Clinical history and diagnosis in hernia cases

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Patients are usually aware of a lump on the abdominal wall under the skin. Self-diagnosis is common. The hernia is usually painless but patients may complain of an aching or heavy feeling. Sharp, intermittent pains suggest pinching of tissue at the hernia neck. Severe pain should alert the surgeon to a high risk of strangulation. One should determine whether the hernia reduces spontaneously or needs to be helped. The patient should be asked about symptoms that might suggest bowel obstruction. Once the clinician is satisfied that a swelling is indeed a hernia, it is important to know if this is a primary hernia, a recurrent hernia or an incisional hernia after previous surgery . Recurr ent and incisional hernias are more di ffi cult to treat and may require a di ff erent surgical approach. General questions about the cardiac and respiratory sys tems are necessary to assess a patient’s anaesthetic risk. Intake of anticoagulants such as warfarin and apixaban or antiplatelet medication such as aspirin or clopidogrel is important because this impacts on future surgery . Many hernia operations can be perfor med as a day case or single overnight stay , so that suitability for such treatment needs to be assessed, including home support, distance from the hospital, mobility levels, etc. (see Chapter 22).

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