Non-Hospital Medical and Surgical Facilities Accreditation Program

Policy

Hernia Procedures in Non-Hospital Facilities

PURPOSE

This policy outlines hernia procedures that are appropriate in the non-hospital setting and the defined parameters.

BACKGROUND

Prior to September 2021, the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) general surgery appropriate procedure list for abdominal wall hernias included umbilical and inguinal hernias but did not include ventral incisional hernias. However, the extensive use of laparoscopic surgery and its resultant ventral incisional hernias of limited size are within the scope of ambulatory surgery and has prompted the NHMSFAP Committee to reevaluate. Expert opinion, experience, and the literature indicate that ambulatory day surgery procedures for ventral incisional hernia repairs are associated with a higher complication rate and/or need for unplanned admission from the following factors.

1. Patient characteristics: High BMI, ASA 3 or greater, advanced age.
2. Size of fascial defect: Exceeding 4 cm and this factor is considered of **high importance**.
3. Surgical approach: Laparoscopic repair of incisional hernias are associated with higher unplanned admission rates similar in effect to ASA 3 or COPD.
4. Incisional hernias arising from previous open laparotomies present a particular risk for ambulatory surgery. These are well-known to manifest as confined smaller fascial defects but at surgery multiple small defects can lead to a much more extensive repair. This leads to greater post-operative pain and potential respiratory difficulty. These prompt unplanned admission, risk for the patient, and a burden for the facility.

POLICY

The following are **not considered necessary criteria** for hernia surgery at an accredited surgical facility.

1. Although imaging may have been done for clinical reasons it is **not** one of the criteria.
2. The size of the fascial defect is of great importance, but the size of the herniating mass is **not** a factor.
3. Whether or not the hernia itself or the planned surgery will involve opening the peritoneum is **not** a factor.

Classification

Primary

A. Inguinal hernias (direct, indirect, femoral)
    a. Umbilical hernias
    b. Epigastric hernias
B. Secondary
    a. Initial or recurrent incisional hernias arising from previous open laparotomy procedures (e.g. midline, transverse, flank)
    b. Initial or recurrent incisional hernias arising from laparoscopic procedures
        i. Port site hernias
        ii. Extraction site hernias (typically the fascial incision was <5 cm)
    c. Recurrent inguinal hernias
    d. Recurrent umbilical hernias

Note: Eventrations of the abdominal wall are not classified here as true hernias.

Procedures appropriate for the non-hospital setting

- Primary inguinal, epigastric, umbilical hernias
- Recurrent inguinal hernias
- Recurrent umbilical hernias
- Incisional hernias arising from laparoscopic procedures (</+=4cm fascial defect)

Procedures *not* appropriate for the non-hospital setting

- Initial or recurrent incisional hernia's arising from previous open laparotomy procedures (e.g. midline, transverse, flank)
- Eventrations
- Fascial defects exceeding 4 cm from **any source** (except in the case of a primary inguinal hernia)

Surgical technique

The choice of surgical technique—laparoscopic or open—is up to the discretion of the surgeon. Surgeons should be aware that literature suggests a higher incidence of unplanned admission with the laparoscopic approach but with smaller wall defects this risk is regarded as acceptable.

Pre-operative documentation

The pre-operative surgical consultation must state the diagnosis (what type of hernia) and the size of the fascial defect, and for incisional hernias, must describe the nature of the surgery that prompted the hernia.

RESPONSIBILITY

Role	Responsibility
Medical director	• Review all applications for medical staff appointment and ensure they meet the criteria for those requesting hernia procedures
NHMSFAP	• Maintain records of current medical staff in facilities • Provide education support to the medical director in processes of selection, appointment and reappointment of medical staff • Ensure that the privileges granted are appropriate procedures for the facility • Review applications and notify the medical director of any limit or conditions on a physician licence affecting the privileges being granted within 60 days