Hernia Surgery Made Simple — Your Guide to Understanding and Healing — Interview with Dr. Eric Pinnar

By Dr. Joseph Mercola

Dr. Joseph Mercola:

Welcome, everyone, Dr. Mercola, helping you take control of your health, and we're delighted to have Dr. Eric Pinnar join us again. He was with us recently because he was my general surgeon, but focusing completely on hernia surgeries, that helped me resolve my hernias. And a lot of people appreciated that and we didn't have as much time as we would've liked, but we're going to fill up that gap with this interview today. And I want to emphasize a few points. I'm going to share my personal experience and some of the things that I believe you need to pay attention, to be aware of, especially if you have scheduled a surgery or going into it. And I think some of my considerations and evaluations will be helpful not only for hernia surgeries, but other surgeries, because there's some important principles you need to really understand if you're going to optimize your healing and improve your biology.

So, there's one point that we really want to emphasize, and I'll let Dr. Pinnar, who is out of Jacksonville, Florida, just a little bit north of me. And the reason I chose him, because my local surgeon was really a good surgeon, probably as equally qualified as Dr. Pinnar, but unfortunately he had an administrative staff that was one of the worst I've ever seen in a medical practice. Just beyond terrible. So, I was so delighted that I actually canceled my appointment because they wanted to reschedule me four times. And the last one was just because this person mistakenly assigned a call and he refused to change it for me. And I said, "Okay, that's unacceptable. You're fired." I'm a physician, I can fire people. But as a patient, you can fire your doctor. They are under your direction. Unless you're forced to because of some insurance factors, you don't have a choice. But most of the time you have a choice. And even if you have insurance, and this is an expensive procedure folks, there's no question about it.

You're going to write a check, most people, and you have to be careful and diligent with that. But most of the time we don't understand and realize that we have options and alternatives and we want you to be empowered and understand that you have the choice. Dr. Pinnar doesn't happen to take insurance. And he opted out of that system for a good reason. And actually, a reason that we both really share. I don't know if you're aware of this. I just found this out recently. I've been a strong opponent of the drug industry for all my professional life, and they collectively, all the drug companies, make less than a trillion dollars a year. And that's a lot of money. There's no question about a trillion dollars. But the health insurance companies dwarf that two and a half times as much as the drug companies together.

And they don't make anything. They're not making a drug that can relieve pain or treat an infection, no. All they're doing is shuffling paper. Shuffling paper, that's it. And they make two

and a half times as much as the drug companies. I am in the process of targeting that industry and either radically improving it or eliminating it. And I think that's the path. And the new administration with Trump is headed in that direction. They're really looking at the hidden causes that contributes to the mess that we've gotten into. And there's a whole extension of insurance because you can go into PBMs, the pharmacy benefit managers that manipulate the prices of drugs and just control it. And all these people gather these premiums, inflate the prices and play this game. And literally the physicians aren't the benefit of this. The physicians are really pawns in this game for the most part. You may not be aware, but they are.

And Dr. Pinnar can share his experience, but we'll tune into that in a bit. It's an important topic that I don't think we addressed enough on the last interview. But what I want Dr. Pinnar to share is to highlight and emphasize the importance of you or someone you know who has a hernia. It's not obvious to you or most likely your primary care physician that this is something that needs to be treated. You do not want to delay. Don't make the mistake I did. I waited a year. And some people wait much longer than that because this thing will never, never spontaneously heal. It will only get worse. And the longer you have it, the worse it's going to get. And the sooner you treat it, the less likely it is you're going to have potential complications. There's going to be an easier repair. So that's the broad strokes, and Dr. Pinnar, welcome back. And I want you to expand on that. Because you shared with me prior to our going on is that this is one of the important feedbacks that you got that you were really surprised.

Dr. Eric Pinnar:

Oh, yeah. No, I guess it's not as much a surprise, but I think what this has done, I think and it's been fascinating and rewarding to me, is that so many of your followers have thanked you for doing this because they either have had a hernia for years and they either didn't know what to do about it because a lot of your patients are so healthy that they don't go to a doctor.

Dr. Joseph Mercola:

One of the best things you can do, there's no question about it.

Dr. Eric Pinnar:

Great. So, they really didn't know what to do about it. And they figured, "As long as it's not bothering me, I'm just going to ignore it."

Dr. Joseph Mercola:

And normally that's a good strategy. It's not a strategy that is always... Because many conditions we have do self-correct with time, no question. But this is not one of them.

Dr. Eric Pinnar:

This is not one of them. And then the other ones are more commonly, they did go to a doctor and their doctor was dismissive of it. And we talked about this last time, is that the primary care docs will often say, "You know what, if it's not bothering you just leave it alone. If it starts to bother you, then we'll deal with it. We'll send you to a surgeon." Always the wrong advice. I've said it

probably six million times in my career, and I said it on the last interview, was the time to fix a hernia is when you diagnose it.

Because the longer you wait, the bigger it gets, the harder it is to fix. It just becomes much more difficult, so a lot of these patients now are coming out of the woodwork because of you and actually us because they were so well-informed after the last interview. And that's the feedback I get that, "This was so helpful. I understood everything you said now. Now I knew what to do and I realized I got to get on this. I've been putting it off and putting it off. And now after seeing you and hearing what you had to say, here I am." So that's been I think, a great service to your subscribers.

Dr. Joseph Mercola:

Well, thanks. Yes. So, I thought it would be helpful at this point too to share some of my personal experiences. So, the preppy, if in fact you are preparing for surgery now or whether it's an inguinal hernia surgery or any other surgery, especially abdominal surgery. And what occurred to me during this, there's basically two ways we've discussed that you can do this. One is an open surgery, which essentially is the older way to do that. And the more advanced, sophisticated, less invasive or minimally invasive approach, which is the closed surgery, a laparoscopic or a robotic laparoscopic surgery. And I had a robotic laparoscopic surgery and I still had a lot of problems. I'm going to share those problems with you now. Not complications from the surgery, but surprising deviations from my normal behavior that really shocked me. I'm on the other side of it now. Literally today is two months since I've had the surgery, two months, and I'm almost 100% except for my ability to recover my strength prior to the training.

I was just telling Dr. Pinnar that the day before my surgery, I did 125 pull-ups. Not all at once. It was spread out over the day, but I did it because I knew I was going to be off for a while and now I can only do about 60, 65 because it takes a while to build back. So that's one of them, if you're exercising... Even something as simple as walking could be a problem. So, you want to prepare and understand that when you go through a massive surgery like this, and it's not massive in the perspective, this was just one of the points I wanted to share because there are other abdominal surgeries like a C-section. Oh my gosh, they're tearing up that woman's entire abdominal wall for a baby to come out. And I literally had three quarters of an inch incision. That was it. And that was a problem. That was a problem.

So, I have no idea how these women, especially having to care for a child, how they function after that. It just boggles my mind. That was one of the fascinations I had because I was literally... I'm really healthy, but I was laid up quite a bit. I'm surprised Dr. Pinnar, and I don't know if it's related to the level of abdominal or whatever, but I was laid up for a long time. And I made the mistake... I thought I'd be walking the beach after the surgery. I really did. I had to be wheeled out. And by law they have to take you on a wheelchair for this because you will probably or likely fall. The risk is way too high. You're a high risk of falling for sure, but it's hard to walk.

And then Dr. Pinnar did a nice regional block. So, there was no pain the first night, but the second night was an issue, and I don't like taking opiates and it's not a good idea. This is another hint. Yes, you should take it. There's no question. You should not be in horrible pain. Definitely there is a time to take them, and this is one of them when you have a surgery like this. Minimize it. I took a half of the dose, but still you go on and take it. And that was one of the biggest mistakes I made. I said, "I'm not going to take this." And I suffered. I really could not move more than an inch or two without having pain. It was that bad. I mean I just like this. And it would take me 15 minutes to walk from my office to the kitchen. I learned the first day that was not a good idea. So, you want to get control of the pain. But then a few days after I did a walk and the walk was short. It was just maybe 2,000 steps.

It was a small fraction of what I normally do. And then I did that again and I then went to 5,000 steps and that took me back. So, what you want to understand is even walking, which is one of the most benign simple things, you have to be careful. Should you walk from your one room to the next? Of course. Because that's not going to be important. But you don't want to go out and do long walking until you recover. And here's the big thing, and I'll let you comment on this because I don't want to over crowd this out, but when you have this type of intervention, you have to repair and hopefully you have enough surplus energy. I had a lot of surplus energy, but you do not want to direct that energy to engage in an exercise. You want to direct that energy inwards to your biology so you can repair and regenerate the tissue.

It's just a short term, but you got to do that. So, I would go in there understanding that you are not going to do any exercise. Most surgeons say, you don't pick up anything higher than five or 10 pounds because of the risk of damaging that wound. But I think from a broader perspective, without any risk of damaging the wound, you're damaging your biology by not giving it the energy it requires to do that repair and healing because you have to have energy to heal. And if you're using it to exercise, that's not a good idea. It's not a good exchange. Just like when you get sick, when you get sick, you don't want to work out. You want that reserve energy to fight the infection. So, this is when you want to rely on your fuel supplies to power you up. So, with that, I'll let you comment on that because I'm particularly intrigued because I didn't share it with you earlier, but I was wondering, "How does a woman with a C-section survive that trauma? And take care of her child?" I don't think I could ever do that. I really don't.

Dr. Eric Pinnar:

And the truth is, most men...

Dr. Joseph Mercola:

I know. I know. If I had to choose it... It's almost unimaginable how they can do that, really.

Dr. Eric Pinnar:

Well, the truth is is because they're women. Women are exceptionally strong when it comes to physical insult. I will tell you that most... And I tell this to patients all the time, most of my patients are men because they're the ones that are more prone to hernias. But men do much worse

with surgery than women do. It's just a given. I've watched this over my entire career that men tend to be kind of wussies in general. I'm not saying that you are, but...

Dr. Joseph Mercola:

No, I'm definitely not a wussy. I have a very high tolerance for pain, which really surprised me.

Dr. Eric Pinnar:

In defense of men, there actually is some evidence to show, and you might know this, that men experience pain differently than women. They tend to experience pain more intensely than women do. So, when you stub your toe, for instance, men experience that pain much more intensely than women do. So that's why I think women are more durable from that perspective. And then you have a woman that has kids. I operated on Tuesday on a woman who had a recurrent hernia. She had one. If you want to talk about it more, I'm happy to tell you more. But in a nutshell, she had an emergency umbilical hernia repair in 2022. For all the reasons I tell people to get hernias fixed, she sat on it, she waited on it, she has four kids, and she got intestines stuck through that hole. It was a two centimeter hole according to the surgeon that fixed it.

And of course it was at 11 o'clock at night when she went to the hospital. After the complete workup, they called the surgeon at one o'clock in the morning to come fix it. So, he had to come at one o'clock in the morning. Long story short, he did it open because it was an emergency and he had to make the hole bigger. So, he said he made it to three centimeters because he wanted to make sure the intestine that was in there was viable, that it wasn't dead intestine. And luckily it wasn't. It was very angry and upset, but not dead. So, he didn't have to resect it. And then he just closed it primarily with stitches. And so now fast-forward to... I can't remember when [inaudible 00:14:42].

Dr. Joseph Mercola:

No mesh? No mesh?

Dr. Eric Pinnar:

No mesh just stitches.

Dr. Joseph Mercola:

Okay.

Dr. Eric Pinnar:

And the truth is the whole thing came back.

Dr. Joseph Mercola:

Big surprise. Big surprise.

Dr. Eric Pinnar:

Big surprise. So, she actually had a gallbladder surgery in 2024 in November, just recently. And the doctor that did the gallbladder surgery told her that her hernia was coming apart, the repair was coming apart and that she should have it fixed. Why he didn't fix it, I don't know.

Dr. Joseph Mercola:

That's irresponsible. That's irresponsible. You would've did it. You would've done it for sure.

Dr. Eric Pinnar:

I would've. Absolutely. And I would've gone through her belly button in to begin with to do the surgery and then I would've fixed it on the way out. But he went above her belly button and that's why he was able to see it. So anyway, I don't know why he didn't fix it, but he didn't. And so, she knows the symptoms, and so she came and I did her surgery and I did it. I could have done it much easier than I did, but it wasn't the best way to do it, but it would've saved me a ton of time and aggravation. But I did it the proper way. At least what we've decided today, hernia surgeons have decided today was the proper way. And we can get into the technical details of that, but suffice it to say I thought it was going to be about an hour and a half surgery. I did it robotically and it ended up taking me four and a half hours to do.

Dr. Joseph Mercola:

Oh, geez.

Dr. Eric Pinnar:

To fix a three centimeter hole because of her previous surgery. So, there was just a lot of scar tissue from the previous interventions, her gallbladder surgery and her previous hernia surgery that just made the dissection a lot more difficult. So, I put it behind the rectus muscles, behind the six-pack muscles, but in front of the fascia that's underneath those muscles. So, I had to dissect through that fascia from my side all the way to the other side, and enough to put a 15 centimeter piece of mesh in to cover a three centimeter hole because that's the recommendation is you have five centimeters of overlap at least. So, it took me a long time. It was very hard. I thought she was going to be in excruciating pain and I wanted to do the block like you had. But by the time we got done with the surgery, they only had one anesthesiologist left and he was covering three rooms, so he couldn't do the block. I felt really bad. Like I said, I thought I was going to have to admit her probably just for pain control.

Dr. Joseph Mercola:

Yeah, yeah, sure. Sure.

Dr. Eric Pinnar:

I go to the recovery room after I do all my paperwork and talk to her husband, and she's up walking around in the recovery room and the recovery room nurses said that she was only in there for 15 minutes, and then she told them she's got to get up and walk. And so, she's walking around and then while I'm talking to her, they put her back in a wheelchair and I said, "How much pain are you having?" She goes, "I'm okay." I'm like...

Dr. Joseph Mercola:

Oh my gosh. Was this the regular recovery, the final recovery or the PACU?

Dr. Eric Pinnar:
This was the PACU, right after she got...

Dr. Joseph Mercola:
Oh my God, she didn't have Versed.

Dr. Eric Pinnar:
Well, I'm sure she had Versed.

Dr. Joseph Mercola:
Oh, she did?

Dr. Eric Pinnar:
Not right then. She had it four and a half hours earlier.

Dr. Joseph Mercola:
Wow. Well, dang. Man. So she may [inaudible 00:18:06]. Yes.

Dr. Eric Pinnar:
And so I called her that night thinking maybe she still had drugs on board after [inaudible 00:18:13] some fentanyl or whatever. So, I called her that night, she was sleeping. I talked to her husband, he said, "She's doing okay. She's been up and around. She's doing fine." And then I called her the next day and I said, "How are you doing?" She goes, "I'm good." That's the difference between men and women. I guarantee you that if I had done that to you, you would've been even more [inaudible 00:18:33].

Dr. Joseph Mercola:
Oh, I would've... Oh my gosh.

Dr. Eric Pinnar:
... than you were. But that's how they can do it. You know this too, that the physiology is different in a pregnant woman. So, they're super physiologic when they're pregnant. So, all of their responses are changed and their pain response is much more muted.

Dr. Joseph Mercola:
Attenuated. Yeah, it's attenuated.

Dr. Eric Pinnar:
And their physiology is just super, so they heal super quickly and I think that's what gets them through childbirth and the ability to take care of kids afterwards is just they're superstars at that moment.

Dr. Joseph Mercola:

Because that has got to be... Do that type of the C-section. And just childbirth itself is enormously challenging of course. And that's probably why nature has that adaptation response. But when you throw a C-section on top of that, it's like, "Oh my God."

Dr. Eric Pinnar:

Well, there's no question that a C-section is a much more difficult recovery than natural childbirth. There's no question on that. I mean, you go to the L&D floor and you see the women walking in the halls, you know which ones had a C-section. They're the ones that are sort of hunched over like this and just sort of shuffling along.

Dr. Joseph Mercola:

Yeah, that was the only way I could get comfortable. You'd have to be bent over like a 90-year-old and walk and shuffle. That's it. The only way you can ambulate. You could not stand up. You could not stand up because I think it just puts tension on that tissue and that hurts.

Dr. Eric Pinnar:

It also could be, in your case... I did have a patient years ago, and this might be just different for you specifically, that I had a patient years ago that I did a... And I'm talking in the early 2000s who was super physically fit. I mean, he was a young guy, just ripped just an adonis of a guy and he had terrible muscle spasms afterwards just from the three little incisions. They obviously go through the muscles of the abdominal wall and his muscles I think were just so developed and maybe just more sensitive. But he had terrible pain afterwards and just terrible muscle spasms.

Dr. Joseph Mercola:

Yeah, I had no spasms, but just pain.

Dr. Eric Pinnar:

And it might be because you're more physically fit than most because like I told you, your experience isn't usual. I operated on a guy from... Actually, I think he or his wife was one of your followers, but he's from Texas. Well, actually he's from Kentucky, but he spends the winter in Texas.

Dr. Joseph Mercola:

Wise man.

Dr. Eric Pinnar:

And he owns a lawn mowing business and he wanted to make sure to get this done before lawn mowing season in Kentucky, young guy. He's a vegetarian, and so he came and I did his surgery yesterday. I did his surgery yesterday.

Dr. Joseph Mercola:

Okay, there you go.

Dr. Eric Pinnar:

I called him last night. They have an RV. That's why he was able to do it because he actually came up on Saturday for surgery yesterday, and he's staying here for two weeks in their RV. But he said, "I was up." And he said, "I walked around the campground several times."

Dr. Joseph Mercola:

Wow.

Dr. Eric Pinnar:

[inaudible 00:21:54]. So that's post-op day zero. And he said, "I'm doing good."

Dr. Joseph Mercola:

So, he have a regional block?

Dr. Eric Pinnar:

He didn't have a regional block. He actually... Well, he was an open repair.

Dr. Joseph Mercola:

Oh, wow.

Dr. Eric Pinnar:

And I did inject a lot of Marcaine, long-acting pain medicine, in the area. But he's a strong young guy. But everybody's different. The point is is that everybody's different. I've given up trying to predict. So, you look at your friend Patrick, who turned you on to me. I just talked to him on Monday this week. He's two weeks out from surgery and he's back to his normal routine. And also going back to... I learned something from him in a way that I was thinking about as you were talking about listening to your body and taking the narcotics. I know you were very resistant to taking it. So, I had a long talk with him about taking the Advil and the Tylenol alternating like I recommend for all the patients. So, the multimodal therapy we talk about, so using other modes of pain control in addition to the narcotic, but with an attempt to decrease the use of the narcotic. So, a lot of your followers are very resistant to Tylenol and Advil as well.

Dr. Joseph Mercola:

Yes, yes, of course. Well, they should be, but for acutely it's a different story.

Dr. Eric Pinnar:

That's what I try to tell them. So, Patrick said an interesting thing, because we were talking about this phenomenon and he said, "I tend to be kind of a health nut." His words. And he said, "So a lot of us are resistant to taking chemicals." The Tylenol and the Advil and adding all these different chemicals. But he said, "I think my advice, having lived it now to tell patients is, especially patients who are natural health minded, is that under normal circumstances you should use your body to heal itself and listen to your body and supplement and biohack or whatever you want to call it."

But having surgery is an unnatural thing. It's not a natural thing that happens to the body that the body has to respond to. And for the short term, he said, "Tell your patients this is an unnatural event and you may have to do unnatural things to deal with it, to augment through that short period." And he said that's how he and his philosophy got through it himself was do what you need to do to get through an unnatural situation using unnatural things. So manmade things in other words.

Dr. Joseph Mercola:

And one caution on that, and I think you should, I strongly endorse using opioid narcotics, but there is a consequence of that. And you need to be mindful, especially in the light of an abdominal surgery, is that if you take a significant amount or even a small amount for some people and you have a tendency towards constipation, it's only going to make that worse. The last thing you want to do with this surgery is to have constipation because you do not want to do a bowel solvent and increase intra abdominal pressure.

So, you can compensate that really simply, inexpensively. So, you take magnesium. I like magnesium malate, magnesium glycinate is another one. Very safe and almost everyone is deficient in magnesium anyway. But if you take enough, you'll get loose stools and you just want to back off. You do not want... You want sort of a semi loose stool when you have this, it just basically comes out and you want to hold. I had a bilateral surgical repair, so I was holding both groin areas as I was having a bowel movement just to make sure there was no extra pressure on there.

Dr. Eric Pinnar:

Yeah. I see a fair amount of patients that have chronic constipation. And that's one of the things that contributes to the hernia. Either it can cause a hernia because of the constant straining, or it can certainly augment a hernia, sort of make a hernia worse, faster by constraining every day. That's what they're doing. It's like they're lifting 200 pounds every day. So those patients, I tell them, "We need to get that under control before surgery. We need to treat this." So, I saw one of your followers, actually. I did a telehealth with him. He's in the Santa Monica area in California, although he often winters in Florida somewhere. But he said in his older self, he's 69 years old, and he said as he's gotten older, he's having more and more problems with bowel movements. Now, like I said, he's one of your followers, so he's very healthy, he eats healthy. But he said that he's been taking this herbal supplement. He said it's a whole bunch of different...

Dr. Joseph Mercola:

[inaudible 00:26:57] senna is a big one for that.

Dr. Eric Pinnar:

Right. Well, senna is a stimulant though. And so, I usually tell people, "Don't take stimulant laxatives." Because you get to a point where the way a patient would understand is you get addicted to it, but really it's your colon that gets addicted to it because if you're constantly stimulating it at some point, it doesn't work without it now. So, you're dependent. You become

laxative dependent. So, he said, "Well, there's nothing in this, but just different herbs." And so, he went and got the box while I was talking to him because he wanted to see if it was okay, and it is a whole bunch of herbs he read off to me. But the active ingredient is sennosides.

Dr. Joseph Mercola:

Was Senna. Is what? Okay.

Dr. Eric Pinnar:

Yeah.

Dr. Joseph Mercola:

Sennosides.

Dr. Eric Pinnar:

So, it's like living on Seneca. I mean people know what Seneca is, it's sennosides.

Dr. Joseph Mercola:

Yeah, but you don't want to do that. You want to take magnesium because your body needs it everywhere. You need magnesium to make cellular energy in the form of ATP.

Dr. Eric Pinnar:

Or more important...

Dr. Joseph Mercola:

Without magnesium you can't make it.

Dr. Eric Pinnar:

And more importantly is what I tell the patients is fiber, water and stool softeners, those are the simplest and most natural of all the things that you can do to mitigate constipation.

Dr. Joseph Mercola:

Well, I would revise that because stool softeners is a drug. So, I would nix that and fiber definitely. In fact, I'm just writing a paper on this, just finished a 15,000 word paper with 400 references that I hope to get to submit to the journals next week. And the problem is is that our fiber intake historically it was over 100 grams of fiber a day. Fiber is absolutely unequivocally useful. Not only useful, but vitally important to have as part of your diet if you want to be optimally healthy. The problem is Dr. Pinnar that we've got this flux of mitochondrial poisons, which has destroyed our microbiome and the result of the microbiome being destroyed we don't have the right concentration proportion of bugs that would eat the fibers. There's other bugs in there that eat it, and then they make something called endotoxin or LPS, polysaccharide, it's another mitochondrial poison and it just makes the whole vicious cycle of premature death accelerate.

So, you got to be really careful with fiber. And if you have any symptoms like bloating, gas, belching, that's a symptom or a sign that you have an impaired microbiome, and there's steps to do it. That's the whole part of the book I wrote that, your gut is another health which focuses on that. Actually, by the time this interview is released, we have a product that's never existed commercially in the whole world, which is a delayed release butyrate. So butyrate for those who don't know, it's a short chain fatty acid. It's four carbons and it's the one of the most beneficial products of the bacteria in your colon that are supposed to be there, the ones that die prematurely because of the mitochondrial toxins. But if you have this butyrate, you could theoretically hypothesize as you don't need to eat any fiber because it's the end result of taking it. Now, these cells only make about 20% of their output of a short chain fatty acid as butyrate.

The other 20% is propionate and then 60% is acetate, all short chain fats. But the butyrate is what fuels the colonocytes. About 70% of the energy is fueled as the colonocytes. The colonocytes are the cells that line the entire colon and prevent leaky gut and worse, the whole situation, not only leaking proteins into your bloodstream causing an immune disease, but also leaking oxygen back in and making the whole problem even worse. So, butyrate's coming out. Butyrate's been available, you can use it rectally or can swallow it orally, but it doesn't reach the intestine. It releases shorter prematurely and gives it to the small intestine. It doesn't work. It just causes damage and harm because you don't want excess butyrate in your colon. That's a nightmare. I mean in your small intestine, you want it in your colon. So anyway, that's coming out. So, they can use that as an alternative. It just got a global patent on it too, which is crazy good. So, no other company can make it. They can, but you just have to pay us a licensing fee.

Dr. Eric Pinnar:

Yeah. Well, that's interesting. That's very interesting. And one other thing I wanted to say too, when you were talking about listening to your body just as a surgical principle and conserving your energy, as you said, one of the things that happens in patients when you operate on their intestines, something as simple as even an appendectomy, but typically like a small bowel resection or a colon resection is the whole GI tract shuts down. So, you do a bowel surgery and intestinal surgery and then the patients are in the hospital for a week or so waiting for their intestines to wake up and start working again. And we're experimenting with a lot of things to try to speed that process up. But the bottom line is when you operate or any major insult, but certainly on the intestines, your GI tract will shut down. And the reason for that is because the GI tract uses a lot of energy, a colossal amount of energy every day that your GI tract uses.

So, when you've sustained an insult, and when I tell patients it's like, "Back in the day, 400,000 years ago, if you fall out of a tree, your body will shut down the low priority mechanisms that use energy." And one of the big ones is the GI tract because you don't need to eat right away, but it needs to maintain the energy for your heart, your lungs, your brain, the important things. And then over time, once it realizes you're sort of getting back to normal, and this is why we get patients up and walking after that kind of surgery as soon as possible because you start to tell your body you're getting back to normal and then it starts turning those systems back on again. But it really does try to conserve energy as much as possible to deal with whatever situation at hand.

Dr. Joseph Mercola:

Yeah, for sure.

Dr. Eric Pinnar:

[inaudible 00:33:09] good point you have there in terms of listening to your body and following what it's telling you to do.

Dr. Joseph Mercola:

And I have extraordinarily good bowel movements, but post-surgery it took at least six weeks. I think at eight weeks post-op I'm almost back to normal, but even still a little bit. But normally I was having two, three or four bowel movements a day before then, but after the surgery it was double because I just couldn't get the movement going. It was just only small amount of stool that'd come out. So, you'd have to double the amount of bowel movements you had to get to get the whole thing out, which was an annoyance for sure.

Dr. Eric Pinnar:

And then again, when you slow your intestinal transit, slow your entire intestinal transit but when you slower colon transit, as I explained to patients, and this is again why the water and the fiber, the colon is a water-saving organ. You do some digestion in the colon, but its main job is really to absorb water. And so, if you look at desert animals like mice and rabbits, their stools are little pellets. So, as things move very slowly through the colon, you get more and more water sucked out of it, so it becomes harder. So, by the time it moves to the sigmoid colon and the rectum, it's firm and hard. When it comes into the colon...

Dr. Joseph Mercola:

It's mostly water.

Dr. Eric Pinnar:

Yeah, it's liquid. It looks exactly like pea soup. That's what it looks like. But as it moves through the colon, it gets water sucked out of it, it becomes firm stool. If things move very quickly through the colon, it doesn't have time to absorb the fluid, so it becomes diarrhea. So, things that are irritating, whether you eat something that's really spicy or you eat something that has toxins in it, endotoxins in it, something that's spoil, things move through very quickly and you get diarrhea. If you are dehydrated, your body's trying to hold onto as much as that water. It's going to move things through very slow and suck out as much water as possible. And then you end up with firmer and firmer and hard pellets, so to speak. So, as you said, hard to get it out.

Dr. Joseph Mercola:

And you don't want to do that post-surgery for sure. So, I had a curiosity question, because you've been doing this for a long time now, which is one of the reasons I saw you, it's one of the criteria. And if you haven't seen first interview we did, I definitely would recommend it, but you want to find a surgeon who's experienced. It's not to say that you wouldn't have been a great surgeon early in your career, but it's a little more reassuring that you've had a lot of surgeries under your belt for sure. And I think that's a criteria that most people should seek when they

identify or choose a surgeon. But I'm wondering historically, this was not an outpatient procedure I think, hernia surgery, weren't you hospitalized post-op or was it always outpatient?

Dr. Eric Pinnar:

For inguinal for open surgeries, I mean it was all outpatient.

Dr. Joseph Mercola:

Open surgeries were outpatient?

Dr. Eric Pinnar:

Yeah, inguinal surgery, it's just making an incision in the groin. It's still relatively small. Depending on the surgeon, I try to make an incision that's four centimeters, which is the size of a golf ball. But depending on how deep the patient is, in other words, how puffy they are, how deep you have to go, and how difficult the hernia is sometimes it might end up twice that big. It might end up eight centimeters like this. But it's all superficial really. When you go through the abdomen a lot of our surgeries that are inpatient are now outpatient.

So, gallbladder surgery, laparoscopy, revolutionized gallbladder surgery because when we used to do open gallbladder surgery, you make an incision under the ribs on the right side and you cut across all the layers of the abdominal wall muscles. Muscles hurt like hell when you cut them. Skin and fat really doesn't hurt, but muscles hurt. And so, the patients used to be in the hospital for a week just recovering from that incision, not the surgery itself, not from the gallbladder, but from the incision. So early on, laparoscopic surgery when we really didn't know much about it, how it was going to go and how patients were going to recover, yes, we kept them overnight, most of them. And up until when I started in practice, we were keeping gallbladder patients overnight. So that was back in 1999. But shortly thereafter, more and more people were sending patients home the day of surgery. So, I would say the majority of our surgeries today are outpatient.

Dr. Joseph Mercola:

Yeah. Yeah. So that's another question I would just extend to many people, maybe men only because women have such a extraordinary tolerance for this post-surgical process, but to have someone... Don't plan on doing much for two, three weeks, maybe four weeks and have someone to help you, a spouse or someone you hire to help you, and certainly for the first few days, there's no question. And if you don't need it, fine, but just make sure you have that available to you and you won't regret it. It's like fire insurance, you don't regret that you don't have a fire and then you wasted your fire insurance. No, it's a prudent process. You want to be prepared. I was a Boy Scout, so I'm a little bit bias. That's Boy Scouts motto in case you didn't know, is be prepared.

Dr. Eric Pinnar:

I usually tell people to plan on taking a week off from work. So, the patients who work, I say, "Plan on taking a week off."

Dr. Joseph Mercola:

Yeah, and...

Dr. Eric Pinnar:

[inaudible 00:38:50]. But I tell them, "There's no restriction. You can go back to work whenever you want, depending on what you do." If you sit at a desk all day, if you feel like going back to work sooner and I do have patients who go back to work sooner. It's really up to them. And that's why I said, "Everybody's different." When people ask me, "How much pain am I going to have?" There's the people who take one pain pill and they're pretty much good the next day or two, they're up and doing whatever they want to do. And then they have the other spectrum, which is more like you, where they were pretty incapacitated for a few days or even a week. They'll tell me, "I was incapacitated for a week. I couldn't even get out of bed for three days." And then you have the patients who are like, "I didn't even take the pain medicine."

Dr. Joseph Mercola:

[inaudible 00:39:33].

Dr. Eric Pinnar:

I had a little Italian guy operated on not long ago. I did an opening. He had a big inguinal hernia and I did an opening inguinal hernia, and he said, "I won't need the pain medicine." So, I said, "Well, I'm going to prescribe it for you anyway." And he said, "I won't take it." And I said, "Well, I'm going to give it to you because if you need it, you'll want to have it. If you don't want to fill a prescription, that's fine, but you're going to have the prescription." So, I saw him two weeks after. Actually, I follow all my patients. I call them the night of and I call them the next day. And he never took one single pill, nothing. Not even Tylenol or Advil. So, some of it I think is mind over matter. There are some people who say, "I'm not going to need it." And they don't. But some of it's just different makeup. They made him differently back then. He was also 70 something years old and made in Italy.

Dr. Joseph Mercola:

Yeah. Well, I was expecting and surprised I didn't because I've had other procedures before which were quite painful and really didn't need hardly any anesthesia. So, I was surprised with this one. But I want to pivot back to another topic that we didn't cover as well as we would've liked to because of time issues and constraints. And that is the mesh that's used, because there's so many different options. Did they have mesh when you first started inguinal surgeries or inguinal hernia repair?

Dr. Eric Pinnar:

No, not when I first started.

Dr. Joseph Mercola:

Okay. So, it was all [inaudible 00:41:07].

Dr. Eric Pinnar:

[inaudible 00:41:06] resident. When I was a resident. General surgery residency is five years after medical school. And it was really at the tail end, maybe when I was a fifth year resident that I had an attending that was younger and they were starting to use mesh elsewhere. And so, he was a believer in mesh, but it was brand then. And all my other attendings were older and different vintage, and they were like, "There's no way. We're not using mesh. Why would you want to do that? Why would you want to put a foreign body in a patient? Increase your risk of infection." And blah, blah, blah, blah, blah.

Dr. Joseph Mercola:

Well, it does. It does have some downsides because this is a foreign body. It causes inflammatory reaction and there can be complications. One of them, what I reviewed, and one of the reasons that I chose the mesh I did was up to one third, maybe you have different data, but the one I reviewed was up to one third of people were complaining of pain from the foreign body reaction post-surgery.

Dr. Eric Pinnar:

Yeah, it's very hard to study that.

Dr. Joseph Mercola:

Yeah.

Dr. Eric Pinnar:

It's very hard to quantify that. And I think we talked about it in the last one. In the last discussion we had was there's anywhere from a one to 9% incidence of chronic pain. And that's across the board whether you use mesh or not. There are a lot of people who have, and I would posit that just as many people have pain for the primary repair. In other words, no mesh, as the patients who have mesh. So, the question comes up is, "If the patient's had a mesh repair and they have pain now, is it because of the mesh or is it because of the surgery?" We don't really know.

I haven't seen anything personally that holds water, I should say, that says that it's the mesh that causes the pain. Yes, there is an inflammatory response. And that's been studied quite a bit. And this is why we hinted at, I think the last time about the evolution of mesh, where we've come in the last 30 or 40 years with mesh. And one of the things has been the engineering of it. You want to talk about the engineering of mesh. It used to be just a sheet of polypropylene, which is a woven plastic, really. Woven polypropylene. But now, and we talked a little bit, this is when you talked about eating credit cards, and I did bring a sample of that mesh to show you that the...

Dr. Joseph Mercola:

Oh, good, good. Is it the polypropylene one?

Dr. Eric Pinnar:

Hmm?

Dr. Joseph Mercola:

Is it the polypropylene one?

Dr. Eric Pinnar:

Yeah, the lightweight polypropylene, which is this, I don't know how it's going to show up.

Dr. Joseph Mercola:

Oh, wow.

Dr. Eric Pinnar:

Let's see if it showed up on here.

Dr. Joseph Mercola:

Oh, it does. Yeah. It's a little easier to see against your black shirt. Contrast.

Dr. Eric Pinnar:

It's got big holes in it. So much larger holes. And so this is why they called it lightweight mesh or macro-porous mesh. So, the other mesh, this is a laparoscope. This is one that's made for the inguinal canal.

Dr. Joseph Mercola:

Do they all have sharp edges on them instead of rounded corners?

Dr. Eric Pinnar:

No. Yeah, they're all rounded. I mean, you can cut them to whatever you need. This is big for most people's inguinal canal. So, I trim it down to what it needs to be. But a lot of them come in a square and you can just cut it, or a rectangle, and you cut what you need out of it. It's a little bit of arts and crafts. This is a laparoscopic one, but this is what we call standard weight or heavy-weight mesh or micro-porous mesh. I don't know if you can see, but you see it. It's much more mesh. It's less holes in it. Let's see if I can hold it up here.

Dr. Joseph Mercola:

Yeah, very fine. Yes, maybe...

Dr. Eric Pinnar:

But it's...

Dr. Joseph Mercola:

One fourth to one-eighth the size of the holes.

Dr. Eric Pinnar:

Yeah. But if you look at this one in comparison.

Dr. Joseph Mercola:

Oh yeah, big difference.

Dr. Eric Pinnar:

So, this inguinal mesh comes in this type of mesh, this weight. These are both polypropylene. This comes in a micro-porous standard weight mesh. And this one actually comes in this mesh too. But I tend to use this mesh more. And when I use a synthetic mesh, I use lightweight mesh or macro-porous mesh, because as you talked about less foreign body, less plastic.

Dr. Joseph Mercola:

Less plastic. Yeah. Did you weigh that, or does it say how much it weighs? Is it less than five grams? Which is about the size of a teaspoon or a tablespoon.

Dr. Eric Pinnar:

It weighs nothing. It's paper thin.

Dr. Joseph Mercola:

It doesn't weigh an ounce for sure.

Dr. Eric Pinnar:

I don't know. No, it definitely doesn't weigh an ounce. I don't know what it weighs.

Dr. Joseph Mercola:

It might weigh four or five grams.

Dr. Eric Pinnar:

Yeah. It would be in grams, but it's lacy. So, the way that the mesh is made, so going back to what you said, the inflammatory response, there's now a lot of engineering looking at how much inflammatory response do you need? Because you need some inflammatory response in order to lay down collagen and fibrin scar tissue.

Dr. Joseph Mercola:

Yeah, there's a difference between acute information and chronic, but some people think all inflammation is bad. No, that's only chronic inflammation. Acute inflammation is highly beneficial and required to stay healthy.

Dr. Eric Pinnar:

Right. And so the question is, "How much is too much and how much is not enough?" And so that's being studied extensively, at least from the engineering level. And that's when I talk about, or I hinted at last time, is the advancements in mesh that we've had over the... It's actually overwhelming to the average surgeon, and I was one of those. There's so much mesh out there now on the market. It's hard to keep track of what it is, who makes it, what the... Well, even just knowing what it is, what it's made of, trying to figure out which you use for what, what's appropriate for what situation is overwhelming. And then you start looking into the nitty-gritty of

it when you start talking about the weight of it. So what's heavyweight mesh? What's lightweight mesh?

When you're talking about filaments, whether you're polypropylene, is it woven or is it knitted? Is it monofilament? Is it dual filaments? Is it multi-filament? These are all broken down into different products now. So, one of the interesting questions, and what I tell patients when they're looking for a surgeon is, "What mesh does your surgeon use and why? Does the surgeon get to use..." So, this answer, because of what we went through but, "Does the surgeon get to use whatever mesh they want to use? Is there a reason? Do you use mesh from a specific vendor?" Because there's many different companies that make mesh. What's the difference from one company to the next? All the companies that make mesh, make polypropylene mesh. What's the difference between Bard or Covidien or Medtronic?

And then the other question is, "Why do you use a certain mesh? So why does a hospital keep a certain mesh on the shelf? What motivates a hospital to buy a certain mesh? Is it the surgeon? Is it the company?" And then, "Why does the surgeon use what's on the shelf as opposed to getting what it is that he wants or the patient wants?" So, we can talk about those things if you want, but it's super complicated because there's so many factors involved about what's available and what you can use. So, as a surgeon, I can't just choose everything I want to use. The hospital contracts with a company to get whatever equipment they get. And so whether it's suture or whether it's mesh or whether it's screws for orthopedic surgery, but the companies make it very hard to stock multiple companies. So, they do what's [inaudible 00:49:31] tiered pricing.

Dr. Joseph Mercola:

The hospital's incentive too to keep their cost optimized as well. They should, but many times that's not to the patient's advantage for sure. And there is some flexibility there. And I want to acknowledge... The name of the hospital I went to was Baptist Memorial. Is that the name?

Dr. Eric Pinnar:

Baptist Beaches.

Dr. Joseph Mercola:

Baptist Beaches. I'm sorry.

Dr. Eric Pinnar:

Baptist Medical Center.

Dr. Joseph Mercola:

Baptist Beaches Medical Center.

Dr. Eric Pinnar:

Baptist Medical Center Beaches is really great.

Dr. Joseph Mercola:

Okay. Yeah. Which is in Jacksonville. And they were extraordinary. Literally, I was very impressed. The whole hospital experience, I don't think could have gone any better and I'm anti-hospital in spades, but I was really impressed with them. And even the pre-surgery, we did this process all over the Christmas holidays, and you had taken your daughter to a birthday event the day before or after Christmas, so you were kind of out because I wanted to do it that weekend, but it wasn't available because you were gone.

Dr. Eric Pinnar:

I was in California. I was in Los Angeles,

Dr. Joseph Mercola:

Yeah, yeah. But the mesh I wanted, and I'm not sure that it was warranted, but it was the best I could figure out from my limited perspective and research and understanding. I wanted this one that was absolutely natural made from porcine intestine. It's called Surgisis. It's really... But it's a very expensive one. It costs literally 10, 20 times more than the other ones. But it's almost a non-issue because you don't pay for the mesh. The hospital's paying for the mesh. But nevertheless, the hospital did not have this in stock. And this is a story I wanted to share about Baptist.

So how deeply appreciative of what their process was because the company was on their list, but they didn't have the specific... They changed companies. It was a real problem. And they went over and above to do this. And I literally, until two days before the surgery was done, I didn't know if I was going to have to cancel for the fifth time. Not with you, but the fifth time, I had to schedule four times previously. And knowing that I want to get this done as soon as possible, it's like, "Oh." But anyway, they went above and aboard, and I think it was the relationship you had with some of the supply people there, they just delivered on [inaudible 00:51:38]. I couldn't have been more pleased.

Dr. Eric Pinnar:

Yeah, that's unusual for a hospital to bend over backwards. Part of that's the surgeon i.e me, who pushed that along. There are a lot of surgeons that aren't willing to fight the fight.

Dr. Joseph Mercola:

Which is what you want. That's another thing that you want in your surgeon as you're picking, is you want someone as your partner, your alliance, your collaborator. And if he's not willing to go to bat for you, you want to think about finding another one. And you want to do it quickly because you don't want to wait on these hernias. We said we want to get them done soon. Not waiting six months a year.

Dr. Eric Pinnar:

Well, interestingly, one of the meshes I like to use is a mesh called Made by Medtronic. And it's one of the meshes I tried to talk you into.

Dr. Joseph Mercola:

That's right. Phasix.

Dr. Eric Pinnar:

Well, Phasix is Bard. And that one interestingly is hydroxybutyrate. So, it's a hydroxylated butyrate. You mentioned butyrate earlier, and that particular one is a hydroxylated butyrate.

Dr. Joseph Mercola:

Was that your favorite bio combative?

Dr. Eric Pinnar:

Biologic.

Dr. Joseph Mercola:

Biologic.

Dr. Eric Pinnar:

[inaudible 00:52:51].

Dr. Joseph Mercola:

Yeah.

Dr. Eric Pinnar:

It's my favorite one from Bard. So, if I'm at a hospital that doesn't have Medtronic or is unwilling to get Medtronic, so this is the story I was going to tell you. So, I saw a patient, that same patient that's in Santa Monica area that I told you about, I spoke to yesterday. So, he saw a surgeon, he's got bilateral inguinals. He saw a surgeon who wants to use ProGrip, Medtronic ProGrip. And so, one of the things... He really wanted a second opinion from me if he was getting the right thing. So, he asked me if I knew about ProGrip, and I said, "I really like ProGrip, it's really my favorite meshes." So, Medtronic makes a whole bunch of meshes. They're probably the second-largest maker of mesh other than Bard. And they make a mesh that is the synthetic mesh as opposed to polypropylene, which is this. They make one that's polyester.

So instead of polypropylene plastic, it uses polyester. But they put a coating on it, a dissolvable coating, and on one side of it it's got little hooks on it like Velcro, just little teeny tiny mesh hooks. So, when you put it against tissue, it sticks. It stays there. It stays where you put it, lick and stick. So, I really like that because it mitigates the use of sutures. To me, sutures hurt and tacks hurt. I started using it before we had the robot, before we had the robot available to use. Because in those days to anchor the mesh you had to use tacks, which are like little rivets that you use an attacker that fires these little tacks into the tissue, and that causes pain. Once we had the robot, we could sew, which makes less pain, but still pain. You use this mesh and you can stick it there. It doesn't need any sutures or tacks. It'll stay where you put it.

Dr. Joseph Mercola:

Really? No sutures, it just stays in place?

Dr. Eric Pinnar:

It stays in place like Velcro.

Dr. Joseph Mercola:

Wow. Wow.

Dr. Eric Pinnar:

So, when I was at University of Florida, they only had Bard. Actually before I came, they had a company called Atrium. And I don't want to insult any companies, but their mesh sucks. So they got Bard.

Dr. Joseph Mercola:

But you just did.

Dr. Eric Pinnar:

[inaudible 00:55:26]. They make other things, but they're not good at mesh. And the only reason they had it there is because the previous chairman of surgery liked it. So, he got whatever he wanted. But they went to Bard because that's what all the other surgeons liked. And Bard makes good products. I've used it for a bazillion years. They're the ones that make these two products and they make Phasix, which is the synthetic biologic. But I really wanted this ProGrip and I had a patient, the one recurrence that I've had from a laparoscopic repair that I know of was about five years ago. And a young guy that had a huge... He was the guy who sat on it for a long time, very athletic, active guy, sat on his hernia for a long time, had most of it... I can't say most. He probably had a lot of his intestine in his scrotum at this point. So, his scrotum was like the size of a football when I met him. So, it was a huge hole. It was a hole like this in the inguinal canal. It was a direct hernia.

And I fixed it. And I used this exact mesh for it. And I think I may have used the light version of this mesh, but typically for a direct, I would use this one though, because it's less flimsy. It's still very flexible, but it's less flimsy than this is really flimsy. But I used this mesh because that's all I had. I would've used ProGrip, but this hospital didn't have it and wouldn't get it. So, I put that in this guy and he didn't follow instructions, and he went back to the gym the next week.

Dr. Joseph Mercola:

No.

Dr. Eric Pinnar:

He was playing basketball and lifting weights the very next week.

Dr. Joseph Mercola:

Don't want to do that folks. Do not want to do that. Don't do it.

Dr. Eric Pinnar:

Right, but you see it is possible.

Dr. Joseph Mercola:

Yeah, it is possible. Yes.

Dr. Eric Pinnar:

In some people. So, he called me up and he said, "I think something's wrong." And I said, "Why?" And he goes, "Because something just doesn't seem right. I think the hernia is back." So, I said, "Well, come in." So, I brought him in right away the next day and sure enough it was back. And I told him he shouldn't been doing all the things I told him not to do, but...

Dr. Joseph Mercola:

"Told you so."

Dr. Eric Pinnar:

"Told you so." But the repair failed. And what happened was this mesh, if this was the hole, looking at it from the pelvis, like this, this is the hole, looking at it from the pelvis, I put this mesh over it.

Dr. Joseph Mercola:

It just sucked right in?

Dr. Eric Pinnar:

But what happened is it did this.

Dr. Joseph Mercola:

Yeah, yeah.

Dr. Eric Pinnar:

It sort of tacoed. Oops. Sorry. It sort of tacoed. Geez. You see how easy that happens?

Dr. Joseph Mercola:

Yeah, yeah, yeah.

Dr. Eric Pinnar:

It sort of tacoed into the hole like this and then all the stuff went back through the hole.

Dr. Joseph Mercola:

Straight through.

Dr. Eric Pinnar:

So that was putting a lot of pressure on something like this. But if I had had that ProGrip mesh, 100% that wouldn't have happened.

Dr. Joseph Mercola:

Wow.

Dr. Eric Pinnar:

100%. So, I went to the hospital and I said, "Listen, I want this ProGrip mesh. I used it for years. I'd like it better than this. And this guy wouldn't have had a recurrent." So, you saw what I went through at Baptist Beaches to get your mesh. I had to go through 50 times that at University of Florida. So, I had to submit a letter explaining why this was important, why we needed it, what was the difference between this and that, what does the mesh we have doesn't do that this one does. Then if it got through that process and then I had to present it at a committee, a value analysis committee, to show that this has a value over the stuff that we have. So long story short, I went through two or three committees and all of the submitting it formally in writing and it got approved that I could just get the Pro... I do have a piece of it, but I don't think I dug it out.

It looks similar to this, but it's a little more squarish. So, I finally got it, but just the inguinal, they make mesh for other things, but just the inguinal and I started using it there. Well, I left there about three years ago. Three years ago I think I left. Well, 2021 I left. July of '21. And it's interesting. I just went back there to do a case, the one I told you about, the very difficult lady case that took me four and a half hours. I did that on Tuesday and the ProGrip is all they have now because all [inaudible 01:00:10].

Dr. Joseph Mercola:

And you're one that introduced it.

Dr. Eric Pinnar:

The surgeons started using it and they really liked it. And there's several surgeons who refuse to use the Bard. So now they don't have any Bard left. It's completely phased out. So now I'm trying that same process at Baptist Beaches and they're getting it for me. They're not stocking it yet.

Dr. Joseph Mercola:

Yet.

Dr. Eric Pinnar:

But they're getting it for my cases. So, when I'm doing [inaudible 01:00:33].

Dr. Joseph Mercola:

I would imagine they would because the cost is pretty comparable, but the one they got for me was really expensive.

Dr. Eric Pinnar:

Yes. And so is the ProGrip version. So, the ProGrip also makes a synthetic biologic. So just jumping back a step, what we have today is we have synthetic, which is man-made product that's permanent, it doesn't dissolve. Then we have...

Dr. Joseph Mercola:

Like polypropylene or polyester.

Dr. Eric Pinnar:

Polypropylene or polyester. And then we have biologic mesh, which is what you have. And that can be anything from dermis. So, it's made from an animal. So, human would be an allograft or we have xenograft, which is an animal product. So, we have human dermis, which is skin, the thick part of skin, and we have animal dermis, which can be cow or usually pig. And then we have intestinal submucosa, which is what you have which is from a pig. We have pericardium, which is the firm lining around the heart from a cow. So, we have bovine pericardium and then we have some bladder lining matrix. I think those are the main biologics.

Dr. Joseph Mercola:

They don't rip them off now. There's a lot of processing that goes on, which is why it's so expensive. There's a lot of proteins they have to clean up to prevent autoimmune reactions and it's...

Dr. Eric Pinnar:

Yeah, because you're left with [inaudible 01:02:05].

Dr. Joseph Mercola:

Essentially just the collagen is left.

Dr. Eric Pinnar:

Just this collagen skeleton. That's it. All the DNA has been removed. Now we have synthetic biologic. So, it's biologic mesh, but we synthesize it. So, as I said, the Phasix version, so the Bard version, this company makes a one called Phasix, which it's a poly four hydroxybutyrate. And so, it dissolves. It lasts 12 to 18 months before it dissolves. And then Medtronic makes a mesh. And I've used plenty of Phasix. I like Phasix and I use it for other things, but it's a micro-porous mesh. So, it's a small holes like this. The Covidien version or the Medtronic version is called Transorb, and that's what I put in Patrick, is Transorb.

It is a poly-L-lactic acid or poly-L-lactide, which dissolves by hydrolysis. So same as the hydroxybutyrate turns into CO2 and water when it's dissolved. So, no chemicals. That one will last 18 to 24 months, but it's also got the little grippies on them. Those grips will dissolve in a few weeks, but the rest of the mesh will stay for 18 to 24 months. And then any fibers that are left after 18 to 24 months, what they say is it'll be gone in 30 to 60 months, 100% gone. So that's the synthetic biologic. And now it's so expanded. Like I said, I can't really keep track of it all, but we have... I wrote it down because there are so many categories now. There's synthetic mesh,

there's synthetic partially absorbable mesh, [inaudible 01:04:09] mesh. It has a coating that partially absolves, and then you've got a permanent mesh that stays partially.

Then there's a biosynthetic completely absorbable mesh, which is what we were just talking about, there's biosynthetic partially absorbable mesh, so its biosynthetic but it's partially absorbable. And then there's the biologic derived partially absorbable mesh and biologic antibiotic impregnated mesh. The field is so huge now that it really is almost impossible to stay on top of. And that's why I said it's important for surgeons to know... Not as much. It's too much for patients to know if it's too much for surgeons to know, but it really comes down to what's available, what your choices are as a surgeon at wherever you go, whatever hospital and a surgeon preference of what they do have. There's many layers of what dictates what you get.

Dr. Joseph Mercola:

Well, thank you for reviewing that topic because it is confusing and obviously there's many permutations and that's why you have a practice and are available as a consultant who's an expert in this field. And as you advocate and implement is that there is no one size fits all for this. It depends on your specific circumstances. What was good for me is not going to be good for 90% of other people and same thing for them. So that's why you're available as a consultant. And you can do the surgery as an elective procedure, rarely emergency at one o'clock. You do not want to wait long enough that you have a one o'clock emergency surgery because it's a rescue and the surgeon's going to be partially asleep when you're doing this. They're humans. Yeah, they're awake but you woke them up in the middle of the night.

Dr. Eric Pinnar:

And they're mad. They're angry to be woken up in the middle of the night. So, they're not in a good mood.

Dr. Joseph Mercola:

I would be for sure. So, they're there to help and save your life, but it's less than ideal. You do not want an emergency surgery. Thank God they exist, but you don't want it. Just don't delay, get this thing done and you could easily be suspicious that Dr. Pinnar is conflicted and he's going to recommend it, "Get a surgery now. Don't wait." But I can tell you authoritatively that he's not. I mean if you knew his backstory, you'd know this is the last thing he is conflicted. He wants the best for you. And this is not common in medical professionals. I can tell you that with authority too, especially oncologists. I don't want to beat on them, but I think they're the only specialty in medicine that makes the most of their... Maybe it's not most of their money, but it's a significant portion of their revenue from selling the drugs they use to treat cancer.

And I believe incorrectly with chemotherapy. They get a huge percentage of that. That should be illegal and maybe it will be when Bobby Kennedy gets in and does his thing for the next four years. I don't know how that passed any ethical standard that they get a huge percentage. That makes no sense. But it doesn't matter. You're just there to help them. You've opted out of the health insurance system, so your services are not covered. But I think they're well worth it. It's a small expense, I think, if you can afford it to do this as opposed to not have access to this level of

skill and expertise. But some people can, but you're still available for consultation to help them customize their plan for their specific circumstances. So why don't you tell us if anyone is interested in connecting you for a personalized review of their circumstances, how they would do that?

Dr. Eric Pinnar:

Well, they can certainly email. Well, they can go to my website. You can contact me through my website, which is advancedherniaspecialists.com. That's advanced hernia specialists, plural, .com. And you can contact us through the website, but also our email address is there. You can send me a personal email if you want. It's at epinnar@advancedherniaspecialists.com. And you can call at 904-808-5658. 904-808-5658. And I'm always...

Dr. Joseph Mercola:

Because you have other educational materials on your site too, right?

Dr. Eric Pinnar:

Oh, yeah. Almost all the stuff that we talked about today is on my website. I spent months writing all the content for my website to answer all... all the questions I've ever been asked by patients are all there on my website.

Dr. Joseph Mercola:

So that's a great service. And if you don't connect with him, that's fine, but that's a resource for you to get data so you can make an informed choice because there's many specialists, maybe you could comment on this before he goes, not specialists, but surgeons who are not going to give you the full picture and you will not be able to make an informed choice. As a primary care physician for many years and helping people navigate this myself, it was hard for me to do that. And I have a lot of training and I would... As a non medical professional, you're at a severe disadvantage navigating through this and it's not easy. And I was able to do it and that's why I found you and would've made a good choice even at my other if I had been able to tolerate their administrative challenges. But you need data to make a good choice, otherwise you're going to get messed up. There's a high likelihood, massively increased percentage.

Dr. Eric Pinnar:

I would say most people just do whatever their surgeon says.

Dr. Joseph Mercola:

Yeah.

Dr. Eric Pinnar:

That's it. The guy that I told you about last night from Santa Monica, he had a consultation with a surgeon and I spent an hour and a half on a call like this with him last night, seven o'clock last night. We spent an hour and a half talking about everything his surgeon didn't tell him. So, he's asking me all these questions. I said, "You went to see a surgeon, he didn't tell you any of this?

You didn't ask him these questions?" And he said, "No, it was only a very short time I spent with him."

Dr. Joseph Mercola:

Five or 10 minutes. That's it. Typically.

Dr. Eric Pinnar:

And so, I told him, like I tell every patient, "No matter what doctor you see, whether it's your primary care doctor or your cardiologist, your oncologist, whoever it is, ask them everything you want to know. Their job is to explain it to you. And if they answer it and you don't understand it, say, "I didn't understand it." But you need to know why they're doing something. Why whatever medication..." You know all these years, patient's taking a drug and you say, "Why are you taking this?" And they're like, "I don't know." And I said, "You're taking a drug you don't know." "Well, I know. My doctor just told me I should be on it." And I said, "But you need to know why you're on it. I don't know why you're on it, but I want to know why you're on it and you should want to know why you're on it." So, ask the questions.

Dr. Joseph Mercola:

Absolutely.

Dr. Eric Pinnar:

So that's an important step I think.

Dr. Joseph Mercola:

Without that information, you cannot take control of your health. You need the information and you're a great resource for that.

Dr. Eric Pinnar:

I will say one more thing is that anybody who wants to just get that, like he did, a second opinion, I'm happy to talk to patients. So, I've had a lot of your people from California, they're not going to travel to Florida, but they want the information. So, I do these type of telehealth visits with those patients. And I do have a guy who's some kind of big wig doctor at a university hospital in Washington State. He's flying down here on Saturday for me to operate on him Monday. He's one of your followers.

Dr. Joseph Mercola:

So, the people do it. I'm surprised people haven't even called in from all over the world now, but maybe they will with time. Because a professional with your level of expertise, if you have the problem, you're not the only one that does this. But the challenge is finding them and identifying them.

Dr. Eric Pinnar:

It is one of the most common surgeries performed around the world, so all general surgeons do hernia repair. They're just not all experts in it, but they all do it.

Dr. Joseph Mercola:

Yeah, that's right. So, you really want the best. But it's one of the things that my dad really instilled in me as a child is always do the best you can in anything and certainly when you're going to do a major operation like this. All right, well thank you for everything. I think we've really helped many people here and hopefully they'll integrate this information and make some wise choices.

Dr. Eric Pinnar:

Thank you very much for having me. And when you want to do a show about the insurance industry, I want to be on that one too.

Dr. Joseph Mercola:

All right, good. Yeah, maybe we'll do another one on that for sure. I think definitely because I'm going down that path. I mean, this is just something that has to be fixed, it's beyond broken at this point.

Dr. Eric Pinnar:

It's very broken.

Dr. Joseph Mercola:

Yeah.

Dr. Eric Pinnar:

Super broken.

Dr. Joseph Mercola:

All right, well thanks again. Take care.

Dr. Eric Pinnar:

You're so welcome.

Dr. Joseph Mercola:

All right.

Dr. Eric Pinnar:

Thank you.

Dr. Joseph Mercola:

All right, bye.