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## UMBILICAL HERNIA REPAIR

*THIS INFORMATION REFLECTS THE PERSONAL PRACTICE OF DR KELLEE SLATER ONLY  
AND DOES NOT SUBSTITUTE FOR DISCUSSION WITH YOUR SURGEON.*

### YOUR ADMISSION DETAILS:

Your admission date is: \_\_\_\_\_

Date of your operation: \_\_\_\_\_

Fasting time from: \_\_\_\_\_

Day Surgery Patient Stay

Overnight Patient Stay

Greenslopes Private Hospital Admissions (Phone 1800 777 101) will contact you  
the day before you are due to enter the hospital to confirm the details.

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## WHAT IS AN UMBILICAL HERNIA?

The umbilicus is a scar left over from where you were attached to your mother in utero by the umbilical cord. Everybody will have a tiny defect in the deep muscle layer at this point. An umbilical hernia presents as a lump in the belly button. It is caused by a protrusion of bowel or fat through this weakening in the abdominal wall.

Hernias can occur at any age from newborns to the very elderly.

Most hernias develop slowly, but some people describe a lump appearing suddenly after heavy lifting. The lump often gets bigger after a day of standing up and usually goes away when the patient lies down. Most hernia are mildly uncomfortable.

If the hernia suddenly becomes painful, then it is possible that it has become trapped. If this occurs, you should lie down immediately, try to relax and gently press over the lump to make it go back in. If the lump goes back in, you should contact your surgeon and let them know what has happened. If it does not go back in, develops reddening of the skin or remains painful in any way, you should urgently attend the Emergency Department.

## WHY SHOULD A HERNIA BE REPAIRED?

Once you have a hernia, there is nothing you can do to make it go away. As time goes on it may become progressively larger and more uncomfortable.

Support garments do not fix the problem and can make the hernia worse.

The most serious complication of not repairing a hernia is strangulation of the bowel contained in the hernia. This may require a major operation to remove the piece of bowel.

## WHO IS MOST AT RISK TO GET AN UMBILICAL HERNIA?

Anything that increases the pressure in the tummy will increase the chance of getting a hernia. Some reasons are:

- Being overweight
- People who lift heavy weights
- Smokers and people with chronic coughs
- Women following pregnancy
- People with constipation and prostate problems, because of straining
- You may be born with an umbilical hernia
- Patients with abdominal cancer like bowel, ovary or pancreas
- Patients with cirrhosis of the liver

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## HOW IS AN UMBILICAL HERNIA REPAIRED?

An umbilical hernia is usually repaired by a small incision made beneath the belly button. Small hernias are closed with strong, permanent stitches. If the hernia is very large, a “tension free” repair is performed to cover the hole that the hernia has come through. This is similar to patching a hole in a wall. It is done by inserting a soft nylon “**mesh**” to cover the hole. This mesh acts like a frame for your body grows strong fibrous tissue into and repairs the defect. The mesh partially absorbs over time and you will not feel it.

## WHAT TYPE OF ANAESTHETIC WILL I HAVE?

Hernias may be repaired under general anaesthesia (completely asleep), regional or spinal anaesthesia (a needle in the back to numb the legs but you are awake) or local anaesthesia (injections into the belly button to numb the area, you are awake). Your anaesthetist will discuss this with you and you will decide the best option for you.

## WHAT ARE THE COMPLICATIONS OF UMBILICAL HERNIA SURGERY?

### Specific Risks:

- **Recurrence of the hernia:** occurs in approximately 1-5% of patients. No repair can ever return your belly button to full strength and the hernia may come back. You will require another hernia operation if this occurs. Hernias frequently come back because the patient has continued to lift heavy objects in the post-op period, gained a lot of weight or they are a smoker with a chronic cough.
- **Leakage of fluid from the wound:** after all umbilical hernia repairs, there is a small space left under the wound. It is common that this space fills with fluid. This clear fluid may escape in the first few days after surgery. This is usually nothing to worry about.
- **Infection:** wound infection is quite common (5%). The belly button is a dirty place. You will be given antibiotics to try and prevent this, but it still occurs. If it happens, it may require treatment with antibiotics. Uncommonly, infection of the mesh may occur. This may result in the need to remove the mesh in another operation.
- **Bleeding:** occasionally there is bleeding under the skin that requires a return to the operating theatre in the first few days after surgery. This is rare. It is very common for some bruising to occur around the wound. This will change colour and get better over the first week.

### General Risks:

- Death: approximately 1/50,000 risk for all patients having a general anaesthetic.
- Allergic reaction to the anaesthetic. 1/10,000 risk. This can be fatal
- Blood vessel problems: heart attack, stroke. This is very rare.

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- Infections: wound, pneumonia, urine, IV line related.
  - Temporary difficulty passing urine after the surgery requiring a catheter.
  - Clots in the legs that may travel to the lungs and be fatal.
  - Wound pain, abnormal (keloid) scarring or hernia of the wound.
  - Damage to the bowel underlying the hernia required further surgery.
  - Bowel obstruction due to adhesions to the mesh.

## WHAT TO EXPECT IMMEDIATELY AFTER SURGERY?

### Pain Relief

Every effort will be made to minimize the discomfort. Your surgeon and nurses will be monitoring your level of pain control frequently.

Local anaesthetic will be used in the wound and lasts for about 12 hours.

There are two major types of pain relievers after hernia surgery.

#### 1. Panadol, Panamax, Paracetamol

You will be amazed the power of regular paracetamol. It will cut down the need for the very strong pain pills.

They do not cause constipation.

Do not take more than 8 tablets a day or serious liver damage may occur.

#### 2. NSAIDs (Indocid, Brufen, Mobic)

An excellent pain reliever. They do not cause constipation.

Must be used very cautiously in the elderly and those with kidney problems because it might cause kidney failure.

They may cause stomach ulcers. If you experience any pain in the upper abdomen you must stop this medication immediately and seek advice.

It is uncommon to need anything stronger than these medications after you go home. Try and avoid codeine or narcotic containing products – like Panadeine, Panadeine Forte or Endone as they cause constipation and may put strain on your hernia repair.

### Eating

It is usual to return to a normal diet within a day of hernia surgery. There are no restrictions.

It is very common to feel slightly nauseated for 12 hours following surgery.

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## Urinating/Bowel Movements

After any surgery a patient may have trouble passing urine. This is not common and if it occurs, is temporary. Occasionally a catheter needs to be inserted to help you pass urine.

There may be some disturbance to your bowels in the week after surgery. Drink plenty of water and eat plenty of fruit and fresh food. If difficulties occur you may need to use over the counter laxatives to move things along.

## Activity

It is usual to be discharged 1 – 2 days after routine umbilical hernia surgery. It is very important to begin light activity shortly after surgery. This is to prevent pneumonia, clots in the legs and loss of general condition. You must not lift heavy weights or play strenuous sport until 6 weeks after your surgery. After this time, the wound will not get any stronger but you should return to these activities cautiously and if the wound hurts, stop doing the activity.

## **AFTER DISCHARGE**

### Your Incision

You can expect to have a waterproof dressing over your incision. There will also be a small square of gauze under the dressing to help mould the belly button. This will be checked prior to your discharge. It may be changed if it is soiled. You may remove this dressing after 5 days or earlier if it has peeled up and water has gotten underneath. You will be able to shower with this dressing. It is quite common to have a small amount of leakage from the wound or a bubble of fluid under the dressing.

The belly button may be swollen and bruised and will not take on a normal appearance for weeks. Bruising is very likely. The belly button itself is simply a scar and over the months after the surgery it will scar down and regain its characteristic shape.

You may get the wounds wet after 5 days. Gently wash dried material around your incision and let water run over it. Pat it dry with a towel. Do not rub soap or moisturizer into your incision for at least 4 weeks or until it is fully healed. After this you may rub vitamin E cream along the wound.

There will not be any stitches to remove. They will be the type of stitches that dissolve. It is very common for an end of the stitch to poke out of the wound. If it bothers you, you may snip it off with a pair of scissors. Otherwise it will fall off about 6 weeks after the operation.

Your incision may be slightly red along the cut. This is normal. It is normal to feel a ridge along the incision. This will go away. It is normal to have a small patch of numbness under the wound.

Because the belly button can be a moist place, it can be helpful to expose the wound to sunlight for 10 – 15 minutes twice a day to help dry it out.

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## **How you may feel**

It is quite common to feel tired for a few weeks after surgery. Do activities as you feel up to it but don't forget to get some rest.

## **Activity**

Do not drive until you feel you could respond in an emergency.

You may walk normally and climb stairs.

Do not lift more than 10 kg for 6 weeks after surgery. (This is about the weight of a briefcase or a bag of groceries). This also applies to lifting children.

You may start some light exercise like walking on a treadmill when you feel comfortable. Strenuous sport should be avoided for 6 weeks.

You may gently swim after 2 weeks

Heavy exercise may be started after 6 weeks - but use common sense and go slowly at first. If your wound hurts, STOP.

You may resume sexual activity when you feel ready unless your doctor has told you otherwise.

## **WHAT PREPARATIONS DO I NEED TO MAKE BEFORE MY SURGERY?**

### **Hospital**

The hospital will call you the day before your operation to confirm your admission time. It will also let you know about any hospital excess you may have to pay.

### **Fasting**

You must have nothing to eat or drink for six hours prior to surgery. (You may take sips of water up until 2 hours before the operation and you may take your medications with a sip of water). You must not chew gum or smoke on the day of the operation.

### **Medications**

- If you are on blood thinners such as aspirin, warfarin, Plavix, Iscover, Clopidogrel, Pradaxa, dabigatran, Xarelto or anti-inflammatory drugs (Brufen, Mobic, Voltaren, etc), they can cause bleeding during surgery. We will advise you about what to do with these drugs prior to surgery. You must let us know about these drugs and the decision to stop them is based on each individual patient's needs.
- Diabetic medications: we will give you advice on whether to take your diabetic medications on the morning of surgery or not. Some diabetics will be admitted the night before the operation.

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- If you are taking any alternative medications e.g. St John's Wort, fish oil or garlic, you should stop these tablets one week before surgery as they may lead to bleeding.
  - You may continue to take a multivitamin.
  - Continue to take all other medications, even on the morning of surgery with a small sip of water.

### **Other things to know**

- You must bring all relevant x-rays to the hospital with you.
- If you smoke, it is in your best interests to stop completely as soon as you can. See your GP for alternatives or call Quitline (131848) if you wish to seek advice.
- You should also abstain from drinking alcohol 24 hours prior to any surgery.
- Bring all your current medications with you to the hospital.
- Bring comfortable pyjamas, personal toiletries, small change for newspapers etc.
- Do not bring large amounts of cash or valuables.

## **WHAT WILL THIS SURGERY COST?**

I largely work as a 'no-gap' doctor. This means that the surgeon fee for your operation will be sent to your health fund and there will be no 'gap' or extra amount of money to pay. There are always exceptions and decisions regarding this are made on a case-by-case basis.

If you do not have private health insurance or if you have overseas insurance, you will be given a quotation for surgery, anaesthetic and hospital fees and must pay in full *prior* to the operation.

If your Body Mass Index is >35 (i.e. you are very overweight), the surgery is far more difficult and the risks of complications including recurrence of the hernia is higher. If it is medically suitable, we may recommend a period of weight loss in a supervised program called INTENSIV before contemplation of this operation, so it can be done more safely and provide the best outcomes. This will incur an extra out-of-pocket expense.

Outpatient consultations are not covered by the health funds and there will be a charge for these meetings. You will get a proportion of this money back from Medicare. There is no fee to be paid for normal care after the operation.

There may be other out-of-pocket fees from your anaesthetist and any other specialists who are asked to look after you. You should ask them ahead of time any out-of-pocket costs. Ask us who will be performing your anaesthetic and you can make enquiries with them about any out-of-pocket expenses.

There may be extra costs for x-ray, pharmacy and pathology. You have a right to gain 'informed financial consent'. Fees from other practitioners are beyond our control and you should ask for the costs from each person who is asked to look after you. Patients have a choice when it comes to paying for their health care and you are fully within your rights to shop around.

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## ABOUT YOUR SURGEON

### **Dr Kellee Slater** MBBS (Hons) FRACS

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|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2006 – Present | Staff Surgeon<br>Hepatopancreatic-Biliary-Liver Transplant<br>Princess Alexandra Hospital and<br>Greenslopes Private Hospital<br>Brisbane, Queensland |
| 2004 – 2006    | Hepatobiliary and Transplant Fellowship<br>Princess Alexandra Hospital<br>Brisbane, Queensland                                                        |
| 2002 – 2004    | Liver and Kidney Transplant Fellowship<br>University of Colorado Hospital<br>Denver, Colorado, United States of America                               |
| 2002           | Fellow of the Royal Australian College of Surgeons (FRACS)<br>General Surgery                                                                         |
| 1989 – 1994    | MBBS (Honours)<br>University of Queensland                                                                                                            |