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ABSTRACT

Introduction: Openventral hernia repair is associated with significant morbidity and high recurrence rates. Recently, the laparoscopic approach has evolved as an attractive alternative. Our objective was to compare open with laparoscopic ventral hernia repairs.

Methods: 50 laparoscopic and 22 open ventral hernia repairs were included in the study. All patients underwent a tension-free repair with retromuscular placement of the prosthesis.

Results: No significant difference was found in the operative time between the 2 groups (laparoscopic 132.7 min vs open 152.7 min). Laparoscopic repair was associated with a significant reduction in the postoperative narcotic requirements (P<0.002); the lengths of nothing by mouth (NPO) status (P<0.001); and hospital stay (P<0.001). The incidence of major complications (P<0.028); the hernia recurrence (P<0.028); and the time required for return to work (P<0.036) were significantly reduced in laparoscopic group.

Conclusions: Laparoscopic ventral hernioplasty offers significant advantages and should be considered for repair of primary and incisional ventral hernias.

Keywords: Ventral hernia, Incisional hernia, Prosthetic inlay repair, Laparoscopy
ed. Lastly, the impact of the laparoscopic approach on postoperative recovery time was evaluated for the first time by comparing the length of nothing by mouth (NPO) status, pain control, and time required to resume regular activities, including the return to work.

MATERIALS AND METHODS

Patient Characteristics and Selection Criteria
This is a retrospective review of ventral and incisional hernioplasties that were performed by the senior authors between 2012 and 2015. 30 patients underwent a laparoscopic ventral hernia repair and 22 patients an open prosthetic repair. All patients had a tension-free repair with retromuscular (extra- or intraperitoneal) placement of the prosthesis with a 2- to 4-cm overlap (inlay), resembling the Stoppa technique. To keep the groups as comparable as possible, all patients who underwent suture repair or prosthetic repair with the onlay, sandwich or edge-to-edge, patch-to-fascia technique were excluded from the study. Furthermore, the patients in the 2 groups were carefully selected to match, as closely as possible, for sex, age, body mass index, associated comorbid factors, and hernia characteristics. No significant difference between the 2 groups was noted regarding patient demographics and hernia characteristics, other than the fact that the open group consisted of a relatively older population (59.4 vs 47.82, P<0.003).

Operative Technique
Laparoscopic access to the abdominal cavity was gained with the Veress needle or the open Hasson technique. The camera port (11 mm) and 2 or 3 working ports (5 mm) were placed as far away as possible from the hernia defect. The 30° laparoscope was used in the majority of cases, although the 0° and 45° laparoscope was available and used when required. Adhesiolysis was performed with laparoscopic scissors, electrocautery, or the Harmonic scalpel. An appropriately sized mesh was placed at the subfascial plane either extraperitoneally or intraperitoneally, extending at least 2 to 4 cm beyond the edges of the defect. The DualMesh and the Composix mesh were secured with a minimum of 4 nonabsorbable sutures placed no more than 5 cm apart prior to intraperitoneal introduction. These sutures were then anchored transmurally with the aid of a percutaneous suture passer. Circumferential fixation of the mesh was completed with tacks placed approximately 1.5 cm apart. All port sites larger than 5 mm were closed with sutures under laparoscopic visualization.

Open ventral hernia repair was performed according to Stoppa’s technique, as previously described. Polypropylene mesh used in 60% and Vicryl mesh in 40%.

Data Collection and Follow-up
Data were collected from hospital and outpatient visits. Standardized data included patient demographics, postoperative pain control, complications, recurrence, and activities. No statistically significant difference in the length of follow-up existed between the laparoscopic and open groups (20.8 and 26 months, respectively). Ten patients (33%) in the laparoscopic group and 6 (27.7%) in the open group were lost to follow-up.

RESULTS
Three patients were excluded from the laparoscopic group because conversion to open repair was required due to adhesions (1 patient), inability to establish pneumoperitoneum (1 patient), and an ill-defined defect (1 patient).

No significant difference in the operative time between the 2 groups (laparoscopic 132.7 min vs open 152.7 min). Laparoscopic repair was associated with a reduction in the postoperative narcotic requirements (4 vs 9 dose of 50mg diclofenac, P<0.002) and the lengths of nothing by mouth (NPO) status (10 vs 55.3 hrs, P<0.001), and hospital stay (2.88 vs 8.23 days, P<0.001). The incidence of major complications (1 vs 4, P<0.028), the hernia recurrence (1 vs 4, P<0.028), and the time required for return to work (15.95 vs 23.9, P<0.036) were significantly reduced in the laparoscopic group.

Table 1:-Complications occurred in the present Study

<table>
<thead>
<tr>
<th>Complications</th>
<th>Lap.</th>
<th>Open</th>
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<tbody>
<tr>
<td>Ileus</td>
<td>01</td>
<td>03</td>
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<tr>
<td>Urinary Retention</td>
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<td></td>
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<tr>
<td>Wound Seroma</td>
<td>01</td>
<td>04</td>
</tr>
<tr>
<td>Suture track infection</td>
<td>02</td>
<td>03</td>
</tr>
<tr>
<td>Recurrence</td>
<td>01</td>
<td>04</td>
</tr>
<tr>
<td>Bowel injury</td>
<td>02</td>
<td></td>
</tr>
<tr>
<td>Lap converted to Open</td>
<td>03</td>
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Postoperative Results
The incidence of major complications was significantly higher in the open group (4 vs 1, P<0.028). One postoperative death occurred due to respiratory failure in the open repair group. Also occurring in this group were a postoperative small bowel obstruction that resolved with conservative management, a splenic abscess, and a case of pulmonary embolism that responded to heparin therapy. One laparoscopic hernioplasty was complicated by a postoperative complex hematoma that eventually required removal of the prosthesis.
On the contrary, no significant difference between the 2 groups was noted in the incidence of minor complications. It is of interest that the incidence of postoperative ileus was higher in the open group (13.6% vs 4%), even though it did not reach a significant difference. The likelihood of wound infection and seroma formation was similar in the 2 groups. All seromas resolved spontaneously without requiring percutaneous needle aspiration.

During follow-up, 4 (18.2%) patients in the open repair group developed a recurrence compared with only 1 (2%) patient in the laparoscopic group, which had recurred after removal of the prosthesis. Our results revealed a significant reduction in the recovery time for patients in the laparoscopic group. They returned to work earlier and resumed regular activities more rapidly.

DISCUSSION

Obviously, a concern exists about selection bias in our study, because of the retrospective nature of the data analysis. To maintain the validity of our results, certain inclusion criteria were used in patient selection. The technique used for inclusion for all ventral hernioplasties included (laparoscopic and open) resembled the tensionfree, inlay prosthetic repair.

Furthermore, particular attention was given to the patient profile and the hernia characteristics, which were relatively similar in both groups. Considering the importance of proper terminology in ventral hernias (primary, incisional, or recurrent incisional), as this reflects upon the outcome and associated morbidity of the repair,9 we discovered no difference in their incidence between the 2 groups. Lastly, a special effort was made to include only patients from a specific period (2012 to 2015) to achieve a similar length of follow-up for all patients.

Nevertheless, our study confirms previous reports demonstrating that laparoscopic ventral hernia repair significantly shortens hospital stay7,8,9,10,11. On the other hand, we found that the laparoscopic approach does not prolong operative time, as previously suggested.8 Although, in our study the overall complication rate was not different between the 2 groups, interestingly we observed a significant decrease in the incidence of major postoperative complications. Our study is to produce statistically supporting evidence for an existing significant difference in the recurrence rate in favor of the laparoscopic group.

Clearly, laparoscopic ventral hernioplasty offers significant advantages over the open approach. It provides better visualization of the hernia defect, leading to a more adequate repair, which probably explains the associated lower recurrence rate. Also, by significantly shortening the hospital stay and to a lesser extent the operative time, it decreases the overall health care costs counterbalancing and most likely offsetting the higher equipment costs. The faster recovery time, the markedly improved postoperative patient comfort and the reduced complication rate observed with the laparoscopic approach will entirely change the concept of the “frustrating problem” and the significant morbidity that surgeons often encounter with ventral hernia repair.

CONCLUSION

Based on these data, the laparoscopic approach is an attractive alternative and should be considered for the repair of primary and incisional ventral hernias.

REFERENCES: