

# Inguinal Hernia Waiting Lists: Medical and Financial Implications

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In two years, 62 patients presented acutely with symptoms secondary to an inguinal hernia. Nine (15%) were already on the waiting list for herniorrhaphy. On projected figures of bed occupancy alone these patients cost the N.H.S. at least £750 more per patient than those admitted for an elective repair. The medical implications were a minimum of a 12 fold increase in postoperative complications in the emergency cases. The above emphasizes the need to keep the waiting list for herniorrhaphy down to a minimum.

## INTRODUCTION

Over a thousand people die per annum in England and Wales as a result of an inguinal hernia. The operation of elective inguinal herniorrhaphy has minimal mortality and morbidity whether performed as a day case or as a formal inpatient procedure. Inguinal herniorrhaphy is often regarded as a minor procedure and consequently is given little priority on general surgical waiting lists. Results show that there is increased morbidity and mortality from the emergency treatment of inguinal hernias 2, 3. The question therefore arises as to the medical and financial implications of long waiting lists for inguinal herniorrhaphy.

## PATIENTS, METHODS AND RESULTS

Over a two year period 62 patients (55 men and 7 women) with a median age of 66 years (20-94) were admitted acutely with an inguinal hernia. These were compared to age and sex matched patients undergoing elective surgery in the same period on two general surgical firms "A" and "B" in the same hospital. Table 1 illustrates the comparison between the acute admissions already on a surgical waiting list and the elective practice on firms A and B with regard to length of admission, complication rate and length of time on waiting list. Table 2 shows the complications found in all the elective patients compared to all the emergency cases. Nine patients (15%) from the acute admission group were on a waiting list, their median time of hospital stay was 16 days (5-90), one of these patients died postoperatively after a myocardial infarct. Whereas the median time of hospital stay for the remaining acute admissions was 7 days (2-26). In comparison to the median time of stay for routine surgery on average an extra 5 days were required for each acute admission and in the case of those patients already on a waiting list an extra 12 days were required. One patient in the latter group was in hospital for 90 days, if he is excluded the median time for the rest of the group was 7 days, which is the same value as for the acute

**Table I**

**Illustrates the time spent on the waiting list and the complication rate for the routine admissions on two separate general surgical firms compared with those emergency cases already on a waiting list**

	<i>Emergency Admission on waiting list</i>	<i>Emergency Admission not on waiting list</i>	<i>Firm A Admission</i>	<i>Firm B Admission</i>
n	9	53	62	62
Median time on waiting list (range) months	9 (1-30)	/	6 (2-14)	7 (1-26)
Median duration of hospital stay (range) days	16 (5-90)	7 (2-26)	4 (1-13)	4 (2-7)
Complication rate	55.6%	35.8%	3.2%	1.6%

**Table II**

**Complications of inguinal herniorrhaphy**

<i>Emergency</i>	<i>Firm A</i>	<i>Firm B</i>
Urinary retention (T.U.R.P.)	Urinary retention 4	Urinary retention 1
Scrotal haematoma	Scrotal haematoma 5	1
Renal Failure	2	
Orchiectomy	3	
Pneumonia	4	
Cardiac (Death)	4	
Urinary tract infection	1	
Small bowel infarct post surgery	1	

admissions not on a waiting list. The cost of bed occupancy for a 24 hour period in the N.H.S. is approximately £150 (dependent on hospital). Therefore the cost per patient on a waiting list needing acute intervention was an extra £1800, if one excludes our patient admitted for 90 days, a corrected figure would be an extra £750. On top of this figure is the expenditure involved in treating the postoperative complications which in this study included two patients who required dialysis for renal failure.

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Fisch summarizes the main dynamic factors predisposing to genital self mutilation in males as guilt, rage, fear and loss connected with sexuality, homosexuality, rejection of masculinity, 'femaleness' and fantasies concerning incest or birth (7).

### DIAGNOSIS

Self injury, like hysteria, is always at the bottom of any differential diagnosis list. Even when every other possibility has been excluded it is often very difficult to find positive proof in the face of the patient's denial. Based on a series of non-healing ulcers and other lesions, criteria have been described which provide a framework for diagnosis (11):

1. The atypical nature of the lesion (e.g. ulcers spreading in an inexplicable manner).
2. The frequency with which such lesions seem to arise in existing wounds.
3. A previous history of similar lesions.
4. No indignation at any time when the patient is accused of causing the lesion, although this is denied.
5. No replies actually convince the doctor that his diagnosis is wrong.

Catching the patient 'in the act' often convinces the doctor but this is not always conclusive proof and can quite easily be argued away by the patient.

### TREATMENT

Despite the extensive literature on self injury little has been written on treatment. Not surprisingly, preventing the patient from touching the lesion, if this is possible, effects a temporary cure and virtually proves the diagnosis. However as the underlying problem is a psychiatric one, it is likely to recur, occasionally at a different site.

Patients often cause strong feelings in staff who end up arguing amongst themselves. By keeping the external world in polarity and conflict, the patient resists exploration of himself with all its attendant anxiety. Therefore it is important to unify splits in opinion amongst staff in discussion with the patient, to prevent him from believing that they are united against him (15).

Management can be divided into 3 phases (16): In the early (admission) phase the priorities are diagnostic evaluation, reduction of symptoms and facilitation of compliance with any surgical procedures. In the middle (post-surgical) phase it

is important to allow the patient and his family to ventilate their feelings and to provide explanations of surgical procedures in order to reduce anxiety and guilt. The patient's suitability for psychotherapy can also be explored at this stage and begun if appropriate. The late (approaching discharge) phase is concerned with formulating clear future plans, which should include family support, and tackling psychodynamic issues.

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### DISCUSSION

These results confirm the increased morbidity and mortality of surgery and the greater financial cost to the N.H.S. for the emergency treatment of inguinal hernias. The recent C.E.P.O.D 3 report showed that 59.2% of deaths due to inguinal hernias were in patients presenting as an acute emergency and in that study half the deaths were potentially preventable.

In this country 17.3% of inguinal hernias present as an emergency 4. By extrapolating from our figures above this means that nearly 1 in 5 inguinal hernia repairs costs at least £750 more than if admitted electively. Furthermore the cost of treating the resultant complications adds even more expense.

This study shows that surgically treating patients with inguinal hernias as rapidly as possible is desirable from both a medical and financial viewpoint. The long waiting lists for

inguinal herniorrhaphy in this country need to be urgently reduced, this could be achieved by increasing the facilities for day case surgery 5.

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