Audit of referral patterns for hernia repair – are general practitioners aware of the changing face of herniorrhaphy?

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ABSTRACT

INTRODUCTION The objective of this study was to examine referral patterns from general practitioners for groin hernia surgery and to assess their knowledge of services available to their patients.

PATIENTS AND METHODS An anonymous postal questionnaire was sent to 120 general practitioners (GPs) in the South East Wales region who routinely refer patients for inguinal hernia surgery to the Royal Gwent Healthcare NHS Trust.

RESULTS A total of 86 questionnaire replies were returned. There was variation in referral patterns between the GPs with the majority (84%) referring their patients for groin hernia repair to either a general surgeon or as an open referral. Only 14% referred directly to a hernia specialist and none regularly referred to a laparoscopic surgeon.

CONCLUSIONS Referral patterns for inguinal hernia surgery do not reflect services provided in secondary care. Further education is required so that a patient's care can be optimised.

KEYWORDS

Referral patterns – Hernia repair – General practitioners

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Accurate referral for inguinal hernia surgery allows the patient to be seen and assessed in secondary care in the most appropriate manner. However, the vast majority of literature on hernias, along with the recent guidelines from The Royal College of Surgeons of England¹ and the National Institute for Health and Clinical Excellence (NICE),² have classically concentrated on surgical technique and the secondary care aspects of hernia surgery.³ The objective of this study was to examine referral patterns from general practitioners (GPs) for groin hernia surgery and to assess their knowledge of services available to their patients.

Patients and Methods

An anonymous postal questionnaire was sent to 120 GPs in the South East Wales region who routinely refer patients for inguinal hernia surgery to the Royal Gwent Healthcare NHS Trust. The questionnaire was divided into two sections.

First, GPs were asked about their current referral patterns and the potential changes that may arise given the increase in local anaesthetic hernia surgery being per-

formed. Second, the questionnaire asked whether patients specifically requested referral to a hernia specialist, a laparoscopic hernia specialist or a general surgeon. Information was also collected on whether the GP was aware of any of these services locally.

Along with the questionnaire, a summary of the latest guidelines from The Royal College of Surgeons of England and NICE together the last UK Government White Paper on health reform was provided to the GPs, for information purposes only.

Results

A total of 86 questionnaire replies were returned from the 120 GPs, a response rate of 72%. Of the respondents, there was a mean referral rate of 9 patients per year for inguinal hernia repair on the National Health Service, with a range of 2–30 patients. Requests for private referrals for inguinal hernia surgery made up only a small percentage of workload with 93% of GPs stating that private referrals made up less than 30% of total groin hernia referrals.

Figure 1 shows the variation in referral patterns between the GPs with the majority ($n = 72$; 84%) referring their patients for groin hernia repair to either a general surgeon or as an open referral. Only 14% ($n = 16$) referred directly to a hernia specialist.

As can be seen from Figure 1, none of the GPs surveyed regularly referred to a laparoscopic surgeon. Only 17% ($n = 15$) of GPs were aware of any specific consultant surgeons in South Wales performing laparoscopic groin hernia repair. However, of those GPs that were aware of this service, 80% had at some time referred patients specifically to these specialists.

With the increased number of local anaesthetic inguinal hernia repairs being performed, 57% ($n = 49$) of GPs believed that referrals would increase given that patients previously deemed unfit for surgery could now be considered.

Patient requests for type of referral were examined and only 11% of GPs stated that patients had ever requested referral to a hernia specialist and only 5% to a laparoscopic hernia specialist.

Discussion

From these data, over 700 patients with inguinal hernias are referred for repair to our hospital each year. Inguinal hernia repair, therefore, comprises a significant percentage of both the out-patient and surgical workload of a general surgeon working in secondary care.

However, this process starts with the original consultation in primary practice and GPs are key, not only to the referral process but in the primary assessment of the patient in terms of their suitability and urgency for surgery. Data and research concerning referral for groin hernia repair are very scarce;³ often, GPs are restricted in their referral patterns by local policies and guidelines.

Askew *et al.*⁴ found that there was difficulty in accurately diagnosing hernias that could potentially strangulate;

therefore, all patients with a groin hernia should be referred to secondary care. Studies looking at both GPs and general surgeons support this, finding that regardless of the examining doctor there is doubt over the accuracy of distinguishing types of groin hernias.^{5,6} The 1991/2 National Confidential Enquiry into Perioperative Deaths (NCEPOD) found that 210 deaths occurred during the study period secondary to complications of inguinal hernias.⁷ In 50% of cases, the hernia had been diagnosed prior to the final illness, suggesting that more patients should have been considered for elective hernia repair.^{7,8}

This study shows only a small percentage of patients request referral for hernia surgery from a hernia specialist or a laparoscopic specialist. This could potentially be due to the geographic location of the study. Also, with only 17% of GPs in our study being aware of specific laparoscopic and open hernia specialists to refer to, perhaps not enough information has been provided by secondary care regarding some of the choices for inguinal hernia repair. Potential changes in referral patterns may change if there was greater information supplied by secondary care regarding the surgical and anaesthetic advances. Following the results of this study, we now aim to provide all local GPs with an update on inguinal hernia services available locally.

Conclusions

Groin hernia surgery has evolved greatly over the last 10 years. It is imperative that surgeons keep GPs supplied with up-to-date information so they can best assess where, and to whom, to refer their patients.

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