Academy of PHYSICAL MEDICINE

Transcript

Treating Hernias with Simon Marsh

Steven Bruce
Welcome to the Academy of Physical Medicine. As always, it was great to have you with us. You settled in for another great evening of CPD because I have got back one of our very, very popular guests. A gentleman who was with us some time ago, he came on the show, then to talk about hernias. And as you probably saw from that insubordinate email that went out from Ana this morning, I steered the conversation down the path of Gilmore's groin. So I'm not allowed to make your noise growing more than five times this evening to gone already. I guess my guest, is consultant surgeon equally 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. So if I suffice it to say now that not only the surgery director and the guild was growing, three, three, almost growing and hernia unit, also had one of the mechanisms for repairing named after him, I think, I think I'm nearly out to a number the number of times I'm allowed to say that topic to talk about that anymore. We're going to talk about hernias this evening, otherwise, otherwise, I'm gonna get a really good kicking from my wife and I see you in a couple of days time. Simon, Simon, it's fantastic to have you agreeing to join us. Just on a visit to see somebody fairly famous some time ago.

Simon Marsh
Yes, Steven. Firstly, thanks for having me back. As you know, I really enjoy doing this sort of thing. I'd love to have you back. If you want to mention Gilmore's going 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 do remember who I actually knew for years and used to visit him in his house in the selfie quite a few times even took my children see him once. But the first time I went 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 into his house into a study. He just kind of sit there Sit down, sit down, sit down, sit down, sit down anyway, like we all look 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 100 Natoma Street. We'll tell people how to contact us later. But 108 Harley Street is the name of your practice,

Simon Marsh
is it not? It is yeah, it's a bit like if you like a medical chambers, there are different groups of specialists all work together. So yes, we've got the groin. In her new 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 dermatology group, very popular for skin lesions on we have plastic surgeons, and radiologists and so on. So it's lots of doctors all working together. And the thing that that I most enjoy about is everybody gets on. So whatever you do we all get on. And there's no 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 and I've been there 23 years now. I'm still going strong.

Steven Bruce
Last time, but it's really strike me then. breast surgery seems slightly removed from hernias. And that other thing I'm not allowed to mention.

Simon Marsh
Yes, you will be given was growing. Yes. I think what happens when you train or at least when I trained you trained as a general surgeon. So you did 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 out, 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
Will 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. If I'd been winking that number of times, I think was 27 times apparently I've said it that's turned to hernias. Do you deal with all different types of hernia? or does it get more specialised than that? Now

Simon Marsh
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 other 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, another condition called phenol Keaton area 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 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 can get muscle hernias. If you damage your muscle and the damage the 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 or garden inguinal hernia. 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 one 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 I work with 108 Harley Street who deal with and particularly things called incisional hernia. 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, me Derek Shan particular, he's very good at dealing with these much more complicated incisional hernias as well. So in the group will 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 talking. This is how you recognise hernias. And I guess that I'm going to put a rough statistic nine times out of 10. Is it fairly easy to recognise a hernia? Or are there Are there cases where we get where we are going to miss it and we ought to be looking for other more subtle signs include

Simon Marsh
it is 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, move around, it's more obvious. If I lie down, I can push it back in, it's a bit squishy. And that's the sort of classical thing you're looking at. Now, if you've got a number like a 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, 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 interesting, if you think about how a hernia happens, and you have all the muscles in the groin, you're 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, got this ache in my groin. And often they describe 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 gonna 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. No, 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 the inguinal hernias. femoral hernias tend not to go back. And the unreliable ones are more difficult as 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 how things poke through their muscles?

Simon Marsh
Yeah, but 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 80,000 hernia operations a year in United Kingdom. Now it is unfortunately one of the things along with hips and knees and gall bladders that has been put on the back burner because the NHS has been struggling dealing with the COVID pandemic and he'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, there's my own when my other hand there's a breast cancer backlog that we're trying to catch up with. So lots of operators 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
Yeah. Hello Kitty. 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 sign up 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 just in Wainfleet just down the road. And if you want an inguinal hernia done, and it's used as an eight day case, it's about 3100 pounds everything so surgeon he says hospital all done follow up as well. 3100 They're all there about right.

Steven Bruce
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 were 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 you can feel is 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 boundaries 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 Fitz Givens that many people find and can look up easily, where they took a chance with what they called minimally symptomatic hernias. So small hernias or wonder 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, well 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 I need an operation so they swapped groups in and about 20% of people they said we'll have an operation before it came to the operation days in our deputy fatten operation we'll just keep an eye on it. So there's a bit of change round almost sounds

Steven Bruce
like very poor poor risk protocols to me.

Simon Marsh
Yeah, I'm not sure it's as rigid as it could be. But it's a it's it's the information the NHS uses to justify not having to operate on hernia so to ration it if you like nobody, the NHS don't like using the word rationing, but hernia repairs mean ration for a long time. It you know, 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 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 shouldn't have done it 10 years ago when it wasn't gonna cause 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 future. And as you rightly say, almost all inguinal hernias ruin the men 98% of inguinal hernias when men, tube centre and 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 ordering or hernias and a third of the femoral ones. 98% of femoral hernias are in women to centre in men. So you have all these figures that tell you which more common but inguinal hernias are still far more common.

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

Simon Marsh
much less obvious, was 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, increasing work your way in, there's a big femoral nerve than 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 ignore things. Else that question

Steven Bruce
is because Sue had sent in an observation series, one of our regular contributors on this show. And Sue, thanks very much for your 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
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 Sati 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 pleases our radiology

comes and does that for us, I'm always in there as well. So you can watch and see. Because if you just get an old sound report, you often don't see what's going on. But it can be quite difficult. And I hope so he's had it all fixed, and it's fine. But I'm actually looking, I've been sent a chat 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 the femoral vessels and then said anything or heard anything 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 them where I can see what's going on, because it could be an enlarged note. I don't think it is. I think it is a femoral hernia in the chat. But I want to be able to see it myself. So I'm going to operate on Sunday. 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 yeah, I'm sorry for it was delayed, but but I do appreciate can be quite difficult. Yeah.

Steven Bruce
Yeah. And what's the when we're taking into account the 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 other causes? Or 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 I missed them I just programmed in, they're gonna 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 Lord man in the back of the car, and I slipped, 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 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 to. So I don't automatically fix assigned as normal, just in case because nine times out of 10 is 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 the truly elite here then if only 5% get to 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 what point at what point should Chris panic and get him into a&e? Because he's 78

Simon Marsh
Oh gosh. So it sounds like it sounds as your recurrent one on one side porch. Yeah, that's not common either. Yeah, and this is exactly what so this is a problem now we're getting them done with the NHS it's difficult I think as long as it goes back and if it if it's a bit painful, a bit uncomfortable thing too 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 belong to

a&e. I sympathise entirely because you know, if somebody came to see me with that, you know, 100 highs during 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 test to go through but those being less and less. If somebody you know, 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. It's where it doesn't go back where it feels tender to me as well as upstart being sick that that's the emergency that you need to get into a&e About

Steven Bruce
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 the phase where it is obstructed, then strangulation is the next phase. I would suggest you get in you know, 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 as a guideline?

Simon Marsh
Yeah, I think you just get into if that's happening, it doesn't go back if he got swollen from you being sick. You go straight in.

Steven Bruce
Yeah. Okay. I just 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. You can almost only 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. Yeah, okay.

Steven Bruce
D has asked what the best treatment advice is for patients who have congenital hiatus hernias and go on to develop Barrett's oesophagus 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 thoracic surgeon I was training and we used to regularly do telescope tests on people with Barrett's oesophagus, and take biopsies to make sure that they weren't becoming cancerous. So there is a higher risk of having it done. For hate as hernias these days is not something that that we do, but you can have telescopic surgery small holes to pull the stomach back down to the chest, you can have it fixed. And if you do that, that reduces the amount of acid that goes into the oesophagus. And that's what you need to do to stop the bad oesophagus 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. Um, you did say that you were you were a bit further south, in in your PIP so going back to the NHS thing here, and and as 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 to be several years, unfortunately, I think it's going to be an awfully long time. And it's just 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 people, you know, people have got paid for hips and painful knees, you know, 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
There right there. I suggest 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 like virtuous because I work half the week in the NHS, and then totally separately, I work half week privately. So I don't want this wasn't directed at you. But I'm just 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 on part time or part time, in the NHS consultants work, you know, there's 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 difficulties, 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 to also work 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 in 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 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. 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
there. 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. Yes, 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 confused lung years ago as well. I broke my collarbone falling off a horse. Yeah, I'm not sure why we still got with even I don't ride anymore. And I try not to go around the back end. That's all I'd say

Steven Bruce

now. Well, somebody should explain this to my wife, Claire, I think Oh, my ory back to this might be too early. I've got I've got one question from Simon Simon. I've got your question here. And you you said it's probably a bit too early. I'll save it for later because I suspect that So Simon will cover it. But my Yuri 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 and your rehab?

Simon Marsh
Yeah, I think in terms of what you do with a hernia while you're waiting 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 say it 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, I go on Friday. And what I say is for the weekend, it's just walking around little often to loosen everything up that 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 the 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 you know what to do. So the exercises will help strengthen the muscle because 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 than the strength thing. But also, it probably reduces the chance of the 10% getting one the other side. So I think the exercise are really important. But before it's done, just don't do things that irritate it is that simple.

Steven Bruce
In the in the old days, people used to regularly I think prescribe doctors used to prescribe trusses to support hernias. Is anyone that done these days to stop them from popping up?

Simon Marsh
Yeah, people do still wear trusses. And I think the only real situation that useful is if if you have got a hernia and you genuinely are unfit for an anaesthetic of any sort, then I trust my help. Now there are two sorts of hernia inguinal hernias you get and their cause direct ones. And these ones come straight out through if you like the posterior walling or going out 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 time which one it is before I operate, so it's not perfect, but just is work better with the direct ones that poke straight through, because you can put your bang put the trust on. Now although most of the time I will do hernias under general anaesthetic, and the reasons for that are general anaesthetics are really safe. And more importantly, when you have a general anaesthetic, the muscles are relaxed so you can move them round and get a much better repair. If you're doing it and atomically in suturing, you get a much better safer repair. You can do it under local anaesthetic, and I do occasionally but only if people are really unfit for general anaesthetic and with a local anaesthetic, 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 anaesthetic, 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's a big hernia or a small hernia or a big chapter or a small chair, almost always these minutes so it's not a long

operation in my hands. You get the anaesthetic very quickly and gentle so it's a safe and it's just more comfortable. So by choice, daycares, general anaesthetic, local anaesthetic, if you 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 ruined, you get a lot of scar tissue which can make it more difficult to fix.

Steven Bruce
What why is that? Why? Why the increase in scar tissue? What's the thing? Yeah,

Simon Marsh
it's just the pressure the trust puts on it. And they come and go and come and go and you keep on the trust on it just gets irritated and scars.

Steven Bruce
Right. Okay. Thank you for that. I've had a question from we haven't we haven't got on to what you do to fix or treat 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 else is there any difference in approach to fixing hernias in URL as danlos patients?

Simon Marsh
Ehlers Danlos patients have an I'm sure the 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 I suspect there might be a higher incidence of problems with meshes, I'd 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 inflammation of the complication and risks, I would say, there is probably a slightly higher chance 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 gotta 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. It's a

Simon Marsh
Yeah, it's it's a sort of belt that you wear. And it's got a pressure pad on it. It's got it sort of in large bit with how to describe it. It's, it's, 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. And they're a bit unwieldy. You're right, very popular in the old days. But so 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. And I think we've just frozen.

Steven Bruce

During just going on with Microsoft Teams, are we back again? Gotcha, gotcha. Good. Excellent. Thank you. I was just preparing to ad lib and do a bit of song and dance and comedy routine there for a minute. But fortunately, the audience are spared that. 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, in surgery in practice.

Simon Marsh
Yeah, has one of the things that interests me in in medicine surgery is 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 anaesthetic. So really, until we had good general anaesthesia, 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 Ursini, the Italian surgeon was probably the father of modern hernia surgery, because with general anaesthetics and also antisepsis because he was the Italian women, Joseph Lister, Josie lived in this country developed anti sceptres and made surgery safer and besieged. He did the same initially 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 Terminate comes through the inner layer of muscle where it's called the deep inguinal ring. It runs along the inguinal canal then comes out through the superficial inner ring then goes down into the testicle. In women there's a similar much smaller thing called the round ligament, the uterus, so the anatomy is similar. But in men, these rings are bigger. And that's why men hernias are common. So he looked at the anatomy look, the function and 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 more perhaps 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 vicini, you know, 200 years ago was better than that. He had seven wound infection and 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 surgery. There was a TB, there was pneumonia and so on, but he followed the 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 19. So did 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 shoulders clinic started in Canada in Toronto. Edward L showed I set it up as a business to fix hernias described as helping men join In the draft, because if they had a hernia, they couldn't be called up. And if you fix the hernia, you could be good. And he was helping these young men join the field 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 vicini did they would do this anatomical sutured repair, take the hernia sack off, push the stuff back, fix the muscles, that's what they do. And this is how people like me who are over 21, learned to fix hernias in the 80s in the early 90s, nice training, this is what you did you learn 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 mesh is turned up. And a guy called Oh Lichtenstein who worked in Los Angeles,

California, thought about he said, I can't be bothered learning the anatomy, the groin I'm just gonna stick a big plastic pack to Richard strengthen it on top of the hernia so the hernia can't come through. And this is where the listener Stein repair came in. And I already learned to do shoulder 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 registrar's Junior surgeons consultants didn't do surgeons they took the hernias, they gave them all the registrar's 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 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 put an even bigger mesh across the whole of the inside of the tummy stop hernias coming through. And then what happened is that I mean, a few years ago, people be aware that we started to get concerns about do meshes cause chronic pain. And this became it started with operation that gynaecologists did for for women with prolapse and so on. But it's it's run on to do these cause pain in men who've had hernia repairs. Now what I would say is do you remember what you said, you know, 70 80,000 hernias done a year? 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 and say I'd like a hand repair and I wanted done without a mesh. And I can't find anybody else to do it. And you know, nor can I honestly. So yeah, I'll do without a mesh. Again, I will warn, 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. But to little, put a little mesh plug through the hole where the hernia goes through the back. So it sits behind the muscles, it's not a big 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 uncover 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 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 shoulder 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 shoulder square without mesh. Again, I can't prove the current rate 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 the full circle from being the pure anatomical repair from Eduardo ever seen in the 1860s and 70s. Through the shoulder, sue the mesh and back if you like to the anatomical functional repair, bearing in mind, again, most people would say well, you have it done fine. And perhaps a surgeon is 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 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 don't didn't have any problems. But it takes a long time to learn. Yeah, from 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 barrier is 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 Pantheon was growing. Because to fix Gilmore's growing needs a thorough understanding of the function and anatomy of the groin put the muscles back so they work properly. And you can transfer that through learning the shoulder, I say, need to doing non mesh suited 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've told, you've 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 have somebody on the 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 don't know how to do it. These are established consultants that probably ask them out there. You know, I'm, I know I don't look at I'm 60 this year, obviously, I don't look that 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. But what do you remember for the horses? Well, there is that all the donkeys, all the pigs. But one of the things we do, one thing I'm very keen on in high 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. Young lady surgeon who worked with us very good understand the growing. And she's now the same age I was when Jerry took me on board. So we'd like to reduce this next generation to keep this specialty going and the expertise going. But it is 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 the is the blue stained glass in sharp to 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. Yeah,

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

Simon Marsh
Yeah, I think 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 seating repair. So I don't think it's picking 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 which these medical technology companies produce these really clever insurance they are 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 know, 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
because nobody wants a scar on their abdomen. Right Miss mainly men they get inguinal hernias pretty much in 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. So 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 epidural minimally invasive because you're right the scars are very small and you can do a little scar on the belly button or one either side and sometimes just one more. But then you got to think about what you do on the inside. Then when you think about that the area that you will deselect to put in a mesh laparoscopically is three times larger than the area I will deselect to do it from the front and the volume you have to deselect 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 is not very big and you put it in a crease and you can put it below the line have 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 could see his little scars. And I did his bilaterals hernias. For him. He was one of the 10% with very low scars. So you could wear skimpy underwear and still be photographed and have no scars showing.

Steven Bruce
Gosh, you mentioned a few minutes ago, the importance of the surgeon now to me that 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 that's certainly true. And again, we've got another side of the 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 it to a certain extent, it's true that the more you do, and here we are, and you can see the low line on the right hand side is the sholde ice clinic. And they say you know they have a they have a 1% recurrence rate. Rather than 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 youngsters, the elbow 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 burst. 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 or your funerals and got possibly in Scotland, you were more likely to survive anyway. And what they said was if you did more, he were better but very minor a couple things. One is, as I say, if you've got hospital 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 the few. And I hate to say it, but yet you've got to be fairly good at what you do as well. So all those things help.

Steven Bruce
Okay. Are you 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 somebody who hasn't done 1000s of new replacements? Yeah,

Simon Marsh
we've dropped specialties they actually move into orthopaedic surgery. But what I would say if you've got somebody who's done hundreds of bowel resections, and they can be pretty good at fixing hernias, because that general surgical side of things. Yeah,

Steven Bruce
we're a few years old now. And we were most orthopaedic surgeons worked on pretty much every part of the body, didn't they? And maybe not the bowel, but so you know, everything seems to be much more specialised these days.

Simon Marsh
It doesn't you have the neck, the hip guys and the knee guys and the shoulder guys and the forearm guys. And when I when I had my arm kick 10 years ago, and I ended up in the local casualty of Nepal seven on Sunday evening. And the uncle 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 will plaster it up and you can have it done in the morning. I'm on 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 you know, the old fashioned general serving as we said in I did everything when I trained. But now you know you are a breast cancer surgeon or you are a bell 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 is people know, as a military town, and we had a squad he bought 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 and a couple of bits of bowel. He got damaged to one of the major blood vessels climb the leg. He'd got a little laceration to the kidney. And he actually got Nick on his aorta, this major blood vessel, and as a general surgeon, you did all that and we fix this chap. He went home Believe it or not seven days later, having had a long operation to the night and had 40 units of blood and he went home within a week because the general surgeon in those days that 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 did Coke, colorectal surgeon if there's a vascular injury doing a vascular surgeon and when all these people come from at two o'clock in the morning when a chap being picked up and rushing outside the pub

Steven Bruce
from a soldier's perspective, I suspect that his regimental Sergeant Major will say that it was just good training and he was having a practice bleed but

Simon Marsh
yes, and the other thing about these guys is they are so fit that if that happens To me, I probably would have died at the roadside. But these guys fit and they compensate so their body can shut down and compensate. So yeah, 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 some of the 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 when I don't know if you know, do you know much about what osteopaths and chiropractors do? Yeah, no, no. Okay, great. So when we say articulation, that probably means stopping short of making the joints crack. But it means lying on their side and giving some forcible wobbles to the lumbar spine, vertebral joints into vertebral joints. And with the hip. Well, I mean, you had to articulate a hip, I'm sure. And he 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? You think there's any likelihood that that treatment could have caused that?

Simon Marsh
Now I go back, I go back to my point, I think most healing is 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 things has happened. But what interesting, so we've talked about the inner one, but you can get rare hernia sort of near the hip drawn, you can get sciatic notch hernias, and you can get obturator hernias. And I remember doing again, as a young consultant doing an operation 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 rid hernias round that round the hip in different areas, the principle is still the same, you have to push the hair in your back, say for the operator, and we did put a machine because it's low down in the pelvis. But this was maybe 20 years ago. But no, I'm not gonna blame the treatment for that I think these things just happen.

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

Simon Marsh
that we did. Because Because human beings we like to think, well, I got this because of this. And 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
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. Right.

Steven Bruce
Okay. Now is 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 happens 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 was about 2000 hernias. 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, he probably haven't done that many. So I guess you somebody else. So you hope you hope it's a lifetime thing. But nothing in medicine is ever always or never

Steven Bruce
gonna 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 do with all the patients who turn yours have failed come to you and say it didn't work or they've gone to someone else.

Simon Marsh
Yeah, do you know? And 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 but I'd like to think 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 probably come back and tell me and I generally don't think there are dozens of records out there that I don't know about. That's a fair point.

Steven Bruce
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 they didn't move. And then particularly the laparoscopic ones. People started using metal staples, and then you started 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 cloth glue takes a little while to set. And while it's setting, bits of Bell can get stuck to this glue, which is even worse. And I've seen all of these complications in hernias, the metal stapling a terrible idea. And they can come out and slip and move and cause pain and you get measures 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 mess inside your tummy, that's pretty

much impossible. So if you're having trouble with a mess, it's inside your tummy laparoscopically, you're in a difficult position, because that's really difficult and very dangerous take out, it wraps itself around the blood vessels and the nerves. And that's almost impossible. Now you can get meshes out there 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 meshes out of they find that their pain gets better. I talked about Robert ben David who run the shoulders clinic and how we used to go around Europe lecturing. And they had a much bigger series at the show nice clinic. And what they would say was if you take the message meshes out, a third of people find they get better. Third of people get a bit better, very small number get worse. And another small number, it makes no difference. So in two thirds of the people who 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 mesh is might cause chronic pain, as well as the fact it's a foreign body and inside you. They've got evidence and studies that show that nerve 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, you can they've got lots of lovely pictures showing 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 most people have heard us fix the 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 what are hernia? What is the material that's used to repair her knees? I think you say was plastic earlier? Yeah,

Simon Marsh
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 and a mesh. We mentioned the incisional hernias, through large scars in your tummy. And sometimes you can't bring those together. And this is where Mr. Derrick share my colleague comes in, 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 are 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 ordering or hernias.

Steven Bruce
Well, I'm going to question about our own differentials in what we do in that if we see a patient who's had a hernia repaired by whatever met, 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 gonna start articulating their lumbar spine articulating their hip, whatever it might be. Are there some 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 muscular skeletal stuff?

Simon Marsh
Yeah, that's gonna be really difficult because you're right, it's gonna be hard to tell because as we said, when we talked about Gilmore's growing, or glass, I'm saying it again, 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. Okay, if it's a recurrent hernia, they're probably going to tell you they can feel another lump. So that's probably gonna 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 growing crease, which is you know, is where you tend to get pain from the hip joint is in the groin crease goes down and legging into your 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 to say it's it's very difficult to get Are these because the mesh just gets enclosed everything and wraps around all the blood vessels and nerves? Really difficult situation? That might

Steven Bruce
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 unnecessary it is, and what her risks are. She's actually active in swimming and running apparently. Okay,

Simon Marsh
these little umbilical hernias, which were little bits of fat, quite safe to leave alone if they cause no problems, not at all worried about those. The diversification the vectors mass, as we call it, where the muscles literally get the bolts down. Yes, you can do something about that. That's done by the plastic surgeons, when that's a big operation to open up the tummy and pull the whole thing together. If you've got a small umbilical hernia, they can usually fix at the same time, but that's a much bigger operation. But an isolated small, little nubbin of fatty tissue in your belly button cause you know, trouble leader leg? 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 paediatric patients. What's the procedure after two years if they haven't self repaired? If surgery is required? Is it the same procedure is in an adult patient? Is there anything you advise as a non surgical option? Patients asked 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 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 you rightly says over one or two years. Now, again, remember that paediatric surgery is a distinct specialty. Now, I don't I'm afraid to anybody under 18 anymore, but I did do paediatric surgery as part of my training, so 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 inner child.

And you would probably only need a small number of stitches put that back. Relatively straightforward. But the important point is a lot of them do get better with their dough. Yes, I wouldn't do anything else. It's an operation.

Steven Bruce
And you also 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 dresser is not advised.

Simon Marsh
And certainly not a child now. Right?

Steven Bruce
Okay. W 5.6. I told you they get funny names from our system sometimes. W 5.6 says what diameter of an umbilical hernia would be considered unnecessary surgery, privately buy health insurance or a private surgeon?

Simon Marsh
Oh, gosh, you know, I'm going to say there's probably going to be not much difference, it depends on how my symptoms it cause you, you can get a lot of symptoms from a small number like Ernie, you can, if the little fatty bit that comes through twists, and that the blood supply to that is compromised. It's not dangerous, but it goes a lot of discomfort. Now, I used to work with a niece just many years ago. And he had little umbilical hernia and one Thursday were operating and he kept clutching his tummy. And this was a bit sore. And I looked at him right that probably needs doing. So what he did was the following morning, very early, he got a colleague of his coming east, I see him and I fixed 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 hurt is gonna get bigger, and you might end up with bow 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 is more straightforward than the inguinal hernias. And again, you can do it from the front. If it's in the unblock as 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 in any so the belly button just gets anchored down to a bar isn't any. The recurrence rate for those is slightly higher than the inguinal ones because it's in general a weakness. So probably even in my hands, I'm afraid it probably is about 5% recurrent 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

Simon Marsh
it. You know, we call it diversification of directors and verification. It's exactly the same thing. And it just means a splitting the muscles, and I've got to be exam 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 with the rectus diastasis diversification salesperson got an epigastric hernia. Can you fix it? The answer is No they haven't. Now I won't. Because it's

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

Simon Marsh
it's a cosmetic operation. So if you've got it, what you do you come through and 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 transverses 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 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 not attractive in a younger anyone really?

Simon Marsh
No, it's not. And this is where the the plastic and reconstructive surgeons comes in. But I'd 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 a while to get over it. It can 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 and groin hernia that doesn't cause them any pain or discomfort. Is it okay for him to carry on playing squash and cycling or will exercise make it worse?

Simon Marsh
Now, 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 you know, 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, the sporty chap, I would certainly recommend doing it the shoulder sway sutures only and not putting any plastic in. But again, it goes back to point if you've got an asymptomatic hernia, you're young and fit when you're older, not so fit, it can be more perhaps more tricky to do it or more risky with anaesthetic. Okay,

Steven Bruce
Stuart has asked whether developing an inguinal hernia can crew 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 the ironing and all janitor femoral nerve that can be stretched so you can get that sort of discomfort. Most hernias once you've got the lump, as you don't cause much pain at all this is it's this initial stage where perhaps the muscles are stretching and tearing that I find can

cause the discomfort but once the hernia is there tends not to cause too much trouble apart being present until it gets bigger and then it gets more achy.

Steven Bruce
Right. Okay. Johnny 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. 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 any hernia on the other side. So I think all of those techniques that will help. Yes, please go ahead

Steven Bruce
to 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 know it's not going to help it's going to bolster more.

Simon Marsh
Yeah, do you know what's interesting? When we give out the exercises, people completely understand what they for. And 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 who perhaps had a hernia done somewhere else. And they come and see me about another one or perhaps from the current. 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 exercise are a really important part of the treatment of hernias. Not to mention the other thing.

Steven Bruce
I've got, I've got one mentioned left, I think, for earlier on, so I'm saving for the end. In terms of 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
and we have a specific, a specific set of exercises we give out so everybody gets those? You mentioned Johnny Wilson is my consultant, physio colleague, I've worked for years around Gilmore's groin. Now, I'll beat you to it and heard us 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 be delighted. He's the editor of the scene. I've got the title of the book, which I've done a chapter on Gilmore's going in. And again, which came out last year, which obviously, we're trying to encourage physios to buy, but Gianni 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 we'll try and get him along as well. He's a lovely softly spoken Irishman. Are you 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 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 me know let 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. Hands says he has a large in coin or 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 Bhoj is about the size of a Bantam, egg, bulges gurgles and can pop out constantly. It's very graphic description, hence, boulders, gerbils, 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, the second bit, the whole point of fixing your hernia is to allow people to lead normal lives. So once you've had your hernia fix, you go back doing everything normally, please, that's the point of doing it. And I would suggest that when you need fixing it, so actually a really good description of a hernia, you know, with the bolts, the gurgling, the fact that gurgles tells me that you've got loot for 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, two months to get it done, because that one sounds like it needs fixing.

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

Simon Marsh
and hands were about EB 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, you know, 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, everyone is 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 you 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 at 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 at 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 a 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 I do hernias every Thursday, we'll get in as many as we can, depending on hospital bed. So I think this week, I said I've got 12345 to do this week. Some weeks, I might only do one or two. But I'm happy to start up after and go through till six or seven 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 is that one way Harley Street, but if people have got pins Oh 207-563-1234. So 807-563-1234, we'll take you through 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
And that was a real challenge for Justin to see whether he can get that telephone number up on lower third on the screen. I can see it but Well, that's great, but we'll share all that detail afterwards anyway and just in case you didn't catch it is 108 108 Harley Street is the the organisation the website address. Jackie says Could you give us could you give us the names again of someone for incisional hernias? Well, I can Simon Marsh is one of the names. Yeah,

Simon Marsh
for the for the big complicated hernias. Then we work with Mr. Derek Shan works as one of my high street. He's the expert in the big complicated incisional hernias. And this is the importance and he raised when he talks about the fact that you know you work with different people, different people, different things that team is important here and 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 one way Harley Street is we go out and look for people. So you can't apply for a job come and work there. We will come and find You if we think you're good enough. That sounds familiar. So ama we got in because he's good. And then we've also got me Kara petty, who does bowel surgery in her hernia surgery as well, who we went find because we know he's good. And I'd like to think that's why the late Jerry Gilmore got ahold of me all those years ago. I'd never met him. He'd obviously heard of me. So this is this is how one rate high speed works. If you've got a complicated incisional hernia, that'll be me a direction 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 I'm not sure this is a name that's been given by the UN apologies to this question. The name is son of data centre, Dave. Now 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 is now quite noticeable again, and was told he or she had a pantaloon hernia? Should it be left alone? Or should it be read on?

Simon Marsh
Right dependently. In her news, 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, remember, we talked about the two different sorts of direct and the indirect is when you've got both at the same time. Right. So you're lucky you've got a recurrent hernia, and you've got two of

Steven Bruce
them. So the next part of the question, when 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 you remember, I talked about Simon bliss, who's my consult radiology colleague expert in hernia scans, we get a scan done with time we'll 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 or 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 we've got a recurrent hernia 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 you contributed a chapter, I think, yes, I'm gonna do that after the show. But people people request it's sitting

Simon Marsh
on the bookshelf behind me, who was the the overall author or editor Johnny Wilson was one of the editors, the

Steven Bruce
physio, the physio you mentioned a moment ago. Works with us. Yeah. I thought when you first said his name, you said Jonny Wilkinson. And I was getting excited, because I thought, I mean, we're gonna get a rugby star on here as well, which is, you know,

Simon Marsh
nearly but not quite.

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

Simon Marsh
that I can what we can do. When I'm back in London on Thursday, I can perhaps email off to you that the Excel sheet we use and you 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 was super. Thank you. I like to give people handouts after the sale. If you don't mind. I'll share their hand the handout

Simon Marsh
relationally no problem at all.

Steven Bruce
Thank you. Thank you this weekend. Bob's Bob's question. I just don't say one hat he says that she has a patient with an inguinal hernia The size is about one point of about one and a half grapefruits. Oh, gosh, right. Waiting for is up for the last two years. Is it due in the next month? It's due in the next month. Now? Is there anything to avoid when treating his back afterwards?

Simon Marsh
That 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 say the aim of fixing your hernia is to do normal things, but I will get that it's obviously got a sizable hernia PORCIA. So I would give that the full month to heal before you started doing anything else within.

Steven Bruce
Okay. Jamie 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. He's right. Please advise.

Simon Marsh
Oh right. Yes, it needs to come and see so we can have a look. You can get quite big this sounds like it's going to be when is epigastric. Once that's in the midline, you can get quite big ones. And the fatty tissue comes out a bit like a mushroom in the hole is often quite small. And there's the fatty tissue come through it just spreads out so the hernia can look quite large. But the defect hold require small again, this is where Simon Blaise radiologist comes as he will scan that for me we can see the defect. And again, we get a much better picture of what we're doing before we do it. So yes, if they're about coming to 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 whole, correct yes, yes. That doesn't make it not a hernia,

Simon Marsh
correct? Yes. Because 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 terminals?

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. Got a G? No, I think I've only ever seen one

Steven Bruce
was good Johnson was, 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
yeah. Okay, that's they've had several people saying that getting the rehab protocols would be very, very useful and very welcome. So as always, I tried to send out an email on the day after the show, 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 on an email to you along with all the other information that can be useful. Amanda, I think you answered this, really, Amanda says what technique you use to repair muscular hernias?

Simon Marsh
Yeah, if we're talking more hernias, that there's 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 the great big mesh, which as we said, although it's mini invasive, it isn't because the amount of work you have to decide is bigger. I don't do those again. I mean, Eric changes the incision. Once he does, he does those it's part of the team, we offer all sorts. You've got the list of Stein repair over the front, which haven't done for 25 years, you've got the plug behind the muscle, followed by the shoulders 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 shoulder 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, just colleagues who's worked with me and done hernias developing or 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 to mesh and he was playing squash again four weeks later is absolutely fine. So those are sort of things to think about. And people do you 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 shoulders technique without any sort of plastic at all. Probably.

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

Simon Marsh
It's sort of true in that the weakness was dramatic cord comes out easily 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 it is a consequence of the fact we woke 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 utterly

worried at the mesh will fail. Can you offer her some reassurance? Well, he and that's my comment there.

Simon Marsh
Yeah, first of all, I said lucky because as we said, only 2% of ladies get inguinal hernias. So of those 2%, only 10% of that 2% are going to 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. Recurrence can happen. But it's rare. So I'd reassurance that it's absolutely fine. But bad luck 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, and so on. Should she be worried about that? Because it's larger than average or?

Simon Marsh
Now I think I think I go back to my point, the vast majority of people who have heard is revenue where they have a fine, I think you can always find cases in people who've had meshes removed whatever chronic pain and that's where you find the problems. But if they're not getting the pain, they almost say don't have the problems. What I do find interesting, and again, I say this with a sort of wry smile on the devil's advocate face on is how often when you have laparoscopic hernia repairs for one side, they say Oh, when I look you have one the other side and I repaired that as well. 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 the prime and then the 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 any 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 say we've got the descent nine times the volume from the front. And any 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. Yeah.

Steven Bruce
I mean, you have you mentioned all the possible complications, there's and again, I asked not just out of a ghoulish interest, but also because when a patient's on our table, and we just we say, we listened to Simon Marsh the other day, and we think you would 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 they'll all be on the sheet that you'll send out, we haven't we have a paragraph that lists all the complications, that with any operation there, the general complications, then acetic, you know, you can get chest infections, and so on. Those are all rare. And then the obvious things for hernia, but you get a scar, but it's a bit sore, and you can get a bruise. And the scar tissues quite normally for a few weeks or a few months before

it settles down, then scars fade and go pale. You can get hematomas really rare, great big blood got underneath the skin, they go down or sometimes they're really big, you have to let them out the second operation. One of the things we find chaps Who are you know, 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 going to spasm can put them into retention, they can't pay for a day or two a may have to have a temporary catheter. Now I've been there done that when I had my arm fixed because the long operation, I couldn't pay and I'd have a catheter overnight, and then it comes out is fine. So that's one thing to think about for the older chaps. Hernias come back, you get recurrent hernias. And then you can you can damage nerves, you can I think it's rare. And because you always look out for them. When you do 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 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 want 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 into to talk to us as well. But it's so kind of you to give up your your evening like this and spend 90 minutes talking to us while we ask what possibly a very silly questions to you about, about your speciality. 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. It's nice, 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.

Simon Marsh
Are you gonna do that?

Steven Bruce
That's it for us this evening. Simon, thank you. As far as you the audience are concerned, a few things to let you know but in the email earlier on, I sent out early warning that Laurie Hartman is prepared to run a course now lonely home if you haven't been on one of Laurie Hartman's course, courses you have missed out in a big way. He has been for 50 years, one of the most famous osteopaths in the in the country. He's one of the the ultimate practitioners of the minimal leverage, high velocity thrust technique. He's been retired for a couple of years. And I have tried not to bother him because he said that he wasn't going to come out and do any more courses. But I was speaking to him the other day he is and I said he was going to do it on the fourth and fifth of June. I've just realised, realised earlier on today that that is actually a four day bank holiday weekend. So we're having to postpone that because we know no one wants to give up two days or afford a bank holiday to come around, of course. So we're going to run it later in the in the in the month probably also semi in the Alaska and Bob Gerwin are going to come over for a three day dry needling and

triggerpoint course, again, I said in the email phenomenal, phenomenal practitioners, world experts in both those subjects dry needling and in trigger points. So there's going to be a pretty marvellous course both of them will be here at the APM studio. And I will give you the dates and details once we finally confirmed them. And obviously members of APM get first dibs on that and get a discount. But I imagine the places will not last very long. Bit of bad news Thursday this week, we've had to pull our lunchtime broadcast, as far as I'm aware, because we heard today from Mr. Ali Noorani, who is going to talk to us about acromioclavicular problems, that he's had something else crop up and so he can't be with us at lunchtime. It may be that we can find something else to fill that gap but it is very short notice so possibly we won't be doing one on Thursday this week. But looking ahead on Monday, the fourth of April sorry keyspace discussion on Tuesday the 22nd. We like those case based discussions. So do join us for that one. We've got lunchtime learning on Monday, the fourth of April with Sandra Harding and Sarah tribe. Now they will Brilliant when they came in before to talk about communication and consent issues. This time they're going to be talking talking about loan working. So another really fascinating broadcast, lunchtime Monday, the fourth, Wednesday, the sixth two days after that. We've got Angie Gopal in the studio. Angie has been brilliant in the past, talking to us about how to use Pilates, and other techniques to improve posture, improve breathing, improve all sorts of things, really looking forward to that one as well. And of course, shortly after that, on the 13th of April, which is a Wednesday evening, we've got an extra broadcast when we have got to fantastic osteopaths analysing a live band so that we can see how we apply our skills as osteopath, chiropractors, physios to live performers, musicians, and we're having a live audience in the studio. There are still a few places on the floor there. If you want to come and join us. Just let us know there's a page on the website under courses where you can just book it's free. We'll be providing the fizzy wine we'll be providing the food. We'll have a great evening CPD and the band will play for a little while after the show's finished. That's it for now. Sorry, I've run over by three minutes. I hope you don't mind but I really didn't want to stop Simon early. But that's it for this evening. Have a great rest of your evening and I hope to see you soon. Good night.