Royal Cornwall Hospitals
NHS Trust

Hernias

Epigastric, umbilical and incisional hernias and treatment









One + all | we care

Who is this leaflet for?

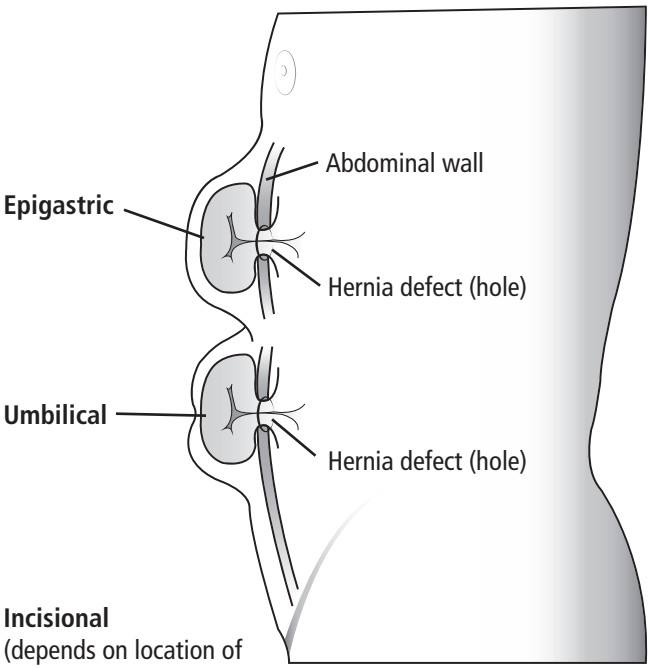
This information is for people who have an epigastric, umbilical or incisional hernia. It explains what they are, how they are diagnosed, treatment options, what surgery involves and the associated risks.

The information provided is intended for patient guidance only.

There are several acceptable treatments and your care may vary depending on the most suitable treatment for you and on your surgeon's preferences.

What is a hernia?

A hernia is a defect (hole) in the abdominal muscles through which the abdominal contents (usually fat but sometimes intestines or other abdominal structures) can protrude. These occur at natural points of weakness in the muscles of the abdominal wall.



What causes a hernia?

These types of hernias may be present at birth, or develop in later life as a result of any factor that weakens the tissues of the abdominal wall (eg inherited genetics, previous abdominal surgery, increasing age, smoking, increased pressure within the abdomen due to long term cough or sustained heavy lifting).

Usually the development of a hernia is a combination of these factors. There is no good evidence that occasional heavy lifting is a risk factor for developing a hernia.

What are the symptoms?

Remember a hernia is simply a hole in the abdominal wall – a hole through which something can protrude. The hole itself is not painful. There is sometimes, but not always, some discomfort – but it is not excruciating pain.

When you lie down the protruding bit usually drops back through the hole and there is often nothing to see or feel – unless the hernia is stuck in the hole in the muscles. If the hernia doesn't go back when you lie down this is called irreducible (or sometimes incarcerated). That is why doctors may examine you standing and coughing when checking for a hernia.

How is a hernia diagnosed?

These types of hernias are normally diagnosed by the clinical history and examination alone.

Occasionally, if the diagnosis is unclear or if pain is the predominant symptom and there is no obvious swelling, further investigations may be used. These include ultrasound scans or very occasionally, a CT or MRI scan. However, these scans have the problem that they may 'over diagnose' hernias. In such cases they report a 'possible' or 'small bulge', which is really just a bit of normal tissue. So you can't rely 100% on scans. Be guided by your surgeon.

Does my hernia need to be treated?

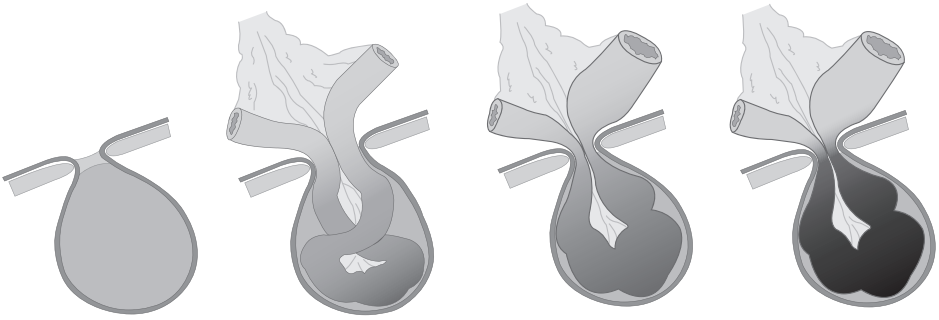
Although having a hernia is not usually a serious condition, hernias will not go away without surgical repair.

There is always the option to do nothing. This may be appropriate for longstanding hernias, which do not cause any symptoms and in patients with lots of other medical conditions. However, the majority of hernias will gradually become bigger and more uncomfortable with time, no matter how careful you are.

There is a small chance that a hernia may lead to an obstruction or strangulation of the bowel.

- **Obstruction** – occurs if the intestine (bowel) has become stuck in the hole in the abdominal wall and, like a kink in a hosepipe, the contents can no longer pass through the intestine.
- **Strangulation** – occurs if the intestine (bowel) becomes stuck and the blood supply to the portion of the intestine in the hernia gets cut off. This can lead to severe pain and some damage to part of the intestine. The pain is often felt in the abdomen, and the swelling in the groin will become very tender to the touch.

A strangulated hernia is rare and has to be dealt with urgently with emergency surgery. However it is always preferable to have a hernia fixed with planned (elective) surgery.



A loop of intestine becoming trapped and strangulated

What does surgery involve?

There are two main ways that a hernia can be fixed.

'Open' surgery – this can be carried out under local or general anaesthetic. Your surgeon will discuss this with you. It's called 'open' because a small incision is made in the skin (usually 2.5-3 inches) at the hernia site. The open approach can be carried out using either general or local anaesthetic, and this will depend on both your current health condition and preference after discussion with your surgeon.

During the operation the hernia is identified and the hole is either stitched closed or a mesh placed over the hole and fixed using fine stitches (this will depend on the size of the hole).

There has been a lot of media coverage more recently regarding the use of mesh but this was in connection with a different type of operation and not associated with inguinal repairs. Your consultant will be happy to discuss this with you if you have any concerns.

The mesh acts like a scaffold and your own tissue will grow through the mesh to reinforce the weakened area without putting tension on the surrounding tissues.

Sometimes a rubber or plastic tube (drain) may be placed in the skin for 1-2 days, which will be removed by the nurses on the ward before discharge.

'Keyhole' or 'laparoscopic' surgery – your operation will be carried out under general anaesthetic. 2-3 small cuts (1-2cm long) are made around the hernia site. Carbon dioxide gas is used to inflate your abdomen and a small telescopic camera is then inserted to view the hernia from within the abdomen. This means that the surgeon is looking at the hole from the inside of your abdomen. A mesh is then place over the hole. It is a bit like repairing a puncture in a tyre with a patch from the inside.

All of the operations usually take between 30 minutes and 90 minutes operating time. Your consultant will discuss with you which type of surgery you will need.

When will I go home?

You will usually be able to go home the same day as your operation.

If you have other medical conditions, or do not have anyone at home with you, you may need to stay in hospital overnight. Sometimes it may be difficult to pass urine immediately after the operation and that is another reason to stay in hospital overnight.

What are the risks of surgery?

Problems after straightforward groin hernia repair are very rare but as with all operations there are some possible risks or complications.

Short-term problems

- Bleeding – can occur after any skin cut.
- Infection – can occur after any skin cut.
- Seroma – a collection of clear fluid that sometimes occurs after surgery at the hernia site.
- Damage to the surrounding structures – the blood supply to the testicle (on the side of the hernia repair) can be damaged (this is extremely rare in first time hernia repair). Other abdominal structures can be damaged in keyhole surgery (also very rare).
- Haematoma – this is a bruise that can occur at the hernia site.
- Deep vein thrombosis and pulmonary embolism – blood clot in the legs, which may then travel to the lungs, can be a problem after any operation. The risk after hernia repair is very, very low. If you are an 'at risk' individual, you will be given special graded compression stockings and possibly blood thinning injections to reduce the risk even further.

Medium and long-term problems

- Recurrence – the hernia comes back – about a 1 in 200 risk
- Mesh infection – this is very very rare (about 1 in 500 risk). The mesh can become infected – usually from bacteria on the patient's skin. If this does occur the mesh will usually have to be removed with another operation and the hernia may come back (recur).
- Heart rhythm disturbances/stroke.

How do I prepare for surgery?

You will need to attend a pre-operative assessment clinic or have a telephone assessment. This allows us to assess your fitness for surgery and ensures you are fully prepared for your operation. This assessment includes:

- giving a health history
- providing blood samples
- obtaining MRSA (Methicillin resistant Staph-Aureus) swabs, if necessary
- giving a medication history (please bring your medications with you)
- giving you the opportunity to answer any questions you may have.

On the day of the procedure

Your surgical team will have given you specific instructions about eating and drinking, depending on the time scheduled for your operation. It is really important that you follow these instructions or your operation may have to be postponed. Make sure that you have a friend or relative who can bring you in to hospital, take you home, and stay with you overnight.

Wear comfortable loose fitting clothing and bring a small overnight bag with dressing gown, slippers, nightwear and toiletries (just in case you need to stay overnight).

How will I feel after surgery?

During your operation, you will have local anaesthetic or will be asleep so should not feel any pain. Afterwards, you may have some mild discomfort and painkillers will be provided to keep you comfortable.

The effects of anaesthetic will usually have worn off after a couple of hours.

You will be able to eat and drink as soon as you feel able.

You will be encouraged to mobilise as soon as possible, for example to walk to the toilet. You will usually be allowed home within four hours following surgery, although this will depend on hospital policy.

What happens when I go home?

- **Pain** – over the counter medication such as paracetamol/ibuprofen should give adequate pain relief so ensure you have a supply at home. It is advised that they are taken regularly (ie four to six hourly as per the instructions) for the first 48 hours following surgery, then continued as required.
- **Bruising** – there may be some bruising at the operation site. This is entirely normal and will gradually go down. If bruising/swelling increases rapidly within hours of surgery and is associated with dizziness/light headedness inform your GP.
- **Diet** – you may eat and drink normally.
- **Mobility** – this is very important. Try to remain physically active. If you feel tired, sit down and put your feet up for short periods, but do not go to bed during the day. This will improve circulation in your legs and reduce the risk of deep vein thrombosis (DVT).
- **Hygiene** – shower rather than bath for the first 10 days. The dressing provided should be waterproof but check this with your nurse before you are discharged.
- **Wounds** – methods of wound closure vary depending on your surgeon. Sutures (stitches) are usually dissolvable and you should be able to remove any steri-strips ('butterfly stitches') yourself at seven days. Do not change the dressings unless they have become very blood stained. Wounds should appear clean, dry and healing. If your wound becomes swollen, red or very tender, bleeds or produces a discharge, contact your GP for advice.
- **Activities** – as you recover you will be able to increase your activities. You will be able to return to work within one to two weeks but if your job involves heavy lifting it may be up to six weeks before you can return to work. Discuss this with your consultant.
- **Driving** – you may drive as soon as you are able to drive safely without impairment to your reaction time or ability to think clearly. It is always a good idea to check with the DVLA and your insurance provider.

Will I need a follow-up appointment?

Most patients recover quickly and do not need to be seen again, but an out-patient appointment could be made if needed.

What should I watch out for following surgery?

You should feel better every day following surgery. However, if you feel worse than the previous day and have any of the following symptoms in the first week:

- sudden, prolonged abdominal pain not improved with medication
- cannot eat or drink and have unexplained nausea and/or vomiting
- have increased abdominal tenderness and bloating (distension)
- develop an irregular heartbeat, palpitations, a high temperature or sweats
- wound redness

Please contact:

Upper GI Nurses

Louise Goldsmith	07557499244
Paul Rosenfeld	07785744872

Colorectal Team

Nurses - Surgical Care Practitioners
Contact via hospital switchboard 01872 250000
Monday - Friday 7.30am to 5.30pm

Or your:

GP – explaining your recent keyhole surgery and your current symptoms.

OUT OF HOURS

You can contact the Emergency Surgical Ward 01872 253921 explaining that you have had keyhole surgery and the problems you are experiencing.
They will take your details and the on-call Registrar should call you back to discuss your concerns.

OR

Call the emergency GP or 111

For a life threatening emergency dial 999

Contact your relevant consultant surgeons secretary via switchboard 01872 250000.

Further information

www.nhschoices.uk

www.britishherniasociety.org

Patient Advice and Liaison Service (PALS) Royal Cornwall Hospital
01872 253545.

Please sign here when you have read and understood the information provided and bring this with you to the hospital on the day of your admission.

Signature _____

Date _____

If you would like this leaflet in large print, braille, audio version or in another language, please contact the General Office on 01872 252690

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