



**BHATIA GLOBAL HOSPITAL
&
ENDOSURGERY INSTITUTE**
NEWSLETTER

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EDITORIAL

INVITATION FOR NOVEMBER 19-21, 2004



Dear Doctor,
Greetings!

On completion of three years of dedicated service with specific focus on patient well being, we, at Global Hospital, express our heartfelt gratitude to you for your valuable guidance, association and co-operation. Global Hospital and Endosurgery Institute is committed to advancing Laparoscopic Surgery through technology, innovative techniques and education. It gives us pleasure to invite you on the Laparoscopic Workshop, Video CME and animate Lab. sessions on Nov. 19-21, 2004. Preparations are underway to make this scientific event a milestone in dissipation of knowledge in all aspects of Laparoscopy. A galaxy of speakers from all over will participate in the CME to share their practical experience and knowledge.

Most gynaecologists have shied away from performing total laparoscopic hysterectomy (TLH) because of the technical challenges and prolonged operating times that are associated with it. **Dr. Rakesh Sinha**, Director and

Consultant Laparoscopic Gynaecologist, BEAMS, Mumbai has consented to share his experience of TLH.

Endo Hernia surgery has taken its time to be in the armamentarium of the laparoscopic surgeons. **Padamshree Dr. Pradeep Chowbey**, would be demonstrating inguinal hernia repair. We would be showing our techniques of TEP, TAPP, ventral hernia repair & retroperitoneoscopic surgery. The theme of the workshop would be to have interactive video session which is visualized as being more educative.

Eagerly looking forward to your presence in the conference and hope to make this event a memorable and enjoyable learning experience.

Once again, please block your dates. Nov. 19, 20, 21, 2004 in your busy calendar according to your field of interest.

R. S. Bhatia Chairman	Dr. Parveen Bhatia Medical Director & Laparoscopic Surgeon	Dr. Indu Bhatia Director & Lap. Gynaecologist
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It's not what you do once in awhile, it's what you do day in and day out that makes the difference. - Jenny Craig



SEP'04

Vol. 4 No. 09



Laparoscopic Hernia Repair (a step by STEP approach)

Forewords by

Dr. J. Barry Mckernan
Dr. Adarsh Chaudhary

Contents

200 pages with 16 chapters,
300 coloured photographs & diagrams)

Authors

Dr. Parveen Bhatia
Dr. Suviraj J John



The eBook

CD on
Laparoscopic Hernia Repair
(a step by STEP approach)

The electronic version of this
ebook (eBook) is also
available on our websites:
- BhatiaGlobalHospital.com
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ARTICLE

COMPLICATIONS OF LAP. INGUINAL HERNIA REPAIR

Dr. Parveen Bhatia
Medical Director,
Laparoscopic Surgeon

Dr. Bharat Bhasin
Surgical Associate Consultant

“When a man says he is an experienced hernia surgeon and has never had a recurrence, he is a liar in one statement and probably in both.”

Laparoscopic groin hernia repair has 'Minimal Access but is not Minimally Invasive' overall complications are comparable if not lower than open hernia repairs. The recurrence rates in literature are - Open Hernia Repair 6.6 – 18%, Laparoscopic Hernia Repair 7.0 – 19%, Recent Reports - 0.6% with the potential for increased precision and effectiveness.

The majority of complications are related to the laparoscopic technique.

VISCERAL INJURIES

Testes

Testicular complications are far less common with laparoscopic hernia repair (0.3–5.0%). because the 'laparoscopic-posterior' repair does not involve that degree of dissection of cord structures as 'open' repairs do. Yet, testicular pain (most common), swelling, orchitis, epididymitis and atrophy can complicate the situation. The aetiology of pain could be attributed to trauma to the genito-femoral nerve or the sympathetic testicular plexus during 'parietalisation' of the cord structures. Orchitis and epididymitis are due to extensive dissection .

Prevention

Atraumatic parietalisation of the cord structures, avoiding complete removal of large indirect hernia sacs, careful tightening of the internal ring in paediatric patients.

Management

Supporting the testis, limiting the activity of the patient, analgesics. Fortunately most of the complications resolve spontaneously without sequelae.

Vas Deferens

Again complications are few with lap. hernia repair. Transection injuries occur while transecting a redundant large indirect sac, obstruction can result from traumatic handling of the vas with instruments causing fibrosis.

BOWEL INJURIES

These occur in three situations:

1. Freeing of an incarcerated segment of bowel loop
2. Inadvertent laceration of large bowel in the presence of a sliding hernia
3. Injuries to strangulated bowel (a contraindication for the laparoscopic approach).

The complications are Laceration of bowel, trocar site herniae (commonly the Richter type), adhesions resulting in acute obstruction, Ileus and chronic pain syndromes, bowel erosion by prosthesis, entero-cutaneous fistulae, internal herniation of bowel

because of the 'shower curtain' effect, secondary to failure of the peritoneum to remain anchored, leading to acute obstruction.

Urinary Bladder

The urinary bladder can be injured (1.5 5 %) as it forms the medial component of a sliding hernia. Types of bladder morbidity are Bladder laceration (laceration should be repaired in two layers), Retention, infection and Haematuria.

Bone

The use of staples and tackers into the ligament of Cooper and underlying pubic ramus and tubercle may cause Osteitis pubis .

Skin

Severe Ecchymoses is due to inadvertent injury to the superficial vessels. Extensive subcutaneous emphysema is due to pneumoperitoneum or pneumo- extraperitoneum leaking into the subcutaneous plane at trocar sites.

Prevention

Avoiding repeated peritoneal perforations with trocars. Therefore, self-retaining trocars are preferred. Fortunately these complications are self-limiting and without serious morbidity.

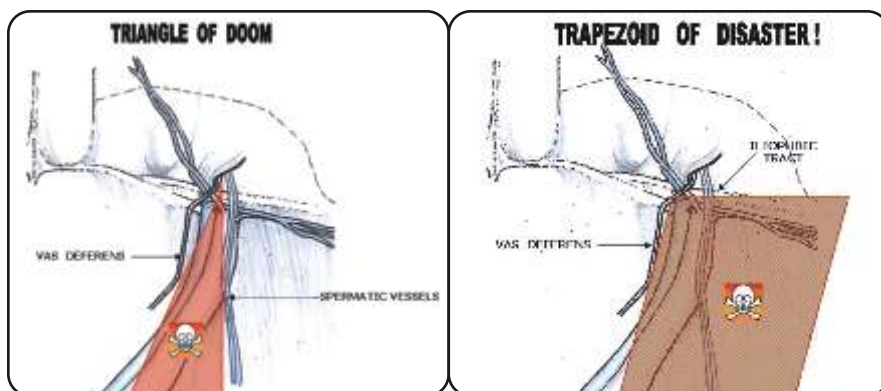
VASCULAR INJURIES

Vascular morbidity could have different presentations:

- Haemorrhage (Most common)
- Vascular impairment - Thrombosis, Embolisation, Gangrene
- Delayed complications - Stenosis, False aneurysm, Avfistula, Mesh Erosion

Vascular injury can occur at the following sites:

- Deep Inferior Epigastric vessels- occurs during dissection around the internal inguinal ring, dissection while bringing down the peritoneum in a TEP procedure. '**Clipping**' the ends of the injured vascular segment is the answer.
- Spermatic vessels & Deep Circumflex iliac vessels
- Iliac artery and vein in the Triangle of Doom could result in severe hemorrhage. In the event of such a injury CONTROL the bleeding PROMPTLY! PREVENT carbon dioxide embolism by compressing the bleeding site!!
- Obturator and aberrant obturator vessels ('Artery of Death')- injured while working in the 'Circle of Death/ Corona Mortis'.
- Vessel in Dulucq's fascia can be injured during lateral dissection.
- Cremaster vessel injury can cause scrotal haematomas.



If everything is under control, you are going too slowly. - Mario Andretti

ARTICLE (contd.)

- Aorta
- Venous injury in the space of Bogros

Haematomas could be in the wound, scrotum or retroperitoneum.

LYMPHATIC MORBIDITY

The incidence of background Seromas (1.2-10%) is higher with laparoscopic than open repairs. These result from trauma of dissection around the hernial sac and by foreign bodies (eg. Prostheses)

Treatment

Most resolve spontaneously and need reassurance.

Aspiration is needed for those lasting more than 6-8 weeks and large seromas. Encysted seromas need excision.

HYDROCOELE (0.6%)

These usually resolve spontaneously, occasionally simple aspiration is necessary.

Nerve injury (12%)

TEP has been credited with having lower nerve injury rates because extra-peritoneal exposure is better with TEP. Causes are:

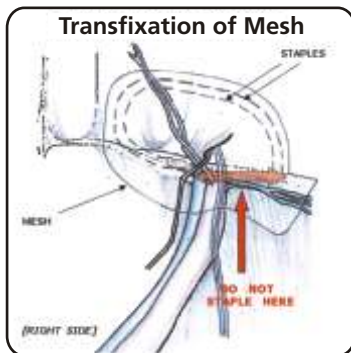
1. Failure to appreciate the anatomy
2. Difficulty in visualizing the nerves preperitoneally
3. Variable course of the nerves
4. Extensive preperitoneal dissection
5. Anchoring

The following three nerves are at risk - **Lateral Femoral Cutaneous Nerve, Femoral Branch of the Genito-Femoral Nerve, Intermediate Cutaneous Br of the Femoral Nerve.** Other three (Ilioinguinal, Iliohypogastric and Genital Br of Genito-femoral nerve) are usually not at risk but can be injured if excessive pressure is applied during mesh fixation, compressing the muscles enough to allow the staples to reach the nerve.

MacFadyen notes that nerve entrapment by stapling or suturing will cause pain lasting 6 months or more!

Prevention

1. A good rule to follow is to AVOID tacking/ stapling/ suturing below the Iliopubic tract and lateral to the gonadal vessels (namely the 'Triangle of Pain')!!!
2. When laid in, prosthesis should never be taut! Mesh shrinkage can be 20-50% which can cause chronic pain syndromes. Secondly the fibrotic scar can entrap nerves.



Treatment

Rest, NSAIDS, Injections with local Anaesthetic or Corticosteroid. **Indications for operative treatment** - neuralgia in the recovery room (Immediate re-exploration), debilitating and unremitting neuralgia.

INFECTIONS (1 - 2%)

Can be Superficial subcutaneous - do not affect recurrence rates or deep seated - associated with high recurrence rates.

Treatment

A broad spectrum antibiotic is started during an observation period of 48-72 hours.

- If symptoms subside - continue this for a week.
- If the condition persists or worsens -the wound should be opened, extra-peritoneally, widely.
- If progresses to a chronic sinus, mesh infection should be suspected and treated with - specific systemic antibiotics , wide opening of the wound and removal of the mesh and all foreign bodies including staples/ tacks/ sutures and necrotic material. This is a demanding procedure as the mesh is intimately adherent to the cord. *Open hernia repair is to be done at a later date.*

Prostheses related Complications

Mesh - infection, adhesions with viscera , erosion, extrusion & migration, fibrosis causing nerve entrapment and Enteric fistula.

PORT SITE HERNIA

It is rare. Felix reported 0.63%. These are lower in the TEP procedure.

Laparoscopic Hernia repair has a definite learning curve and it needs surgeon interest and persistence to overcome it. Reviewing of one's video tapes is a useful and often crucial 'learning' modality, in this regard!

RECURRENCE

Technical factors

- Learning curve
- Inadequate dissection
- Inadequate mesh size (60%)
- Slitting the mesh
- Improper mesh placement
- Mesh twisting / folding
- Mesh migration
- Inadequate mesh overlap of hernia defect
- Inadequate or lack of fixation (32%)
- Lifting of the mesh by haematoma, peritoneal strand, etc.
- Missed herniae(15%)
- Missed lipoma
- Combination of the above(30%)

Surgeon Factor

The problem is chiefly the lack of importance given to hernia repair! Despite a poor record, abdominal wall herniae continue to be repaired quite often by junior level staff.

"Although all surgeons must be prepared to admit that recurrences will occur, the only proper attitude to take is that any recurrence is the fault of the surgeon." - M.M. Ravitch.

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EVENT CALENDAR

EVENT CALENDAR

just hysterectomy

Workshop, Conference, Animate Lab Training

9th 10th Oct., 2004

J. W. Mariott Hotel, Juhu, Mumbai

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November 19, 2004 (Friday)
- 2. Focus on "Urinary Stones"**
November 20, 2004 (Saturday)
- 3. Focus on "Endo Hernia 2004"**
November 21, 2004 (Sunday)

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