VIDEO SESSION

TOPIC: INCISIONAL HERNIA - “Easy case” as daily case: open vs lap, where the mesh, which fixation...in center midline cases

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VS:28

SELF-GRIPPING SUBLAY MESH TO REPAIR RECURRENT VENTRAL HERNIA WITH PREVIOUS ONLAY PROSTHESIS

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Introduction: Retromuscular mesh placement has become one of the gold standards in the repair of middle line incisional hernias. We present a video showing the most important tips and tricks to solve a recurrent ventral hernia in a patient who has been previously operated for incisional hernia with primary closure and an onlay mesh technique.

Material & methods: This is a 81 years old lady with hypothyroidism who was operated 3 years ago. In the previous surgery an onlay mesh placement was performed. The patient developed a symptomatic recurrent incisional hernia that impaired her quality of life. The patient was operated under general anesthesia. A Rives procedure was planned. The main goals of the retromuscular repair were achieved and are explained during the video: dissection of the sac delimiting the borders of the defect, removal of the previous onlay mesh that was completely integrated in the scar, dissection of the retromuscular space leaving the posterior sheath attached to the sac, closure of the posterior rectus sheath, dissection of the “fatty triangle” of Conze extending it more than 8 cm from the defect and dissecting the retroperitoneal space beyond the arcuate line. In this case, a large-pore 30 x 20 cm self-gripping mesh made of polyester and polylactic acid was used as tissue reinforcement. The anterior aponeurosis was completely closed in the midline without tension. No drains were used.

Results: The patient did not develop any complications and was discharged home on the third postoperative day with an adequate control of pain that was evaluated as 3 (VAS scale) on discharge.

Conclusion: This video shows the most relevant tips and tricks of the retromuscular repair for a recurrent ventral hernia. We think that the self-gripping mesh also contributes to a less painful procedure as no fixation was used.

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RIVES TECHNIQUE WITH AUTO-ADHESIVE MESH

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Most surgeons performing abdominal wall surgery consider the Rives Stoppa technique to be the gold standard procedure in the open treatment of midline incisional hernias.

In this video we present a Rives Stoppa technique in a patient with a large incisional midline hernia, showing all steps and anatomic references from the original description, but using a new autoadhesive mesh avoiding the stitches.

With this procedure, we obtain a very low rate of recurrences, while the new mesh offers a good tolerance without adding the complications due to the stitches-sutures.

Rives Stoppa is a low recurrence technique, easy to perform for abdominal wall surgeons. The knowledge of abdominal wall anatomy is the key for this technique to be correctly performed. Some variations have been described; we used a new mesh with no sutures required.

VS:30

PRIMARY FASCIAL CLOSURE IN LAPAROSCOPIC VENTRAL HERNIA REPAIR

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Introduction: Laparoscopic ventral hernia repair (LVHR) was described on firsts by Leblanc in 1993. This procedure is performed with a mesh bridge technique, without the primary fascial closure. Recent studies suggested that primary fascial closure compared to nonclosure, resulted in lower recurrence rates, seroma formation, clinical bulging and patient satisfaction.

Methods: Between January 2010 and June 2014, we treated 40 patients with LVHR at Luigi Sacco University Hospital. In 30 patients we performed this procedure without the primary fascial closure; 10 patients were treated with a closure of the fascia defect. The closure of the defect is performed either extracorporeally and intracorporeally with nonabsorbable stitches using transperitoneal U reverse suturing technique, sec. Chelala.

Results: We showed better outcome with primary fascial closure. The closure of central defect resulted in less bulging, seroma and patient dissatisfaction. No surgical morbidity occurred in this first ten cases; no difference in post-operative pain was observed with the fascial closure technique compared to nonclosure.

Conclusion: LVHR with primary fascial closure is feasible and more difficult than nonclosure technique. To evaluate difference in recurrence rate between the primary fascial closure and nonclosure during LVHR, a randomized controlled trial is warranted.