NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin105
Hydrocele – Surgical management (adults and children)

Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: May 2025

This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Surgical management of hydrocoele in adults (men) aged 17 years or older is not routinely commissioned unless the following criteria are met:

1.1.1 diagnosis is confirmed by ultrasound

AND

1.1.2 there are significant functional problems and/or pain.

1.2 Surgical management of hydrocoele in children aged 2 -16 years is routinely commissioned as a paediatric surgical service.

2. Exclusions

2.1 This policy does not apply to suspected malignancy.

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 The policy has been developed in line with recommendations from the British Association of Urological Surgeons.

5. Summary of evidence review and references

5.1 A hydrocoele is an abnormal collection of fluid within the tunica vaginalis. [1] A small amount of fluid is considered to be normal, and as a general rule, if this volume as above 4ml, this is suggestive of hydrocoele. [2] Although most frequently found in the scrotum, hydrocoeles are less commonly found in the external genitalia and pelvic regions. The fluid collection may result from a patent *processus vaginalis*[1] or an imbalance of secretion and absorption within the tunica vaginalis.[3] *Primary* hydrocoeles include the congenital, communicating (i.e. a patent processus vaginalis) and non-communicating or closed types. Secondary hydrocoeles are associated with pre-existing diseases such as epididymitis, testicular torsion, previous surgery or tumour. [4]

5.2 In children, the destruction of the processus vaginalis begins soon after birth and nearly 90% of neonatal or congenital hydrocoele cases disappear within 24 months. [4] However, acquired hydrocoeles are estimated to affect approximately 1% of adult men, mostly older than 40 years and these are bilateral in up to 10% of cases.[2] The condition is highly prevalent in those men in the 65+ age group. [5]

5.3 During the initial diagnosis, hydrocoeles can be differentiated from other testicular masses by transillumination of the fluid with a penlight. Patients with hydrocoeles also have a palpably normal spermatic cord and inguinal ring above the swollen area. Scrotal ultrasonography may be helpful with the diagnosis.[6,7]

5.4 It has been suggested that hydrocoeles may interfere with spermatogenesis and there is debate on the necessity for surgery in paediatric patients. In adults, treatment isn't required unless the size causes functional difficulties or embarrassment. In general, hydroxoeles are painless or present as a sense of heaviness in the scrotum which rarely interferes with daily activities or sexual intercourse.[2] In a retrospective, single-centre review of surgical specimens presented to its laboratory, there were no cases of malignancy over the 14 years' study period.[8]

5.5 Other authors have also concluded that whilst the fluid of a hydrocoele could negatively affect testicular function, this doesn't seem to be of any clinical significance and have suggested that asymptomatic patients shouldn't be treated. [5] Surgery for cosmetic reasons alone isn't considered to be appropriate. [9]

5.6 Treatments include both surgery and aspiration with or without sclerotherapy. If aspiration alone is performed, the hydrocoele typically reappears. [3] Recent data suggest that aspiration plus multiple courses of sclerotherapy can achieve a 94% cure at least in the short term. [10] Otherwise, hydrocoelectomy is preferred particularly when the hydrocoele is large and persistent. Post-operative complications include scrotal oedema, haematoma, chronic pain, decreased fertility, persistent swelling, Fournier's gangrene and infection. Haematoma and infections are the most common complications. [5]

5.7 The British Association of Urological Surgeons have recommended that following an ultrasound diagnosis, hydrocoeles can be safely observed in primary care without the need for a secondary care referral. Surgery should only be considered for functional problems. The Association also confirms that aspiration is often ineffective in the long term and should be considered in patients with mechanical problems who are unfit for surgery. [1]

[1] The ***processus vaginalis*** is the peritoneal tunnel through which the testes migrate from the retroperitoneum toward the scrotum during embryological development.

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6. Advice and Guidance

6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms 'men' and 'women' are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 Clinical Trials

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

1.3 Office of Population Censuses and Surveys (OPCS)

N11.1 Excision of hydrocele sac
N11.2 Plication of hydrocele sac
N11.3 Eversion of hydrocele sac
N11.4 Drainage of hydrocele sac
N11.5 Aspiration of hydrocele sac
N11.6 Injection sclerotherapy to hydrocele sac

N11.8 Other specified
N11.9 Unspecified
Any in primary position

1.4 International classification of diseases (ICD-10)

With any below
N43.0 Encysted hydrocele
N43.1 Infected hydrocele
N43.2 Other hydrocele
N43.3 Hydrocele, unspecified
P83.5 Congenital hydrocele

Document Control

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Version History
Version 0.2 – October 2021 The wording has been slightly amended to be in line with recommendations from the Association of Urological Surgeons.
Version 0.3 – July 2024 – re-formatted
Version 0.4 - This policy was part of a public engagement exercise, there was no feedback received.