Policy for the Management of Umbilical, Para-Umbilical and Incisional Hernias
The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decision are considered within the wider constraints of the CCG’s legally responsibility to remain fiscally responsible.
Category: Restricted

Umbilical, Para-umbilical and Incisional Hernias

Umbilical, para-umbilical and incisional hernias are common abdominal hernias encountered in clinical practice, and involve the protrusion of intra-abdominal tissue through a defect in the abdominal wall. With umbilical and para-umbilical hernias, the defect is at or around the umbilicus, and with incisional hernias the defect is at the site of a previous operative incision.

Umbilical hernias are common at birth, but often resolve themselves over time; in adults these hernias are less likely to resolve spontaneously and may require surgical management. Umbilical/para-umbilical hernias are more common in women with multiple pregnancies and people who have a high BMI.

Incisional hernias emerge through defects at a previous incision site and are seen with 5 in 1,000 after laparoscopy and 150 in 1,000 after open abdominal wall incisions.

Management Options

Advances in laparoscopic approaches, prosthesis (‘mesh’ repairs), and operative care have resulted in research interest into the relative costs and benefits of alternatives to traditional ‘open repair’ approaches. Furthermore, there is increasing interest in watch and wait approaches, where previously surgery was routinely performed for asymptomatic presentations.

Success of surgical techniques can vary considerably based on surgical experience, equipment and technique used, nature of defect, patient characteristics and hospital/operative environment, making comparisons difficult. However, evidence reviewed showed a significantly reduced risk of surgical site infection following laparoscopic procedures.

Eligibility Criteria:

This policy is for the management of umbilical, para-umbilical and incisional hernias in adult patients.

- Strangulated umbilical, para-umbilical or incisional hernias should proceed to the most clinically appropriate surgery in a timely manner OR
- For non-urgent procedures, the patient must be diagnosed with a symptomatic umbilical, para-umbilical or incisional hernia AND
- The patient should be reviewed by the surgical clinician and in a shared decision making process, a decision should be reached as to the most clinically effective method of surgery for the individual patient, i.e. laparoscopic or open surgery. However, the evidence shows that laparoscopic surgery, where clinically appropriate, due to the significantly reduced rates of surgical site infection should be the preferred choice.
For the purposes of this policy symptomatic hernia is described as debilitating pain which impacts on activities of daily living, e.g. walking; sleeping; working

This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
Guidance:

