Algorithm for the Management of Ventral Hernia in Morbidly Obese Patients

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Dear Sir,

We read with interest the article of Eid et al. [1] about ventral hernias in morbidly obese patients and are really impressed by the algorithm in managing this dilemma that general and bariatric surgeons can face.

We feel that the major points to consider regarding this problem are the following:

1. Majority of these ventral hernias in morbidly obese patients are paraumbilical hernias containing omentum, which is irreducible or partially reducible, and they are usually asymptomatic.
2. Certainly, inserting an intraperitoneal mesh during laparoscopic gastric bypass or sleeve gastrectomy will carry the risk of mesh infection, which we consider a surgical disaster in this particular clinical scenario. The risk of mesh infection could reach 5.56 % when a simultaneous gastrointestinal division procedure was performed [2]. There is also a contradictory opinion imposed by other authors that the combined ventral hernia repair and bariatric surgery did not result in any infection, but unfortunately, it had increased the incidence of small bowel obstruction [3].
3. We have tried a variety of intraperitoneal meshes, and, in retrospect, all of them cause some degree of intraperitoneal adhesions that make further complex laparoscopic bariatric surgical intervention more difficult.

Based on these points, we would like to share with you our algorithm in managing this problem:

1. For morbidly obese patients with a ventral hernia who are not willing to undergo bariatric surgery, we will proceed

with laparoscopic repair of ventral hernia using non-absorbable mesh.

2. For morbidly obese patients with asymptomatic ventral hernia who are willing to undergo bariatric surgery, we will proceed with laparoscopic bariatric surgery and during the operation will leave the omentum untouched, plugging the defect in the abdominal wall. Reducing the omentum from this ventral hernia will create an open defect that may incorporate the small bowel in the post-operative period and result in small bowel obstruction.
3. For morbidly obese patients with symptomatic ventral hernia, they will have a CT scan of the abdomen to determine whether the contents of the symptomatic hernia are bowel or omentum. If the contents are omentum, then we will proceed as point 2 in the algorithm. If the contents are bowel, then we will reduce the contents of the hernia laparoscopically and repair the defect with interrupted PDS stitches with a reduced pneumoperitoneum after completion of the proposed laparoscopic bariatric procedure.

We acknowledge that our algorithm is not based on a structured study like the study of Eid et al., but it is based on experience of 30 years in general surgery and 15 years of bariatric surgery practice.

Conflict of Interest The authors declare no conflict of interest.

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