Patient Information Sheet

INCISIONAL HERNIA REPAIR

What is an incisional hernia?

An incisional hernia is an outpouching of the internal lining of the abdominal wall occurring within a weakness in a previous scar (incision). Sometimes bowel will prolapse into the hernia.

What is the treatment?

Surgery is the only definitive treatment, although occasionally a corset (an occlusive girdle covering the hernial defect) can be used temporarily to control an incisional hernias. The best type of surgical repair with the lowest rate of recurrence involves securing a 'nylon mesh' to bridge the defect.

There are two main surgical approaches:

- **open mesh repair** – via a cut overlying the hernia a mesh is inserted
- **laparoscopic mesh repair** – 'keyhole surgery' where a telescope is inserted through small incisions into the abdomen, the hernia repaired and the mesh inserted 'from within'

Which surgical treatment is best?

All mesh repairs have recurrences, but laparoscopic rates of recurrence are less at 2-3% versus about 5-10% for open mesh repairs. The major disadvantages of **open** repairs are the longer period of recovery (5-6 weeks versus 2-4 weeks laparoscopically), and higher risk of mesh infections (which normally mean the mesh will require removal). Because **laparoscopic** hernia repairs are performed with 'telescopes' through the abdomen, the main disadvantages are of damage to bowel or blood vessels in the abdomen particularly since there may be adhesions following the initial operation, and whilst these complications are rare they are more serious. Also with laparoscopic repairs because the mesh is fixed 'inside' the abdominal cavity, there is the potential for bowel to get stuck to the mesh though the longterm effects of this are unknown. Generally patients report less pain from the laparoscopic

repair, but please note that keyhole approach is not ‘magic’, there will still be some pain and discomfort post-operatively.

What happens next?

Once we have agreed which type of mesh repair would suit you best, then a date will be set for your surgery. Usually, you will be ‘pre-admitted’ in the week before surgery where blood tests and perhaps chest X-rays and a heart recording will be taken. You will be admitted a few hours before the approximate planned time of surgery having had *nothing to eat or drink for six hours before* the start time (you may take a sip of water with any medications you regularly take). After your surgery you will wake up in the recovery room, and then be transferred back to your hospital room. Later the same day you may have something to eat and drink if you wish. Most people who have an incisional hernia repair can be discharged home within a few days, and very occasionally the following day. You will be discharged home with pain killers, but it is usually a good idea to get some paracetamol and ibuprofen (as long as you can take these) in the house in preparation for your return. Additionally, it is wise to buy some Fybogel or lactulose to avoid any constipation and straining.

Sometimes immediately after the surgery you might notice a small lump in the groin rather similar to the original hernia. Don’t worry, the operation hasn’t gone wrong, this is just a fluid reaction to the mesh and surgery (a haematoma or seroma), and this will subside in a few months.

How long will I be ‘out of action’?

You can expect to have some discomfort for up to 3-6 weeks after surgery, but it will gradually subside. This takes a little longer with the open method of mesh repair, perhaps by another 2 weeks or so. With both types of surgery there will inevitably be minor twinges thereafter for many months as the tissues around the mesh reorganize themselves. You will be advised to take gentle exercise but *no heavy lifting or strenuous work for 6 weeks* by which time you will have been seen for a follow-up appointment in the outpatients department and will be advised at that time. You will probably be off work for 5-6 weeks with open surgery, and 3-4 weeks with the laparoscopic method. You may drive a car when you are able to perform an emergency stop and turn around fully when seated to look behind you, but for most people this will be 10 days to 3 weeks, and not before one week.