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OPEN MESH REPIAR FOR INGUINAL HERNIA

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

Pre-operative preparation.

It is important that we know every medical issue that might affect you. What may appear unimportant to you may be essential for us to know. In particular, we need to know all the drugs you are taking. You should bring them to the hospital in their original packet. Unless advised specifically to the contrary you should take all your drugs up to and including the morning of surgery. The exceptions to this are blood thinning agents, such as aspirin, plavix or warfarin, and diabetic drugs. These require special arrangements and must be discussed on an individual basis.

Surgical techniques.

There are numerous techniques for repairing an inguinal hernia. This advice sheet describes the open, anterior mesh repair. There are several open, anterior methods of repair, but they are all very similar and not dealt with separately here. The alternative options are a posterior approach which may be performed open (Kugel technique) or laparoscopically (key hole). Advice sheets on the other types of repair are available on request.

In the open, anterior mesh technique a small cut is made over the groin. The hernia is reduced and a mesh stitched into position.

Pain relief.

Proper pain relief is very important for both holistic and physiological reasons. Your post-operative recovery will be slower if you do not have adequate pain relief. Patients often have an understandable reluctance to take pain relieving drugs. This is a mistake and may increase post-operative complications. The principal that underlies all methods of pain relief is that the drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at that time) will work better than waiting for the pain to occur and then taking a larger dose.

After the operation you may require an injection to provide you with pain relief, but after that adequate pain relief can normally be achieved by simple oral medication. Regular Panadol, regardless of whether you have pain or not, should be used to provide background pain relief for a week after your operation. Additional, stronger pain killers and/or anti-inflammatory drugs should be taken on top of the Panadol for break through pain. Many stronger pain relieving drug contain morphine and this will tend to make the stool hard. You may need to take a laxative such as lactulose to counteract this. Drink plenty of water. Anti-inflammatory drugs can irritate the stomach and should be taken with food. Normally they can be stopped after five days.

Post-operative recovery.

Many patients can go home the same day. However, if you wish to go home the same day you must have the necessary back up. Patients going home the same day of surgery must not drive, operate machinery, make important decisions or sign legal documents for at least 24 hours after the operation conclude. These restrictions also apply to patients who have had an overnight hospital stay and still within the 24 hour post-operative period. For medico-legal reasons you must not drive for one week. Almost all others go home the next day.

Care of the wound.

Patients can go home the day of surgery or the next day. This will vary with your progress and home circumstances.

The wound is closed with stitches that are under the skin. They will be absorbed and do not need to be removed. Steristrips will be placed over the incision, and on top of that a plaster.

The plaster will tolerate a shower or a quick splash in a bath, but do not soak it. The plaster that is on the wound when you leave the hospital should be removed no later than 48 hours after the surgery and the steristrips no later than four days after the surgery. If they become dirty or start to fall off before that they can be removed. Thus by 96 hours all the original dressings should have been removed. The incision will be covered by new cells and can then be left open.

After washing the wound it should be padded rather than rubbed dry. Adding salt to the bath will not help heal the wound and may make your skin dry and tight. You should not soak the wound or swim for at least ten days. If the incision is a bit sensitive you can cover it with a new plaster, but it should be left open at night.

A major concern to patients is that they will strain the wound and that it will rupture. With today's suture materials this very unlikely. On the very few occasions that a wound does rupture it will be before you leave hospital. This would require an operation to repair the rupture. Once you have gone home a rupture is almost unheard of. If you 'over do it' the worse that will happen is that wound will be very sore.

Wounds progress through several stages of healing. You may experience:-

- unusual tingling, numbness or itching sensations.
- a slightly hard or 'lumpy' feeling as new tissues form.
- pulling around the stitches or staples as the wound heals.

This is normal. Do not pull at any scabs as they act as a natural dressing and protect the new skin underneath. They will fall off when no longer required. You should seek help if any of the following occur:-

- the wound pain increases
- the wound becomes more reddened or swollen
- there is any discharge from the wound

Sleep.

Changes in your routine, restricted movement, lack of exercise and wound discomfort will interrupt your normal sleep pattern or wake you during the night. Uninterrupted sleep is more valuable than 'cat-napping' so you may find it helpful to take a pain killer before you go to bed. You can resume sexual activity when this feels comfortable.

Work.

Your return to work depends on many factors, including your occupation, age and general health. The single most important factor that will determine your return to work is pain. If you feel comfortable doing a particular activity then it is very unlikely you will do any harm. In general it is sudden, unplanned movements that cause problems.

As a guide patients with sedentary work can return to work after three to seven days. If you have a manual occupation you will normally be able to return to work after two to three weeks. It will take six weeks to be 100% recovered.

You can resume exercise as guided by discomfort. If you use pain as a guide it is almost impossible to 'over exercise' yourself to the extent that you damage the surgical area. When you return to exercise do not do it in a competitive environment until you feel you can cope.

For medico-legal reasons you should not drive a vehicle for at least seven days.

Surgical trainees

Some patients may have part of their inguinal hernia surgery undertaken by a surgical trainee. A trainee performing a inguinal hernia is normally, but not always, under the direct supervision of the consultant. It is important that, as part of their training, trainees gain independent experience whilst consultant cover is still immediately available. There is a substantial body of surgical literature that shows the outcome of operations undertaken by properly supervised trainees is no worse than those performed by the consultant. This literature includes hernia surgery.

What can go wrong?

In surgical terms this is a minor operation. Major complications are a rare event, but adverse events are possible, as after any surgical procedure. These include drug reactions, post-operative bleeding, deep vein thrombosis, heart and lung complications and wound infections. This list is not exhaustive and if you have any concerns about the possible side effects or complications you should ask about them before you sign the consent form.

Recurrence is a well recognised problem of hernia repair. The recurrence rate after a mesh repair is less than 5%.

The ileo-inguinal and genito-femoral nerves pass through the area of surgery and are at risk to trauma. This may manifest itself in several ways:-

- The nerves are bruised. This will result in transient numbness. Some patients note an area of hypersensitivity. Normally this is below the scar and may extend into the under scrotum. Light touch (e.g. clothes) may feel unusual. This settles after one to three months.
- A nerve, or some of its branches, may be cut. This will result in a more profound numbness that may take many months to fully resolve.
- A small number (1 – 2 %) of patients develop groin pain that persists. This can be quite debilitating. Various strategies may be required to help. This includes long term use of drugs used for chronic pain, ablation of the nerve(s) and occasionally re-operation to divide the nerve. Both these latter strategies may leave an area of permanent numbness in the groin.