NGN NCLEX 2026 · HIGH-YIELD REVIEW

Hernia

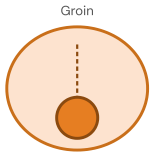
Types · Complications · Priority Nursing Management

Gastrointestinal | Surgical | Men's Health | Adult Med-Surg

1 📖 Definition / Overview

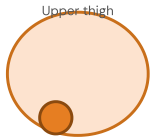
- **Hernia** = protrusion of an organ, tissue, or part of an organ through a weakened area in the muscle or fascia that normally contains it.
- Most hernias are **abdominal** — where intestine or omentum pushes through the abdominal wall.
- Matters because a hernia can become **incarcerated** (trapped) or **strangulated** (blood supply cut off) — a **surgical emergency.**

Common Types of Hernias



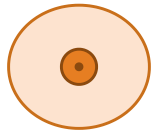
Inguinal

Most common · Men · Bowel through inguinal canal



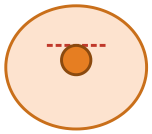
Femoral

More common in **women** · High strangulation risk



Umbilical

Infants, obese adults, pregnancy



Incisional / Ventral

Through previous **surgical scar**

Hiatal

Stomach pushes through diaphragm · GERD symptoms

Indirect / Direct

Indirect: congenital · Direct: acquired (straining)

2 🔬 Pathophysiology (Simplified)

1. **Weakness develops** in abdominal wall → congenital defect OR acquired (aging, surgery, obesity, pregnancy).
2. **↑ Intra-abdominal pressure** → coughing, lifting, straining (constipation), chronic cough, ascites, heavy lifting.
3. **Tissue protrudes** through the weak area → visible bulge, often worse when standing / Valsalva.
4. **Reducible** → pushes back in → **Incarcerated** → trapped, cannot reduce → **Strangulated** → blood flow lost → **necrosis + perforation**.

⚠️ Progression = Increasing Danger

Reducible
pushes back easily

→

Incarcerated
trapped, won't reduce

→

Strangulated
🩸 BLOOD CUT OFF

3 🩺 Signs & Symptoms

🟢 Early / Reducible

- **Visible bulge** — worse with standing, coughing, straining; disappears when lying down
- Mild **discomfort** or feeling of heaviness/pressure
- Pulls back into abdomen with gentle pressure
- Relieved when supine
- Usually **no systemic symptoms**

🔴 Late / Strangulated 🚨

- **SEVERE pain** at hernia site (sudden ↑)
- **Nausea & vomiting**
- **No passage of stool or flatus** (obstruction)
- **Abdominal distention** + absent bowel sounds
- Bulge is **firm, tender, dusky/red**
- **Fever, tachycardia**, ↓ BP (sepsis/shock)

🚨 RED FLAG — Strangulation is a Surgical Emergency

Think "**SICK hernia**": **S**evere pain, **I**leus (no flatus), **C**olor change, **K**inetic vitals (fever, tachycardia). This tissue is dying — call the surgeon NOW. *Never attempt to force-reduce a strangulated hernia.*

4 ✅ Priority Nursing Interventions (ABCs + Safety)

🏥 Pre-Op / Conservative

- **Assess** hernia: size, reducibility, skin color, bowel sounds
- Monitor for signs of **strangulation/obstruction** q2–4h
- **NPO** if surgery anticipated; IV fluids as ordered
- Insert **NG tube** for decompression if obstructed
- Apply **truss** ONLY over a reduced hernia (not strangulated)
- Teach **splinting** with pillow when coughing/sneezing
- Prevent straining: stool softeners, ↑ fluids, ↑ fiber

🩹 Post-Op (Herniorrhaphy / Hernioplasty)

- **Monitor incision** for bleeding, drainage, infection
- **Assess pain**; medicate before ambulating
- **Inguinal repair (male):** apply **ice pack** + **elevate scrotum** on rolled towel to ↓ swelling
- **Encourage deep breathing**; avoid vigorous coughing (splint if must)
- Early **ambulation** — prevents DVT & ileus
- Monitor **first void** within 6–8 hrs (urinary retention common)
- **No heavy lifting > 10 lbs × 4–6 weeks**

🥇 Priority Order When Strangulation is Suspected

1. **ABCs** → airway, breathing, circulation (watch for shock)
2. **NPO** → prepare for emergency surgery
3. **NG tube** to low suction → decompress bowel
4. **IV access**, fluids, labs (CBC, lactate, electrolytes)
5. **Notify surgeon** immediately
6. **Pain control**, antiemetics, antibiotics as ordered

5 💊 Pharmacology

Docusate sodium (Colace)

Stool softener

Mechanism: ↑ water in stool → softer BM → less straining

Side effects: Mild cramping, diarrhea

Nursing: Give with full glass of water. Priority in hernia patients — straining worsens herniation.

Opioid analgesics (e.g., hydrocodone, oxycodone)

Post-op pain control

Mechanism: μ-receptor agonist → ↓ pain perception

Side effects: **Constipation**, respiratory depression, sedation, N/V

Nursing: Always pair with stool softener — constipation → straining → re-herniation risk. Monitor RR > 12.

Antiemetics (ondansetron / Zofran)

$5\text{-}HT_3$ receptor antagonist

Mechanism: Blocks serotonin at vomiting center

Side effects: Headache, **QT prolongation**, constipation

Nursing: Critical if obstruction — protect incision from vomiting strain. Monitor ECG with prolonged use.

Prophylactic antibiotics (cefazolin, etc.)

1st-generation cephalosporin

Mechanism: Inhibits bacterial cell wall synthesis

Side effects: GI upset, allergic reaction

Nursing: Given pre-op (within 60 min of incision) to prevent surgical site infection, especially with mesh repair.

PPIs (omeprazole) / H_2 blockers (famotidine) — *for Hiatal hernia*

Acid suppression

Mechanism: ↓ gastric acid secretion → relieves GERD reflux

Side effects: Long-term PPI: ↓ Mg, ↓ B12, ↑ C. diff, osteoporosis risk

Nursing: Give before meals. Teach diet/lifestyle changes (see education section).

6 ⚠ NCLEX Test Traps

The Trap	The Truth
Which hernia is the emergency?	STRANGULATED — not reducible, not incarcerated alone. Strangulation = lost blood flow = tissue death.
"Push the bulge back in"	**NEVER** attempt to reduce a strangulated or painful/discolored hernia — can push necrotic bowel into abdomen.
Heat vs. Ice post-op (inguinal repair)	ICE to scrotum + elevation ↓ swelling. Heat ↑ swelling → bad.
"Cough hard to clear lungs"	Deep breathe and use incentive spirometer — avoid forceful coughing. If must cough, **splint** incision with pillow.
Which is the priority assessment post-op?	**First void within 6–8 hours.** Urinary retention is a common complication after inguinal hernia repair.
"Resume normal activity right away"	**No lifting > 10 lbs × 4–6 weeks.** Most common trap answer on NCLEX.

The Trap	The Truth
Hiatal hernia → lay flat to relieve reflux	OPPOSITE — elevate HOB, stay upright after meals, avoid supine × 2–3 hrs post-meal.
Fever + severe pain post-op	Infection OR missed strangulation — notify HCP. Not "normal" post-op pain.

7 🎓 Patient Education

🏋️ Activity & Lifting

- **No lifting > 10 lbs × 4–6 weeks** post-op
- Avoid straining, pushing, heavy exercise
- Use **proper body mechanics**: bend at knees, not waist
- Walk daily — but no running, stairs excessively
- Resume sex/work only when HCP clears

🍎 Diet & Bowels

- **High-fiber diet** (fruits, vegetables, whole grains)
- **Fluids: 2–3 L/day** — prevents constipation
- Take prescribed stool softener daily
- Don't strain during BM — if stool hard, ask for laxative
- For **hiatal hernia:** small frequent meals, avoid caffeine, alcohol, spicy/fatty foods, chocolate

🛏️ Positioning

- **Hiatal hernia:** HOB ↑ 30° at night; no eating within **3 hrs of bedtime**
- Post-op inguinal (male): scrotal support + ice × 24 hrs
- Splint incision when coughing/sneezing
- Avoid tight clothing around waist

🚨 Call HCP If...

- **Severe pain** at hernia or incision site
- **Nausea, vomiting,** inability to pass stool or gas
- **Fever > 101°F (38.3°C)**
- Incision: redness, swelling, purulent drainage, gaping
- Bulge becomes **hard, red, or painful** (strangulation)
- Unable to urinate within 8 hours post-op

8 🧠 Memory Boosters & Mnemonics

🚨 "SICK Hernia" = Strangulation Emergency

If you see these 4 signs → call the surgeon NOW.

S	I	C	K
Severe pain	Ileus (no flatus)	Color change	Kinetic VS (↑HR, fever)

💧 "RICE-E" for Post-Op Inguinal Repair (Male)

R	I	C	E	E
Rest	Ice scrotum	Check voiding	Elevate scrotum	Early ambulation

🔄 Progression: "R → I → S" Gets Worse as It Grows

Reducible (safe, pushes back) → **I**ncarcerated (stuck, painful) → **S**trangulated (EMERGENCY, dying tissue)

⚡ Quick Associations

- **Inguinal** = men + groin + most common (75%)
- **Femoral** = women + upper thigh + high strangulation risk
- **Umbilical** = obese, pregnant, infants
- **Incisional** = think "scar" → any previous abdominal surgery
- **Hiatal** = GERD, nighttime heartburn, "sliding" stomach through diaphragm
- Any bulge that's **Blue + Bad pain + Bound (no BM)** = "3B's → bring to surgery"

9 🧩 NCJMM Clinical Judgment Framework

1. Recognize Cues

Visible bulge, pain with lifting, obstruction signs, ↓ bowel sounds, N/V, fever, skin color change at bulge, prior abdominal surgery.

2. Analyze Cues

Differentiate reducible vs. incarcerated vs. strangulated. Correlate severe pain + obstruction + systemic signs = strangulation.

3. Prioritize Hypotheses / Generate Solutions

Strangulation = highest priority (risk for necrosis, perforation, sepsis). Plan: NPO, NG, IV fluids, surgery prep, pain/antibiotics.

4. Take Action / Evaluate

Implement: stop oral intake, decompress, notify surgeon, prep for OR. Evaluate: pain ↓, bowel sounds return, incision intact, voiding, no fever.
