SUBJECT: GENERAL GUIDELINES FOR MANAGEMENT OF HERNIAS

EFFECTIVE: 1/30/18

I. PURPOSE

The purpose of this health services bulletin is to provide guidance to institutional health services personnel on the diagnosis, evaluation and treatment of hernias.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff.

II. COMMON TYPES OF HERNIAS:

Inguinal hernias (direct or indirect), Femoral hernias (more common in women), and Ventral/Umbilical hernias (Ventral hernias are usually incisional). Direct inguinal hernias are common in the industrial setting. Indirect hernias and femoral hernias are rarely caused by work and are usually congenital. Femoral hernias tend to strangulate more commonly. Therefore, surgical referral is the most prudent course of action. Hernias may be new, recurrent, or bilateral

III. INITIAL ENCOUNTER:

A. Determine the type of lifting episode or incident.
B. Determine whether the problem is acute, sub-acute, chronic, or of insidious onset.
C. Determine the severity and specific anatomic location of the pain.
    1. If patient is experiencing pain, determine if it affects daily life activities including but not limited to walking, running, working, playing sports, sleeping, lifting, urinating and bowel movement.
D. Ask about the ability of the patient to lift.
E. Determine any present medication.
F. Determine any previous medical history, history of systemic disease, or history of previous hernia or related disability.
G. Obtain history of any previous inguinal discomfort of hernia repair.
H. Investigate non-industrial reasons that commonly exacerbate hernias; i.e., history of chronic cough, history of constipation with straining at stool, and any symptoms of prostatism leading to straining at urination. Note: it is very uncommon for hernias to occur as a result of a fall.
I. Obtain family history regarding hernias.

IV. EVALUATION:

A. Evaluations are to be conducted by a physician or mid-level provider.

B. Examine the patient in the standing position and determine the presence or absence of a hernia impulse on coughing or straining. If found, the hernia size should be documented.

C. If a hydrocele is suspected, use transillumination: a hydrocele will transilluminate; a hernia will not.

D. If a hernia is found, examine the patient in the supine position to ascertain whether it is reducible.

E. An irreducible hernia is not always strangulated. In the standing positions, an irreducible hernia will increase in size with straining while a strangulated one will not. There will be other signs and symptoms with strangulation, including the presence of a firm, painful, tender mass in the inguinal region, which is irreducible. It may be associated with signs of bowel obstruction (i.e., nausea and vomiting, abdominal/visceral pain, abdominal distention, absent bowel sounds, history of infrequent movements), fever and elevated white blood cell count.

F. Examine for signs of a Richter's hernia (a strangulated hernia involving part of the circumference of the bowel wall).

G. Imaging techniques such as magnetic resonance imaging (MRI), computed tomography (CT) scan, and ultrasound are unnecessary except in unusual situations. Diagnosis is normally via physical examination but imaging, such as ultrasound scan or CT may be used, especially if there is a scrotal hernia/mass to exclude hydrocele or testicular mass.

H. Examine the opposite inguinal (femoral) region for signs of bilateralism.

I. Classify the hernia into one of the following diagnoses:

1. Reducible hernia

2. Irreducible non-strangulated hernia

3. Suspected strangulated or Richter's hernia (strangulated hernia in which only a part of the caliber of the gut is involved).

a. If signs of a strangulated or Richter's hernia are present, these are emergent conditions and require immediate transport to a hospital.

V. MANAGEMENT:

A. A patient presenting with a hernia shall be referred to a surgeon for a surgical consultation if, in the medical judgment of the treating physician, the patient

is experiencing pain affecting daily life activities (including but not limited to walking, running, working, playing sports, sleeping, lifting, urinating, and defecating), the hernia is not easily reducible, the hernia is incarcerated, the hernia is in the scrotum, or the patient is experiencing any other symptom that, in the medical judgment of the treating physician, warrants surgical referral. The recommendation of the surgeon shall not be unreasonably refused. The reasons for refusing the recommendation of the surgeon shall be documented in the patient's medical file.

B. If nothing in Section A. above is present in the patient and the patient is not referred to a surgeon, then conservative measures may be the initial management, including passes for low bunk and restricted activities. The patient must be counseled to access Medical should he or she develop any pain in the area or generalized abdominal pain, constipation/vomiting, enlargement of the hernia, or if the hernia falls into the patient's scrotum.

C. The benefit of surgical treatment versus the inherent risks and complications of anesthesia and surgery should be explained to the patient.

D. The patient will be provided with appropriate follow-up care.

VI. DOCUMENTATION:

Document the initial evaluation, presumptive diagnosis and treatment recommendations on the DC4-701, Chronological Record of Health Care. If it is determined that a referral is needed for diagnostic evaluation or surgical consultation, follow the process outlined in Health Services Bulletin 15.09.04, Utilization Management Procedures.

Health Services Director Date

This Health Services Bulletin Supersedes: HSB dated 7/25/16 and 11/8/17