

Laparoscopic Ventral Hernial repair

Description:

The principle of surgical repair entails the use of prosthetic mesh to repair large defects in order to minimize tension on the repair. A tension free repair has a lesser chance of hernia recurrence. Traditionally, the old scar is incised and removed, and the entire length of the incision inspected. Generally, there are multiple hernia defects other than the one(s) discovered by physical examination. The area requiring coverage is usually large and requires much surgical dissection. A prosthetic mesh is used to cover the defect(s), and the wound closed. This is a major surgical procedure and often complicated. Infection rates following repair may be as high as 7.0%. Recurrence can be up to 5%, or higher, depending on the patient's preoperative risk factors. While the use of prosthetic mesh has decreased the number of recurrences, it has also been implicated in increased infection rates, adhesion or scar formation of the abdominal contents to the anterior abdominal wall leading to intestinal obstruction and fistula formation. However, overall, recovery is usually excellent and patients return to normal activity within a matter of weeks.

The laparoscopic repair of ventral hernias was designed to minimize operative trauma to the patient. As mentioned, these are often complicated repairs requiring large incisions and extensive tissue dissection. The principles governing a laparoscopic ventral hernia repair are based on those of open Stoppa ventral hernia repair. A large piece of prosthetic mesh is placed under the hernia defect with a wide margin of mesh outside the defect (see figure). The mesh is anchored in to place with eight full thickness sutures and secured to the anterior abdominal wall with a varying number of tacs, placed laparoscopically.

A patient is a candidate for laparoscopic incisional hernia repair if they are medically able to undergo general anesthesia. Also, the defect must "allow" the surgeon to place the laparoscopic trocars in such positions that repair are ergonomically possible. In some very large or giant hernias, the abdominal wall is distorted to such a degree that it is impossible to safely place laparoscopic trocars. Ancillary studies, such as CT scan of the abdomen and pelvis are helpful in making this decision. Patients are also given a bowel preparation to evacuate the colon and decrease the number of intestinal bacteria prior to surgery.

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