

AS14-1

### TEP treatment for incisional hernia

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**Purpose:** Laparoscopic onlay mesh repair has been used successfully to reduce the postoperative recovery and associated wound complications. However, tissue ingrowth to the raw surface of the onlay mesh might not be as good as that after retromuscular polypropylene mesh repair. Extraperitoneal mesh herniorrhaphy has been proved to be beneficial in surgical result and was widely used in inguinal hernia repair. Therefore, TEP repair was attempted for incisional hernia repair.

**Materials and Methods:** Incisional hernia with abdominal wall defect less than 10cm in diameter was included. Retromuscular space was created by manual telescope dissection and hernia sac was pulled back or transected, a polypropylene mesh was implanted over the intact peritoneum. Peritoneal tear was always closed. Midline fascial defect was closed whenever possible. Patient demographic profile and perioperative results were analyzed from a prospectively collected data base.

**Results:** From September 2008 to June 2016, twenty five patients with incisional hernia underwent totally extraperitoneal herniorrhaphy were enrolled. Mean diameter of hernia sac was 7.3cm. All procedures were completed endoscopically without open conversion. Mean operation time was 132 minutes. Mean blood loss was 12 cc. Mean hospital stay length was 1.9 days. Post operation morbidity included subcutaneous seroma and hematoma but no wound or mesh infection, which was treated conservative. After mean following up for 30 months, one obese patient developed recurrence.

**Conclusion:** From this preliminary experience, totally extraperitoneal dissection of retromuscular space and mesh placement is a safe and effective technique for incisional hernia repair.

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### Endoscopic TEP Rives - Stoppa repair, a single centre experience

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**Introduction:** E-Rives Stoppa repair is a relatively new method of repair of moderate-ly large ventral hernias. We present our early experience with this form of surgery from a single unit.

**Material and Methods:** 10 patients were operated with the technique of endoscopic Rives-Stoppa, between January 2015 and May 2016. All patients had primary ventral hernias between the sizes of 2 and 5 cm. The usual contents of the hernia was the omentum. All patients were operated electively, thus emergency admissions were not considered. The average operating time in the patients were 130 minutes. In 8 patients, a 10 x 15 cm self fixating mesh (Progrid TM. Medtronic/Covidian) was placed without tackers and in two patients, a 15 x 15 cm Polypropylene mesh was placed and secured using the fibrin glue. Average pain score was < 3 (VAS) for all patients for the first 24 hours while it remained < 2 during the follow up visits. Average stay in the hospitals were 1.7 days. The cost of the surgeries were 2/3 of the traditional IPOM. There were no complications or recurrences during the follow-up period.

**Conclusion:** Endoscopic - Rives Stoppa technique has shown great promise, not only in terms of reduction in early post operative pain but also in reducing the overall surgical cost to the patient! We feel, that with time, we will be able to reduce our surgical time, and standardise our technique.

AS14-3

### e-TEP: a new approach to abdominal wall reconstruction

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Abdominal wall reconstruction for complex abdominal defects has always been the domain of the open surgeon. Only in the recent times has there been an attempt to replicate the open component separation techniques by minimally invasive approaches, usually robotic. The authors present a series of 70 cases of posterior component separation techniques including Transversus Abdominis Release (TAR) and Rives-Stoppa repair using the e-TEP approach. They share the techniques used in these procedures.

AS14-4

### Management of huge defects following extensive abdominal wall neoplasm resection: classification and immediate reconstruction

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**Objective:** We report our experience in extensive resection and immediate reconstruction in treatment of patients with abdominal wall neoplasms based on a simple and practical classification of abdominal wall defects.

**Methods:** Between January 1999 to December 2015, 112 patients with abdominal wall neoplasms were treated with extensive resection which included a >3 cm tumor-free margin, this led to a huge abdominal wall defect, the mean size of defects was  $211.58 \pm 89.3$  cm<sup>2</sup>. All patients were performed immediate abdominal wall reconstruction including primary sutures or free skin graft for Type I defects, component separation(CST) with or without mesh reinforcement for Type II defects and pedicled or vascularized myocutaneous flap with or without mesh or prosthetic + biological mesh with or without CST for Type III defects.

**Results:** The average follow up was  $76.86 \pm 21.22$  months, There was no severe morbidity after the operation. 3 patients developed flap necrosis, other major wound complications were identified in 9 patients and local neoplasm recurrence was observed in 20 patients including 12 primary neoplasm and 8 secondary neoplasm patients.,25 patients developed distant metastasis including 10 primary neoplasm and 15 secondary neoplasm patients. There was 4 patients developed hernia.

**Conclusions:** Strategy based on the abdominal wall defect classification system for immediate reconstruction of huge abdominal wall defects seems to be safe and effective in treatment of patients with abdominal wall neoplasms.

AS14-5

### Abdominal wall reconstruction using human dermis biologic mesh after resection of recurrent fibrosarcoma of the rectus muscles

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The Fibrosarcoma is a tumor composed of malignant fibroblasts in a collagen background. In general terms it occurs as a primary or secondary bone tumor but more rarely as a soft-tissue mass. It is a locally invasive neoplasm with a high recurrence rate. The treatment of fibrosarcomas involves a combination of adequate surgical resection with a cuff of normal tissue and Adjunctive therapy, to improve local control. In case of large soft tissue tumors the challenging reconstruction of the subsequent defect is one important step in the management. The authors report a case of 31 years old gentleman with a history of resected fibrosarcoma in the left rectus muscle, who presented 2 years later with painless mass in the anterior abdominal wall. After investigation with ultrasound, CT scan and MRI it was diagnosed as 7 cm recurrence in the right rectus muscle.

The patient had "en bloc" excision of the tumor (taking the full thickness of the abdominal wall from the skin till the peritonea) with 3 cm safety margin around the tumor. Keeping a defect of about 20x15 cm. the abdominal wall reconstruction was done by human dermis biologic mesh used as substitute flap. After component separation a second light weight mesh was placed between the large muscles.

The postoperative was uneventful. Histologic findings were consistent with the diagnosis of fibrosarcoma and the patient had adjunctive radiotherapy. After one year of follow up the patient is in remission.

AS15-1

### The Essentials of Writing a Surgical Manuscript

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The different types of surgical manuscript possible for publication include Letter to the editor, Case report, Surgical technique (How I do it), Cohort study, Case control study, Randomised controlled trail, Review article and Editorial. A formal consent of a proposed study protocol first needs to be obtained from the local Institutional ethics committee. All clinical trails need to be registered. The basic structure for writing a surgical manuscript consists of the IMRAD structure which stands for Introduction, Methods, Results and Discussion .The Introduction comprises a brief lesson on the proposed subject available in literature and the problem that was addressed in the study. The method section comprises the story of what the authors did and this should be arranged in a logical framework of time. The Results section is the story of the main findings of the study. In the Discussion section, the first paragraph summarises the methodology and results of the study. Also the discussion segment includes a synopsis of similar studies (and how the present study fits in), strengths and limitations of the study and implications of the current study on future research, future policy and clinical practice. The role of a Biostatistician is important for protocol development, data management, and study implementation and monitoring. The contents of the manuscript need to be short and precise. The language should be clear and words / phrases should be simple. Generally, the shorter the manuscript the better.