Clinical Policy Committee

Commissioning policy: The specialist management of abdominal wall hernia in adults

Lifestyle Management

All patients with a BMI >30 should be encouraged to lose weight and referred to local weight management programmes where appropriate, prior to elective hernia repair; since obese patients may have an increased risk of post-operative complications following inguinal hernia repair. Obesity is also a risk factor for developing incisional and umbilical hernias and as a result recurrence rates may be higher in obese patients.

All patients should be encouraged to stop smoking and offered information on local smoking cessation support services prior to elective hernia repair; since smoking is a recognised risk factor for developing a hernia, as well as increasing the risk of recurrence and postoperative complications following surgical repair.

Groin Hernia

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

All inguinal hernias should be considered for referral to secondary care. Patients with minimally symptomatic inguinal hernias who have significant comorbidity and do not want to have surgical repair can be managed conservatively in primary care.

Surgical Management of Inguinal Hernia

For asymptomatic or minimally symptomatic inguinal hernias in men, a watchful waiting approach is advocated including providing reassurance, pain management etc. under informed consent.

Surgical treatment will only be routinely commissioned when **one or more** of the following criteria is met:

- History of incarceration, difficulty in reducing the hernia or risk of strangulation.
- Pain or discomfort sufficient to cause significant functional impairment*.
- Inguino-scrotal hernia.
- A hernia that is increasing in size month on month.
- Suspected strangulated or obstructed hernia.
- Inguinal hernia in women.

Umbilical Hernia

Referral for specialist advice and surgery, if appropriate, will only be routinely commissioned when **one or more** of the following criteria is met:

- Pain or discomfort sufficient to cause significant functional impairment*.
- A hernia that is increasing in size month on month.
- If the patient is considered at risk of incarceration or strangulation.

Incisional Hernia

Referral for specialist advice and surgery, if appropriate, will only be routinely commissioned when **both** of the following criteria are met:

- Pain or discomfort sufficient to cause significant functional impairment*
- Appropriate conservative management has been tried first e.g. weight reduction, smoking cessation where appropriate.

*** Note: Significant functional impairment is defined as –**

- Symptoms that interfere with employment or education despite reasonable adjustment, or act as a barrier to employment or education.
- Symptoms that interfere with self-care, maintaining independent living or carrying out carer activities.

Surgical repair of divarication of recti/diastasis of abdominal muscle (without herniation) is not routinely funded.

Rationale for the decision

Evidence suggests that overweight or obese patients have an increased risk of postoperative complications including infection and severe pain following groin hernia surgery. Obesity has also been associated with the development of umbilical and incisional hernias as well as an increased risk of recurrence following surgical repair of incisional hernias.

Smoking is a recognised risk factor for both the development and recurrence of inguinal hernias and is thought to contribute to the development of incisional hernias. Evidence suggests there is an increased risk of postoperative complications following inguinal hernia surgery, in patients who smoke.

Randomised control trials (RCTs) which compared watchful waiting with surgery in men with asymptomatic or minimally symptomatic inguinal hernias, found no significant difference in pain between treatment strategies at 1 or 2 years. Although over time, a significant proportion of patients will develop symptoms and require surgery, long-term follow up studies found that a proportion of men in the watchful waiting group did not require surgery at 7.5 years. (RCTs of watchful waiting vs. elective repair of asymptomatic or minimally symptomatic inguinal hernias estimated crossover rates from watchful waiting to surgery of around 70% at 7.5 to 10 years). The most common reason for cross-over to surgery was increasing pain; whilst the emergency surgery rate in the watchful waiting group was approximately 2.5%.

Hernias are common. The CCG is responsible for ensuring that the treatments provided for the local population represent the best use of the NHS budget allocated to us for our population's health services. We have to choose how to use our funds carefully to ensure that the local population has access to the healthcare that is most needed. Given the costs of providing surgery, and the balance of benefit in asymptomatic and minimally symptomatic inguinal hernias, it is considered appropriate that these are managed through watchful waiting until symptoms worsen and the benefit/risk balance changes. Since these hernias are not expected to spontaneously resolve, the policy does not limit the period of watchful waiting; rather surgery is deferred until patients' symptoms reach specified criteria.

Femoral hernias account for less than 10% of groin hernias but studies suggest that they are associated with a least a seven times greater risk of strangulation at 3 months compared to inguinal hernias. Femoral hernias are more common in women with a male to female ratio of 1:4. Irrespective of groin hernia anatomy women had an increased risk of emergency procedure compared to men.

Based on low quality evidence the International Endohernia Society recommends that symptomatic umbilical and incisional hernias should be treated surgically. Evidence suggests asymptomatic patients who undergo surgical repair of an incisional hernia may be at risk of long term post-operative pain as well as recurrence, highlighting the need for careful consideration of surgery in these patients. Precise data on strangulation rate or risk of acute incarceration for incisional hernias is unavailable.

Divarications of the rectus abdominis muscles may be unsightly but they do not carry the same risks as hernias; since there is no herniation, there is no recognisable risk of strangulation or incarceration of the contents.

Whilst it has been suggested that divarication of recti may result in problems such as lower back pain and urinary incontinence; the evidence for this is limited and conflicting. A recent 12-month prospective cohort study of 300 women found no difference between those with post-partum divarication and those without in terms of pelvic floor muscle strength, urinary incontinence, pelvic organ prolapse, or lumbopelvic pain.

Guidance notes on exceptionality

Where the circumstances of treatment for an individual patient do not meet the criteria described above exceptional funding can be sought. Individual cases will be reviewed by the appropriate panel of the CCG upon receipt of a completed application from the patient's GP, consultant or clinician. Applications cannot be considered from patients personally.

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