NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Policy title	**Hernia repair in adults and Biological mesh for abdominal hernia repair v1.1**
Policy position	**Hernia repair: Criteria Based Access** **Biological mesh for abdominal hernia repair: Not Normally Funded**
Date of CCG recommendation	**2017, updated January 2021**

A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. This policy covers the management of abdominal hernias including inguinal, femoral, umbilical, and incisional hernias, with criteria for referrals for specialist opinion/treatment.

Immediate referral for surgical opinion for patients with the following conditions is recommended:

- diagnosis of femoral hernia
- diagnosis of spigelian hernia, following ultrasound confirmation,
- diagnosis of an inguino-scrotal hernia

For other abdominal/ventral hernias, including inguinal, umbilical, para-umbilical, epigastric and incisional, referral may be considered only if at least one of the following criteria are met:

- Documented history of incarceration of, or difficulty in reducing, the hernia
- Documented pain or discomfort significantly interfering with activities of daily living. Details of nature and extent of impact must be provided at referral
- Documented increase in size month on month
- Work-related issues (includes domestic duties and unpaid caring):
  - has become restricted to light duties because of hernia
  - off work/missed work/unable to work because of hernia

Bilateral groin hernia repair will be funded if one or both of the hernias fulfil the above criteria.

Repair of asymptomatic or minimally symptomatic inguinal hernia is **not normally funded**. Watchful waiting is a safe option for people with minimally symptomatic inguinal hernias. Many people with an inguinal hernia are asymptomatic or minimally symptomatic and may never need surgery[7].

Patients have a right to be fully informed about surgical procedures, and as part of this process, clinicians should engage the patients (or their carers) in shared decision making about alternative management and the risks and benefits of surgery.

The risk/benefit of elective surgical hernia repair requires careful consideration. In general short-term complications of abdominal hernia repair include bleeding, bruising, infection, seroma, deep vein thrombosis and pulmonary embolism[1]. 30 day reoperation and readmission rates are reported at 0.3 to 2.2% and 5.9 to 13.3% respectively[2]. Long-term complications include chronic pain reported in up to 30% (debilitating pain in 3%)[3] and mesh infection. Recurrence rates vary according to hernia type and size, patient specific factors, and surgical technique, and are reportedly up to 29%[4]. Mortality rates are 0.2 to 0.5%[2].

In groin hernia repair it is suggested that the rate of chronic pain is up to 5%[1] and mesh infection 0.2%[1]. Recurrence rates have been reported at 0.5%[1] to 2 to 5%[5]. Mortality rate is estimated at 0.5%[6].

Biological mesh

Biological mesh has been used in a variety of reconstructive surgical procedures. The Priorities Forum has considered the evidence of clinical and cost-effectiveness of use of biological mesh in complex and contaminated abdominal wall repair.

Use of biological mesh in abdominal wall hernia repair or closure of laparostomy **is not normally funded or** funded in addition to the usual tariff price for the procedure, due to insufficient evidence of clinical and cost-effectiveness.

References:

1. British Hernia Society: For patients - groin hernia and you.
2. Helgstrand F et al. (2013). Outcomes after emergency versus elective ventral hernia repair: a prospective nationwide study. World J Surg (2013) 37:2273–2279
3. O'Dwyer P et al. (2005) Groin Hernia Repair: Postherniorrhaphy Pain. World J. Surg. 29: 1062.
4. Ballem N, Parikh R, Berber E, Siperstein A. (2008) Laparoscopic versus open ventral hernia repairs: 5 year recurrence rates. Surgical endoscopy. Sep;22(9):1935-1940.
5. The Society for Surgery of the Alimentary Tract (USA): Patient Care Guidelines, Surgical Repair of Groin Hernias (2013)
6. Van den Heuvel et al. (2011). Is surgical repair of an asymptomatic groin hernia appropriate? A review. Hernia 15:251–259
7. NHS England Evidence-Based Interventions List 2 Guidance (2020)

NOTE:

- This policy will be reviewed in the light of new evidence or new national guidance e.g. from NICE
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process

Clinical coding:

OPCS Procedure codes:

T19: Simple excision of inguinal hernia sac (herniotomy)
T20: Primary repair of inguinal hernia.
T21: Repair of recurrent inguinal hernia.
T22: Primary repair of femoral hernia.
T23: Repair of recurrent femoral hernia.
T24: Primary repair of umbilical hernia.
T25: Primary repair of incisional hernia.
T26: Repair of recurrent incisional hernia.
T27: Repair of other hernia of abdominal wall.
T28: Other repair of anterior abdominal wall.
T97: Repair of recurrent umbilical hernia.
T98: Repair of recurrent other hernia of abdominal wall

Key words: hernia, biological mesh, mesh