Editorial response: Let’s get started

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INCISIONAL HERNIAS are common and the practice of most general surgeons includes their repair. Despite a high prevalence and frequency in practice, there have been few data available to assist in decisions about practice guidelines for incisional hernia repair. Few studies have been prospective, adequately powered, or have a sufficient period of postoperative follow-up to determine whether any of the various repair techniques give superior results.

In a series of retrospective reports from 16 Veterans Administration hospitals using the National Surgical Quality Improvement Program database, Hawn and her colleagues have provided important observations about the effect of different methods of incisional hernia repair and recurrence. In the present report, they have demonstrated that the use of permanent prosthetic mesh for incisional hernia repair resulted in a 2-fold reduction in recurrence. In another recent publication, Hawn et al demonstrated that the use of an underlay prosthetic mesh technique, either open or laparoscopic, led to a lower incisional hernia recurrence rate in the same Veterans Administration study population. Their results confirm a study by Burger et al, which showed a similar reduction in long-term hernia recurrence with prosthetic mesh underlay repair for primary and first time recurrent incisional hernias. The complication rate is modest and should alert surgeons to the appropriate expectations for the operative risk to discuss with their patients.

As the authors state, the relationship between the technique of incisional hernia repair and recurrence is complex and likely involves a variety of patient factors, type and size of hernia, and surgeon experience. Although the data presented were aggregated at a hospital level and individually, the message is clear. Unnecessary variability in the use of mesh was associated with hernia recurrence.

There is general consensus that incisional hernias >4–9 cm² in diameter should be repaired with permanent prosthetic mesh. It has become increasingly clear that the mesh should be placed beneath the posterior abdominal wall musculature whenever possible and that an overlap of 4–5 cm is optimal. What is not well-defined is the exact contribution that defects in healing, patient morphology, hernia location, method for securing the mesh, and tension on the repair have on the results. These answers require prospective collection of information from a variety of hospitals and surgeons who agree to use standard definitions and techniques for repair.

It took much too long for the principles advocated by the early proponents of tension-free inguinal hernia repair to become accepted by the surgical community. Yet, recurrence rates declined, postoperative pain was reduced, and costs of care decreased with adoption of those principles. We should learn from that experience and apply the lessons of appropriate mesh usage to reduce the complication and recurrence rates for incisional hernia repair. This study is a good start.

REFERENCES

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192 SURGERY