

Guidance for coaching ONERO with hernias

1. Common hernias

- Hiatal (~40 - 60% of adults > 50 yrs)
Stomach herniates through the oesophageal hiatus into the thorax. Sliding type (~ 90 % of hiatal hernias) causes reflux symptoms triggered by supine position, full stomach or breath-holding; no external bulge. Para-oesophageal types (~10%) carry risk of obstruction or strangulation.
- Inguinal (~ 3% lifetime risk in women; ~ 75% of abdominal hernias)
Protrusion through the inguinal canal. Heavy lifting and raised intra-abdominal pressure (IAP) are recognised risk factors.
- Femoral (~ 2 - 4% of groin hernias; female-to-male ratio ~ 5 : 1)
Passage through the femoral canal below the inguinal ligament. Less common but high risk of entrapment; more frequent in older women.
- Umbilical/Para-umbilical (common in multiparous or obese women)
Midline fascial defect near the navel; often small but may enlarge under load
- Epigastric (< 2% of abdominal hernias)
Mid-upper linea alba defect; often multiple small defects
- Incisional/Ventral (Up to 20% after midline laparotomy; recurrence \leq 50% without risk-factor control)
Herniation through a previous surgical incision; recurrence rates up to 50% without risk-factor management.

Note: Diastasis recti - Widening of the linea alba without fascial defect. Not a true hernia but clients will often confuse it with an umbilical hernia. Appears as a midline bulge but carries no risk of incarceration. Management is progressive core control, not hernia precautions.

2. Exercise principles & intraabdominal pressure (IAP) management

- Typical IAP peaks: squats ~ 200 mmHg; deadlifts ~ 155 mmHg at high loads
- Repeated uncontrolled peaks may enlarge defects, but progressive strengthening improves fascial load sharing and resilience
- Teach 360° diaphragmatic brace with “hiss exhale” through sticking points.
- Use exhale-through-effort cueing; avoid prolonged breath-hold in early stages
- Supine abdominal work immediately after meals are the most common triggers for hiatal hernia symptoms
- Begin drop chins with heel drops or minimal jump height (~ 3 cm)

3. Coaching guidelines

A. Unrepaired or Watch-and-Wait Hernias

- Re-establish hip hinge, squat, overhead press patterns; reinforce breathing/bracing; introduce low-height drop chins. Start ~ 40% estimated 1RM; add 5% fortnightly if asymptomatic.
- Use dumbbell variations or reduced range of motion to modulate IAP

B. Post-Surgical Repair (mesh or suture)

- Early wound-protection work (0 – 6 weeks) is normally overseen by the surgical rehab team. ONERO should begin only after 6 weeks and medical clearance
- Weeks 6–12 Moderate load - no more than (40–60% 1RM)
- ≥ 12 Weeks Gradually progress to standard ONERO parameters (~ 85% 1RM, drop chins) if asymptomatic and cleared by the surgeon.

4. Hernia-specific modifications

- Inguinal/Femoral
Limit maximal hip flexion early; monitor groin pressure.
- Umbilical/Epigastric
Avoid excessive spinal extension under load until 8 weeks post-op; watch for midline doming.
- Incisional/Ventral
Delay barbell overhead pressing until 10 - 12 weeks - use light dumbbells.
- Hiatal
Schedule sessions ≥ 2 h after meals; emphasise diaphragmatic breathing and neutral spine. For reflux symptoms during deadlifts, use rack pulls to reduce forward lean. Maintain a neutral spine on impacts.

6. Monitoring & progression

- Monitor for symptoms and modify as required
- Progress load/impact only after four consecutive symptom-free sessions
- Stop & refer with new or worsening symptoms despite load reduction/modifications

References

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