We may question but cannot abandon mesh repair for inguinal hernias

To the Editor:

I have read with great interest the article entitled “Hernia repair: why do we continue to perform mesh repair in the face of the human toll of inguinodynia?” by Professor Fischer. He wrote an outstanding article including not only the complete story of inguinodynia but also historical milestones of the inguinal hernia repair.

Inguinodynia, chronic pain after inguinal hernia repair, is really an annoying complication that makes life miserable for both the suffering patients and their surgeons. The exact mechanism of the chronic pain has not been documented thoroughly. Mesh itself may cause chronic pain. Some factors, which are not related to surgery, can have a place in the etiology. On the other hand, nonmesh tissue repairs and the transversalis or Shouldice repair be adopted still seem to be a bit strongly worded. The author compiled the data about both prophylaxis and treatment of inguinodynia by employing selective or triple neurectomy, however, did not investigate the comparison of open mesh repairs and Shouldice operation regarding chronic pain thoroughly.

Open mesh repairs and Shouldice operations have been compared many times, but a well-designed clinical comparison regarding postoperative clinical pain is rare. There is only one randomized clinical study in the literature in favor of Shouldice operation which reported that it resulted in a slightly lower rate of chronic pain than Lichtenstein repair has (4.2% vs 56%); however, 2 patients with severe pain were in the Shouldice group. A German study revealed that chronic pain and physical strain correlated pain somewhat more frequently after Shouldice repair in comparison with Lichtenstein repair. Swedish and Danish Hernia Data Base made a comparison of open mesh and nonmesh techniques in 2004 and stated that there was no difference in the chronic pain rates. A recent Cochrane Database Systematic Review also revealed that the recurrence rate with Shouldice repair is higher than mesh repairs.

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http://dx.doi.org/10.1016/j.amjsurg.2014.02.005

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whereas there is no significant difference regarding chronic pain.7

Prosthetic mesh repairs have dramatically lowered the recurrence rate following inguinal hernia repairs. In 2010, a North American group of academic surgeons considered the mesh use in inguinal hernia repairs as “one of the dramatic innovations in modern surgical subspecialties.”8 Meshes have certain concerns in clinical use; however, their advantages outweigh their disadvantages and complications together with recurrent and multirecurrent cases.

In conclusion, we can question liberal use of prosthetic meshes for the treatment of inguinal hernias, but abandoning the mesh use completely does not seem to be logical at this stage and currently not concordant with the evidence-based medicine. Instead, we can follow a couple of ways to improve the outcomes after inguinal hernia repairs. One of these is teaching our young colleagues about detailed anatomy of the inguinal region and regional nerves and how to deal with these structures delicately and how to fix mesh carefully. Another way is to perform tailor surgery for our patients according to the type and characteristic of the hernias. The proper technique might be a Lichtenstein repair, a laparoscopic mesh placement, or a Shouldice operation. At this point, I definitely agree with Professor Fischer that transversalis fascia tissue repairs like Shouldice technique should be a part of postgraduate education programs in general surgery.

Skin grafts for the open abdomen

To the Editor:

I read with interest the article by Cheesborough et al,1 and was reminded of the adage that “everything old will become new again.” Skin grafting was the default technique to provide coverage of the open, frozen abdomen after trauma, compartment syndrome, or intra-abdominal catastrophe in the 1990s and 2000s in many centers, especially those affiliated with regional burn centers such as ours, where skin grafting was already a frequently performed procedure. However in doing large numbers of these grafts, several issues were encountered. First, the skin grafts provide visceral coverage but do nothing to oppose the lateral migration of the recti, resulting in a gradual increase in the diameter of the fascial defect and thus increasing the complexity of the eventual definitive operation for hernia repair. Second, in patients who have had the skin graft for over 1 year, we would occasionally encounter the “burst” abdomen where the healed skin graft would separate from the edges of the wound because of increasing pressure from the herniation of abdominal viscera, and the patient would present after sudden rupture of the graft and intestinal evisceration—a significantly distressing event for the patient, as you would imagine. Third, in a very small number of patients, the “pseudoperitoneum” between the healed skin graft and the viscera would not form as it usually does and even after 1 to 2 years, the skin graft would remain densely adherent to the underlying intestine, preventing definitive repair because of the high risk of enterotomy and fistula while attempting to remove the skin graft.

The authors are to be congratulated on achieving definitive repair of all their patients within a relatively short time, thus avoiding the problems mentioned above. However, I would like to caution that this technique should be applied judiciously; for example, trauma patients are notoriously prone to attrition,2 so these results may not be generalizable to all populations, especially those of rural centers with a large and far-flung draw area. Therefore, while skin grafting over a frozen abdomen is indeed a safe, effective, and easy method of visceral protection, it should probably still be considered a salvage option compared with definitive abdominal closure with fascial

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