

AKL2-1

The Evolution of Lichtenstein Hernia Repair

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Groin hernia surgery underwent an evolution from the use of tissue repairs to the use of prosthetic implants. Evidence have shown that recurrences are reduced with the use of mesh material. Among the different prosthetic repairs, the Lichtenstein technique is the most popular and the most studied in terms of evidence based literature. The technique of Lichtenstein repair underwent an evolution from the time it was started in 1984 until it was reported in 1989. Different techniques evolved from the Lichtenstein technique as well as modifications in the prosthetic materials used which will be discussed in this presentation.

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Self Adhering Mesh For Laproscopic Inguinal Hernia Repair

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Inguinal hernia repair is the most commonly performed general surgery operation worldwide. The techniques to repair inguinal hernias have evolved over the past 30 years from primary open tissue repair to open mesh repairs. Recently the endo-laparoscopic mesh repair has gain increasingly the popularity as an alternative treatment, especially for bilateral inguinal hernia and recurrence inguinal hernia after open procedure. The mesh fixation in endo-laparoscopic inguinal hernia repair is still debatable. Mesh fixation is widely believed important for mesh stabilization and consequently for early recurrence prevention. But the mechanical fixation with metal or synthetic tacks or clips are implicated as a cause of early post operative pain and chronic pain. Fibrin glue or cyanoacrylate for non mechanical mesh fixation has been showed a good result and it can also eliminate the complication caused by mechanical devices. However using glue increased the operation time and cost. Self adhering mesh was introduced to the market in 2006, started with the mesh for open inguinal repair with good outcome and later also for laparoscopic approach. The purpose of this paper is to review the mesh fixation methods and to present our early experience of our laparoscopic inguinal hernia repair with self adhering mesh.

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Open inguinal hernia repair for recurrent and complicated hernias

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TOP repair adopts the principle, proposed for the first time by Stoppa and later by Wantz, to place a large prosthetic mesh over myopectineal orifice

Indications: - Recurrent inguinal hernia R2, (Campanelli classification): first recurrence, above the pubic tubercle, medial reducible hernia with a small (<2 cm) defect in thin patient;
- Recurrent inguinal hernia R3, (Campanelli classification): big defect (inguinal eventration) or multi-recurrent hernias or non-reducible recurrent hernia;
- Chronic post-operative pain;
- Giant inguinal hernia
- Femoral hernia.

Surgical steps: - Transversal lateral incision, 2 cm below the ASIS

- Opening of the anterior sheet of rectus muscle aponeurosis and of the external oblique aponeurosis and splitting of the fibers of internal oblique and transversus muscle laterally.
- Retraction of the rectus muscle medially and approach of the preperitoneal space.
- Identification of the psoas muscle, of the nerves, of the iliac vessels, of the Cooper ligament and the Retzius space and eventually removal of mesh/plug
- Isolation of the cord and identification and reduction of the inguinal hernia sac
- Verify the presence of femoral sac
- Placement of a flat mesh synthetic or biological
- Suture of the aponeurosis

This technique allows: - To operate in a virgin field

- The completely and safe view of the region
- The possibility of approach to the abdominal cavity, if necessary
- The identification of the three nerves and eventually the removal of mesh h and plug, in case of chronic post-operative pain

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TEP vs TAPP repair of groin hernia- experience of over 1000 cases at a tertiary care centre

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Abstract: TEP and TAPP are standard techniques for laparoscopic repair of groin hernia. There have been many studies comparing TEP vs TAPP in terms of safety and efficacy, however there are conflicting reports of advantages of one over the other. We present our experience of more than 1000 TEP and TAPP cases.

Methodology: This study is retrospective analysis of prospectively maintained database of all patients who underwent laparoscopic groin hernia repair in a single surgical unit. Patient's demographic profile, hernia characteristics were noted. Clinical outcomes included the operation time, intraoperative and postoperative complications, length of postoperative hospital stay, hernia recurrence, chronic pain (defined as pain that persisted for more than 3 months), recurrence, seroma and wound infections. Patients were followed up in the outpatient clinic by the attending surgeons during the postoperative course.

Results: Over ten years duration, TEP repair was performed in 841 patients and TAPP on 542. Mean age of patients was 50.7 years (range 17-86 years). Both the techniques were comparable in terms of operative time, intraoperative complications and post operative outcomes. However there was a significantly higher pain scores (p value <0.05) at 24 hours in the TAPP group. The incidence of seroma was higher in TEP and scrotal edema was more common after TAPP repair. Both the techniques were also comparable in terms of QoL, testicular function and sexual functions

Conclusion: In conclusions both TEP and TAPP repair are comparable and should be considered as complementary procedures.

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Large Ventral Hernia and need for component separation

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Large ventral hernias (LVH) (> 10 cm in any direction) are an enigma. Continuing search has led us to important conclusions understanding abdominal wall anatomy, restoring a physiologic abdomen (choosing correct procedure), prevent perioperative complications and provide long term quality of life. Reconstruction of midline (buttressed with or without prosthesis) and a physiological abdomen is the endpoint in LVH. Component separation (CS) has evolved from Ramirez's anterior separation to Fabian (Internal Oblique) and Novitsky (Posterior CS). IPOM Plus has replaced conventional IPOM in the era of laparoscopic repair (MIS). Open CS followed by laparoscopic IPOM and reports of total laparoscopic CS are in literature. Reduction of LVH can lead to intra-abdominal hypertension (IAH) or even Abdominal Compartment Syndrome (ACS) in the immediate perioperative period or be the cause for recurrence in the long term. CS is an answer for both. The vascular supply of the abdominal wall is important for prevention of wound morbidity. Three zones in the abdominal wall described by Johnson et al emphasize the importance while performing open CS. The comparison of MIS with open CS by Ghali et al shows superiority of MIS technique in preventing these problems. The importance of core group muscle strengthening is gaining importance in post-operative care. CS (open or MIS) with or without prosthesis is therefore important in providing a physiologic abdomen and long term quality life in patients with LVH. Giant hernia (> 20 cm) require abdominal reconstruction while those in between are best left to individual surgeon-patient assessment.

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PROs (Patient reported outcome measures). The good, the bad and the ugly

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"The ultimate measure by which to judge the quality of a medical effort is whether it helps patients (and their families) as they see it. Anything done in health care that does not help a patient or family is, by definition, waste, whether or not the professions and their associations traditionally hallow it."

(Berwick 1997)

A patient-reported outcome (PRO), is a series of questions that patients are asked in order to gauge their views on their own health. PROMs are completed by patients themselves to allow their own assessment of their health and health-related quality of life PROMs questionnaires do not ask about patients' satisfaction with or experience of health care services, or seek their opinions about how successful their treatment was.

The purpose of health care is not just to minimise the harm caused by its activity, but also to produce health and social benefits for patients and society. Despite a century of developments in medical technology, and vast improvements in the ability of medical science to prevent, diagnose and treat disease and ill health, attempts to measure the outputs of health care in terms of their impact on patients' health have barely progressed beyond Florence Nightingale's time. More than 100 years ago, she suggested a simple three-point health-related outcome measure for her patients: relieved; unrelieved; and dead.

This lecture explores what is good about PROs, what is bad, and where PROs can be misleading, with a particular focus on hernia surgery.