N4750 Pathophysiology Sheet

\*Site References in APA format at the bottom of the sheet

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| Disease | Basic Pathophysiology | Clinical Manifestations | Your Patient’s Clinical Manifestations | Labs and Other Diagnostics | Treatment |
| **Hernia** | Ignatavicius and Workman (2013) stated, “A hernia is a weakness in the abdominal muscle wall through which a segment of the bowel or other abdominal structure protrudes. Hernias can also penetrate through any other defect in the abdominal wall, through the diaphragm, or through other structures in the abdominal cavity.  The most common types of abdominal hernias (Fig. 59-2) are indirect, direct, femoral, umbilical, and incisional.  •An indirect inguinal hernia is a sac formed from the peritoneum that contains a portion of the intestine or omentum. The hernia pushes downward at an angle into the inguinal canal. In males, indirect inguinal hernias can become large and often descend into the scrotum.  •Direct inguinal hernias, in contrast, pass through a weak point in the abdominal wall (Fig. 59-3).  •Femoral hernias protrude through the femoral ring. A plug of fat in the femoral canal enlarges and eventually pulls the peritoneum and often the urinary bladder into the sac.  •Umbilical hernias are congenital or acquired. Congenital umbilical hernias appear in infancy. Acquired umbilical hernias directly result from increased intra-abdominal pressure. They are most commonly seen in obese people.  •Incisional, or ventral, hernias occur at the site of a previous surgical incision. These hernias result from inadequate healing of the incision, which is usually caused by postoperative wound infections, inadequate nutrition, and obesity.” (p. 1243) | Ignatavicius and Workman (2013) stated that the patient may complain of, “a “lump” or protrusion felt at the involved site. The development of the hernia may be associated with straining or lifting... Absent bowel sounds may indicate obstruction and strangulation, which is a medical emergency... Signs of strangulation are abdominal distention, nausea, vomiting, pain, fever, and tachycardia” (p. 1244) |  | Ignatavicius and Workman (2013) stated that to diagnose a hernia, the advanced practice nurse or other healthcare professional will, “Perform an abdominal assessment inspecting the abdomen when the patient is lying and again when he or she is standing. If the hernia is reducible, it may disappear when the patient is lying flat. The advanced practice nurse or other health care provider asks the patient to strain or perform the Valsalva maneuver and observes for bulging. Auscultate for active bowel sounds. To palpate an inguinal hernia, the health care provider gently examines the ring and its contents by inserting a finger in the ring and noting any changes when the patient coughs. The hernia is never forcibly reduced; that maneuver could cause strangulated intestine to rupture. If a male patient suspects a hernia in his groin, the health care provider has him stand for the examination. Using the right hand for the patient's right side and the left hand for the patient's left side, the examiner pushes in the loose scrotal skin with the index finger, following the spermatic cord upward to the external inguinal cord. At this point, the patient is asked to cough, and any palpable herniation is noted.” (p. 1244) | According toIgnatavicius and Workman (2013), **Nonsurgical**: “The health care provider may prescribe a truss for an inguinal hernia, most often for men.  **Surgical:** A minimally invasive inguinal hernia repair (MIIHR) through a laparoscope, also called herniorrhaphy, is the surgery of choice.” (p. 1244) |

References: Ignatavicius, Workman (2013*). Medical-Surgical Nursing: Patient-Centered Collaborative Care* (7th edition). Blackwell Publishing Limited.