NHS
Cambridgeshire & Peterborough

Surgical Threshold Policy

Hernia Surgery in Adults

(Inguinal, Femoral, and Abdominal Hernias and Divarication of Recti)

Scope

This policy covers the referral for surgery for adults with groin (inguinal and femoral) hernias, abdominal (including incisional and umbilical) hernias and divarication of the recti.

The Policy does not apply in the circumstances below:

- Does not cover children.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases. Panel by completing the exceptional funding section of the **referral proforma**.

Surgery will be funded for adult patients with symptoms of incarceration, strangulation or obstruction (see note 1 over page).

Adult patients without symptoms of incarceration, strangulation or obstruction:

Femoral hernia (see note 1 over page)
Surgery will be funded.

Inguinal hernia
Patients with asymptomatic or mildly symptomatic inguinal hernias should not be referred. Surgery will not be funded unless there is (see note 2 over page):

- difficulty in reducing the hernia; **Or**
- an inguino-scrotal hernia; **Or**
- pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living (see note 3 over page); **Or**
- the patient is female.

Abdominal (including incisional and umbilical) hernia
Surgery will not be funded unless (see note 2 over page):

1. there is pain/discomfort significantly interfering with activities of daily living (see note 3); **And** for patients with BMI≥30kg/m^2, they have been advised on weight reduction to reduce the risks of recurrence and post-operative complications; **Or**
2. the hernia is causing difficulty with the fitting of a stoma appliance, eg bag leaking or skin damage.

For incisional hernias, surgery will be funded where a significant increase in size is noted over time.

Divarication of recti
Divarication of recti as a stand-alone procedure will not be funded.

Groin pain with clinical suspicion of hernia (obscure pain or swelling)
These patients should not have diagnostic testing in primary care but be referred for specialist assessment. Funding criteria for surgery are then applied as laid out in this policy.

Day surgery
For patients meeting the criteria for day-case surgery and where day-case surgery is possible, only day-case surgery should be funded.

Recurrent and bilateral hernia
These are considered in the same way as primary hernias and funding criteria for surgery will be applied as described in this policy. Referral should be made to appropriate specialists with expertise in open and laparoscopic surgery.

Notes:
1. Patients should be referred directly for surgery.
2. Patients should be managed with observation and review.
3. Activities such as meal preparation, laundry, housekeeping, shopping, using the phone, driving or using public transport.

Smoking
Advise people who smoke to attempt to stop smoking and refer to stop-smoking services – see stop smoking policy

Rationale and Evidence

Patients with symptoms of incarceration, strangulation or obstruction: These patients need to be referred urgently.

Femoral hernia: Has a high risk of morbidity and mortality and surgery is recommended, even in the absence of symptoms (see reference 1).

Inguinal hernia: Inguinal hernias have a low risk of strangulation(see reference 2) and account for 95% (see reference 3) of all groin hernias. Men with asymptomatic or mildly symptomatic inguinal hernias should not be referred for surgery as it is safe to use a watchful wait approach(see references 4 & 5). Inguinal hernias in women have a higher risk of strangulation (see reference 1) and so women with either a femoral or inguinal hernia should be referred urgently.

Abdominal hernias (including incisional and umbilical): Incidence of incisional hernias is higher in overweight (BMI 25-30 kg/m2) or obese (BMI 30-40 kg/m^2) persons compared to lean (see references 6 & 7). When surgery is conducted on incisional or umbilical hernias, rates of recurrence are around 5-25% (see references 8-10) and increased BMI is associated with even higher rates of recurrence and with post-surgical morbidity (see references 11 & 12).

Divarication of recti: Does not carry the risks that are associated with actual hernias and repairs are primarily cosmetic (see references 13 & 14). Surgery should, therefore, be avoided unless extreme symptoms present.

Groin pain with clinical suspicion of hernia (obscure pain or swelling): A quarter to a third (see reference 15) of patients presenting with groin pain were found to have an occult hernia. Diagnostic procedures may identify the majority of occult hernias (see reference 16), but the specificity of some tests may be low (ultrasound - 77%, CT - 65%) (see reference 17) and incorrectly identify patients as having a hernia. Where symptoms do not indicate incarceration, strangulation or obstruction of a potential hernia, the costs of diagnostic procedures and any surgical interventions, and the risks associated with misdiagnosis and surgical morbidity, do not justify investigation with imaging tests and patients should be offered watchful waiting.

Day surgery: European guidelines for the management of inguinal hernia recommend that: 'An operation in day surgery should be considered for every patient' (see reference 18). This may be possible for many cases of non-emergency hernia surgery (see reference 16).

Recurrent and bilateral hernias: NICE guidance recommends that "Laparoscopic surgery for inguinal hernia repair should only be performed by appropriately trained surgeons who regularly carry out the procedure" (see reference 19).

Estimated Number of People Affected

The lifetime risk of groin hernia is 27% in men and 3% (see reference 20) in women and the frequency of surgical correction is estimated at 10 per 100,000 of the population in the UK. Femoral hernias are more common in women (4:1) (see reference 1) and inguinal hernias are more common in men (10:1) (see reference 20).

Glossary

Asymptomatic:	The lack of any symptoms of disease, whether or not a disease is in fact present.
Divarication of Recti:	Divarication of the recti (diastasis recti) is the separation of the rectus abdominis muscle.
Hernia:	Protrusion of an internal organ of the body through a weakness in the muscle or surrounding tissue wall of the cavity that normally contains it.
Laparoscopic surgery:	Minimally invasive surgery using a laparoscope.
Obstruction:	Mechanical or functional obstruction of the intestines which prevents the normal movement of the products of digestion.
Incarceration:	Hernia becomes stuck in the groin or scrotum and cannot be massaged back into the abdomen.
Strangulation:	Portion of the bowel is trapped, cutting off the blood supply and causing the trapped bowel to die or rupture.

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