UMBILICAL AND EPIGASTRIC HERNIA

Information for patients

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The European Hernia Society is a medical association uniting professionals, industry and patients interested in the repair of abdominal wall defects (called hernias) and other problems related to the abdominal wall.

Our primary aim is to improve patient care in relation to the diagnosis and treatment of abdominal wall disease. We do this by promoting educaton, facilitating the provision of the most uptodate evidence and information on the latest research, technologies, materials and techniques available.

The EHS writes clinical guidelines for all healthcare professionals involved in hernia surgery, which are also a source of valuable information for patients.

Since our creation in 1979, we serve to improve your safety and quality of care before, during and after hernia operations and surgery to the abdominal wall.

We encourage membership of the European Hernia Society to all surgeons, doctors, scientists and indeed patients who are interested in hernia disease. The modest membership fee goes a long way to help us achieve our aims.

www.europeanherniasociety.eu

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EUROPEAN HERNIA SOCIETY

Contents

1. Who is this booklet for?

This booklet is for you if you suffer from an umbilical or epigastric hernia or if you have a friend / family member who does and you are involved in their decision making or care.

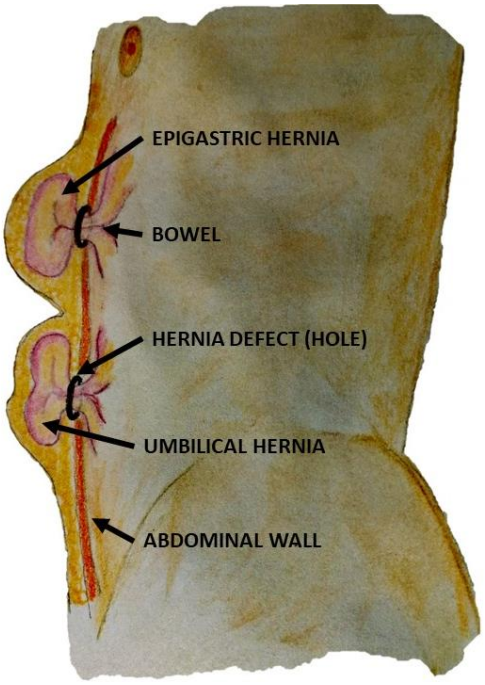
It is important to state that your treatment should be a joint decision between you and your surgeon.

This booklet summarises the most current recommendations on the management of an umbilical or epigastric hernia produced by the European Hernia Society. It is based on evidence sourced from the medical scientific literature.

Many questions about the management of umbilical or epigastric hernias remain unanswered as there is not enough information to make a true evidence-based recommendation. However, expert opinion is also able to help you make the right choice for you or a loved one.

2. What is an umbilical and epigastric hernia?

An abdominal wall hernia is defined as a protrusion of the contents of the abdomen through a defect in its wall. In other words, part of your insides sticks out through a hole in your tummy muscles.



Primary ventral hernias are commonest in the midline of the abdomen. These are called umbilical or epigastric hernias depending on their location. An umbilical hernia is a hernia in the umbilicus (tummy button). An epigastric hernia is any other hernia in the middle of your tummy. There are a group of much rarer lateral hernias, called Spigelian and lumbar hernias. These occur on the side of the

abdomen. They are not discussed in this booklet.

If you have a hernia in your groin (an inguinal or femoral hernia) or a hernia under a scar from previous surgery (an incisional hernia), this is not the correct information booklet for you.

Umbilical hernias are very common and it is estimated that 25% of the population has or has had one repaired.

Most have a hole (defect) in the abdominal wall that is small (between 1-2cm) and the hernia contains fat only. However, the hernia sac can also contain intestines and other organs from your abdominal cavity.

3. How do I know if I suffer from an umbilical or epigastric hernia?

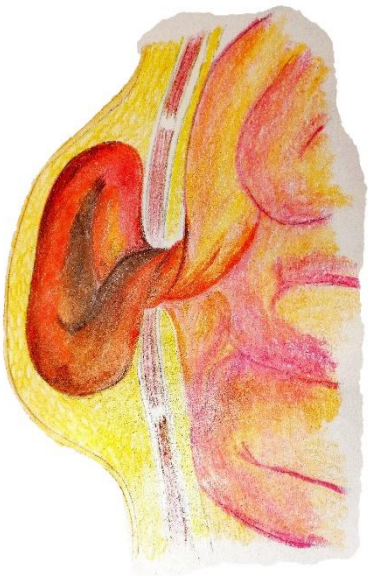
Most people who have an umbilical or an epigastric hernia have little or no symptoms caused by the hernia. However, a swelling or lump around the umbilicus (tummy button), or above your umbilicus is usual when you have one of these hernias. It is often more obvious to feel or indeed see the hernia, when you are standing up, and the hernia may get smaller again or disappear when you lie down. Most of these hernias can be diagnosed by simple physical examination by your surgeon.

Discomfort in the area of the hernia may develop/increase if the hernia gets bigger. This can take months to years. During this time, you do not need to restrict your activities in any way, unless your hernia causes you symptoms that are too uncomfortable when you are doing certain activities.

4. Do need any tests to confirm my diagnosis?

Most umbilical and epigastric hernias are easy to diagnose by your surgeon. Occasionally, when there is diagnostic uncertainty, an ultrasound scan or a CT scan may be required. This is more likely in people who are overweight. In large hernias, a CT scan may be necessary to help plan your surgery.

5. Is having an umbilical or epigastric hernia dangerous?



This depends on a number of factors but in most cases, umbilical and epigastric hernias are not dangerous. If your hernia doesn't cause you any problems or is not causing you discomfort or pain, you do not need to rush to the doctor. For painful and larger hernias it is wise to seek medical advice.

If your hernia suddenly becomes painful or cannot be reduced (does not disappear when you lie down and press gently on the hernia) or if you develop nausea and/or vomiting, or if the skin overlying the hernia becomes red and tender to touch, there is a risk that the hernia is 'incarcerated' or 'strangulated'. This is a medical emergency and you need to seek immediate surgical care. An incarcerated hernia is one with the hernia contents being "stuck" in the hernia. And strangulated means that the hernia contents lack sufficient blood supply and this is considered a medical emergency that requires immediate attention.

6. Is an operation the only way to fix my hernia?

Yes, an operation is the only way to fix your hernia. However, this does NOT mean that you have to have an operation. If your hernia is small and gives you none or very few symptoms; and you are doing all the things you want to do (including heavy lifting, work and sport), then you may decide not to have an operation. This is sometimes called 'watchful waiting'.

NOT performing an operation is safe in most cases but you should discuss with your surgeon, your individual risks of not having an operation. There is a risk that your hernia will increase in size over time and start to become more painful. An operation might become a better plan as the months/years pass, but again, you should discuss this with your doctor.

Any decision between an operation and 'watchful waiting' for your hernia should be a decision following discussion between you and your surgeon. If the decision is to undertake an operation, then there are a number of things to think about, which are discussed further below.

7. What should I do before the operation?

There are several things that you can do before your operation. In general, you should keep fit and increase your daily exercise activity. Eat sensibly, with a varied diet, and keep alcohol consumption to within safe drinking levels.

If you have any medical conditions, in particular diabetes, or high blood pressure, then these should be checked by your general physician and treatment optimised, to reduce your risks of complications around the time of surgery.

Smoking and obesity are huge risk factors for complications after an operation such as wound infection and hernia recurrence (hernia coming back). If you are a smoker it is important to stop smoking at least 6 weeks prior to your surgery. If you are overweight, you should really try to lose weight. The amount of

weight loss and the time frame to achieve this should be agreed with you in discussion with your surgeon. Remember, stopping smoking and losing weight is to make your surgery SAFER for YOU.

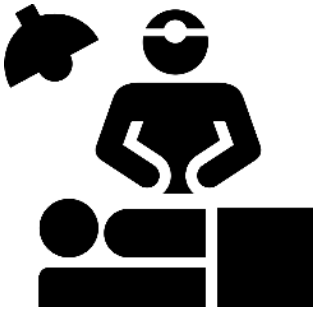
8. Patients with special considerations

An individual plan for your care may have to be organised if you suffer from a medical condition that could interfere with your operation. Heart and lung conditions may need to be reviewed before surgery. If you are taking anti-coagulant medication - drugs to 'thin the blood' (common drugs such as aspirin, clopidogrel, warfarin, apixaban), it is important to tell your surgeon. Some of these drugs need to be stopped or replaced days before your surgery. If you suffer from liver disease or kidney disease, you may need help from your liver or kidney specialist to correct some of the consequences of your liver of kidneys not working properly.

Umbilical or epigastric hernias, can occur in pregnant women. Nearly always, surgery can be safely delayed (for both the mum and the baby) until after the baby is born. An exception to this is if there are signs of strangulation in the hernia as mentioned above. In which case emergency surgery is required, although this is very rare.

Women with a primary ventral hernia who are planning to have further children, it is generally good advice to delay any formal repair of the hernia until their family is complete. This is because subsequent pregnancies increase the risk of the hernia coming back. If for any reason hernia repair cannot be postponed due to the presence of significant symptoms, a suture repair is usually preferred with a more definitive repair after the last pregnancy if needed.

9. What to expect during surgery?



This will depend on your local health care system. Small umbilical or epigastric hernias are often managed in a day case surgery setting. Larger hernia repairs will likely require an overnight stay or several days depending on the size of your hernia, the method of repair, your fitness and post-operative pain level.

It is possible that you will be given one dose of antibiotic before the operation. If you know about any drug allergies you should inform your surgeon.

If your hernia is more than 1cm in diameter you will likely be offered a repair using surgical mesh. The chance of an umbilical or epigastric hernia coming back after surgical repair depends on several factors. A simple suture repair, even in small hernias, has a higher risk of recurring or coming back. When a surgical mesh technique is used, the chance of the hernia coming back drops significantly. However, there are some risks associated with the use of mesh.

Under certain circumstances when your hernia defect is a bit bigger (but not massive), if you are overweight, or if you have an increased risk of wound complications – a “keyhole” technique to repair the hernia from the inside of your abdominal wall using a mesh may be offered. It does reduce the risk of wound complications, but there is a slightly higher chance of injury to your bowels during the surgery.

Bleeding, wound infection and fluid collecting under the skin, called a seroma are common complications, but nearly always get better without any treatment. More serious complications, such as a clot in your leg (deep vein thrombosis), pulmonary embolus or bowel injury are rare.

There are different surgical options to recommend depending on the size of hernia ‘hole’, the condition of your skin around the hernia and the size of the bulge of the hernia. One can use a “simple” suture repair or a reinforcement with a mesh using different techniques. Your surgeon will discuss these options with you and help you making the best choice for you after discussing the pros and cons of different options. Remember, every operation leads to a scar regardless of the technique used.

You may ask your surgeon if she/he is familiar with the EHS and AHS guidelines on umbilical and epigastric hernias (Primary Ventral Hernias). If they are, this will reassure you that your surgeon is aware of evidence base for the treatment strategy of your hernia.

10. Is mesh always necessary to repair my hernia and is it safe?

No – a mesh is not always necessary but it does significantly reduce the chance of your hernia coming back.

Surgical meshes are usually safe in the hands of a hernia expert. The choice of which mesh type and where to position it should be discussed with your surgeon before surgery. However, mesh infection does happen, and sometimes the mesh needs to be removed. This is however very uncommon.

There is another condition of the abdominal wall that can influence the need for a mesh repair. Some patients with umbilical or epigastric hernias have an associated weakness of their abdominal wall in the midline; called divarication of the recti (diastasis recti). It is more common in middle-aged men or in women who have had children. This condition is typically seen as a bulge between your breast bone and your belly button, most clearly seen when performing a sit up. A suture repair of an umbilical or epigastric hernia is not suggested in this situation since an even higher chance of failure is likely.

If you decide, in shared decision making with your surgeon, to go for a suture repair, a slowly absorbable or non-absorbable sutures made from the same material as the mesh will be used.

Remember, when booking an appointment to see a surgeon about your hernia, do not hesitate to ask for a surgeon with hernia expertise.

11. What will be my limitations after surgery?

In general, the best advice is to undertake whatever you want to do within your level of comfort after surgery. Every patient is different and has a different pain tolerance and level of fitness. You should start going for walks from day 1. There is no minimum or maximum distance, as this will depend on many factors including your previous fitness, the terrain you will walk over and not least the weather! Walking with someone in the first few days is recommended.

You can drive as soon as you feel able to do so, but it is advisable to check your car insurance policy before you do so. As long as you are able to get in and out of the car, and to press firmly on the brake pedal without much discomfort, and your head is clear (pain killers not affecting your ability to concentrate) you are fit to drive. Avoid swimming until your skin wounds have healed. You can jog, cycle and go to the gym within your level of comfort. Use lighter weights in the gym than you would usually do to begin with. Build your way back over time adapting your training to your comfort levels. The same advice applies to all sports – work within your level of comfort.

You can return to work when your pain levels allow you to, also taking into consideration how physically demanding your job is. Typically, you should be able to undertake desk-based work with relative ease within 1-2 weeks. Heavy labour may take closer to 2-4 weeks before you are fit for this. These are guide figures to help you plan for after your surgery. Some people are able to return to work within a day or two, and your surgeon will be able to give you more detailed advice specific for you. Yes, you can have sex whenever you feel up to it.

There are no dietary limitations, but a healthy diet rich in protein and vitamins will aid healing. A diet rich in fibre and plenty of fluid will also help to prevent constipation.

In the long term, you can do whatever you want. There is no evidence that strenuous activity (in the long or indeed the short term) increases the chance of your hernia coming back.

12. Where do I find more information?

The original guidelines on primary ventral hernias are free to view using the following web addresses.

https://bjssjournals.onlinelibrary.wiley.com/doi/full/10.1002/bjs.11489
https://bjssjournals.onlinelibrary.wiley.com/doi/10.1002/bjs5.50252

Based on current EHS and AHS Guidelines

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Notes

This page is intentionally blank. Use it to write down any questions that you may have for your surgeon, and remember to take this booklet with you!