

# Blocks Help Hernia Patients Go Home Faster

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IN INGUINAL HERNIA REPAIR, past is prologue. Despite its “state of the art” cachet, enthusiasm for laparoscopic hernia surgery has waned. Lap hernias take longer, pose a higher risk of bladder and vascular complications, and incur much higher supply costs. The problem with open inguinal hernia repair, though, is that it’s more painful. This hinders recovery and makes it much harder for patients to void, significantly prolonging discharge. Patients typically say: “As soon as I try and press down, it hurts, and I have to stop.” The good news is that a new approach to pain management—short-acting spinal anesthesia with an ilioinguinal iliohypogastric(II/IH) nerve block performed in the recovery room—is an excellent way to manage the pain, promote voiding, and help patients go home sooner.

Here’s how it works. Before the procedure, the anesthesiologist administers a short-acting spinal block. Spinal anesthesia virtually eliminates the PONV seen with general anesthesia. Lidocaine is an acceptable choice; but in many patients, it causes moderate to severe back and buttock pain lasting up to 24 hrs. This symptom constellation is called TNS. I prefer preservative-free 2-chloroprocaine (2-CP) since it provides rapid, intense muscle relaxation with no TNS. My usual 2-CP dose is 35-50 mg for hernia surgery. It lasts 30-60 minutes, and motor recovery is quick. To prevent or minimize spinal headache, I use small-gauge pencil point needles.

Immediately after surgery, the anesthesiologist administers an ultrasound-guided II/IH nerve block. Even though paravertebral block offers a perfect triad of segmental anesthesia, muscle relaxation and prolonged post-op analgesia, the II/IH block is more practical. Paravertebral blocks have a “soak time” of 20 to 30 minutes, and in our center, pre-op beds are at a premium, hernia patients often arrive late, and surgeons prefer to enter the room with the patient prepped,



A B. Braun 22G Epidural Needle used for a U/S guided II/IH block.

draped and fully anesthetized. The anesthesiologist can perform II/IH block right after surgery in the recovery area in less than five minutes, provided the ultrasound and block supplies are ready to go.

Ultrasound guidance is important because it improves block accuracy. Traditionally, practitioners performed these blocks using the iliac crest as a landmark, with tactile feedback to advance the needle through the fascial planes. These “pops and plops” are a little unreliable, and blocks are incomplete in 20 to 30 percent of patients. With ultrasound, the anesthesiologist can visualize the needle entering the fascial plane between the transverse abdominus and internal oblique muscles. Even if one can’t see the small nerves directly, local anesthetic injected in this plane reliably blocks the nerves.

By performing the block in recovery, after transferring monitoring responsibility to the recovery nurse, even the solo anesthesia provider doing consecutive cases can take advantage of II/IH blocks. This block also works well for patients who prefer general anesthesia. The practitioner can also perform these blocks pre-operatively. In each scenario, the improved analgesia will help patients recover more quickly, void faster, and go home sooner—keeping your patients happier and your facility efficient.

*References supplied upon request.*



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