Treating Hernias - Ref220

with Simon Marsh

15th March 2022

TRANSCRIPT

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Steven Bruce
Good evening, welcome to the Academy once again. Great to have you with us. Our guest tonight is Simon Marsh. Simon is a consultant surgeon, he qualified way back in 1987. And I'm not going to run through the list of accolades and positions and things that he's done in all that time. Suffice it to say now that not only is he the Surgical Director of the Gilmore's Groin and Hernia unit. He's also had one of the mechanisms for repairing Gilmore's Groin named after him. I think I'm nearly out of the number of times I'm allowed to say that topic now. But anyway, I'm not going to talk about that anymore. We're going to talk about hernias this evening. Otherwise, I'm going to get a really good kicking from my wife and I see her in a couple of days' time. Simon, it's fantastic to have you back on the show. Thanks for agreeing to join us from your very, very busy study, which you based on a visit to see somebody fairly famous some time ago in London, didn't you?

Simon Marsh
Yes, Steven. Firstly, thanks for having me back. As you know, I really enjoy doing this sort of thing. It's lovely to be back. If you want to mention Gilmore's Groin again, give me a wink and I'll say it for you. And that's probably the way to do it. And you're right this time. Last time we did it, I was sitting in the rather plush office at 108 Harley Street and now I'm at home in Suffolk with my study behind me. And you're right. It is modelled on the study of the late Patrick Moore, the astronomer who most people who remember who I actually knew for years and used to visit him in his house in the Selsey, quite a few times, even took my children to see him once. But the first time I went was when I was a 16 year old lad. And we turned up in his house, myself, my parents and my brother went to see him and he shows us into his house, into study. He does kind of, sit there, sit down, sit down, sit down, sit down. Anyway, like, we all looked around and thought, there's no way to sit, because there were just books and papers everywhere. And although we've lived in this house 30 years, the study never really has been tidy. So yes, it's based on Patrick Moore study, but at least I know where everything is.

Steven Bruce
You mentioned 108 Harley Street and we'll tell people how to contact you later. But 108 Harley Street is the name of your practice, is it not?

Simon Marsh
It is yeah, it's a bit like if you like a medical chamber, there are different groups of specialists that all work together. So yes, we've got the groin and the hernia group, we have a breast cancer group and I do do breast cancer surgery as well. We've got a bowel group, we've got a dermatology group, very popular for skin lesions and so on and we have plastic surgeons and radiologists and so on. So it's lots of doctors all working together. And the thing that I most enjoy about is that everybody gets on. So whatever you do, we all get on. There are no big egos there. Everybody knows there's lots of work to do, we all get on and we all put the patient first and make sure everybody gets on okay. So that's why I enjoy it and I've been there 23 years now. I'm still going strong.

Steven Bruce
I think I asked you this last time, but it did strike me then that breast surgery seems slightly removed from hernias. And that other thing I'm not allowed to mention.

Simon Marsh
Yes, your wink coming, Gilmore's groin. Yes. I think what happens, when you train or at least when I trained you trained as a general surgeon. So you did everything through your training. So I've done everything from brain surgery to heart surgery, lungs, bowel blood vessels, you do the whole lot when you qualify as a general surgeon so you can cope with anything that you get thrown at, particularly if you're doing emergency work. Now what happens when you get less young, you decide to pick on one or two things that you perhaps enjoy the most, or people tell you you're best at. So I've sort of settled on the breast cancer side of things and the hernias and the Gilmore's groin side of things. I'm doing it now. And it gives me two different things to do. And I think contrast is a really important part of enjoying life and not getting stale. So it's two different things that just keep me going.

Steven Bruce
We'll talk about specialisation a bit later on I suspect, having seen your slides, but yeah, interesting stuff. Apparently when we started this, and I'm hoping it's been fixed now, there was an echo on my mic. So I'm well over my five quota for saying the forbidden words this evening. If I'd been winking that number of times, I think it was 27 times apparently, I've said it. Let's turn to hernias. Do you deal with all different types of hernia? Or does it get more specialised than that?

Simon Marsh
No, you're right. There are lots and lots and lots of different sorts of hernias. And I'm going to throw a medical definition at you now, so bear with me. So we were taught in the anatomy room in Cambridge where I trained and it was drummed into us that a hernia is, get ready, the protrusion of part or whole of a viscous through the wall of the cavity that normally contains that viscous. So you can have a hernia of the lens of your eye for example, because that sits in a capsule, and there are a couple of conditions and one is Marfan-Syndrome and also a condition called phenylketonuria where the lens slips out of the capsule. So the lens herniates through the wall of something that normally contains it. You can have hernias in your brain. If you, unfortunately, suffered trauma to the brain and have a blood clot, the pressure goes up, and that will push part of your brain down through the hole, the foramen magnum into where the spinal cord is. So that's another hernia. You can get a hiatus hernia, so your stomach can go up through the hole in the diaphragm into your chest. That's another sort of hernia. And you get muscle hernias. If you damage your muscle and you damage the coating of the muscle, the muscle can pop out, and that's a muscle hernia. But the ones you're right, the ones I focus on are the good old common old garden inguinal hernias. So this is the lump in the groin. This is the rupture that most people know about. But we also deal with the ones around the belly button, the umbilical hernias, and you can get similar hernias sort of further up the tummy, away from the belly button, you call these epigastric hernias. And the other hernia you can get in the groin, the common one is the femoral hernia. So those are the sort of ones that I'm dealing with most of the time. I've got colleagues who I work with at Harley Street who deal with particularly things called incisional hernias. So if you've had a big operation on your tummy, and the muscles are weak, you can get a hernia through the scar. And I've got colleagues, Amir Darakhshan in particular, he's very good at dealing with these much more complicated incisional hernias as well. So in the group, we'll deal with all sorts. But because I'm over 21, and have been for a few years, I tend to stick to the inguinal, the femoral, the umbilical, the epigastric hernias.

Steven Bruce
Now I can remember my own osteopathic training. And of course, we're all taught, this is how you recognise hernias. And I guess that, I don't know, I'm going to put a rough statistic, nine times out of 10 is it fairly easy to recognise a hernia? Or are there cases where we are going to miss it and we ought to be looking for other more subtle signs and clues?

Simon Marsh
What we are looking for is a lump. So for example, somebody will come and see me and say, I've got a lump in the groin. When I wake up in the morning, it's not there. And as I get up and move around, it's more obvious. And if I lie down, I can push it back in, it's a bit squishy. And that's a sort of classical thing you're looking at. Now if you've got an umbilical hernia, there's a lump in the belly button. Or sometimes you feel a lump further up, this is the epigastric one, but it's nearly always a lump. Now, some people will come along with pain in the groin, that's more difficult because sometimes it could be that thing we're not going to mention, particularly if they're a sportsman, and we've done all that. But as again, as we said before, there are lots of things that can cause pain in the groin. But interestingly, if you think about how a hernia happens, and you have all the muscles in the groin, everybody's familiar with these and what has to happen, these muscles have to split or tear before the hernia can come through. So you will often find that there is a stage where people come along, oh, I got this ache in my groin. And often they describe a sort of burning sensation as well, but there's no lump. And at that stage, what I tend to say, okay, there's nothing at the moment. So I'm not going to do an operation, but a small number of people like this will develop a lump and some of them will come back six months later and go, oh, I've got a lump now, and I'll go right, now I'll fix it. But actually, we are looking for a definite lump that usually goes back. We say it's reducible, particularly with the inguinal hernias. Femoral hernias tend not to go back. And the umbilical ones are more difficult as are the epigastric ones, but we're looking for a definite lump, but there may be this period of pain or discomfort before the lump occurs.

Steven Bruce
So would it be fair to say that an older sarcopenic generation are more likely to have things poke through their muscles?

Simon Marsh
Yeah, they're more common as you get older. Obviously, if you get to 70 as a chap, you've got at least a 25% chance of getting an inguinal hernia, they're that common. And it is one of the commonest operations that general surgeons do. Pre pandemic, there were, you know, 80,000 hernia operations a year in the United Kingdom. Now it is unfortunately one of the things, along with hips, knees and gall bladders that has been put on the back burner because the NHS has been struggling dealing with the COVID pandemic. And you know, it's done a brilliant job at that. There's no doubt about it. But if you've got a hernia, and it's not causing you much trouble at the moment, you're going to find it difficult to get it done on the NHS now because they are still dealing with backlogs of other things, including all cancers. And of course, in my other hat, there's a breast cancer backlog that we're trying to catch up with. So lots of operations beforehand, fewer now and some people are looking elsewhere to have it done. And yes, you know, Harley Street is a private institution. We do private medicine, it is a choice for some people, but people are finding it more difficult to get these things done now, because the NHS is busy catching up with everything else.

Steven Bruce
Out of curiosity, and I know that somebody is going to ask this at some point anyway, if we were talking to patients who are unable to get a referral for surgery for a hernia, how much would they be looking at paying for it to have it done privately?

Simon Marsh
We work with the Weymouth hospital in Wainfleet just down the road. And if you want an inguinal hernia done, and it's usually done as a day case, it's about 3100 pounds everything. So surgeon leaves his hospital, all done, follow up as well. 3100 there or there abouts.

Steven Bruce
Right. Okay. Just going back a stage here, of course, because you said you've got this long waiting list and but you've got a lump of something poking through something, probably bowel or something like that. How would we recognise where that needs to be dealt with urgently? Because presumably, they could become fixed strangulated?

Simon Marsh
Yes, although, I'm delighted to say strangulated hernias are really uncommon. Most of the time, the lump that you can feel his fatty stuff. Now, that's almost always the case with the umbilical ones or the epigastric ones in the midline. And in the inguinal hernias, it's usually this stuff called the omentum, which is this fatty sheet that sits over the bow that's that that slides down first, you can get bowel in them. And sometimes if you do ultrasound scans, you can see bowel loops in it. But I'm very pleased to say that the strangulation everybody worries about is really, really, really rare. And there was a very good study that the NHS uses a lot to justify not operating on hernias by a chap called Fitzgibbons that many people find and you can look up easily, where they took chaps with what they called minimally symptomatic hernias. So small hernias or ones that didn't trouble them too much. And they put them in two groups. And in one group, they said, we're just going to watch and see what happens. And the other group, they said, we're going to do an operation on you. And they followed them for five years. And the most important thing is, in the group where they said, we'll just sit and watch, nothing terrible happened. So that's sort of quite reassuring. What is interesting is about 20% of the people they were watching, the hernias got bigger and they said they'll need an operation. So they swapped groups, in about 20% of the people they said we'll have an operation before it came to the operation, they said, no, I don't fancy an operation, we'll just keep an eye on it. So there's a bit of change round.

Steven Bruce
That sounds like very poor risk protocols to me.

Simon Marsh
Yeah, I'm not sure it's as rigid as it could be. But as I say, it's the information the NHS uses to justify not having to operate on hernias. So to ration it, if you like, the NHS don't like using the word rationing. But hernia repair has been rationed for a long time. The things they say is they don't do them if you're overweight, it has to increase size, month on month, but hernias don't do that, they come and go. You know, it has to affect your daily activities or stop you working before you can get it done. So all these things they are trying to do. And then the trouble with that is if you've got a minimally symptomatic hernia,

and you're 70, if you're 80, it's going to be big and you might have other things wrong with you. And you think, you know, we should have done it 10 years ago when it wasn't going to be causing any trouble. So that's my issue with that. If you have it fixed when you're relatively young and fit, it may well save you trouble in the future. And as you rightly say, almost all inguinal hernia for the men, 98% of inguinal hernias are in men, 2 percent are in women. People talk about the femoral hernias as being more common in women, which they are, but still, two thirds of all hernias in women are inguinal hernias and a third of the femoral ones. 98% of femoral hernias are in women two percent are in men. So you have all these figures that tell you which are more common, but the inguinal hernias are still far more common.

Steven Bruce
The other three being relatively obvious things being poked through, how obvious are femoral hernias?

Simon Marsh
Yeah, much less obvious, they're much lower down in the groin. And they slide down this thing called the femoral canal, which is just towards the inside of the femoral blood vessels. So if you start from the outside of the groin crease and work your way in, there's the big femoral nerve, then the femoral artery, then the femoral vein. And then there's what's called the femoral canal where the hernias come through. Now, they tend not to go back. It's a much smaller hole and it tends to be fatty stuff to start with. But I must admit, if I see these I tend to get on and fix them sooner rather than later, just just in case, but again, it's a long time since I've seen a strangulated femoral hernia, but they do happen. It tended to be in older women who put up with things and ignore things.

Steven Bruce
The reason I ask that question is because Sue had sent in an observation. Sue is one of our regular contributors on this show and Sue, thanks very much for your point here. She says her femoral hernia was mistaken by her GP for a swollen gland until she went back and asked why it was still swollen after three months. And you know, we're not here to criticise GPs or any other professionals because everyone makes mistakes. But clearly there is the potential to mistake this for something else. So how do we make sure we know what we're dealing with as musculoskeletal practitioners when we put our fingers on it?

Simon Marsh
Yeah, and you know, it can actually be quite difficult because that's exactly the area where you would get in large lymph glands. And often it's for a fatty bit, it's not going to cause that much in the way of symptoms. So the answer is, if you're not sure, you get an ultrasound scan done. Now, when I do scans, or I don't, or rather, when I have scans done, and Simon Blease, our radiologist comes in and does them for us, I'm always in there as well. So you can watch and see. Because if you just get an ultrasound report, you often don't see what's going on. But it can be quite difficult. And I hope he's had it all fixed, and it's fine. But I'm actually looking at I've been sent a chap very recently. And you think, oh, is that a lymph node? Or could that be one of the rare femoral hernias in a man and he'd had a scan by a very eminent Professor of Radiology, who described this lump next to the femoral vessels and then said it's an inguinal hernia and you think what it is, it's probably a femoral hernia, actually. But even then, just by looking at the report, bearing in mind that it was wrong. I want to have a scan then where I can see what's going on, because it could be an enlarged node, I don't think it is, I think it is a femoral hernia in a chap. But I want to be able to see it myself. So if I'm going to operate on somebody I like to get it right. So that's

something we're doing the next few days. He's coming back, and we're getting a scan done. So I can see what's going on. So I'm sorry for Sue it was delayed, but I do appreciate can be quite difficult.

Steven Bruce
Yeah. And, when we're taking into account the case history here, what should we be looking at in terms of the aetiology? I mean, I always think of hernias as being exercise, stress related if you like. So, are there other causes? Or do they just appear spontaneously?

Simon Marsh
Yeah, do you know I think most of them and bearing in mind, you know, in 25 years, I've seen a very few 1000. Most of them are just programmed in, they're going to happen, there probably isn't much you can do. I think you're right, there are a small number, where somebody is going to say, you know, I was trying to put the lawnmower in the back of the car, and I slipped and my leg went out and it hurt the next day, there was a lump. But I think most of them are probably genetic or familiar, whatever we like to say, and it's just going to happen anyway. And I'm very keen that we don't blame themselves for their hernias. Because I think they're just going to happen. We know 90% of people only get one, we know 10% will eventually get two. So I don't automatically fix a site that's normal, just in case because nine times out of 10 it's not going to be necessary. But you know, I think it probably runs in families. They are very common, that's difficult to prove. But I think it's just an inherited weakness. It's going to happen at some point and there probably isn't much you can do about it.

Steven Bruce
Well, Chris has sent in an observation about one of the truly elite here then if only 5% get two hernias. What I've got here is, my husband has a mahoosive inguinal hernia, five inches plus, waiting since last July when it was three inches for an OP. It gets very painful, he has to lie down to get it to go back, used to be an athlete he's had one on each side done previously. At what point should Chris panic and get him into A&E? Because he's 78.

Simon Marsh
Oh, gosh. So it sounds like, poor Chris, sounds like he's got a recurrent one on one side, poor chap. That's not common either. Yeah, and this is exactly, this is a problem now with getting them done with the NHS, it's difficult. I think as long as it goes back and if it's a bit painful, a bit uncomfortable, the thing to do is lie down and just gently put your hand over and squeeze it back. What you're looking for not so much about strangulated hernias, but hernias can get obstructed. If you get a loop of bowel in it, that can get caught, they get obstructed and then they don't go back and what happens is your tummy tends to swell up and you get these grippy abdominal pains and you start vomiting. So that situation obviously you would belong to A&E. I sympathise entirely because you know, if somebody came to see me with that in 108 Harley Street, I'd say right, we'll get you in in the next week or so and getting that done for you because we can. There are still you know, COVID tests to go through but those are being less and less. If I saw somebody on Monday, they're having an operation this week because they've got a hernia that's quite tender and I just want it fixed. But it's that obstruction that you're looking for. Where it doesn't go back, where it feels tender, tummy swells up, start being sick, that's the emergency that you need to get into A&E about.

Steven Bruce
Out of curiosity. It's an emergency, but how long have they got?

Simon Marsh
The thing you mentioned about the strangulation, that's where the blood supply gets cut off. Now that's much more rare, difficult to predict that. But I think if it gets to the phase where it's obstructed then strangulation is the next phase, so I would suggest you get in within a few hours if that happens, if not sooner than that.

Steven Bruce
But the obstructed hernia, is that the same thing, a few hours is the guideline?

Simon Marsh
Yeah, I think you just get in. If that's happening, it doesn't go back. If you've got a swollen tummy, you're being sick, you go straight in.

Steven Bruce
Yeah. Okay. I guess, just pursuing this with my first aid head on, is this a blue light call for the ambulance or is this, make your own way in by taxi or car?

Simon Marsh
I think you can almost certainly make your own way in because you'll probably get there quicker, to be honest. Again, sad to say, but I think you'll get there more quickly.

Steven Bruce
Yeah, okay. Dee has asked what the best treatment advice is for patients who have congenital hiatus hernias and go on to develop Barrett's esophagus later in life. Is there a high risk of developing esophageal cancer?

Simon Marsh
Well, that's a good question, that is slightly outside of my area of expertise. I used to do, the thoracic surgeon I was training, and we used to regularly do telescope tests on people with Barrett's esophagus, and take biopsies to make sure that they weren't becoming cancerous. So there is a higher risk of having it done. For hiatus hernias these days, this is not something that we do, but you can have telescopic surgery, small holes to pull the stomach back down. Through the chest you can have it fixed. And if you do that, that reduces the amount of acid that goes into the esophagus. And that's what you need to do to stop the Barrett's esophagus, and the esophageal cancer. So there is a higher risk, but you can have surgery to do it, but it's not something that we do. So apologies for that.

Steven Bruce
Okay, well, that's fair enough. You did say that you were a bit further south earlier on. Pip's going back to the NHS thing here and has asked you if you've got any idea how long before they get back to doing routine hernia operations in the way they did pre COVID perhaps?

Simon Marsh
Yeah, I suspect it's going be several years, unfortunately, I think. It's going to be an awfully long time. And as I say, it's the same with hips and knees and gall bladders, those are the four big things that are really waiting now, which is just awful for people, you know, if people have got painful hips and painful knees, and you know, painful knees, you can't exercise, you put weight on, which just makes it worse. And then it makes the operation more difficult. And it's a vicious circle for all of these things, I'm afraid. But I think sadly, it's going to be several years.

Steven Bruce
Dare I suggest, this is slightly a devil's advocate position that if people are still able to go and get those things done privately, if those private surgeons worked in the NHS, we'd get them done more quickly.

Simon Marsh
Yeah, okay. This is where I can be a little bit time virtuous because I work half the week in the NHS, and then entirely separately, I work half week privately.

Steven Bruce
This wasn't directed at you at all.

Simon Marsh
I'm just justifying what I do. And I did that choice deliberately. So that nobody could level that at me, I keep it entirely separate. And I'm part time and part time. In the NHS consultants work, you know, there are certain number of sessions and that's all supposed to be timetabled in. And then they can do their private work in separate sessions. So it's not, it shouldn't be within NHS time. And it should be separate, the difficulty is, you're right, if you're outside London, then you're still using NHS resources to do it if you like because the scans are all done by radiologists who also work with the NHS. So I would say that private practice in London is very different because it is separate. And I think that's important. And that was important for me to make sure it was separate and two different things. So I work half week in the NHS, the NHS is brilliant. You know, when I had a serious accident 10 years ago, they were fabulous. When my youngest daughter who's a head of science in the local high school, when she fell off the horse and ruptured her kidney a few weeks ago, they were fabulous. And she's recovering and she'll be fine. But brilliant. So the NHS does a brilliant job. But there are choices for some people.

Steven Bruce
Dare I also point out to the audience that your daughter's ruptured kidney was from falling off a horse, your own injury, I think was getting kicked by a horse. So, there is a lesson to be drawn from this.

Simon Marsh
There's a theme, isn't it somewhere? Yeah. My wife has had broken fingers. And yeah, and she had a contused lung years ago as well. I broke my collarbone falling off a horse. Yeah, I'm not sure why we still got those, Steven. I don't ride anymore. And I try not to go around the back end. That's all I'd say now.

Steven Bruce
Well, somebody should explain this to my wife, Claire, I think. I've got one question from Simon. Simon, I've got your question here. And you said it's probably a bit too early. I'll save it for later because I suspect that Simon will cover it. But Miory has asked what exercises would be contraindicated if you have a hernia? And I guess that's before you've had surgery and after surgery in your rehab.

Simon Marsh
Yeah, I think in terms of what you do with a hernia while you're waiting for it to be fixed, and again, I try and keep things simple, and the answer is don't do things that irritate it or make it hurt. Now what is useful, if you have a hernia fixed or dare I said the other condition we talked about last time. One of the things that helped is having good core stability. So if your core muscles are good, you get a better hernia repair and you will actually recover quicker. But there are specific exercises we give people to do after the operation. So typically, I would spend Thursday afternoon fixing hernias, most people go home the same day, if it's late in the day, they go home on Friday. And what I say is for the weekend, it's just walking around, little and often to loosen everything up so it doesn't get stiff. Because what I don't want people doing is spending a weekend in bed because everything will just stiffen up and it'll take much longer to get better. And on a Monday, we get them to start doing some stretching exercises, they get the exercise sheet beforehand. And also Janine, who's the physio in the hospital will see every patient before they have the operation go through everything so they know what to do. So the exercises will help strengthen the muscle because as we talked about, for a hernia to come through the muscles have to tear or rip. So yes, we repair them, but they will be weaker, so they need strengthening. And also, it probably reduces the chance of the 10% getting one on the other side. So I think the exercises are really important. But before it's done, just don't do things that irritate it. It's that simple.

Steven Bruce
In the old days, people used to regularly, I think, doctors used to prescribe trusses to support hernias, is any of that done these days to stop them from popping out?

Simon Marsh
Yeah, people do still wear trusses. And I think the only real situation it is useful is if you have got a hernia and you generally are unfit for an anesthetic of any sort, then a truss might help. Now there are two sorts of inguinal hernias you get. And they're called direct ones. And these ones come straight out through, if you like the posterior wall, inguinal canal and the indirect ones, the ones that slide down the cord and end up in the testicle. I can usually tell about two thirds of the time which one is before I operate, so it's not perfect, but trusses work better with the direct ones that poke straight through, because you can push it back and you can put the truss on. Now although most of the time I will do hernias under general anesthetic and the reasons for that are general anesthetics are really safe. And more importantly, when you have a general anesthetic, the muscles are relaxed, so you can move them around and get a much better repair. If you're doing it anatomically in suturing you get a much better, safer repair. You can do it under local anesthetic, and I do occasionally but only if people are really unfit for general anesthetic and with a local anesthetic, it's not pain free, you're aware something's going on. And when you're handling the tissues, it can feel really uncomfortable. So I don't do it by choice but I do do it because even with a general anesthetic, you know the operation takes me 36 minutes, believe it or not, and I know this because a few years ago, for three months I measured the time for every hernia I did and it was almost

always, and I was staggered, 36 minutes, whether it was a big hernia or a small hernia or a big chap or a small chap, almost always 36 minutes. So it's not a long operation in my hands. You get over the anesthetic very quickly and general anesthetics are safe and it's just more comfortable. So by choice, day case general anesthetic, local anesthetic, if you're really unfit and the hernia is troublesome and things like trusses don't work. Don't like trusses if you're going to have an operation because what it does, it causes scarring in the groin around the hernia and it can make it more difficult to fix it because the tissue planes, so the anatomical planes we look for when we fix a hernia are ruined. You get a lot of scar tissue which can make it more difficult to fix.

Steven Bruce
Why is that? Why the increase in scar tissue?

Simon Marsh
Yeah, it's just the pressure the truss puts on it. And the hernia can come and go and come and go and you keep putting the truss on it just gets irritated and scars.

Steven Bruce
Right. Okay. Thank you for that. I've had a question from, we haven't got on to what you do to fix or treat hernias, but Gleeful Creature., I'm not going to go into this but one of our systems gives I think random names to people, or they give themselves random names and this one's called Gleeful Creature. Gleeful Creature is a lovely name. I don't know whether you're male or female, so I shall refer to you by a random pronoun. Gleeful Creature asks, is there any difference in approach to fixing hernias in Ehlers Danlos patients?

Simon Marsh
Ehlers Danlos patients have, and I'm sure the audience knows connective tissue disorders, so their connective tissue is a bit stretchy. I would prefer not to use meshes on these patients; I think their connective tissues are more sensitive. And I suspect there might be a higher incidence of problems with meshes. I prefer to use a suture technique and we'll probably talk about in more detail the different ways of fixing it. And I would usually warn, there's probably a higher chance of recurrence just because the way everything's a bit stretchy. So I would stick with sutures only. But again, when we go through the information of the complications and risks, I would say there is probably a slightly higher chance of recurrent. Difficult to prove that of course because the vast majority of people don't have Ehlers Danlos or other connective tissue disorders. So it's hard to statistically prove that. But I think that's a sensible thing to warn people about.

Steven Bruce
I got to take you back one to trusses, again I'm afraid I must have been showing my age here because I had a question which doesn't have a name behind it. But they said, What's a truss? Sorry if that sounds stupid. And of course, it isn't stupid.

Simon Marsh
Yeah, it's a sort of belt that you wear. And it's got a pressure pad on it, it's got sort of an enlarged bit with, how to describe it. It's not so much a pyramid, but it is rounded. But you put that over where the hernia

comes through. So it pushes through, and it stops the hernia coming through where it would normally come through the muscles. They're a bit unwieldy. You're right, very popular in the old days. But I'd say the only real use now is for somebody who's got a hernia that's troublesome, who just isn't ever going to have an operation.

Steven Bruce
I'm going to save some of these questions, because perhaps we ought to do some of the basics. So to start with, I'm guessing that the approach to treating hernias has changed over your time in surgery, in practice.

Simon Marsh
Yeah it has. And one of the things that interests me in medicine and surgery is how we get to where we are. So you're right. I think it's worth having a think about the evolution of hernia repairs and how it all started. And I did put a few things on a slide, on slide number one and we can show but even in ancient Egyptian times and Roman times, people write about hernias and these lumps, but obviously, it's very difficult to do much about it, unless you've got a general anesthetic. So really, until we had good general anesthesia, there wasn't much you could do. And that came along in the sort of middle of the 19th century, 1840s. And then the chap on the left, Eduardo Bassini, the Italian surgeon, he was probably the father of modern hernia surgery, because with general anesthetics and also antisepsis because he was the Italian equivalent of Joseph Lister. Joseph lived in this country, developed antisepsis and made surgery safer. And Bassini did the same in Italy and also did a series of around 300 hernias in the late 1800s. And he was very thorough. And what he did was he studied the anatomy of the groin. He looked at the muscles and the structure and the function, he realised how the hernias came through. And in men, there is this spermatic cord that comes through the tummy and it comes through the inner layer of muscle where it's called the deep inguinal ring. It runs along the inguinal canal and then comes out through the superficial inguinal ring, then goes down into the testicle. In women there's a similar, much smaller thing called the round ligament of the uterus, so the anatomy is similar. But in men, these rings are bigger. And that's why in men, hernias are common. So he looked at the anatomy, he looked at the function, he realised where the hernias came. And he learned about this thing called the hernia sack. And he realised that if you cut the sack off and sewed it up and pushed it back and repaired the muscles, you could fix the hernia. And of his 300 or so cases, he had a 3% recurrence rate, which is better, believe it or not, the Royal College of Surgeons tells us we get now which is 5%. I would say and perhaps we'll come on to this. I'll be mortified if I had a 5% recurrence rate, my recurrence rate is probably about one in 400. But apparently, it's 5%. So Eduardo Bassini, you know, 200 years ago was better than that. He had seven wound infections in 300, which again, is pretty good, we would say probably fewer than 1% now. He was so thorough, he also kept a note of any people who died and he had five deaths in his series, none of them due to his surgery. There was a TB, there was pneumonia, and so on. But he followed these people up for so long, he even reported the deaths. So that's probably how it all started. And that went on through the 19th century. In the middle of 19th, I miss out lots of people, obviously, I'm just picking on a few key things. And around the time of Second World War, the Shouldice clinic started in Canada in Toronto, Edward Earle Shouldice set it up as a business to fix hernias, described as helping men join the draft, because if they had a hernia, they couldn't be called up. And if you fix their hernia, they could. And he was helping these young men join the forces. I'm sure they were delighted. And it ran as almost as a hernia factory. This is all they would do. They would do hernias day in day out, and they would do the

same sort of thing Bassini did, they would do this anatomical sutured repair, take the hernia sack off, push the stuff back, fix the muscles. That's what they'd do. And this is how people like me, who are over 21, learned to fix hernias. In the 80s, in the early 90s, when I was training, this is what you did. You learned about the anatomy, the structure and function of the groin and you learn how to put it back together again. Now, in the mid 90s, this is when the meshes turned up. And a guy called Liechtenstein who worked in Los Angeles, California, thought about it and he said, I can't be bothered learning the anatomy of the groin, I'm just going to stick a big plastic patch over it to strengthen it on top of the hernia so the hernia can't come through. And this is where the Liechtenstein repair came in. And I already learned to do Shouldice repairs in the mid 90s. Suddenly we're all putting these mesh patches on, and it was sold as an easier surgical technique for a relatively inexperienced surgeon. Now in the mid 90s, the NHS what you have to remember is most hernia repairs were done by surgical registrars, junior surgeons. Consultants didn't do hernias, they gave them all the registrars and this was sold as an easier technique for an inexperienced surgeon to do. It was also said it would have a lower recurrence rate and lower complication rate. Neither of those is true. So it didn't live up to its billing. But what it did mean if you didn't have to understand the anatomy of the groin. And from the 1990s onwards, that's how most hernias have been done. In the late 90s, the laparoscopic surgeons got hold of it. And by using telescopes inside the tummy, they could put an even bigger mesh across the whole of the inside of the tummy to stop hernias coming through. And then what happened is, I mean, a few years ago, people be aware that we started to get concerns about, do meshes cause chronic pain. And this became, because it started with the operation that gynecologists did for women with prolapses and so on. But it's run on to, do these cause pain in men who've had hernia repairs. Now what I would say is you remember we said, you know, 70 80,000 hernias done a year. And in the vast majority of cases, whichever way you have it done, people are fine. But I do think there probably are a minority of people who do get trouble with the mesh, whether they get a reaction, whether they get chronic pain and so on, I think there are a small number that do. So the question comes if you can avoid that, by not using a mesh, surely that's the right thing to do. So I now get more than a few people who will come to see me in London that say I'd like a hernia repair and I want it done without a mesh. And I can't find anybody else to do it. And you know, nor can I, actually. So yeah, I'll do it without a mesh. Again, I will warn that possibly, there's a slightly higher risk of recurrence. Now my standard technique over the last 25 years was to use not a mesh patch on the front of the muscles. Put a little mesh plug through the hole where the hernia goes through, put it at the back. So it sits behind the muscles and then actually repair the muscles over the front. So if you like I was doing a double repair. But any technique of repairing a hernia is a compromise between making sure it doesn't come back as best you can and cut the complication rate. And that's my standard technique for 20 plus years and probably still I would do that. And I don't find with the plug, I don't find the chronic pain an issue as it might be with the mesh patch on the front or the great big mesh laparoscopically on the inside. And you put the plug in and you fix the Shouldice repair of the top so you get a double repair. And I think that's probably one of the reasons why my recurrence rate is particularly low. But again, I'm quite happy to do it the way I learned to do it, standard Shouldice repair without mesh. Again, I can't prove the current rates might be slightly higher. Because I haven't had many, but it's something you always warn people about, it goes on the information sheet we give out. So if you like it's almost gone full circle from being the pure anatomical repair from Eduardo Bassini in the 1860s and 70s. Through the Shouldice, through the mesh and back if you like to the anatomical functional repair, bearing in mind, again, most people whichever way you have it done, they're fine. And perhaps the surgeon's important as well. And we can perhaps talk about that

too, because you need to go and see somebody who's done a few 1000, whichever way you have it done, that's probably one of the most important things.

Steven Bruce
All of which of course, raises the obvious problem that not every surgeon can have done a few 1000 of these, they've got to do their first one sometime.

Simon Marsh
Yes. And although I hate to say it, I had probably done a dozen as a very junior surgeon before I realised exactly what goes on. I didn't have any problems, but it takes a long time to learn the anatomy of the groin, it's a really complicated part of the body. And what you find is, because the current generation of surgeons have all learned mesh repairs, you do worry the expertise of doing the anatomical repair as being lost. And that does bother me and that's why I'm still keen to do it. And again, that's where the link comes in with that condition that we're not going to mention, cough, Gilmore's groin, cough, because to fix Gilmore groin needs a thorough understanding of the function and anatomy of the groin to put the muscles back so they work properly. And you can transfer that through learning the Shouldice technique to doing non mesh sutured only hernia repair. So that's the link between those two if you like.

Steven Bruce
I suspect that a lot of people watching will be slightly horrified that you are one of the only surgeons who can do a non-mesh repair. Because I suspect on the basis of what you told us now, people will be saying to patients, well, if you can get a non-mesh repair, then get one. But of course, you're saying they can't, unless they live somewhere near Harley Street.

Simon Marsh
Yeah, I'm not aware of anybody else. And I've even had surgeons contact me and say, can I come and watch you do the non-mesh repair, because I don't know how to do it. These are established consultants. There probably are some out there, I know I don't look it, I'm 60. This year, obviously, I don't look at at all. And I've got many years to go because my wife won't let me retire. She said, If I retired, be at home, and you'd have to talk to me. So I should be going on for years yet.

Steven Bruce
If you retire, you won't be able to afford the horses.

Simon Marsh
Well, there is that or the donkeys or the pigs. But one of the things we do, one thing I'm very keen on in Harley street is we produce a new generation of surgeons. So the late Jerry Gilmore, took me on board and brought me along, I've got a current surgeon that we're hoping to bring along, a young lady surgeon who worked with us, very good, understands the groin. And she's now the same age I was when Joe took me on board. So we'd like to produce this next generation to keep this specialty going, and the expertise going. But it's a bit like, you know, the Stradivarius violin, nobody can make one of these anymore because they don't know how to, the expertise is lost. And the other example I use is that is the blue stained glass in Chartres Cathedral in France, nobody can reproduce that colour anymore because

the expertise has been lost. And I do worry that we've been misled that doing things the easy way is better, because it's just not.

Steven Bruce
Yeah. And I find that quite disturbing myself that someone has marketed very well I imagine the mesh repair. But more disturbing is that if the statistics are as you say, that they are more prone to recurrence or more prone to complications, than the Shouldice repair, then we shouldn't be doing them. And yet we still are and presumably the NHS is promoting it. Why? Is it easier in medical training to do this as well? It saves time?

Simon Marsh
Yeah, I think it's just felt to be easier. Is it quicker? I don't necessarily think so. You know, it takes me 36 minutes to do a proper structured sutured repair. So I don't think it's particularly any quicker. I think you're right. And I do sometimes wonder whether we are the victims of marketing in all this, particularly with the laparoscopic stuff which these medical technology companies produce. These really clever instruments. They're very clever and very good. But it's a $30 billion industry, laparoscopic surgery. And you just wonder, and I'm just, like you playing devil's advocate a bit, but you just wonder whether we are being the victims of marketing here. And we should perhaps just take a step back and just reassess everything.

Steven Bruce
But of course, nobody wants a scar on their abdomen. Right. It's mainly men that get inguinal hernias. But I imagine the 5%, 2% of women who get them don't want scars on their abdomen. So therefore, it's better if you can do it laparoscopically, isn't it? Can you do your combined repair that way?

Simon Marsh
You can put the plug in laparoscopically, you can do it that way. You can't repair the muscles on the front, you've got to come from the front. Now you actually raise a really interesting point here and again, something that people almost take for granted when they shouldn't, is that laparoscopic surgery, it has this epitope, minimally invasive because you're right, the scars are very small and you can do with a little scar on the belly button on one either side and sometimes just one more. But then you got to think about what you do on the inside. And when you think about that, the area that you will dissect to put in a mesh laparoscopically is three times larger than the area I will dissect to do it from the front. And the volume you have to dissect laparoscopically is nine times larger than I will have to do by doing it from the front. So I will make, yes, a scar that is four or five centimetres, it's not very big and you put it in a crease and you can put it below the line of clothes, under clothes or even the hairline. And actually, I did have years and years ago, I had a chap who was one of these male underwear models, very fussy about not having scars anywhere. And he would not have it done laparoscopically in case anybody can see his little scars. When I did his bilateral hernias groin, he was one of the 10% with very low scars so he could wear skimpy underwear and still be photographed and have no scar showing.

Steven Bruce
You mentioned a few minutes ago, the importance of the surgeon and now to me, is there more to it than the obvious in this that, you know, if you've done a few 1000 operations, you're going to be better than someone who's just starting out.

Simon Marsh
Yeah, I mean, that's certainly true. And again, we've got on the slide a little graph that just shows you I think we call it slide number three on this one that shows you the more you do, the lower your complication rate. And to a certain extent, it's true that the more you do, you can see the low line on the right hand side is the Shouldice clinic. They say you know, they have a 1% recurrence rate. Rather than, you know, if you don't do as many it comes up as five, six or 7%. And perhaps that's where the Royal College of Surgeons figure comes from, because most people, most young surgeons will do hernias, but perhaps they don't do that many. Now there is something else to consider. And all this sort of do lots and be good at it is based on an article from a journal in Edinburgh, where they looked at aortic aneurysm releases where the blood vessel in the tummy swells and bursts. Now this is life threatening, and you have to be in hospital really quickly. And in Scotland, it takes you quite a while to get to a hospital because they're more spread out. So if you managed to survive the aortic aneurysm and got to hospital in Scotland, you were more likely to survive anyway. And what they said was, if you did more, you were better but bear in mind a couple things. One is, as I say, if you've got to the hospital in Scotland, you're more likely to survive. But also, if you look very closely at what it showed, what it showed is if you're a good surgeon, you're a good surgeon, and you can probably turn your hands to quite a few things. So yes, you have to do a few and more than a few. And I hate to say it, but yeah, you've got to be fairly good at what you do as well. So all those things help.

Steven Bruce
Okay. Are you implying there, are you saying there that somebody who's done 1000s of knee replacements will be potentially better at doing a hernia repair than someone who hasn't done 1000s of knee replacements?

Simon Marsh
Yeah we've crossed specialties there, because we moved into orthopedic surgery, but what I would say is if you've got somebody who's done hundreds of bowel resections, they can be pretty good at fixing hernias because that's all the general surgical side of things.

Steven Bruce
Yeah, we're a few years old now where most orthopedic surgeons worked on pretty much every part of the body, didn't they? Maybe not the bowel but everything seems to be much more specialised these days.

Simon Marsh
Yeah, it does. And you have the hip guys and the knee guys and the shoulder guys and the forearm guys. I mean, when I had my arm kick 10 years ago, and I ended up in the local casualty at half past seven on a Sunday evening. And the on call orthopaedic surgeon was actually the back specialist. And I heard him put my X ray up and I heard him swear and he came in and said I'm not touching this, we'll plaster it up and you can have done in the morning with one of the forearm guys. I'm not going near it because he saw what a mess I made of it. So yeah, they do specialise. And it's the same with the old-fashioned general surgeon. As we said, you know, I did everything when I trained. But now you know, you are a breast cancer surgeon or you are a bowel surgeon or you are a vascular surgeon or you're a liver surgeon and you wonder where the specialty is for coping with everything. So, again, for example,

when I started as a consultant as a general surgeon, I hadn't been there long and I was working in Colchester, which as people know as a military town. And we had a squaddy brought in and he'd been beaten up and stabbed. And this was all caught on CCTV, so he came in, and he'd been stabbed in the left groin fairly low down and was obviously bleeding fairly heavily. And when we operated on him, he got a little puncture wound in a couple of bits of bowel. He got damage to one of the major blood vessels plying the leg. He'd got a little laceration to the kidney. And he's actually got a knick on his aorta, this major blood vessel. And as a general surgeon, you did all that. And we fixed this chap. He went home, believe it or not seven days later, having had a long operation through the night and had 40 units of blood and he went home within a week. Because the general surgeon in those days, that's what you did. But now you think, well hang on, if there's a kidney injury, do we need a urologist? If there's a bowel injury, do we need colorectal surgeon, if there's a vascular injury, do we need a vascular surgeon and where do all these people come from at two o'clock in the morning when a chap being picked up and rushed in from outside the pub?

Steven Bruce
From the soldier's perspective, I suspect that his regimental Sergeant Major would say that it was just good training, and he was having a practice bleed.

Simon Marsh
Yes. And the other thing about these guys is they are so fit that if that happened to me, I probably would have died at the roadside, but these guys are fit and they compensate, so their body can shut down and compensate. So yeah, a part of him surviving was because he was a soldier. You're absolutely right.

Steven Bruce
Let me turn back to some of the questions that have been coming in if I can. So this is an interesting one. And again, you might say this is outside your area of expertise. I don't know. Eli says that he gave an articulation to a hip and a lumbar spine on a patient. Now, I don't know if you know, do you know much about what osteopaths and chiropractors do?

Simon Marsh
Yeah, no, no.

Steven Bruce
Okay, great. So when we say articulation, that probably means stopping short of making the joints crack. But it means lying them on their side and giving some forcible wobbles to the lumbar spine, the vertebral joints intervertebral joints. And with the hip. Well, I mean, you had to articulate a hip I'm sure. And she says that the next day this patient developed a hernia and what are the chances do you think that it was spontaneous rather than due to the treatment? Do you think there's any likelihood that that treatment could have caused that?

Simon Marsh
No, I go back to my point that I think most hernias are going to happen anyway. So I tried very hard not to blame people for hernias. What is interesting is we talked about the inguinal ones. So yeah, I'm going to say it's probably nothing to do with the treatment. That's what I say, you can never be sure, of course,

you can't. But I think most hernias just happen. But what is interesting to say, we've talked about the inguinal ones, but you can get rare hernia sort of near the hip joint, you can get sciatic notch hernias, and you can get obturator hernias. And I remember doing, again, as a young consultant doing an operation on an obturator hernia, which you have to do from inside the tummy. And they're very rare. And I even got an article written up about it by one of the juniors wrote it up. So you can get rare hernias round the hip in different areas, the principle is still the same, you have to push the hernia your back and I say for the obturator one, we did put a mesh because it's low down in the pelvis. But this was maybe 20 years ago. But no, I'm not going to blame the treatment for that. I think these things just happen.

Steven Bruce
I suspect in the patient's mind, it's easy to connect the two and rather than simply being a coincidence, it becomes cause and effect, doesn't it?

Simon Marsh
It does, and that's really difficult, because we're human beings, we like to think, well, I got this because of this. If I don't do this again, this will never happen again. But actually, most of the time, it is just one of those things and lots of things in medicine. And we can tell you what it is, what to do about it, but not why you've got it in the first place.

Steven Bruce
Yeah. Well, actually, Eli, you didn't tell us what type of hernia it was. And maybe you can't remember? I don't know. But it'd be interesting to know whether in retrospect, as we like to reflect on our cases, of course, whether you think there was any indication of a potential hernia there in the first place or any warning sign? Could there be warning signs, Simon? Is there anything that might?

Simon Marsh
Yeah, there aren't. It goes back to these chaps who come along with just a dull ache in the groin. And sometimes a bit of a burning sensation and some of those, this will be the muscles beginning to stretch or tear where the hernia will come through and be apparent a few months later. So it might well have been, you know, if this chap had some trouble with his hip joint or perhaps had a bit of an ache lower down. That could have been the beginnings of his hernia that was going to happen anyway.

Steven Bruce
Right. Okay. Now's the time for Simon's question. Simon wants to know how long a mesh repair will last?

Simon Marsh
Yeah, we hope it lasts for life. The meshes are supposed to be very inert. And once they're in that's fine. Recurrent hernias happen, as I say we've given the figure of 5%, they do happen. My own figure is probably about one in 400. I've seen five in the last 20 odd years which is about 2000 hernias. Um, so they do happen. I make no bones about that. Everybody who fixes hernias have recurrences. If you go and see somebody and they say, I'll fix your hernia, I've never had a recurrence, they probably haven't done that many. So I'd go and see somebody else. So you hope it's a lifetime thing. But nothing in medicine is ever always or never.

Steven Bruce
Can I ask you a cheeky question on that? We love to think if we don't see a patient again, that they must have got better, would all the patients whose hernias had failed, come to you and say it didn't work or would they've gone to someone else?

Simon Marsh
Yeah, that's a really good question. And I do usually address that. And I made that exact point. It may be I've had hundreds of recurrences, but I just never know. But I'd like to think and I'm pretty sure this is true, that if people did have problems, they would come back. You know, I'm a relatively nice chap. And I think they'd probably come back and tell me, and I generally don't think there are dozens of recurrents out there that I don't know about.

Steven Bruce
That's a fair point. Julian has asked whether meshes can move.

Simon Marsh
Yeah, they can. They can shift and they can roll up. And it comes down to, again, how you secure them. Now, again, originally, we would use little stitches to stitch them down. And we'd use little permanent ones that didn't move. And then particularly the laparoscopic ones, people started using metal staples, and then you start using metal staples on the front. I think that's a terrible idea to be honest. I think the metal staples can probably cause as much pain as the meshes. And then believe it or not, for laparoscopic ones even started using glue where they glue it down. And of course glue takes a little while to set. And while it's setting, bits of bowel can get stuck to this glue, which is even worse. And I've seen all of these complications in hernias, the metal stapling is a terrible idea. And they can come out and slip and move and cause pain and you get meshes that will shift, they will roll up, particularly the ones that are done from the front. The laparoscopic ones tend not to do so as much. And that sort of leads on to the point I guess if you're having trouble with a mesh, can you take it out? Now if you've had a laparoscopic mesh and a big mesh inside your tummy, that's pretty much impossible. So if you're having trouble with a mesh that's inside your tummy laparoscopically, you're in a difficult position because that's really difficult and very dangerous to take out, it wraps itself around the blood vessels and the nerves and that's almost impossible. Now you can get meshes out if they're done from the front and I do do that occasionally. It's a last resort thing. And again, it's difficult to give statistics because it's a small number, but my experience is on the small number of people I've taken the matches out of, they find that their pain gets better. I talked about Robert Ben David, who runs the Shouldice clinic and how we used to go around Europe lecturing. And they had a much bigger series at the Shouldice clinic. And what they would say was, if you take the meshes out, a third of people find they get better, a third of people get a bit better, a very small number get worse. And another small number, it makes no difference. So in two thirds of the people if you take the mesh out, you will get an improvement in the symptoms they're getting. But there are some people who make no difference. Some people they get worse. And they had quite a large series because they looked at it over a long time. They've also interestingly got data about why the meshes might cause chronic pain. As well as the fact it's a foreign body inside you. They've got evidence and studies that show that nerves will grow into this mesh and nerves will get stuck. And bits of the mesh can flake off and end up in your bladder, or the bowel or in chaps in the spermatic cord, for example. They've got lots of lovely pictures of bits of mesh just flaking off and infiltrating into other organs. So all

these things are probably the causes of chronic pain. But again, I go back to the fact that most people who have hernias fixed are fine. But I think there is a potential problem with the mesh patches either on the front or the back.

Steven Bruce
And that also begs the question, Anita has raised this question is, what is the material that's used to repair hernias, I think you say was plastic earlier on.

Simon Marsh
Yeah, it's polypropylene. So it's a sort of nylon, if you like, you can get what are called biodegradable meshes. I don't see the point of using those in the groin. Because if you can fix it without a mesh, fix it without of mesh. We mentioned the incisional hernias, through large scars in your tummy. And sometimes you can't bring those together. And this is where Amir Darakhshan, my colleague comes in. And he will sometimes use these biodegradable meshes to cover a very large defect, which acts if you like, as a sort of scaffold for the tissues to grow over. So by the time the tissues have grown over the mesh is sort of melted away, and it's no longer there. So that's a use for those, but I don't see the point of those in ordinary inguinal hernias.

Steven Bruce
Well, I've got a question about our own differentials in what we do in that, if we see a patient who's had a hernia repaired by whatever, let's say, with a mesh a year ago, and they come in reporting hip pain, low back pain, whatever, we might do, just as Eli said earlier on, we're going to start articulating their lumbar spine, articulating their hip, whatever it might be. Are there any clear indicators which might tell us this actually might be a failed repair rather than or a chronic pain from the repair rather than musculoskeletal stuff?

Simon Marsh
Yeah, that's ging to be really difficult. Because you're right, it's going to be hard to tell because as we said, when we talked about Gilmore's groin, there are lots of things that cause pain in the groin. I think if you're looking for mesh related pain, it's going to be very specifically underneath the scar where the hernia was, they're not going to get lower back pain, they're not going to get hip pain. If it's a recurrent hernia, they're probably going to tell you they can feel another lump. So that's probably going to be straightforward. So I've had one before they'll know what to look for. But mesh related pain tends to be under the scar in the groin. Above the groin increase, which is you know, is where you tend to get pain from the hip joint, if it's in the groin, crease goes down the leg and into buttock. But it's that sort of thing. But it's not easy. It's not and I don't mind admitting that these things are not straightforward sometimes.

Steven Bruce
And if it's been a laparoscopic repair, the pain presumably won't be under the scar so much, it'll be just sort of...

Simon Marsh
They tend to get this sort of generalised, really nonspecific, just gnawing pain that goes on and on. It's very, very difficult. And I'd say it's very difficult to get rid of these because the mesh just gets enclosed everything and wraps around all the blood vessels and nerves. Really difficult situation.

Steven Bruce
That might be very useful for us to know. I got some questions about specific patients here. Well, some of them. Rebecca says that she has a patient with a small umbilical hernia, the patient's 36 years old. She has diastasis recti after two children and has been advised to have the repair. She's got no pain, so she wonders how necessary it is. And what her risks are. She's actually active in swimming and running apparently.

Simon Marsh
Okay, these little umbilical hernias, which will be little bits of fat, quite safe to leave alone if they cause no problems, not at all worried about those. The diverication of the rectus muscles, we call it, where the muscles that you get the bulge down, yes, you can do something about that. That's done by the plastic surgeons. That's a big operation, you have to open up the tummy and pull the whole thing together. If you've got a small umbilical hernia, they can usually fix that at the same time, but that's a much bigger operation, but an isolated small little nubbin of fatty tissue in your belly button causes you no trouble, leave it alone. I wouldn't worry about that.

Steven Bruce
Useful advice, Rebecca. And Katie says that in her clinic they see a lot of umbilical hernias in pediatric patients. What's the procedure after two years if they haven't self-repaired? If surgery is required, is it the same procedure as in an adult patient? Is there anything you advise as a non-surgical option? Patients ask whether to use belts or coins to stop the protrusion. But she knows that the NHS guidance is not to.

Simon Marsh
Yes, I think it makes a couple of important points. One is a lot of umbilical hernias in children will heal themselves, they will slowly go away. It's the weakness where the umbilical cord was, a bit of scar tissue, you will often get a bulge in newborn babies, this will go, as she rightly says over one or two years. Now, again, remember that pediatric surgery is a distinct specialty now, I don't I'm afraid see anybody under 18 anymore, but I did do pediatric surgery as part of my training, as I said we did everything. And if it gets to two years, and it's not going away, it probably needs to be repaired. And you would never use a mesh in a child. And you would probably only need a small number of stitches to put that back. Relatively straightforward. But the important point is a lot of them do get better, but if they don't, yes, I wouldn't do anything else. It's an operation.

Steven Bruce
And you mentioned earlier on that trusses can cause problems. And I guess the idea of using belts or coins to stop the protrusion is pretty much the same as having a truss. It's not advised.

Simon Marsh
And certainly not in a child, no.

Steven Bruce
Right. Okay. 005.6. I told you they get funny names from our system sometimes. 005.6 says what diameter of an umbilical hernia would be considered a necessary surgery, privately by health insurance or a private surgeon?

Simon Marsh
Oh, gosh, do you know I'm going to say there's probably going to be not much difference. It depends on how much symptoms it caused you, you can get a lot of symptoms from a small umbilical hernia, you can, if the little fatty bit that comes through twists, and the blood supply to that is compromised. It's not dangerous, but it causes a lot of discomfort. Now I used to work with an anesthetist just many years ago. And he had a little umbilical hernia. And one Thursday we're operating and he kept clutching his tummy. And this was a bit sore. And I looked and said, alright, that probably needs doing. So what he did was the following morning, very early, he got a colleague of his come anaesthetise and I fix his hernia. And it wasn't really big one but it was causing trouble. Once they get more obvious so that there's a very obvious swelling in the belly button that suggests that the defect is going to get bigger, which tells you that over time, the hernia is going to get bigger, and you might end up with bowel coming through it. So you know if it's probably two centimetres or more to be honest, and probably less than that, because it's going to be quite obvious, people are going to want it fixed. And it's a very straightforward operation, it's more straightforward than the inguinal hernias. And again, you can do it from the front. If it's in the umbilicus, you can make a little cut either above or below the belly button, which will then sink back in, you can find that little hole, push the fatty bit back, a couple of strong stitches. Everybody wants to be an inny, so the belly button just gets anchored down. So everybody's an inny. The recurrence rate for those is slightly higher than the inguinal ones because it's a general area of weakness. So probably, even in my hands, I'm afraid it probably is about 5% recurrence to the umbilical hernias. And again, that's one of the reasons for doing nothing if they don't cause you any trouble.

Steven Bruce
Okay, now a minute ago, I mentioned diastasis recti. And you said there was a much better expression for it, which I'm keen to learn, I didn't catch it.

Simon Marsh
Yeah, we call it diverication of the rectus muscles.

Steven Bruce
Diverication.

Simon Marsh
It's exactly the same thing. And it just means a splitting of the muscles. And I've got a bit because, I'm 59, I've got a bit and if I do the plank exercise, you can see it, you do nothing about it. And we do occasionally get sent people with the rectus diastasis. And the diverication that say, oh, the person's got an epigastric hernia. Can you fix it? The answer is, no they haven't. And no, I won't.

Steven Bruce
Well that answers the question which led me to mention it because a number of people have asked what the treatment is for it. And is it similar to hernia treatment, so that presumably there are occasions when you might want to do it?

Simon Marsh
It's a cosmetic operation. So if you've got it, what you do you do core stability exercises, particularly working on the transversus muscle, the rectus muscle itself you can do you like for that and get a six pack, doesn't help, it's the transversus exercise you have to do. So that will not get rid of it, but stop it getting bigger but it's normal as you get older so do nothing about it.

Steven Bruce
But I imagine that there are, I mean not uncommon after pregnancy, is it, and I imagine that a lot of people would want a cosmetic solution to this because it's not attractive in anyone really.

Simon Marsh
No, it's not and this is where the plastic and reconstructive surgeons come in. But I say it's a big operation, right down the middle to split everything and pull it all together. So it's a big operation. It takes you a while to get over it. It can be done; it can be done. I'm not having mine done, just so you know, but it can be done.

Steven Bruce
Mysterious Individual says that his patient has a small inguinal hernia that doesn't cause him any pain or discomfort. Is it okay for him to carry on playing squash and cycling or will exercise make it worse?

Simon Marsh
No, I think it's okay to carry on. I mean, the thing is, as we talked about these small, asymptomatic hernias, it's quite safe to leave them. I think if this is a particularly athletic chap, it is going to get bigger over time and if he is relatively young and relatively fit, now would be a good time to have it fixed and again, in a sporty chap I would certainly recommend doing it the Shouldice way, sutures only, and not putting any plastic in. But again, it goes back to the point if you've got an asymptomatic hernia, you're young and fit, when you're older and not so fit, it can perhaps be more tricky to do it or more risky with anesthetic.

Steven Bruce
Okay, Stuart has asked whether developing an inguinal hernia can cause true femoral pain that extends as far as the knee or is it more usually just confined to the groin area.

Simon Marsh
It is usually just confined to the groin. And you wonder whether if you're getting pain down the leg, whether it is actually a femoral hernia, because that can perhaps push on the femoral nerve. A lot of people do describe a burning sensation when they get a hernia that often goes down into the testicle, down the inside of the thigh. And that comes from the ilioinguinal femoral nerves that can be stretched so you can get that sort of discomfort. Most hernias, once you've got the lump, actually don't cause much pain at all.

And it's this initial stage where perhaps the muscles are stretching and tearing that I find can cause the discomfort but once a hernia is there, tends not to cause too much trouble apart from being present until it gets bigger and then it gets more achy.

Steven Bruce
Right. Okay. Jolly Local says, do you check the alignment of the pelvis prior to surgery? And would it be okay to correct a misalignment with muscle energy technique before and or after surgery?

Simon Marsh
Yeah, I've no objective to that. That is not something I do. I'm not an expert in that. I think as I said, when I talked about the exercises for afterwards, I think a strong core is really important for reducing the risk of recurrence and preventing getting a hernia on the other side. So I think all of those techniques that will help. Yes, please go ahead.

Steven Bruce
Do you get some kickback from patients on that, because you know, typically, for example, one core exercise might be doing the plank. Now, somebody who's had something bulging out of their abdomen might be reluctant to do that your patient might be reluctant, because instinctively they think that's not going to help, it's going to bulge some more.

Simon Marsh
Yeah. Do you know what's interesting, when we give out the exercise, is people completely understand what they're for. And they're actually usually very grateful and say, oh, good, I need some exercises. And what always surprises me is, you know, I will see chaps you perhaps had a hernia done somewhere else. And they come and see me about another one or perhaps with recurrents. And I go through the information and say, this is the exercise we get you to do and they say, oh, nobody told me to do anything before, they just did the hernia and told me to go away. And I think the rehab and the exercises are a really important part of the treatment of hernias. Not to mention the other thing.

Steven Bruce
I've got one mention left, I think. So I'm saving for the end. In terms of rehab, then I think you said you might be able to get us to chat to one of your colleagues on this show about rehab for this and for the other thing at some point. So I mean, is there a specific protocol or is it just general core stability training?

Simon Marsh
We have a specific set of exercises we give out so everybody gets those. You mentioned, Johnny Wilson is my consultant physio colleague that I've worked with for years around Gilmore's groin. Now, I'll beat you to it, and hernias as well. And yeah, I'll have a chat with him. See if we can get him to come on and talk about groin rehab in general. I'm sure he'd be delighted. He's the editor of, I forgot the title of the book, which I've done a chapter on Gilmore's groin in, I said it again, which came out last year, which obviously, we're trying to encourage physios to buy, but Johnny edited that and it goes through all sorts of sports medicine things, but, you know, a lot of it is relevant to ordinary hernias. But yeah, we'll try and get him along as well. He's a lovely soft-spoken Irishman, but very, very experienced, particularly in areas where perhaps it doesn't go as well as you'd like and people need extra help.

Steven Bruce
Well, I'd be interested to get your feedback in the audience on that one because I personally, I think that would be a really, really good show to get somebody so experienced in rehab from operations like this and complicated cases. And of course, I know that we osteopaths, chiropractors, and so on, we like to think that we're good at all this stuff, but I suspect that there are people who are much better at rehab, certainly than I am. So let us know through the chat if you'd like us to do that, because I'm keen myself. Getting back to my questions here, Simon. Hans says he has a large inguinal hernia. It's about five inches long, he's had it for eight years since radical prostatectomy and it gradually seems to be getting larger. The bulge is about the size of a Bantam egg, bulges, gurgles and can pop out constantly. It's very graphic description Hans, bulges, gurgles, can pop out constantly but can be reduced manually, what are the chances of complications post operation? Is vigorous exercise, tennis, skiing possible after the operation?

Simon Marsh
Yes to the second bit. The whole point of fixing a hernia is to allow people to lead normal lives. So once you've had your hernia fixed, you go back doing everything normally, please, that's the point of doing it. And I would suggest that Hernia needs fixing, it's actually a really good description of a hernia, you know, with the bulge, the gurgling, the fact it gurgles tells me that you've got loops of bowel coming down into that. So that is something that I would get on and fix. And if you came to see me in Harley Street, I would say we'll fix that in the next few weeks at your convenience. It's not an urgent thing, but I would get on and do it, you know, perhaps over the next few weeks to months to get it done, because that one sounds like it needs fixing.

Steven Bruce
Oh, there's 36 minutes of your time that will be well worth spending in the hands of Mr. Marsh there, Hans.

Simon Marsh
And Hans wouldn't notice anything about it, he'd be fast asleep.

Steven Bruce
Suzanne says, what's the recovery time in general for an inguinal hernia? And does it depend on whether they're an officer or manual worker?

Simon Marsh
Yeah, it does, obviously. Classically, it was always said to be a month, and our rehab used to go in weekly stages, week one, week two, week three, week four. Now, as you rightly suggest, everybody's different. And we change the phraseology, so we have stage one, stage two, stage three, stage four. And if you are an office worker, I find a lot of people will go back to work in the next week, because they can work from home, I do actually encourage people to take a week off because it allows them to concentrate on themselves. And to do some of the exercises just to get them going, to get a good start, everything is going to go better. So I encourage people to take a week off and most people and go back to work. The week after that, yes, if you're a landscape gardener, you probably are going to need the full month I think to be to be really safe. And I always see people a month after the operation to check the repair and fill the back of the groin to make sure it's solid. And then it's safe to go back to normal activity. Bear in mind

that if you haven't done anything for a month, and you go back to some heavy work, you're going to make your groin ache, because the muscles will need strengthening. So I always warn people about that and not to worry because you have to go through this phase of building up the muscles again. And they will ache before they settle down. But that's expected and normal.

Steven Bruce
Well, on the basis of all that Chris has said, how long is your waiting list? And how do we get appointments?

Simon Marsh
Okay. Well, I do hernias every Thursday, we'll get in as many as we can, depending on hospital beds. So I think this week, I said I've got 5 to do this week. Some weeks, I might only do one or two. But I'm happy to start it up after and go through till 6am in the evening, whatever it takes. In terms of contacting us, again, it's the old thing, isn't it? If you go on the website and find us at 108 Harley Street, but if people have got pens, 0207-563-1234, will take you through to the lovely office staff who will let you know what you need to do to come and see one of us to get yourself sorted out.

Steven Bruce
Now it's a real challenge for Justin to see whether he can get that telephone number up on the lower third on the screen. That's great. But we'll share all that detail afterwards anyway, and just in case you didn't catch it is 108 Harley Street is the organisation, the website address. Jackie says, could you give us the names again of someone for incisional hernia as well. I can, Simon Marsh is one of the names.

Simon Marsh
Yeah, for the big, complicated hernias, we work with Amir Darakhshan, works at 108 Harley street. He's the expert in the big complicated incisional hernias. And this is the importance and you raised it when he talks about the fact that you work with different people different, things. The team is important here and it involves everybody you know, it's the GP, it's the physio, it's the chiropractor, it's the rehab specialist. This is what gives you the best results in whatever sort of medicine or surgery you're doing. You have a team of people. And the thing about 108 Harley Street is we go out and look for people. So you can't apply for a job to come and work for us. We will come and find you. If we think you're good enough. That sounds familiar. So Amir we got in because he's good. And then we've also got Emin Carapeti, who does bowel surgery and hernia surgeries as well, who we went to find because we know he's good. And I'd like to think that's why the late Jerry Gilmore got a hold of me all those years ago. I'd never met him. He'd obviously heard of me. So this is how 108 Harley street works. If you've got a complicated incisional hernia, that'll be Amir Darakhshan for you. And the office can tell you and if somebody phones up and one of the girls is not sure, they come and ask me, and I will point you in the right direction.

Steven Bruce
Yeah, okay. Good advice there for you. Now, I'm not sure this is a name that's been given by them, apologies to this question. The name is Sunna Dave. And that could be an Asian sounding name, or it could be a name that somebody has put in there for mischievous reasons. So I apologise if I'm being offensive to one or the other. I don't mean to be. Anyway, this person had a mesh repair 15 years ago,

it's now quite noticeable again and was told he or she had a pantaloon hernia. Should it be left alone or should it be redone?

Simon Marsh
The pantaloon hernia is what used to be called the double hernia. So the first point is if they've got a recurrent hernia, that's probably something to think about being fixed. And the pantaloon or the double hernia is you remember we talked about the two different sorts, the direct and the indirect is when you've got both at the same time. So you're double unlucky you've got a recurrent hernia, and you got two of them.

Steven Bruce
So the next part of the question, should it be redone or left alone?

Simon Marsh
You know, I would probably think about redoing that. So what would happen if somebody came to see me, we'd have a look, examine it, I will probably get by talking about Simon Blease, he's my consult radiology colleague expert in hernia scans, we get a scan which Simon would be watching so we could get an idea of the anatomy, you can sometimes see the mesh on the scans, but it tells you where the holes are, the defects are. And that helps me get in mind a 3d picture of what I'm going to do before I do it. So that would be the sort of picture. But I think if you got a recurrent hernia, you're probably going to need fixing.

Steven Bruce
Right. Thank you. We've had some more questions about the physio, the rehab, and someone's asked if we could share the name of the book that you couldn't remember earlier on where you contributed a chapter, I think. We can do that after the show. But people are interested.

Simon Marsh
It's sitting on the bookshelf behind me.

Steven Bruce
Who was the the overall author or editor?

Simon Marsh
Johnny Wilson was one of the editors, the physio.

Steven Bruce
The physio you mentioned a moment ago.

Simon Marsh
Who works with us. Yeah.

Steven Bruce
I thought when you first said his name, you said Jonny Wilkinson. And I was getting quite excited, because I thought, I mean, we're going to get a rugby star on here as well, which is quite exciting.

Simon Marsh
Nearly but not quite.

Steven Bruce
Bob has asked whether you could share a copy of the exercises you recommend, and I'm not sure whether that's possible, or whether it was just general core stability stuff that you recommend?

Simon Marsh
I can what we can do. When I'm back in London on Thursday, I can perhaps email off to you the exercise sheet we use and I can perhaps send the information sheet about the operation, the complications, the wound care and the rehab, we can let you have more to share with people, no problem at all.

Steven Bruce
Oh, that would be super, thank you. And I like to give people handouts after the shows. And obviously, if you don't mind, I'll share the handout as well.

Simon Marsh
No problem at all.

Steven Bruce
Thank you, that's very kind. Patty says that she has a patient with an inguinal hernia the size is about one and a half grapefruits.

Simon Marsh
Oh, gosh, right.

Steven Bruce
Waiting for the OP for the last two years. It's due in the next month now. Is there anything to avoid when treating his back afterwards?

Simon Marsh
No, you'll need to give the groin time to heal so i would give it the full month before you start stretching and exercising that but apart from that, no, as I say the aim of fixing a hernia is to do normal things, but he's obviously got a sizable hernia, poor chap. So I would give that the full month to heal before you started doing anything else with him.

Steven Bruce
Okay. Jeanne says that she has a patient who she thinks has a hernia. He was told by GPs it was just fat. But when he sits up on the bench from lying on his back, to be honest, she says it looks like an alien trying to get out of his stomach. Please advise.

Simon Marsh
Oh, right. Yes, he needs to come and see somebody and have a look. You can get quite big, this sounds like it's going to be when these epigastric ones that's in the midline, you can get quite big ones. And the fatty tissue comes out a bit like a mushroom, the hole is often quite small. And as the fatty tissue come through, it just spreads out. So the hernia can look quite large. But the defect, the hole will be quite small. And again, this is where Simon Blease, the radiologist comes in, as he will scan that for me, we can see the defect. And again, we get a much better picture what we're doing before we do it. So yes. If they're about, come and see me, we can arrange scans and see what we need to do.

Steven Bruce
So I suppose the GP technically is correct, because it's fatty tissue that's coming through the hole.

Simon Marsh
Correct, yes.

Steven Bruce
But actually, that doesn't make it not a hernia.

Simon Marsh
Correct, yes. Because as we said, hernias are anything outside of where it normally is.

Steven Bruce
Amanda wants to know if you can get hernias under the costal margin in the upper abdominals.

Simon Marsh
Oh, yeah, you can. They're really rare. You can get hernias down the edge of the rectus muscle they're called spigelian hernias. Most of them are lower down, but you can get subcostal hernias where the rectus sheath is weak. Gosh, do you know, I think I've only ever seen one.

Steven Bruce
Well, there's a good chance then if Amanda's interested, you might see another one.

Simon Marsh
We would certainly get a scan of that to make sure, absolutely.

Steven Bruce
Okay, I've had several people saying that getting the rehab protocols would be very, very useful and very welcome. So as always, I try to send out an email on the day after these shows. Sometimes we wait a bit longer if there's still information to come in. And so later in the week, once Simon's had the chance to send those over, assuming he's not too busy, then I'll get those out in an email to you along with all the other information that can be useful. I think you answered this really, Amanda says what technique do you use to repair muscular hernias.

Simon Marsh
Yeah, if we're talking inguinal hernias, there's a choice and I think one of the things important is making people aware of the choice and potential complications. So you've got the laparoscopic, telescopic inside with the great big mesh, which as we said, although it's minimally invasive, it isn't because the amount of where you have to incise is bigger. I don't do those, again, Amir Darakhshan, the incisional ones he does, he does those. It's part of the team, we offer all sorts. You've got the Liechtenstein repair over the front, which I haven't done for 25 years, you've got the plug behind the muscle, followed by the Shouldice repair, the sort of double repair, which has been my standard technique for the last 25 years or so. And then you've got the Shouldice repair only, just a suture repair, which I'm doing more and more of, because that's what people are asking for. And that's fine. I did have, again, one of my consultants colleagues who's worked with me and done hernias, developed an inguinal hernia. He's a squash player, he's a very fit guy. And he came to me and said, I've got a hernia, I want you to do it because I don't want a mesh. And he was playing squash again four weeks later and is absolutely fine. So those are sort of things to think about. And people do say to me, and it's a bit unfair, if I got a hernia, which way would I have it done? Oh, and you know, I'd probably have it done with the Shouldice technique without any sort of plastic at all. Probably.

Steven Bruce
Okay. I haven't heard this. But John has asked, he says he recalls the years ago that the prevalence of inguinal hernias related to the vertical or horizontal orientation of the abdominal musculature. Is that true?

Simon Marsh
It's sort of true in that the weakness where the spermatic cord comes out is an evolutionary error. So the fact that we stand upright means the abdominal pressure is higher, and it tends to push things out. So it's to do with the fact that we've only been around for, you know, as modern humans for 250,000 years, we haven't evolved enough to stop hernias happening. So yeah, it is a consequence of the fact we walk up right.

Steven Bruce
Okay. And Simon says, this is, I feel for his wife. His wife had bilateral inguinal hernias, and the surgeon said he had to put in the largest mesh she'd ever had to fit. And she's eternally worried that the mesh will fail. Can you offer her some reassurance? Well, that's my comment.

Simon Marsh
Yeah, first of all, that's unlucky because as we said only 2% of ladies get inguinal hernias. So of those 2% only 10% of that 2% get both sides. It sounds to me as if this was a laparoscopic repair, because laparoscopic surgeons love really large meshes. And most of the time, that will be absolutely fine. There'll be no problems. The mesh just sits there. Recurrents can happen but it's rare. So I'd reassure her and say it's absolutely fine. But bad luck for getting both in the first place.

Steven Bruce
Yeah. And in terms, I mean, you mentioned nasty complications, like bits ending up in the bladder and so on. Should she be worried about that? Because it's larger than average or?

Simon Marsh
No, I think, I go back to my point, the vast majority of people who have hernias, whichever way they have it are fine. I think you can always find cases in people who've had meshes removed, or they've had chronic pain and that's where you find the problems. But if they're not getting the pain, they almost don't have the problems. What I do find interesting, and again, I say this with a sort of wry smile and the devil's advocate face on, is how often, when you have laparoscopic hernia repairs, for one side, they say, oh, when I had a look you had one on the other side, and I repaired that as well. And you've had a double hernia repair. And I always find that interesting, because if you did have a small hernia on the side that's causing no trouble, I wouldn't touch it. And you could argue that doing a bilateral hernia repair, it costs more than a one sided one. I don't know. Again, a wry smile and devil's advocate, but it just surprised me how often a one-sided laparoscopic repair turns into a bilateral.

Steven Bruce
Yeah, is there a downside to it? I mean, I suppose technically, you must be doing some damage by repairing the other side.

Simon Marsh
Yes, you've got to do the dissection and you've got to dissect nine times the volume from the front. And any operation has potential complications. Of course it does. And I'm a great believer in not fixing things that aren't broken. It's as simple as that.

Steven Bruce
Yeah. And have you mentioned all the possible complications? And again, I ask not just out of a ghoulish interest, but also because when a patient's on our table, and we say, we listened to Simon Marsh the other day, and we think you ought to go and see somebody, they will probably ask us well, what's the downside of a hernia repair?

Simon Marsh
Yeah, no sure. And they'll all be on the sheet that you'll send out, we have a paragraph that lists all the complications, but with any operation there are the general complications with an anesthetic, you know, you can get chest infections and so on. Those are all rare. And then the obvious things for a hernia repair, you get a scar and it's a bit sore and you can get a bruise and the scar tissue is quite knobbly for a few weeks, for a few months before it settles down. Then scars fade and go pale. You can get hematomas, really rare, great big blood clot underneath the skin, they go down or sometimes if they're really big, you have to let them out with a second operation. One of the things we find chaps who are, please forgive me, over 21 and perhaps get up once or twice at night to go to the loo because they've got an enlarged prostate. Sometimes having a hernia done because the muscles go into spasm can put them into retention, they can't pee for a day or two and may have to have a temporary catheter. Now I've been there, done that when I had my arm fixed because it was a long operation, I couldn't pee and I'd have a catheter overnight, then it comes out and it's fine. So that's one thing to think about for the older chaps. Hernias come back, you get recurrent hernias. And then you can damage nerves, you can, I think it's rare, because you always look out for them. When you them, you move them to one side. But even when you touch a nerve, it will shut down. So it's often quite numb for a while after a hernia repair, and then it goes a bit oversensitive, then it settles down again. So all these things are on the sheet that we'll send

out, but all those things you go through. They're all relatively rare, but they happen and most of them will get better.

Steven Bruce
That's very reassuring. And I hope that's reassurance for Simon's wife as well. We're right at the end of our time, Simon, thank you very much indeed. It's fantastic. I mean, we've had so many people, we've had 450 People, just shy of 450 people watching and we've had lots and lots and lots of positive feedback, lots of enthusiasm over getting your rehab specialist John Wilson and to talk to us as well. But it's so kind of you to give up your evening like this and spend 90 minutes talking to us where we asked what possibly are very silly questions to you about your specialty. We certainly appreciate it.

Simon Marsh
It's a pleasure. And thank you very much for having me on.

Steven Bruce
No, this is our pleasure entirely. But we will let you get back to your evening and you can get back to playing that guitar, which is propped up against the wall behind you. You can't see that yet. But I saw it when Simon was moving around earlier on. He used to be a bit of a rocker in his youth, I think and he's getting back into playing the guitar now.