Standard Operating Procedure

Hernia

1. Purpose

To provide a standardized protocol for the assessment, diagnosis, and management of patients presenting with inguinal hernia, to ensure timely elective or emergency repair and reduce complications such as strangulation.

2. Scope

Applicable to all healthcare providers (Emergency Physicians, General Surgeons, Medical Officers, and Nursing Staff) managing patients with suspected or confirmed inguinal hernia.

3. Responsibilities

- Emergency Physician/Medical Officer: Initial assessment, stabilization, and urgent surgical referral.
- Surgeon: Confirm diagnosis, decide on watchful waiting vs repair, perform elective or emergency surgery.
- MO/Nursing Staff: Assist with procedures, monitoring, pain control, and patient education.

4. Procedure

A. Initial Assessment

- **Symptoms**: Inguinoscrotal swelling (reducible or irreducible), discomfort, pain on straining/coughing. History of constipation, heavy lifting, or previous hernia.

• **Signs**: Visible/palpable swelling in groin that increases on coughing/standing; cough impulse present. Differentiate direct (medial) vs indirect (lateral) hernia.

B. Diagnosis & Investigations

• Clinical examination (standing and lying, cough test, deep ring occlusion test).

• Ultrasound or CT only if diagnostic uncertainty (e.g., occult hernia, large scrotal swelling, or differential diagnosis).

• No routine imaging in straightforward cases.

CXR (PA), USG abd and pelvis to exclude underlying pathology

C. Conservative Management

• Watchful waiting for minimally symptomatic direct hernias especially elderly patients

• Warn patient to seek immediate care if irreducible or painful.

• Trusses not recommended.

D. Surgical Management

Indications:

• Symptomatic hernia.

• Irreducible or strangulated hernia (emergency).

Elective Repair (under local, regional or general anaesthesia):

• Open flat mesh repair (Lichtenstein technique) – most common.

• Laparoscopic (TEP or TAPP)

Emergency Repair:

• Urgent reduction or exploration.

• Mesh repair acceptable if no gross contamination; bowel resection if ischaemic.

E. Postoperative Care

• Early mobilization.

• Analgesia and stool softeners.

• Monitor for haematoma, urinary retention, seroma.

F. Discharge & Follow-up

• Same-day or next-day discharge for elective cases.

- Advise avoid heavy lifting for 4–6 weeks.
- Surgical OPD follow-up in 1–2 weeks.
- Educate on signs of recurrence or chronic pain.

5. Documentation

- Admission notes (history, examination findings)
- Resuscitation record
- Operative notes (if surgery done)
- Post-op progress notes
- Discharge summary and follow-up instructions