Patient Information

Patient information and consent to laparoscopic groin hernia repair

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.
- Please read this information carefully, you and your health professional will sign it to document your consent.
- **It is important that you bring the consent form with you when you are admitted for surgery.** You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.
- **Please bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies)** and any information that you have been given relevant to your care in hospital, such as x rays or test results.
- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.
- If you experience any concerns requiring urgent medical advice please call the nurse specialist during working hours on **01223 596383** or through the hospital contact centre on **01223 245151** and ask for **pager 154-348**. During evenings or weekends please call ward C7 on **01223 217300**.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998. Laparoscopic groin hernia repair, CF418, v3, August 2015
About laparoscopic groin hernia repair

Your surgeon has recommended that you undergo repair of a groin hernia using a keyhole technique. There are different types of groin hernias. They can be described as inguinal or femoral. Keyhole surgery to repair a femoral or inguinal groin hernia is identical.

Laparoscopic groin hernia repair uses a mesh technique very similar to the standard open operation but instead of a cut in the groin you have three very small (1-2cm) wounds after the operation.

What is a groin hernia?

A groin hernia is an abnormal protrusion through the abdominal wall into the groin. The protrusion contains a cavity (the hernial sac) which can be empty or it can fill with abdominal contents such as bowel. Often fat is the main component of a hernia. Typically, hernias are more obvious when standing or straining (for example coughing, heavy lifting, and digging) as this forces abdominal contents into the sac. Hernias usually develop over time for no obvious reason, although in some people there may be an inborn weakness in the abdominal wall. Occasionally a strenuous activity will cause a lump to appear suddenly. They may occur at any age and are more common in men than women.

Hernias may simply present as a painless bulge that enlarges with standing or coughing. Commonly they cause an aching discomfort or a dragging sensation. Occasionally a piece of bowel or fat can get stuck and twisted within the hernia. This is very painful and can lead to a strangulated hernia which can become a serious emergency requiring emergency surgery. It is often recommended that hernias be repaired to prevent such complications arising.

Is the laparoscopic technique better than the standard technique for my hernia?

The National Institute for Health and Clinical Excellence (NICE) has recommended that patients with two hernias (i.e. one in each groin) or those with recurrent hernias (hernias that have been previously repaired) should have their repairs performed by this technique. In addition, NICE now recommends that laparoscopic repair should be discussed with all patients presenting with an inguinal hernia.

The amount of cutting used in this operation is less than the standard open technique, therefore recovery is usually quicker and less painful. Most patients are back to their normal activities within 10 to 14 days. Many patients return to work within seven days of surgery.

Are there any disadvantages of having the laparoscopic operation compared with the open technique?

The only slight drawback is that you need to have a general anaesthetic. For most patients this is not an issue and modern anaesthetics have very low risks.

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However, if you are a patient with particular risk factors for getting complications from anaesthetics it may not be appropriate for you to have this technique. For patients who have had previous cuts in their abdomens, particularly below the tummy button this technique may not be possible. Your specialist will advise you.

You may have heard your hernia referred to as an inguinal or femoral hernia. The keyhole technique repairs all these hernias at the same time.

**Intended benefits**

To repair your hernia, this should reduce discomfort and prevent the hernia from bulging. It should also prevent the hernia from enlarging over time.

Hernias very rarely “strangulate”. This is when the hernia comes out and gets stuck. In this situation an emergency operation is required. If your hernia has been repaired it cannot strangulate, therefore this complication is prevented by repairing your hernia electively.

**Who will perform my procedure?**

This procedure will be performed by a consultant surgeon or by a senior surgeon in training under the supervision of a consultant surgeon.

**Before your operation**

Most patients attend a pre-admission clinic, when you will meet a member of the medical team (either a doctor or a nurse) who will be looking after you in hospital. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you.

This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

Hernia surgery is usually performed as a daycase procedure. Sometimes we will recommend you stay in hospital overnight after your operation. This will be discussed with you when you are seen in clinic and at the time of your operation.

It is very important that you tell us if you are allergic to any medications or dressings.

You will be admitted on the day of your operation.

**Hair removal before an operation**

For most operations, you do not need to have the hair around the site of the
operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

**During the operation**

Before your procedure, you will be given a general anaesthetic.

This is usually performed by giving you an injection of medication intravenously (i.e. into a vein) through a small plastic cannula (commonly known as ‘a drip’), placed usually in your arm or hand.

While you are unconscious and unaware your anaesthetist remains with you at all times, monitoring your condition and controlling your anaesthetic. At the end of the operation, your anaesthetist will reverse the anaesthetic and you will regain awareness and consciousness in the recovery room, or as you leave the operating theatre.

The operation involves an incision by your umbilicus (tummy button) and two further incisions. The incisions are about 1-2cm long each). Through these, we inflate your tummy up with carbon dioxide gas which is completely harmless.

We place an approximately 15 cm x 10 cm sheet of artificial mesh, mostly composed of prolene, which does not dissolve, into the space directly behind the weak area in the groin. This prevents the bulge of the hernia from returning. It has the advantage of treating different types of inguinal and femoral hernias all in the one procedure. It is strong immediately and does not require long periods of convalescence. The mesh is made of the same material as stitches we commonly use in other operations and does not normally cause any adverse reaction from your body. You will not be aware that it is there.

At the end of the operation, before you wake up, all the puncture sites in your abdomen will be treated with local anaesthetic so that when you first wake up there should be very little pain. Some patients have some discomfort in their shoulders, but this wears off quite quickly.

The cuts we have made will be covered with small waterproof dressings or glue.

**After the operation**

Once your surgery is completed you will usually be transferred to the recovery area where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable.
enough to return to your ward.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.

After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR).

These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after surgery.

**What are the wounds like?** They will be closed with dissolvable stitches under the skin and covered with either a shower-proof dressing or glue. The dressing should be left on for five days after which it can be removed and the wounds left open to the air. If glue has been used you do not need to remove the dried glue.

**Will I have much pain?** Immediately as you wake up from the surgery there will be very little pain as all the wounds are full of local anaesthetic. As this wears off you will have some discomfort and a pulling sensation around the tummy button wound. This will last between seven and fourteen days. We give you a pack of pain-killers which we advise you to take for the first three days regularly, regardless of whether you have pain or not.

**Eating and drinking.** You will be able to drink immediately after the operation and, provided you do not feel sick, then you will be able to eat something.

**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. You will be allowed home when you are comfortable, have had something to drink and eat and have passed urine. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.

**Leaving hospital.** Hernia surgery is usually performed as a daycase procedure. Sometimes we will recommend you stay in hospital overnight after your operation. This will be discussed with you when you are seen in clinic and at the time of your operation. Following discharge we will give you a copy of your discharge summary.
Resuming normal activities including work. After surgery the only limitation that you will have is the discomfort from the three small stab incisions. You are encouraged to ensure you remain active (gentle walking) within a day or two of surgery. Most people who have had this procedure can resume normal activities after two weeks. During the first two weeks it is suggested you try not to lift anything heavier than five kilograms and certainly stop doing anything that causes you pain.

You might need to wait a little longer (up to six weeks) before resuming more vigorous activity, such as manual labour, moving furniture or load bearing (such as weight training) activity at the gymnasium. When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. You will be given a certificate to cover the time off work you require. As a general rule, if you are able to do something without discomfort it is safe to continue doing this.

Driving. You should not drive until you are safe to do so, this is usually a minimum of seven to ten days following surgery. Regardless, you should not drive until you can confidently press the brake pedal in an emergency. You also need to be mobile enough to look around and beside you as you normally would when driving. If you have a degree of pain, your ability to drive is compromised. If you are not sure about your ability to drive then you should see your general practitioner prior to starting.

Check-ups and results. We do not perform routine check ups after straightforward hernia repairs. However if you have any difficulties or wish to be seen an appointment can be made by contacting your consultant’s secretary.

Does my hernia need to be repaired?

Not all hernias need to be repaired. If a hernia is not causing symptoms or enlarging it may not need to be repaired.

Hernias that are not causing symptoms are unlikely to develop serious complications such as strangulation.

Sometimes people have pain in the groin but no lump. This condition would usually not benefit from a hernia repair.

Ultrasound scans frequently diagnose groin hernias that cannot be seen or felt. We would usually be cautious to offer surgery if a hernia has not been seen or felt by you and cannot be identified when your surgeon examines you. This is because a hernia repair in this situation may be less likely to make you any better and the symptoms may be from another cause.

If you have other serious medical problems or are frail, then the risks of repairing the hernia may outweigh the benefits.
Your surgeon will advise you whether he or she recommends surgery. You need to decide whether you wish to go ahead with surgery and this is usually a decision best made in conjunction with your surgeon.

Is there a guarantee that the operation will be completed using keyhole surgery?

No. Unfortunately, there is never a guarantee that keyhole surgery will be possible. Occasionally there are technical reasons why conversion to an open technique is necessary. This is, however, unlikely (1-2% risk).

Will my hernia return?

There is no method of hernia repair that can give a 100% guarantee that you will never develop another hernia in the same place after your operation. Fortunately, recurrence after hernia surgery should be rare. The lowest reported risk is with the mesh repair technique we use and is about one to five cases per hundred over five years. Patients who are obese have a greater risk of recurrence.

Significant, unavoidable or frequently occurring risks of this procedure

As with all surgery there are some risks involved with laparoscopic groin hernia repair. However, this is a safe procedure and the risk of a serious complication is very low. The risks relate to both the anaesthetic and to the actual surgery itself. So long as you are fit the anaesthetic should not pose any significant concerns but this should be discussed with your anaesthetist.

Injury to intestine, bowel and blood vessels – Injury or damage to these structures can, very rarely, occur during any operation within the abdominal cavity. This is particularly the case if there has been previous surgery with scarring and structures are abnormally stuck to each other. Usually such an injury can be seen and repaired at the time of the operation, but occasionally may only become clear in the early postoperative period.

If we suspect that you may have sustained such an injury, a further operation will be required. This will be performed as a keyhole operation but may need conversion to an open operation if necessary.

Conversion to an ‘open’ operation – All keyhole procedures carry a small risk of the need to convert the procedure to an ‘open’ technique. This is usually because of some technical difficulty during the procedure. If this is necessary, it may result in a much larger scar, a longer hospital stay and more postoperative pain and discomfort. However, if it is unavoidable, then we must have your permission to proceed to ‘open’ surgery should it be necessary.

Bleeding – This very rarely occurs after any type of operation. Your pulse and blood pressure are closely monitored both after your operation as this is the best way of detecting this potential problem. If bleeding is thought to be happening, you may
require a further operation to stop it. This can usually be done through the same key hole incisions as your first operation. It is possible that you also may require a blood transfusion.

**Wound infection** – The wounds can, rarely, become infected. If you notice redness, discharge or increasing pain from a wound you should consult with your doctor in case you need treatment.

**Wound haematoma** - Bleeding under the skin can produce a firm swelling of blood clot (haematoma), this may only become apparent several days after the surgery. This may simply disappear gradually or leak out through the wound. Any bruising that occurs tends to be on the lower abdomen and track down into the scrotum and base of the penis in men. This can look rather worrying. Do not be alarmed if this happens to you, it will resolve spontaneously over two to three weeks. A degree of visible bruising occurs in up to 25% of people having this surgery. If this is causing a lot of pain or you are worried, you should see your general practitioner or contact the Upper GI Surgical Unit on the numbers listed in this information sheet.

**Mesh infection** – All artificial materials that are placed into the body carry a risk of becoming infected. This is very rare (estimated 1 in 500 chance). If this were to occur you would notice redness and pain around the hernia site, you may also have a fever and some smelly fluid escaping from the wound. Often this problem can be treated with powerful antibiotics, although a course of four to six weeks may be required. If the infection does not resolve then the mesh may have to be removed with an operation. This would mean that the hernia may eventually come back and several months or years later it may need to be repaired again.

**Urinary retention** – There is a small risk (5%) that immediately following your operation you will not be able to pass urine. This is usually more likely in men than in women. The reason is that a combination of medications and performing surgery near the bladder can cause muscular spasm of the region and block the outflow of the bladder. Additionally, if you have underlying prostate problems, such as poor stream or you have to frequently get up overnight to pass urine, you may be at increased risk of suffering urinary retention. If you become uncomfortable trying to pass urine after the operation, a catheter needs to be passed into the bladder. This is done under local anaesthetic. Normally, you stay overnight and the catheter is removed the following day after things have settled. Very rarely, the catheter may need to stay in for one to two weeks, after which the practice nurse at your GP surgery will remove it for you.

**Nerve damage** - Several nerves cross the operative field in hernia surgery. It is usually possible to preserve them but some minor nerve injury, rather like a bruise, is common and usually returns to normal in time. Permanent numbness may sometimes occur. This risk is very low with key hole surgery.

**Chronic pain** – Rarely, some patients develop chronic pain after hernia surgery, in the region of surgery. It is not clear why some patients develop this and not others. It may be due to a nerve getting trapped in scar tissue. This pain can be treated with Laparoscopic groin hernia repair, CF418, v3, August 2015
medications or injecting local anaesthetic or anti-inflammatory medications into the area. This risk is very low with keyhole surgery.

**Seroma** – An accumulation of fluid adjacent to mesh that is used to repair a hernia is called a seroma. This is actually part of the body’s normal healing response. It may actually feel as if the hernia lump is still there! If the hernia is large it is expected that a seroma will develop – it will subside over a few weeks to months. Fortunately, in itself, a seroma is not serious and most people do not notice it. If a seroma causes discomfort it may need to be drained under local anaesthetic in the X-ray department. This is where a small drain is placed into the fluid and the fluid is removed.

**Testicular damage** - Hernias in men develop very close to where the major structures to and from the testicle lie. These structures include the blood vessels to the testicles (arteries and veins) and the vas deferens that carries sperm from the testicle. Hernia repair, whether carried out as a keyhole or open procedure is associated with a very small risk of damage to these structures. This can lead to development of pain in the testicle post-operatively or problems with having children in the future.

**Deep vein thrombosis (DVT) and pulmonary embolus** - All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. Keyhole surgery has a lower risk of this, and we also are able to get patients up and about much quicker after these procedures than after conventional ‘open’ procedures. We do, however, give you some injections to ‘thin’ the blood. We also ask you to wear compression stockings on your legs before and after surgery and also use a special device to massage the calves during the surgery.

**Scarring** – Any surgical procedure that involves making a skin incision carries a risk of scar formation. A scar is the body’s way of healing and sealing the cut. It is highly variable between different people. All surgical incisions are closed with the utmost care, usually involving several layers of sutures (the sutures are almost always dissolvable and do not have to be removed). The larger an incision the more prominent it will be. Despite our best intentions, there is no guarantee that any incision (even those 1 to 2cm in length) will not cause a scar that is somewhat unsightly or prominent. Scars are usually most prominent in the first few months following surgery, however, tend to fade in colour and become less noticeable after a year or so.

**Other complications** – We have tried to describe the most common and serious complications that may occur following this surgery. It is not possible to detail every possible complication that may occur following any operation. If another complication that you have not been warned about occurs, we will treat it as required and inform you as best we can at the time. If there is anything that is unclear or risks that you are particularly concerned about, please ask.

**Alternative procedures that are available**

An open hernia operation involves placing a mesh on the outside of the weak area in the groin through a 10cm cut overlying the hernia. It can be performed under a Laparoscopic groin hernia repair, CF418, v3, August 2015
general or local anaesthetic. There is a slightly longer recovery period due to the bigger cut and also a greater risk of chronic pain in the groin from damage to the nerves there. Details of this can be discussed with you by your specialist.

An alternative to this surgery is a decision not to have surgery. We will discuss with you the implications of deciding not to have surgery.

**Information and support**

We may give you some additional patient information before or after the procedure for example, leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including your surgeon or one of the senior trainees. The surgeons can be contacted on either 01223 217421 or 01223 348024.

**Anaesthesia**

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

**Before your operation**

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medicaton**

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

**Moving to the operating room or theatre**

You will usually change into a gown before your operation and we will take you to the Laparoscopic groin hernia repair, CF418, v3, August 2015
operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted.

If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted and some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.
**Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain, the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

**What will I feel like afterwards?**

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health. Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties. You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

**What are the risks of anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**

Chest infection
Muscle pains
Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)
Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications
Damage to the eyes
Heart attack or stroke
Serious allergy to drugs
Nerve damage
Death
Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: www.rcoa.ac.uk
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease (‘CJD’)
We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings
As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training
Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue
As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & Dignity
Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:
If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.info@addenbrookes.nhs.uk.
Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

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To repair your hernia

Full details are set out in the information leaflet and include:

bleeding; bruising; wound infection; recurrence of hernia; damage to structures to and from the testicles; damage to other structures inside the abdomen through keyhole surgery; groin pain; groin numbness; open procedure.

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Laparoscopic groin hernia repair

2 The following information leaflet has been provided:

Laparoscopic groin hernia repair

Version, reference and date: Version 3, CF418, August 2015

or  I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:

☐ General and/or regional anaesthesia  ☐ Local anaesthesia  ☐ Sedation  ☐ None

Signed (Health professional):  Date: D D / M M / Y Y Y Y

Name (PRINT):  Time (24hr): H H : M M

Designation:  Contact/bleep no:

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

☐ Yes  ☐ No

2 Photography, Audio or Visual Recording

a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

☐ Yes  ☐ No

3 Students in training
I agree to the involvement of medical and other students as part of their formal training.

☐ Yes  ☐ No

Addenbrooke’s Hospital | Rosie Hospital

Patient safety – at the heart of all we do

Laparoscopic groin hernia repair, CF418, v3, August 2015
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ................................................................. Date: __/__/__
Name of patient (PRINT): .................................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ............................................................................................................ Date: __/__/__
Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): ................................................................. Date: __/__/__
Name of witness (PRINT): .................................................................
Address: .................................................................
Consent Form

Laparoscopic groin hernia repair

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .................................................. Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: .................................................................

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT): .................................................................

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.

Signed (Health professional): .............................................. Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: .................................................................