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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 and you should bring them to 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 exception to this are blood thinning agents, such as warfarin, and diabetic drugs. These require special arrangements. Stop any aspirin containing drugs 10 days prior to surgery.

Surgical techniques.

There are several techniques for repairing a 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 breakthrough pain. Many stronger pain relieving drugs 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 backup. 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 concludes. 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.

Bathing and showering.

It is quite safe to get your wound wet with a shower or quick bath immediately after your operation. However, long soaking baths with a Jeffrey Archer novel should be avoided for at least three weeks as the wound will become soft and the scab may become infected. Adding salt to the bath will not help heal the wound and may make your skin dry and tight. After washing, pat the wound dry with a clean towel. A bath mat helps prevent slipping and a towel hooked around the bath taps can be a helpful lever when you try to get out. It can also be reassuring to have someone else in the house the first time you have a bath, even if you do not need help.

Dressings and stitches.

You should try and keep the dressings on the wound for two or three days. If they become dirty or start to fall off they can be removed and it is not normally necessary to cover the wound. All the original dressings should be removed no later than the third day. A light dressing to protect the wound from clothes *etc* may be worn. The skin stitches will be under the skin and do not have to be removed. The wounds will be uncomfortable for four or five days, but after seven days most patients find they have minimal discomfort.

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. Most people, including those with manual occupations, return to work after two to three weeks. It will take six weeks to be 100% recovered.

Gradually increase the exercise you take. However, you should avoid strenuous exercise for two to three weeks. 'Little but often' should be your aim and a short walk two or three times a day is better than one long walk. Gradually increase the distance you walk over the next few weeks. It is almost impossible to 'over exercise' yourself to the extent that you damage the surgical area. If you feel comfortable doing a particular activity then it is very

unlikely you will do yourself any harm. In general it is sudden, unplanned movements that cause problems.

The wound.

A major concern to patients is that they will strain the wound and that it will rupture. With today's suture materials and a mesh 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.

Surgical trainees

Some patients may have part of their laparoscopic cholecystectomy undertaken by a surgical trainee. A trainee performing a laparoscopic cholecystectomy 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 to intermittent operation. Although major complications are a rare event other 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. Occasionally the mesh may slip immediately after the surgery. If this occurs the mesh has to be resited at a second operation. The recurrence rate after a mesh repair is less than 5%.