Any revisions to the policy will be based on local and national evidence of effectiveness and cost effectiveness together with recommendations and guidelines from local, national and international clinical professional bodies. Minimum 3 yearly.</td>
</tr>
<tr>
<td>Review date:</td>
<td>April 2016</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Mr Stuart Bourne, Public Health Consultant</td>
</tr>
<tr>
<td>Target audience:</td>
<td>NHS Trusts, Independent Providers, CCGs, GP’s, patients</td>
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<tr>
<td>Distribution:</td>
<td>NHS Trusts, Independent Providers, CCGs, GP’s, patients, Public &amp; Patient Involvement Forum</td>
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<tr>
<td>Equality &amp; Diversity Impact Assessment</td>
<td>March 2012, scrutinised June 2012</td>
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Contribution list
Key individuals involved in developing the document

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Commissioning Statement:

NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed “the Commissioner” in this document) endorses the NHS funded management of inguinal, femoral, umbilical, and incisional hernias, with criteria for referrals/treatment in adults (18yrs+) provided the clinical presentation of the patient meets the following criteria (exceptional clinical circumstances are considered via the Worcestershire Individual Funding Request process).

Inguinal Hernia:
For asymptomatic or minimally symptomatic hernias, the Commissioner advocates watchful waiting.

Surgical treatment should only be offered when one of the following criteria is met:

- A history of incarceration, or real difficulty reducing the hernia;
- A hernia that is increasing in size month on month;
- Pain or discomfort sufficient to interfere with activities of daily living;
- An inguino-scrotal hernia;
- A strangulated hernia (emergency surgery);
- A recurrence to a previously treated hernia.

Femoral Hernia:

- All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation.

Umbilical Hernia:

Surgical treatment should only be offered when one of the following criteria is met:

- Pain or discomfort sufficient to interfere with activities of daily living;
- A hernia that is increasing in size month on month;
- To avoid incarceration or strangulation of the bowel.

Incisional Hernia:

Surgical treatment should only be offered when both of the following criteria are met:

- Pain or discomfort sufficient to interfere with activities of daily living;
- Appropriate conservative management has been tried first e.g. weight reduction where appropriate.
1. Definitions

1.1 Exceptional clinical circumstances are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional. This will usually involve a comparison with other patients with the same clinical condition and at the same stage of development of that clinical condition and refer to features of the particular patient which make that patient out of the ordinary, unusual or special compared to other patients in that cohort. It can also refer to a clinical condition which is so rare that the clinical condition can, in itself, be considered exceptional. That will only usually be the case if the NHS commissioning body has no policy which provides for the treatment to be provided to patients with that rare medical condition.

1.2 A Similar Patient refers to the existence of a patient within the patient population who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. When the treatment meets the regional criteria for supra-CCG policy making, then the similar patient may be in another CCG with which the Commissioner collaborates. The existence of one or more similar patients indicates that a policy position is required of the Commissioner.

1.3 An individual funding request (IFR) is a request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.

1.4 An in-year service development is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

2. Scope of policy:

2.1 NHS principles have been applied in the agreement of this policy. This policy covers the management of inguinal, femoral, umbilical, and incisional hernias, with criteria for referrals/treatment.

2.2 This policy should be considered in line with all other Worcestershire Commissioning Policies. Copies of these Commissioning Policies are available on the NHS Worcestershire website at the following address:

http://www.worcestershire.nhs.uk/policies-and-procedures/commissioningindividual-funding-requests-ifr/

2.3 The Commissioner considers all lives of all the patients whom it serves to be of equal value and, when making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability. The exception to this precedent is where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.
3. **Background:**

3.1 A hernia is defined as a protrusion of a sac or 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 and the ability to work.\(^1\)\(^,\)\(^2\) In addition, hernias can present as a surgical emergency should the bowel strangulate or become obstructed due to the hernia.

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

3.3 An inguinal hernia is a protrusion of the contents of the abdominal cavity or preperitoneal fat through a defect in the inguinal area. Indirect hernias follow the inguinal canal, whereas direct hernias usually occur due to a defect or weakness in the transversalis fascia area of the Hesselbach triangle. 98% occur in men due to the vulnerability of the male anatomy.\(^1\)\(^,\)\(^2\) Femoral hernias follow the tract below the inguinal ligament through the femoral canal, and account for less than 10% of all groin hernias. However, due to the small size of this space through which they protrude, they frequently become incarcerated or strangulated\(^1\) with 40% presenting as emergencies\(^3\). The incidence of femoral hernias is higher in women than men, with a ratio of 4:1.

3.4 Incisional hernias are iatrogenic, with protrusion through a defect caused during surgery. They account for 80%\(^4\) of ventral hernias, and may arise from 3-11% of all laparotomies, rising to >23% should wound infection occur. Other predisposing factors include diabetes, smoking and obesity. Again, they can give rise to symptoms such as discomfort or pain.

3.5 Approximate frequencies for each type of hernia are\(^5\):  
- Inguinal = 70-75%
- Femoral = 17%
- Umbilical 3-8.5%
- Rarer form 1-2% (epigastric/incisional)

4. **Commissioning Policy**

4.1 **Inguinal:**

For asymptomatic or minimally symptomatic hernias, the Commissioner advocates watchful waiting.

Surgical treatment should only be offered when one of the following criteria is met:

- A history of incarceration, or real difficulty reducing the hernia;
- A hernia that is increasing in size month on month;
- Pain or discomfort sufficient to interfere with activities of daily living;
- An inguino-scrotal hernia;
- A strangulated hernia (emergency surgery);
- A recurrence to a previously treated hernia.
Older patients should have the symptoms clearly explained so that they can present promptly for referral if pain worsens or hernia size increases. Emergency repair carries an elevated mortality risk and emergency repair becomes more common as patient age increases. Prompt referral is therefore important for patients beyond 65yrs of age to reduce the risks associated with emergency surgery.

4.2 Femoral:

- All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation

4.3 Umbilical:

Surgical treatment should only be offered when one of the following criteria is met:

- Pain or discomfort sufficient to interfere with activities of daily living;
- A hernia that is increasing in size month on month;
- To avoid incarceration or strangulation of the bowel.

4.4 Incisional:

Surgical treatment should only be offered when both of the following criteria are met:

- Pain or discomfort sufficient to interfere with activities of daily living;
- Appropriate conservative management has been tried first e.g. weight reduction where appropriate

Activity carried out in relation to this policy will be monitored through the following procedures codes:

OPCS codes:

- Umbilical Hernia T24.1 – T24.9
- Recurrent Umbilical Hernia T97.1 – T97.9
- Femoral Hernia T22.1 – T22.9
- Recurrent Femoral Hernia T23.1 – T23.9

Where activity exceeds an appropriate benchmark (e.g. the regional average procedure rate), a retrospective casenote audit may be instigated in secondary care to confirm compliance with this policy.

5. Clinically Exceptional Circumstances

5.1 If there is demonstrable evidence of a patient’s clinically exceptional circumstances, the referring practitioner should refer to the Worcestershire “Individual Funding Request Operating Procedures” document for further guidance on the process for consideration.

5.2 For a definition of the term “clinically exceptional circumstances”, please refer to the Definitions section of this document.

6. Relevant National Guidance and Facts

6.1 A trial carried out by Fitzgibbons\textsuperscript{6} randomised 720 men to watchful waiting vs surgical repair of their inguinal hernia. Primary outcomes were pain limiting
activities and their ‘physical component score’. It was found that results for these outcomes were similar between watchful waiting and surgical repair at 2 years. Although a relatively high proportion of the watchful waiting group (23%) crossed over to operative repair of the hernia (usually due to pain), there was no difference in post op complications between this group and those allocated initially to repair. Only one watchful waiting patient experienced acute hernia incarceration within 2 years, with a second experiencing this at 4 years. The authors therefore concluded that watchful waiting is an acceptable option in minimally symptomatic inguinal hernias, and that in effect surgery was delayed rather than avoided. They also concluded that delaying surgical repair until symptoms increase is safe because acute incarcerations occur rarely and there was no increase in operative complications. This approach is also advocated by the BMJ clinical evidence team. Furthermore, in a response to the article by Fitzgibbons, Flum agrees with this position and reiterates the benefits of watchful waiting where clinically appropriate.

6.2 Furthermore, the Danish hernia database recommend surgical repair in the presence of symptoms affecting daily life. In addition, they advise surgical repair in women due to the higher risk of strangulation. However, in men with minimal or absent symptoms, a watchful waiting approach is recommended.

6.3 There is also evidence from the European Hernia society supporting this recommendation and advocating a watchful waiting approach for those who are asymptomatic or minimally symptomatic. However, they recommend that those who are symptomatic should be considered for elective surgery. This approach is also in line with recommendations from other Commissioners such as Buckinghamshire, Oxfordshire, West Essex and Westminster.

6.4 However, there are some conflicts in the studies looking at watchful waiting compared to early placement on the list for elective surgery. For example, Primatesta looked at the incidence of elective and emergency surgery, readmission and mortality, finding that patients who underwent emergency repair were older, had higher emergency readmission rates than electives, and significantly elevated postoperative mortality rates, and they therefore advised that elective repair of inguinal hernia should be undertaken soon after diagnosis to minimise the risk of adverse outcomes. However, in the study carried out by Fitzgibbons, patients were operated on once their symptoms (i.e. pain) increased, rather than the decision being made to delay surgery until strangulation occurred and an emergency procedure was carried out.

6.5 The case is different for femoral surgery. Femoral hernias account for less than 10% of groin hernias but 40% of these present as emergencies with incarceration or strangulation. Also, femoral hernias are more common in women (ratio 4:1) in contrast to inguinal hernias which have a higher incidence in men. Therefore, we have recommended that femoral hernias should be referred for specialist assessment, and that clinicians should note that these hernias are more common in women. This view is supported by the Danish hernia database.

6.6 Incisional hernias represent approximately 80% of ventral hernias, and are more common in people who have experienced wound complications or infections post operatively. Friedrich et al recommend conservative management such as weight reduction to relieve symptoms, and that surgery should be carried out in those who are symptomatic and conservative management has given no benefit. The most common complaint is pain, with on 12% presenting acutely with incarceration or strangulation. Courtney found that only one third of incisional hernias became
symptomatic and required repair. The Society for Surgery of the Alimentary Tract advise that incisional hernias occur in 3-13% of primary abdominal incisions, although recurrence rates can be quite high at 25-50%, with risk factors for hernias being wound infections, obesity, diabetes and smoking. They advised that reasons for repairing incisional hernias would include relieving symptoms, to prevent gradual enlargement over time, and to avoid incarceration and strangulation of bowel. Therefore these latter recommendations have formed the basis of our criteria for referrals and treatment for umbilical and incisional hernias.

7. References

2. NICE guidelines: TA83 (Sept 2004) – Laparoscopic surgery for hernia
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.

8. Documents Which Have Informed This Policy

- NHS Worcestershire: IFR Commissioning Policy
- NHS Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Commissioning Group Policy 13: Defining the boundaries between NHS and private healthcare
- West Midlands Strategic Group Commissioning Policy 16: Prior approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests
Equality Analysis Report Template

Your Equality Analysis Report should demonstrate what you do (or will do) to make sure that your function/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

1. Name of policy or function:
   Hernia Repair Commissioning Policy

2. Responsible Manager:
   Dr Stuart Bourne – Consultant in Public Health – 01905 760066

3. Date Equality Analysis completed:
   19<sup>th</sup> March 2012

4. Description of aims of function/policy:
   This policy is intended to provide guidance about how to clinically manage people with inguinal, femoral, umbilical and incisional hernias. The policy provides different information (clinical eligibility criteria) that clinicians can use to help to determine when a patient needs surgical repair of their hernia.

   While it is recognised that most patients with hernias may be adult, the policy does not have an age limit as it is accepted that some children may experience this clinical issue too.

5. Brief summary of research and relevant data:
   - NICE guidelines: TA83 (Sept 2004) – Laparoscopic surgery for hernia
   - Friedrich, Muller-Riemenschneider, Roll, Kulp, Vauth, Greiner, Willich and von der Schulenburg (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
   - Dabbas (2011) Frequency of abdominal wall hernias: is classical teaching out of date. JRSM Short Reports: 2/5; 5
   - Fitzgibbon (2006); Watchful waiting versus repair of inguinal hernia in minimally symptomatic men, a randomised controlled trial. JAMA: 295; 285-292
   - Flum (2006): The asymptomatic hernia: If it’s not broken don’t fix it. JAMA: 295; 249
   - BMJ clinical evidence on Inguinal Hernias; Chos, Purkayastha, Anthanasiou, Tekkis and Darzi.
   - Rosenberg (2011). Danish hernia database recommendations for management of inguinal and femoral hernias in adults. Danish Medical Bulletin; 58/2: C4243
   - NHS Worcestershire: IFR Commissioning Policy
   - NHS Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
   - West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Commissioning Group Policy 13: Defining the boundaries between NHS and private healthcare
- West Midlands Strategic Group Commissioning Policy 16: Prior approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests

6. Methods and outcomes of consultation:
   Face to face discussions, clinical meetings, independent policy review (including all of the above noted stakeholders) with comments taken into account and discussed at various clinical and PWG meetings

7. Results of Equality Analysis

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<th>Protected Characteristics</th>
<th>Assessment of Impact</th>
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<td>Age:</td>
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<td>Disability:</td>
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<td>Gender reassignment:</td>
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<td>Marriage and Pregnancy:</td>
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<td>Marriage and Civil Partnership:</td>
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<td>Race:</td>
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<tr>
<td>Religion or Belief:</td>
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<td>Sex:</td>
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<td>Sexual Orientation:</td>
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<tr>
<td>Any other groups:</td>
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8. Decisions and or recommendations (including supporting rationale)
   Policy criteria justified, mitigation actions identified – continue to publish policy

9. Equality action plan (if required)
   None

10. Monitoring and review arrangements (include date of next full review)

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<th>Department</th>
<th>Public Health and Acute Commissioning</th>
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<tr>
<td>Directorate</td>
<td>Public Health and Directorate of Delivery</td>
</tr>
<tr>
<td>Director</td>
<td>Mr Simon Hairsnape</td>
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<tr>
<td>Report produced by and job title</td>
<td>Mrs Helen Bryant – Commissioning &amp; ReDesign Manager</td>
</tr>
<tr>
<td>Date report produced</td>
<td>19 March 2012</td>
</tr>
<tr>
<td>Date report published</td>
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