

AS15-2

How to improve the chances for getting your paper published in Hernia

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AS15-3

Electronic publishing in biomedical journals

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Journals in printed format have been the traditional mode of dissemination of scientific knowledge. The disadvantages of the print journals include a) time consuming peer review process, b) lag between submission and publication, c) distribution limited to paid subscribers and d) problems associated with archiving and storage of the journals. With the explosion in the computer technology and worldwide web, electronic publishing of biomedical journals has become the norm over the past several decades. This online and web based publishing is either standalone or complements the print version of the journal. This presentation examines and highlights the pros and cons of electronic publishing of biomedical journals.

AS16-1

Laparoscopic Approaches for Parastomal Hernia Repair of Permanent Colostomy: A Seven-year Follow-up with Low Chronic Pain and Recurrence Rate

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Aim: To assess the treatment and prevention of parastomal hernia using a laparoscopic repair technique.

Methods: From January 2007 and January 2014, we retrospectively reviewed 184 patients who underwent a permanent colostomy. As a routine oncologic follow-up, abdomino-pelvic computed tomography was used to examine the occurrence of the parastomal hernia. The parastomal hernia was repaired by laparoscopic approach using prosthetic material. The associations of age, sex, pain, recurrence, body mass index (BMI), history of steroid use and comorbidities to the development of the PH were analyzed. The 7-year cumulative incidence rates of parastomal hernia were compared according to clinical variables using a Kaplan-Meier analysis.

Results: Our data showed that our postoperative recurrence was very low (3.95%). We found that moderate pain was 12 patients (15.79%), and severe pain was 5 patients (6.58%). During follow-up, 76 patients developed a PH and the 7-year cumulative incidence rate of a parastomal hernia, obtained by using the Kaplan-Meier method. In the multivariate COX analysis, route of stoma creation, BMI, radiation history, and diabetes mellitus were all independent risk factors for the development of a parastomal hernia.

Conclusions: The significant risk factors of a parastomal hernia were as follows: route of stoma creation, BMI, radiation history, and diabetes mellitus. Laparoscopic approach is an effective and simple procedure to correct parastomal hernias with acceptable complication rates and is feasible even in the parastomal hernia patients.

AS16-2

The effect analysis and experience shared of parastomal hernia treatment with HyPER/SPHR technique (with 96 cases report)

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Objective: This article aims to explore the effect of parastomal hernia treatment with HyPER/SPHR technique (hybrid parastomal endoscopic re-do), and share the operation experience and skills.

Material and methods: Clinical data of 96 patients with parastomal hernia who were underwent the operation with HyPER/SPHR technique from Oct. 2014 to Jun. 2016 in Beijing Chao-Yang Hospital of Capital Medical University were retrospectively analyzed.

Results: All patients completed the operation successfully, 53 of them were male and 43 were female, average age 66.8 ± 9.0 y, BMI (Body Mass Index) 25.5 ± 2.7 , primary disease was rectal cancer(86 cases), bladder cancer(8 cases), colon cancer(1 case) and recurrence after parastomal hernia operation(1 case). All patients found the mass around the stoma, 28 of them got pain, 15 patients had the incarceration or obstructive symptoms. The operation time was 114.1 ± 48.2 min, blood loss 17.2 ± 16.7 ml. 60 patients had the abdominal wall remodeling in the operation and 93 patients got peritoneal and/or subcutaneous drainage tube for a few days. The LOS(length of stay) was 20.0 ± 7.2 d. poor healing of the incision was found in 7 patients and healed after treatment, intestinal obstruction was found in 1 patient and return to the operation, 1 patient got intestinal mucosal necrosis of stoma and 1 patient recurrence.

Conclusion: The HyPER/SPHR technique to treat parastomal hernia was safe and effective with the good effect and low recurrence. It is a good parastomal hernia treatment to choose.

AS16-3

Laparoscopic Parastomal Hernia Repair: The Better Outcomes with Primary Fascial Defect Closure Sugarbaker Technique

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Background: Parastomal hernia is one of the most common complication following stoma formation, which high incidence of recurrence and relatively poor outcomes. The Modified Sugarbaker technique has been shown to result in lowest recurrence rate. Many studies suggest that primary fascial closure in laparoscopic ventral hernia repair seem to reduce the recurrence and seroma formation rates. We perform the defect closure add on to modified Sugarbaker technique and compare to non-closure group.

Methods: Retrospective review of patients who underwent laparoscopic parastomal hernia repair between 2009 and 2015. These patients were divided into modified Sugarbaker technique (non-closure) and modified Sugarbaker plus primary fascial closure. The patient demographics, postoperative morbidity, pain score and recurrence rate were compared.

Result: Thirty-two parastomal hernia repairs were performed in last seven years. 26 laparoscopic parastomal hernia repair with modified Sugarbaker technique were reviewed. 19 (73.1%) of 26 repairs were in the defect closure group and 7 (26.9%) in non-closure group. There was no difference in demographic data and early post-operative pain. No recurrence hernia in defect closure group and one case recurrence in non-closure group (14%). 2 seroma formation were occurred in non-closure group compared to one in defect closure group (28.6% vs 5.3%). One patient in defect closure group had internal hernia due to adhesion of prosthetic mesh.

Conclusion: Laparoscopic parastomal hernia repair with primary fascial closure is feasible and safe. It may to reduce the recurrence and seroma formation than non-closure Sugarbaker technique.

AS16-4

Laparoscopic modified keyhole plus repair for parastomal hernia: Single centre experience from India

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Introduction: Laparoscopic parastomal hernia repair has been reported in literature which is associated with low morbidity and acceptable recurrence. The objective of the present study is to present our experience over past 15 years of our modified keyhole plus repair technique for parastomal hernia.

Material & Methods: A retrospective review of last 15 years data of patients who underwent laparoscopic modified keyhole plus repair for parastomal hernia.

key steps:

1. Removal of hernia sac
2. Closure of the defect with non-absorbable suture
3. Proper fixation of composite Mesh with a central keyhole slit
4. Mesh fixation with both trans fascial sutures and tackers

Results: Total 19 symptomatic parastomal hernia patients underwent this procedure among which 15 were end colostomy hernias, 1 was end ileostomy hernia, 2 cases were post ileal conduit and 1 was suprapubic cystostomy. 2 patients underwent additional IPOM for ventral hernia. 8 patients had BMI > 30 kg/m². The mean operative time was 108 minutes. Mean hospital stay was 3 days. Median follow up was 2 years. Seroma in 4 patients. There was no mesh infection. 1 patient presented with asymptomatic recurrence after 3 year of surgery.

Conclusion: Laparoscopic key hole plus repair for parastomal hernia seems safe, effective and feasible with good cosmetic and functional outcome with acceptable recurrence.

Key words: Parastomal, Keyhole plus, Colostomy, Ileal conduit.

AS16-5

Laparoscopic Paraileostomal Hernia Repair

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Aim: Paraileostomal hernia (PISH) is a major clinical problem. The aim of this study is to evaluate the laparoscopic PISH repair.

Method: The demographics, perioperative preparations, operative procedures and the follow-up data will be presented in this report.

Results: We received 17 PISH patients from Jan 2005 to Dec 2015 including 13 of ileal conduit and 4 of ileostomy. We performed 'laparoscopic Sugarbaker' on 12 PISH patients including 11 ileal conduit and 1 ileostomy, 'Lap-re-Do Sugarbaker' on 2 PISH patients of ileostomy, and 'Lap-re-Do Keyhole' on 1 PISH patient of ileostomy. 'Suture repair' had to be performed on 2 PISH patients of ileal conduit because of emergent incarcerated PISH or serious intraperitoneal adhesion detected during laparoscopic procedures with high risk of unrecognized enterotomy. The mean operating time was 89.4min and the mean length of postoperative hospital stay was 6.1 days. 14 patients performed by 'laparoscopic Sugarbaker' or 'Lap-re-Do Sugarbaker' technique were observed without recurrence, while another 3 patients after suture repair or 'Lap-re-Do Keyhole' technique were observed as recurrence in one year postoperatively. Postoperative complications including 4 incompletely ileus, 3 seroma, and one after puncturing seroma complicated with subcutaneous abscess with re-operation of incision drainage. No unrecognized enterotomy or mortality occurred in this series.

Conclusions: 'laparoscopic Sugarbaker' and 'Lap-re-Do Sugarbaker' technique can be considered as a clinical choice for PISH patients of ileal conduit and ileostomy, while the operative technique shall be improved to reduce the incidence of postoperative complications. Any procedures involved 'Keyhole' technique are not recommended.

AS16-6

Lap-re-Do Sugarbaker is the ideal option for PSH

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AS17-1

Clinical characteristics of recurrent cases with inguinal hernia after Kugel repair

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Kugel repair is the minimally invasive open transinguinal preperitoneal approach for inguinal hernia. In my series from January 2003 to July 2016, 2718 patients (2389 males and 329 females, average age 55±15 years old) and 2949 lesions with inguinal hernia underwent Kugel repair. Overall, 21 patients (0.7%) recurred after Kugel repair. All of the recurrent patients were males. Four patients had the operation during a learning curve period. Six patients relapsed within 3 months after Kugel repair. According to the classification of Japanese Hernia Society, more than 50% (12 cases) of recurrent cases were classified in type II-1. After simultaneous bilateral inguinal hernia repair, 9 cases of 231 cases recurred at a higher rate of 3.9%. Following the repair for direct inguinal hernia, 5 cases had the relapse of indirect inguinal hernia. Of patients with postoperative giant hematoma or seroma, 5 patients recurred. The mechanisms of recurrence after Kugel repair are considered as follows: 1) insufficient dissection around the pubis and the cavity of Retzius or oversight of concomitant type II-1 hernia; 2) insufficient dissection of the vaginal process or oversight of small indirect inguinal hernia; 3) mesh migration during simultaneous bilateral inguinal hernia repair; 4) mesh migration under the pressure of postoperative giant hematoma or seroma; 5) insufficient parietalization of the testicular vessels and the spermatic cord; and 6) inadequate mesh size. In order to prevent recurrence of inguinal hernia after Kugel repair, Kugel patch must be self-expanded in preperitoneal space as covering the entire myopectineal orifice.