Dr Prashant Philip Das

THE PATIENT'S HANDBOOK

Ventral Hernia Reconstruction rebuilt from within.

An in-depth guide to laparoscopic eTEP-RS repair — an advanced, minimally invasive technique for umbilical and ventral (midline) hernias that rebuilds the abdominal wall and places mesh in a strong, natural plane.

Laparoscopic eTEP-RS | Abdominal wall reconstruction | Retro-rectus mesh placement

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START HERE

What this handbook is for

You have an **umbilical or ventral (midline) hernia**, and an advanced keyhole repair called **eTEP-RS** has been recommended. This is a modern technique for abdominal wall reconstruction. This guide explains what these hernias are, what makes eTEP-RS special, what the operation involves, and how recovery unfolds — so you can decide with confidence.

Understanding ventral & umbilical hernias

A **ventral hernia** is a bulge through a weakness in the front (midline) of the abdominal wall. Common types include:

Umbilical hernia

A bulge at or near the navel (belly button), through a natural weak point. Very common in adults.

Incisional hernia

A hernia through the scar of a previous abdominal operation, where the wall has not fully healed.

Epigastric hernia

A bulge in the midline above the navel, between the breastbone and belly button.

Recurrent hernia

A hernia that has returned after a previous repair — often best addressed with a robust reconstruction.

Midline
where these hernias occur

Retro-rectus
where the mesh sits

Keyhole
minimally invasive approach

Durable
built for large & recurrent defects*

Why these hernias need repair

Like all hernias, ventral hernias are mechanical gaps that **cannot heal on their own and tend to grow**. As they enlarge they become harder to repair and carry a risk of bowel becoming trapped (obstruction) or losing its blood supply (strangulation) — an emergency. Planned reconstruction while the hernia is manageable gives the best, most durable result.

THE OPERATION

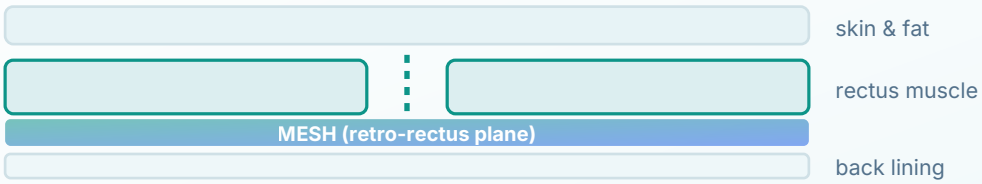
What eTEP-RS means

eTEP-RS stands for **enhanced-view Totally Extra-Peritoneal, Rives-Stoppa** repair. It sounds complex, so here it is in plain terms:

- **Enhanced-view, Totally Extra-Peritoneal:** the surgeon works in a plane **outside the abdominal cavity**, behind the muscle — keeping instruments away from the bowel.
- **Rives-Stoppa:** a long-respected principle of placing the mesh in the **retro-rectus space** — behind the strong vertical muscles, in front of their back lining. This is widely regarded as one of the most durable places to put mesh.

The midline defect is closed to **rebuild the abdominal wall** into its natural shape, and a large mesh is laid in this protected plane, where the body's own pressure holds it firmly against the wall as tissue grows in.

CROSS-SECTION: WHERE THE MESH SITS



midline defect closed — wall rebuilt

Mesh sits in the protected retro-rectus plane while the midline is reconstructed — a strong, natural repair.

Why eTEP-RS, instead of older methods?

eTEP-RS (this technique)

- ✓ Keyhole — small incisions, less pain
- ✓ Mesh in the durable retro-rectus plane
- ✓ Mesh not in direct contact with bowel
- ✓ Rebuilds the wall to natural shape
- ✓ Well-suited to large & recurrent hernias
- ✓ Faster recovery than open reconstruction

Older / alternative approaches

- × Open repair needs a large incision
- × Some methods place mesh inside the cavity
- × Simple suture-only repairs recur more often
- × Longer hospital stay & recovery (open)
- × Still appropriate in selected cases

Is the mesh safe?

Mesh is a sterile, medical-grade reinforcement used worldwide. In eTEP-RS it sits in a natural tissue plane **away from the bowel**, which is one of the technique's key advantages. It greatly lowers the chance of recurrence. Your surgeon will explain the specific mesh planned for you and why.

BEFORE THE DAY

Preparing for surgery

Because this is a reconstruction, good preparation helps your repair last. Optimising weight, blood sugar control and stopping smoking before surgery all measurably improve healing.

1 **Pre-operative assessment**

Blood tests, imaging (often a CT scan to map the hernia), and sometimes an ECG or chest X-ray. Tell us all medical conditions, allergies and previous surgeries.

2 **Optimisation**

Where relevant, we'll advise on **weight, blood sugar control and stopping smoking** beforehand — these strongly influence healing and durability.

3 **Medication review**

Blood thinners and some diabetes medicines may need pausing. Never stop anything without instruction — we'll guide you.

4 **Fasting & admission**

Empty stomach for anaesthesia (usually no food 6 hours, no clear fluids 2 hours before). On admission: gown, consent, and meeting the anaesthetist.

✦ Bring with you

- ✓ All previous reports, scans (incl. CT) & prescriptions
- ✓ A list of current medications
- ✓ Insurance / cashless card details
- ✓ Loose, comfortable clothing
- ✓ A family member or friend

✦ Leave at home

- × Jewellery & valuables
- × Contact lenses (wear glasses)
- × Large amounts of cash

On the day of surgery

ARRIVE

Admission & check-in

Paperwork, consent confirmation and gown. The anaesthetist plans your anaesthesia and pain relief.

ANAESTHESIA

You go to sleep

The reconstruction is done under general anaesthesia — you are fully asleep throughout.

THE REPAIR

Reconstruction

The retro-rectus space is developed, the midline closed and the mesh placed. Duration depends on hernia size and complexity.

RECOVERY

Waking up

You wake in recovery, monitored closely, with pain managed proactively. An abdominal binder may be fitted for support.

STAY

Hospital stay

A short stay (often a day or two, sometimes longer for larger reconstructions) lets us ensure comfort and early mobilisation.

RECOVERY

After your operation

Recovery from a wall reconstruction is steady and rewarding. You may be given an **abdominal binder** to wear, which supports the repair and improves comfort. Expect tightness across the abdomen at first — this is the rebuilt wall, and it eases as you heal. Early gentle walking is strongly encouraged.

Your recovery timeline

DAYS 1–3

Mobilise early

Regular pain relief, the binder for support, and short frequent walks. Wounds kept clean and dry.

WEEK 1

Settling at home

Discomfort eases day by day. Light activity around the house; continue the binder as advised.

WEEKS 2–3

Return to desk work

Many return to light/office work in around 2 weeks, depending on hernia size and your job.

4–6 WEEKS

Building back strength

Gradually resume exercise and lifting over 4–6 weeks, guided by comfort and your follow-up reviews. Avoid heavy strain until cleared.

✓

Do

- ✓ Walk gently and often from day one
- ✓ Wear the abdominal binder as advised
- ✓ Take painkillers regularly at first
- ✓ Keep wounds clean and dry
- ✓ Eat fibre & drink fluids to avoid straining
- ✓ Support your abdomen when coughing

×

Avoid

- × Heavy lifting for 4–6 weeks
- × Straining on the toilet (treat constipation)
- × Sit-ups / core exercise until cleared
- × Driving until pain-free & alert
- × Soaking wounds (baths, pools)
- × Smoking — it significantly slows healing

i Swelling & the "healing ridge"

Some swelling, bruising or a firm ridge along the repair is normal as tissue heals and fluid is reabsorbed; a fluid collection (**seroma**) can also form and usually settles by itself. Wearing the binder helps. Raise anything large or uncomfortable at your follow-up.

SAFETY

Risks & when to seek help

eTEP-RS is an advanced, durable repair with an excellent track record, but reconstruction of the abdominal wall is bigger than a simple hernia repair, and carries risks that we discuss with you fully. Serious complications are uncommon.

Generally minor & common

- Abdominal tightness & soreness
- Bruising and temporary swelling
- A fluid collection (seroma)
- Tiredness for a couple of weeks

Uncommon, discussed with you

- Bleeding or wound infection
- Mesh-related infection (rare)
- Injury to nearby structures
- Recurrence of the hernia (low)
- Conversion to open surgery
- Chest infection or clots — reduced by early walking

! Contact us or go to A&E if you have:

- **Fever or chills** (temperature above 38°C)
- Severe or increasing abdominal pain not eased by painkillers
- A rapidly enlarging, hard or very tender swelling
- Redness, swelling, warmth or discharge from a wound
- Persistent vomiting or a swollen, distended abdomen
- A swollen painful calf or sudden breathlessness

✓ Your follow-up

You'll have review appointments to check wound healing, manage the binder, and progressively clear you for activity and lifting. These visits are an important part of a lasting result — please keep them, and bring your questions written down.

Common questions

Why is recovery a little longer than for a groin hernia?

Because the abdominal wall is being reconstructed, not just patched. The repair is strong but needs a few weeks to mature — hence the gradual return to lifting and core activity.

Will I need the binder forever?

No. The abdominal binder is for support in the early weeks of healing. Your surgeon will tell you when you can stop wearing it.

Can large or recurrent hernias really be done by keyhole?

Yes — extending the principles of open reconstruction to a minimally invasive approach is exactly what eTEP-RS is designed for, including many large and recurrent defects.

Is it covered by insurance?

Most laparoscopic hernia repairs and reconstructions are covered by health insurance and cashless schemes, subject to your policy. The hospital's insurance desk can verify cover before admission.

Questions before your surgery?

Bring your reports and scans, and your list of questions, to the consultation — an informed decision is always the best one.

SURGEON

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