

MANAGEMENT OF LARGE /GIANT HERNIAS

By

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LAPAROSCOPIC AND BARIATRIC SURGEON

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HERNIA IS ONE OF THE MOST COMMON SURGICAL PROBLEM BUT GAIANT HERNIAS ARE VERY SELDOM TO ENCOUNTER AND CHALLENGING TO TREAT

GAIANT INGUINAL HERNIAS
LARGE VENTRAL HERNIAS



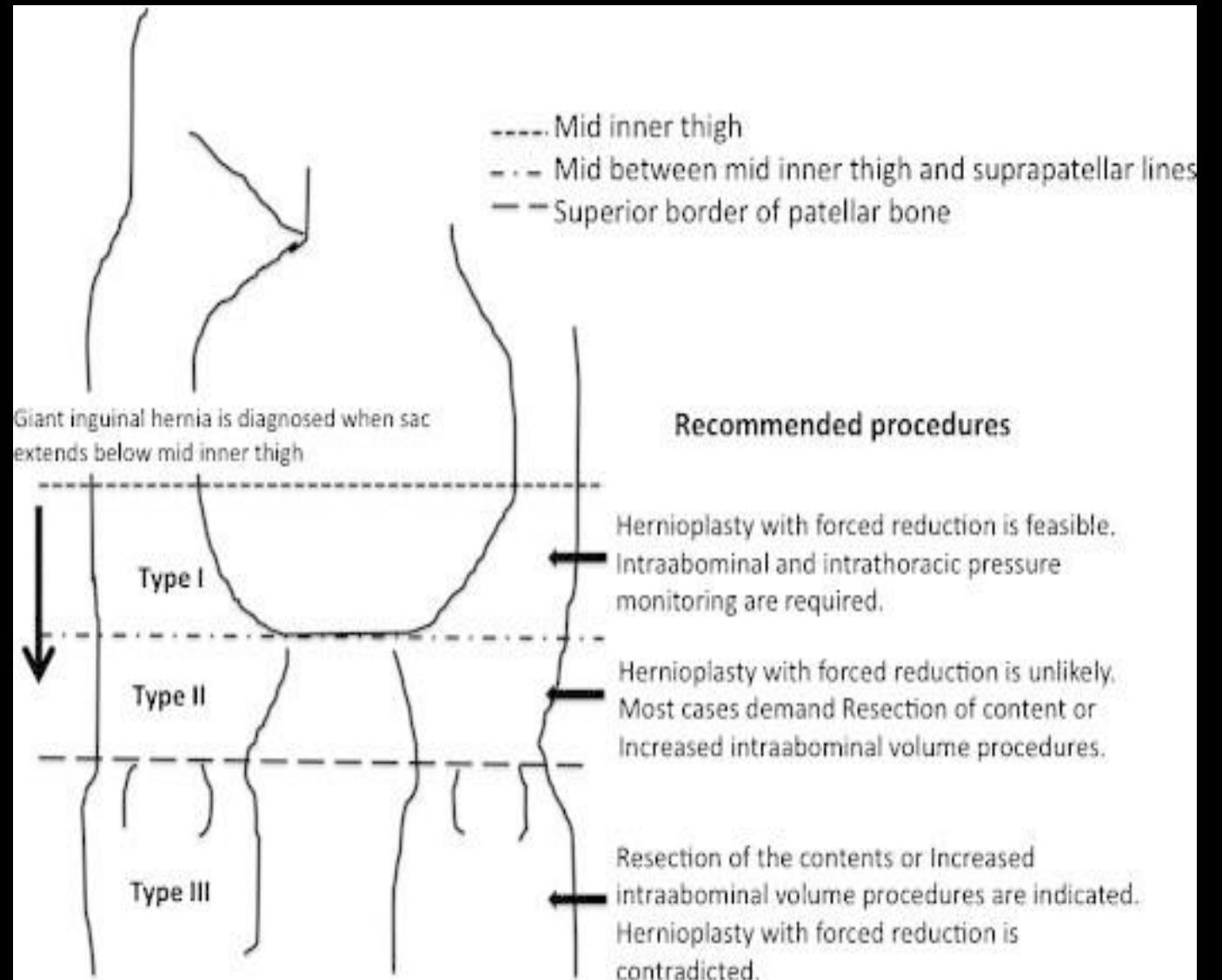
WHAT IS A GAIANT INGUINAL HERNIA

A GAIANT INGUINAL HERNIA IS DEFINED

AS **“THE HERNIA
WHICH EXTENDS
BELOW THE
MIDPOINT OF THIGH
IN STANDING
POSITION”**



GIANT INGUINAL HERNIA S NEW CLASSIFICATION IS



GAIN VENTRAL HERNIA

IT IS DEFINED AS

“DEFECT MORE THAN 10 CM IN ANY DIMENSION WITH LOSS OF DOMAIN”

ABDOMINAL CT VOLUMETRY “HERNIAL VOLUME IS ALMOST 30% OF ABDOMINAL VOLUME” IS CONSIDERED AS GAIN VENTRAL HERNIA



WHEN WE SEE SUCH A PATIENT WHAT DO WE THINK???????

IS IT REDUCIBLE ??????

IS IT MANAGABLE AT MY CENTRE???

IF NO—

IF YES---

YES/NO

REFER TO HIGHER CENTRE WHERE A COMPLICATION CAN BE
MANAGED

IS THERE ANY STANDARD TECHNIQUE ?

WHAT ARE THE OPTIONS TO MANAGE

WHAT COMPLICATIONS CAN ARISE?

ANY STANDARD TECHNIQUE

BECAUSE OF RARE PRESENTATION OF SUCH CASES THERE ARE NO STANDARD TECHNIQUES

MOSTLY DEPENDENT ON SURGEON'S CHOICE INTRAOPERATIVE PERIOD

IN LITERATURE NO SERIES OF CASES PRESENTED RATHER MANY DIFFERENT SINGLE CASE PRESENTATIONS WERE THERE FROM DIFFERENT CENTRES



WHAT
ARE THE
OPTIONS

?

BEFORE WE
THINK OF
OPTIONS WE
SHOULD KNOW
ABOUT THE
COMPLICATIONS
WHILE DEALING
WITH SUCH
PROBLEMS

KNOWLEDGE
ABOUT THE
COMPLICATIONS
WILL GUIDE US
TO TAKE A
PROPER
DECISION

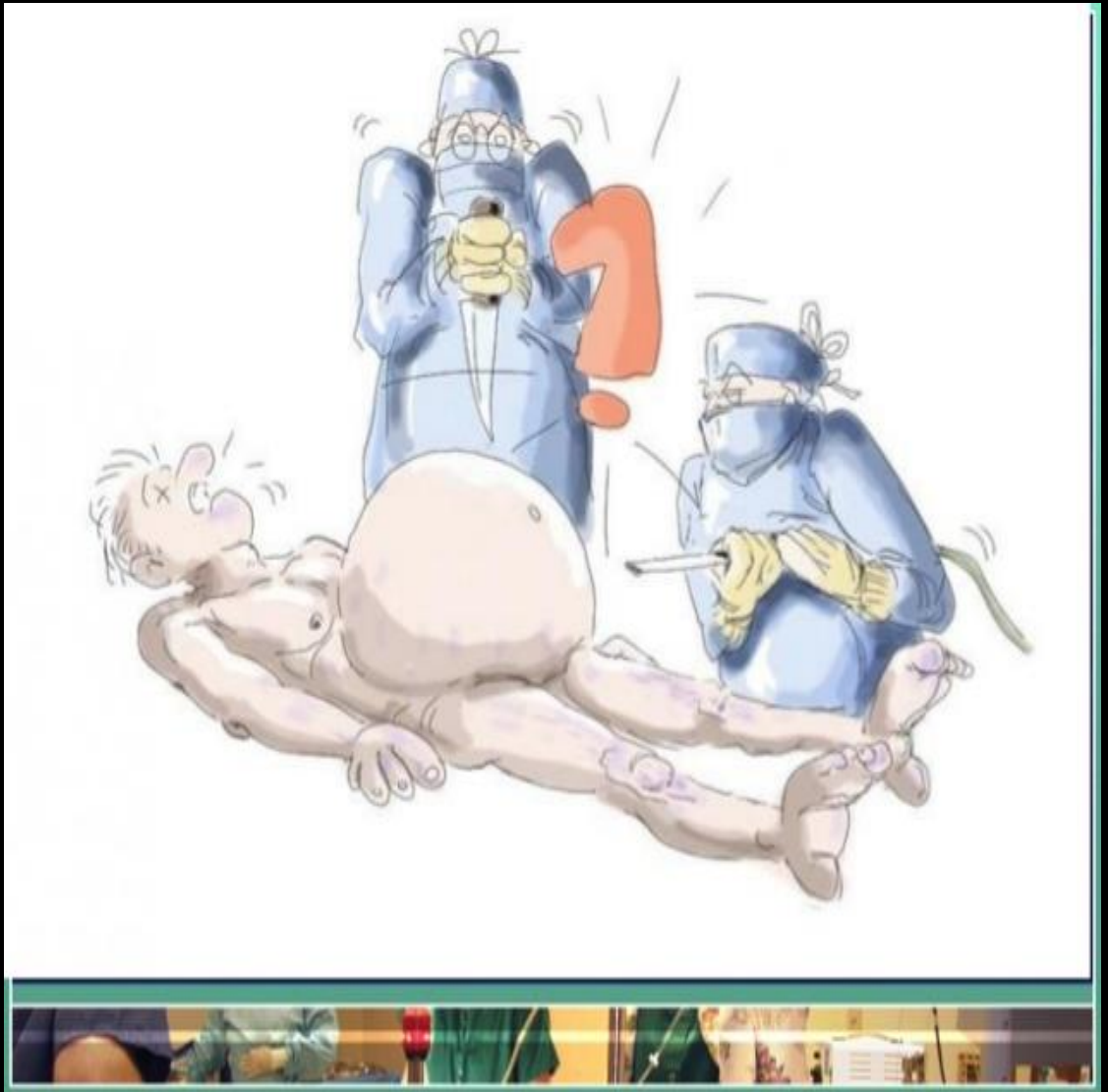
WHAT TO
KNOW
WHICH
MAKES OUR
LIFE EASY

KNOWING ABOUT THE LOSS OF DOMAIN OF
INTRA ABDOMINAL CAVITY –IT IS THE CRUCIAL
INFORMATION TO KNOW IN THE MANAGEMENT
AND OUTCOME OF THE SURGERY

WETHER TO INCREASE THE ABDOMINAL CAVITY
SPACE OR REDUCE THE CONTENTS TO KEEP IN
THE ABDOMINAL CAVITY OR ABDOMINAL WALL
RECONSTRUCTION

AVOID INCREASE IN THE ABDOMINAL CAVITY
PRESSURE

WHAT IS IT
ANY
SURGEON
IS WORRIED
ABOUT





INTRA
ABDOMINAL
HYERTENSION
(IAH)

- ITS EVERY SURGEONS NIGHTMARE ----WHEN WE DONT FIND A WAY TO COME OUT OF THE SURGERY

WHAT IS IAH?

IAH IS DEFINED

AS -----SUSTAINED INTRA
ABDOMINAL PRESSURE >12
mmHg WHICH IS MONITORED
BY STANDARD TRANSBLADDER
TECHNIQUE



WHAT ARE THE CONCERNS ABOUT THE IAP??



NORMAL

•0-5 mmHg



NORMAL IN ICU PATIENTS

•5-7 mmHg



IAH

•>12 SUATAINED PRESSURE



IMPENDING ACS

15-20mmHg



ACS

>20 SUSTAINED WITH OR WITHOUT APP<60mmHg

WHAT IS
ABDOMINAL
PERFUSION
PRESSURE??

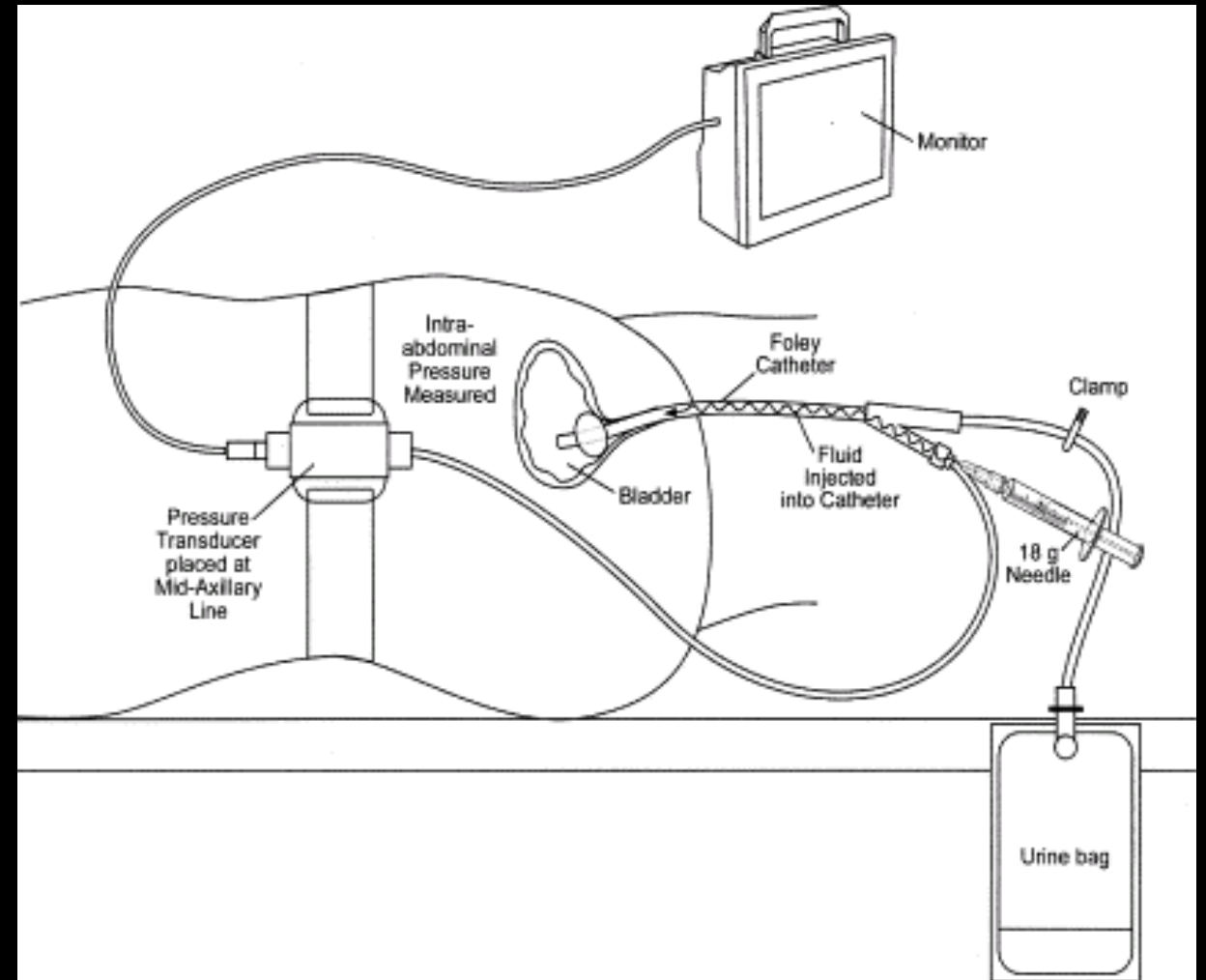
WHY IS IT SO
IMPORTANT??

ABDOMINAL PERFUSION PRESSURE IS =

MEAN ARTERIAL PRESSURE – INTRA ABDOMIAL
PRESSURE

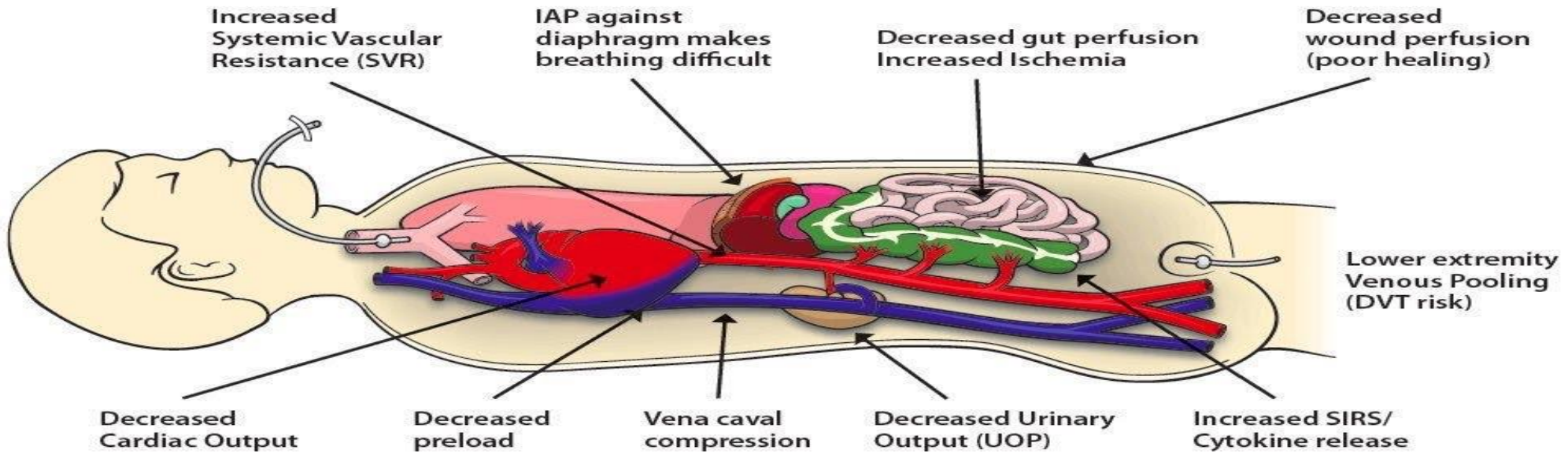
A TARGET APP OF AT LEAST 60mmHg IS
CORROLATD WITH IMPROVED SURVIVAL FROM IAH
AND ACS WAS FOUND TO BE BETTER THAN OTHER
RESSUSCTATION END POINTS eg: HOURLY URINE
OUT PUT FOR PREDICTING OUTCOMES.

HOW TO MONITOR IAP BY STANDARD TRANSVESICULAR TECHNIQUE

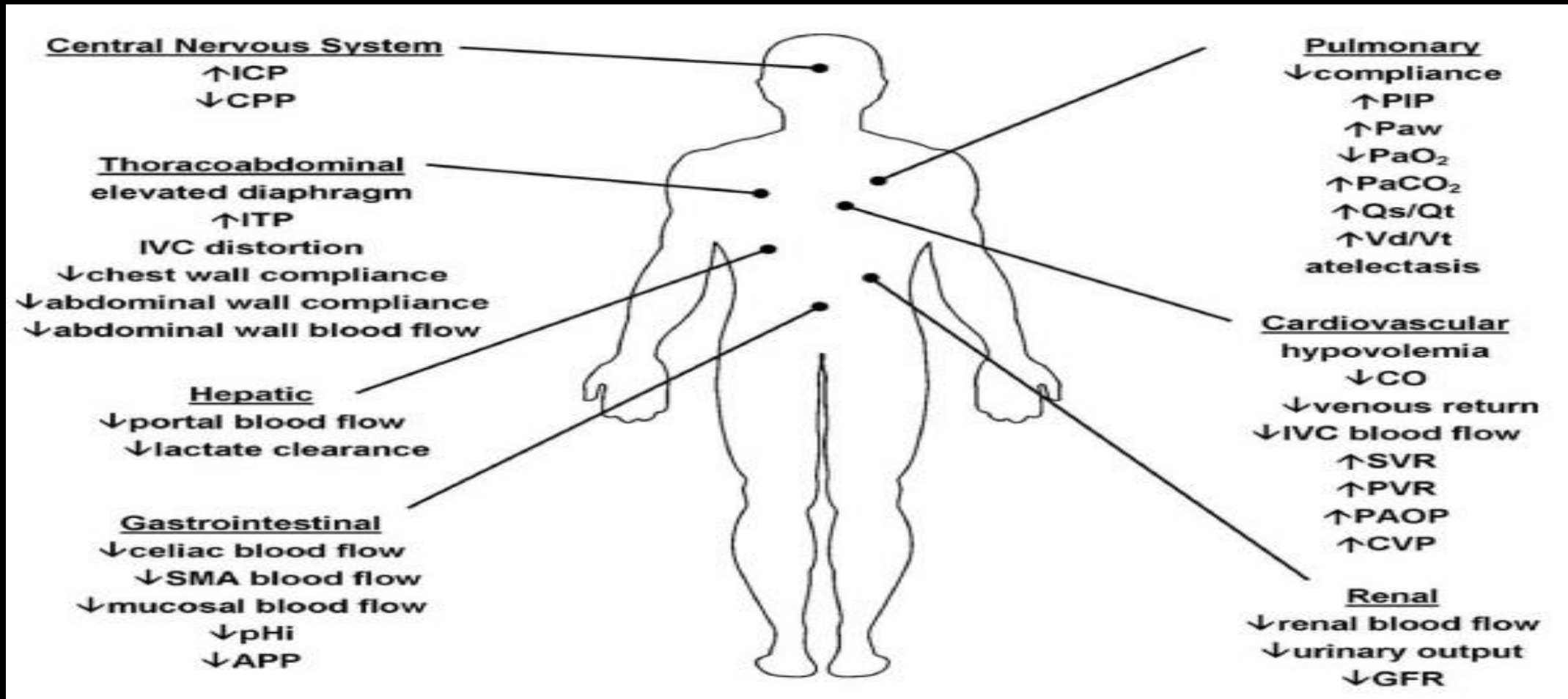


PHYSIOLOGICAL CHANGES WITH INCREASED IAP

Increasing Physiologic Compromise IAP 12 – 15 mmHg

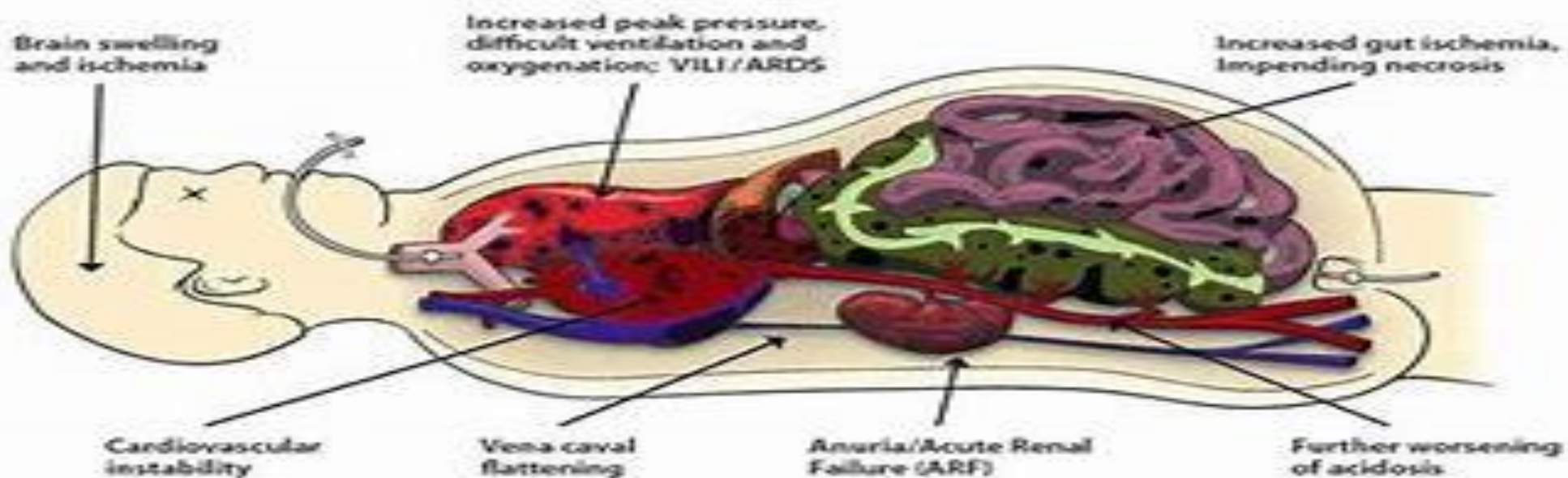


PATHOPHYSIOLOGY IN ACS



IN ACS

Onset of Multiple Organ Dysfunction Syndrome (MODS) IAP > 20 mmHg



HOW TO INCREASE THE ABDOMINAL CAVITY SPACE TO ACCOMMODATE THE CONTENTS

PRE OPERATIVE PROGRESSIVE
PNEUMOPERITONEUM

DISADVANTAGE: PROLONGED
PREOP HOSPITAL STAY 7 TO 10
DAYS , / ENTRAPEMENT OF GAS
IN THE HERNIAL
SAC/STRANGULATION DUE TO
NARROW NECK OF THE DEFECT
ECT.

USING A CATHETER PLACED
INTRAABDOMINALLY –
INSUFFLATE THE ABDOMEN
DAILY UPTO 500 TO 2000CC
USING CO2 /OXYGEN/NITROUS
OXIDE .



REDUCTION
OF THE
CONTENTS



COMMONLY
BY COLON
AND OMENTAL
RESECTION



RECONSTRUCTION
OF THE
ABDOMINAL WALL

FEW TECHNIQUES KNOWN FROM THE LITERATURE ---

ROTATION OF THE VIABLE TISSUE TO INCREASE THE ABDOMINAL WALL SURFACE BY COVERING THE MIDLINE DEFECT ON TOP OF WHICH PROSTHETIC MESH IS PLACED.

TISSUE USED FOR IT ARE---

SCROTAL MUSCULOCUTANEOUS FLAP

HERNIAL SAC USED AS PERITONEUM AND ABOVE WHICH MESH IS PLACED

TENSOR FASCIA LATAE IS USED ALTERNATIVELY

DUAL MESH /BIOMESH

COMPONENT SEPARATION TECHNIQUE

DIFFERENT TYPES OF MATERIALS USED TO APPROXIMATE THE ABDOMEN IN STAGED OR SINGLE PROCEDURE



Plastic



Absorbable mesh



Vacuum



Polypropylene mesh

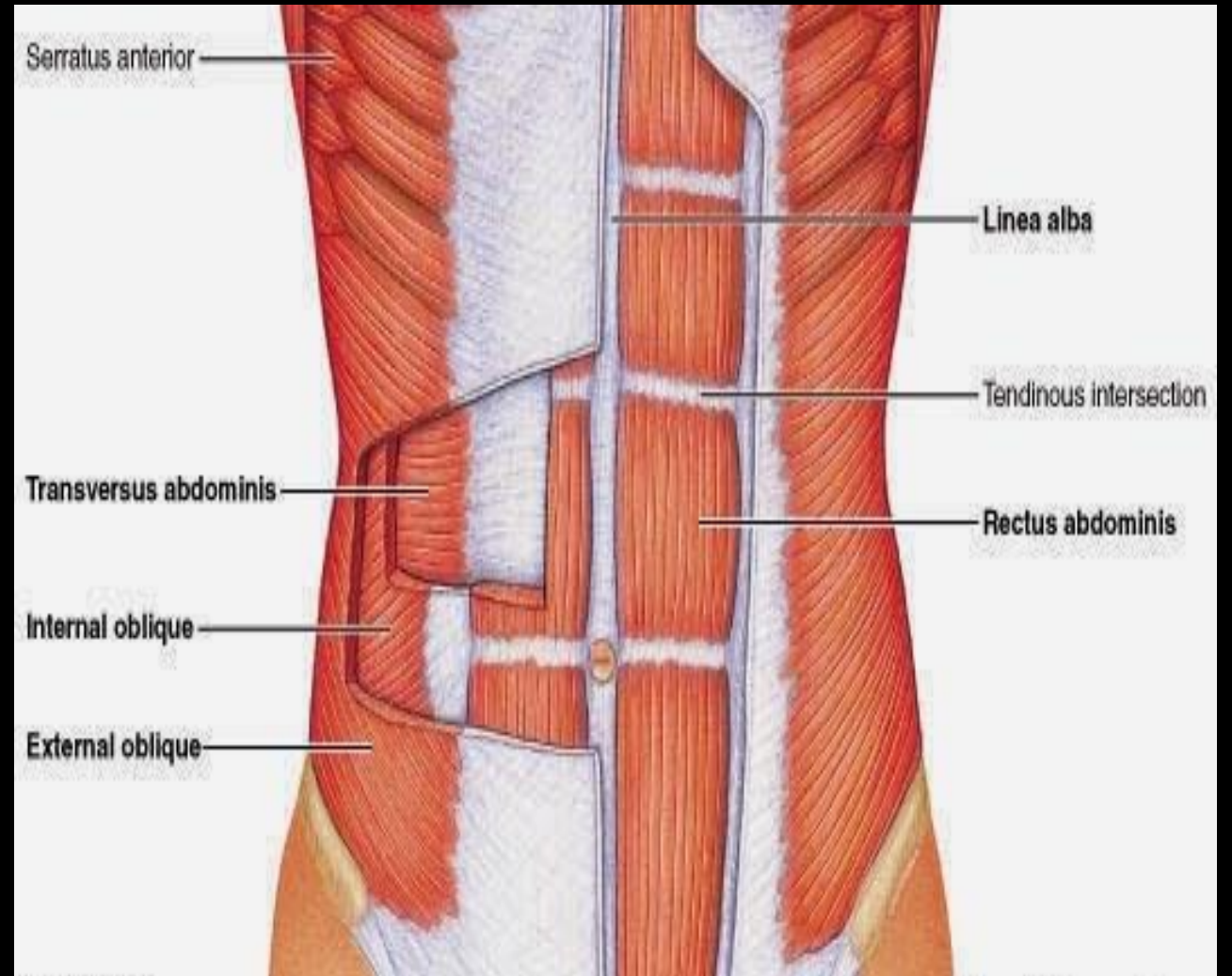


Whittmann patch

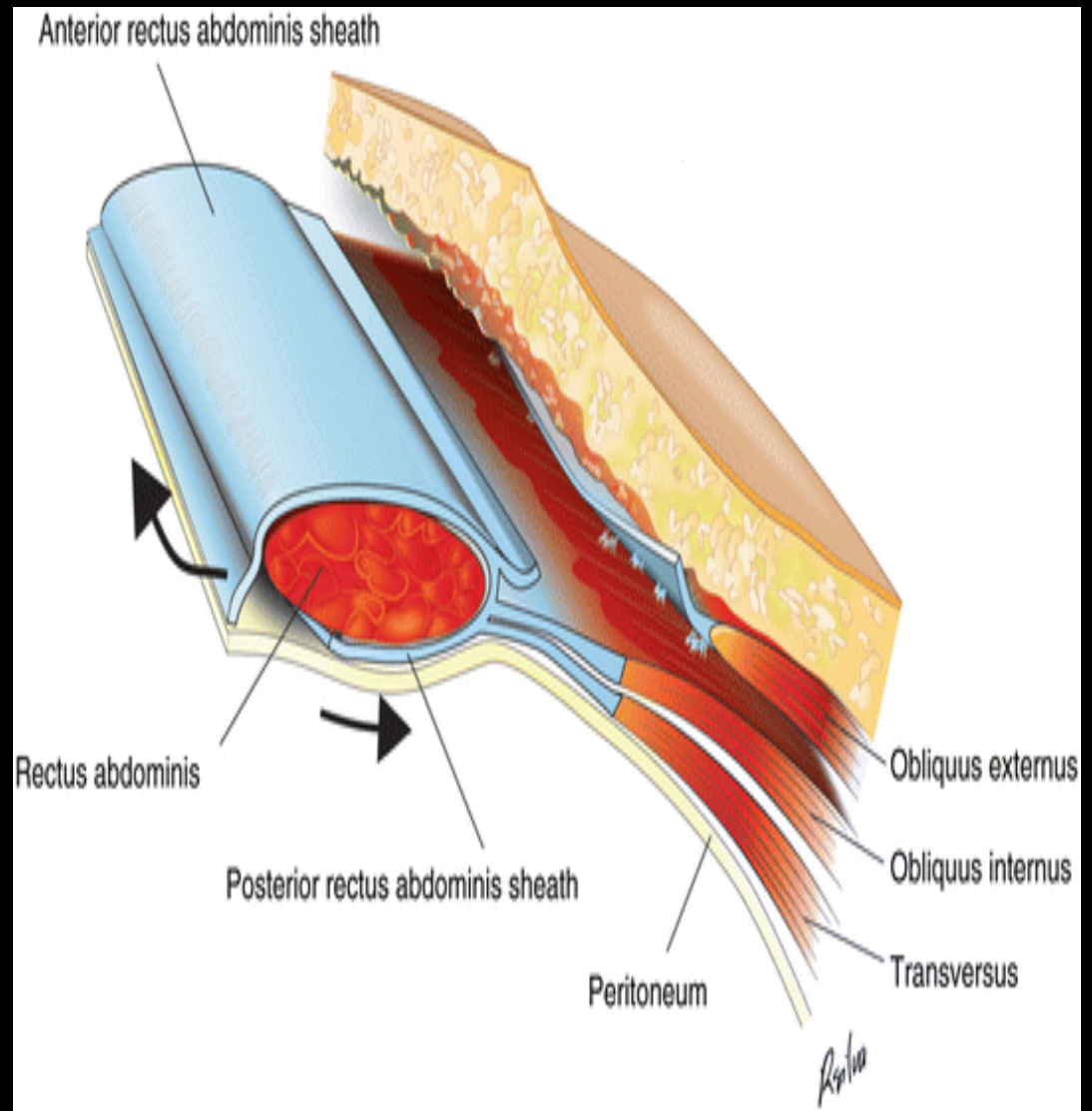


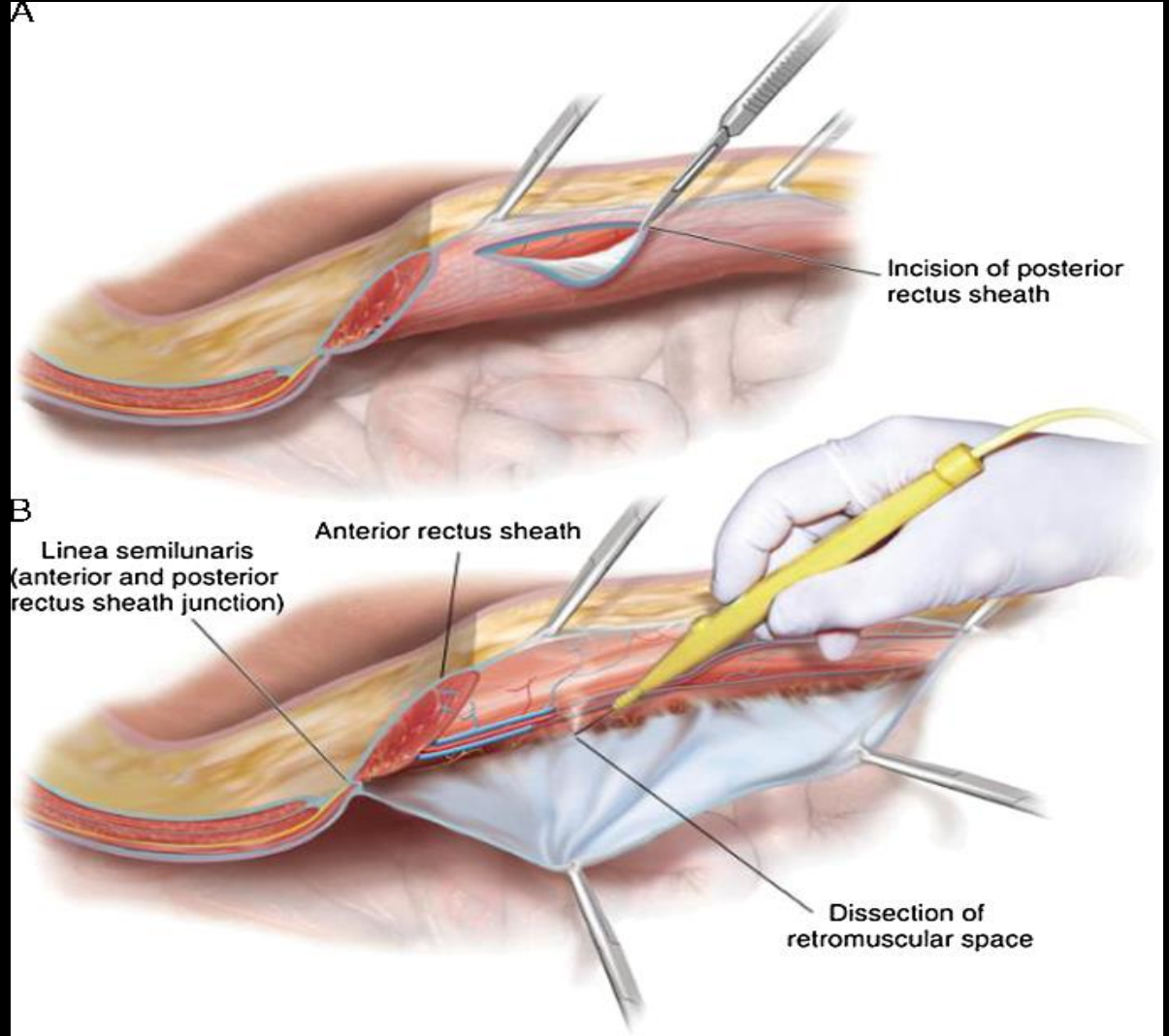
Polytetrafluoroethylene

ABDOMINAL WALL

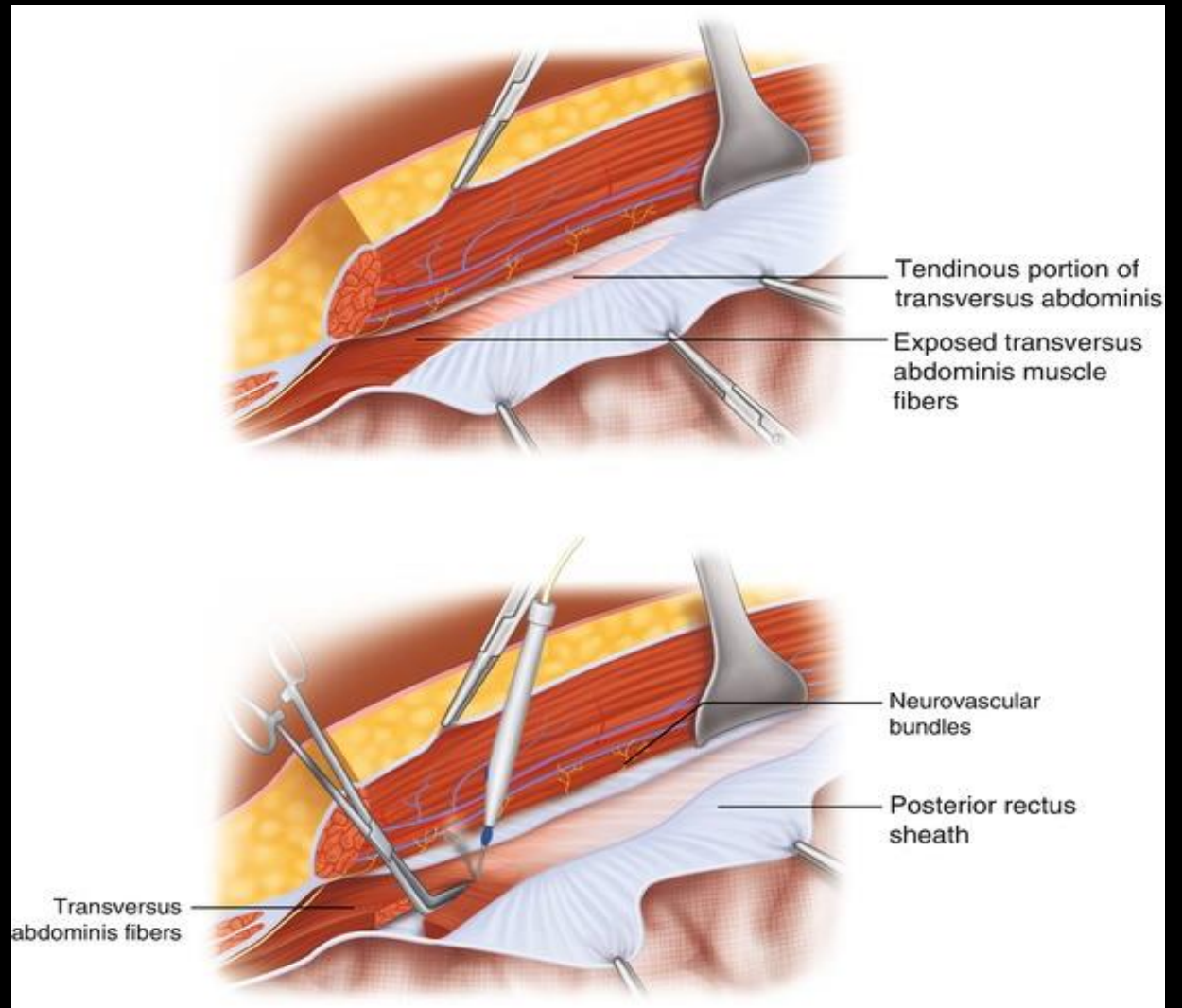


COMPONENT SEPARATION TECHNIQUE

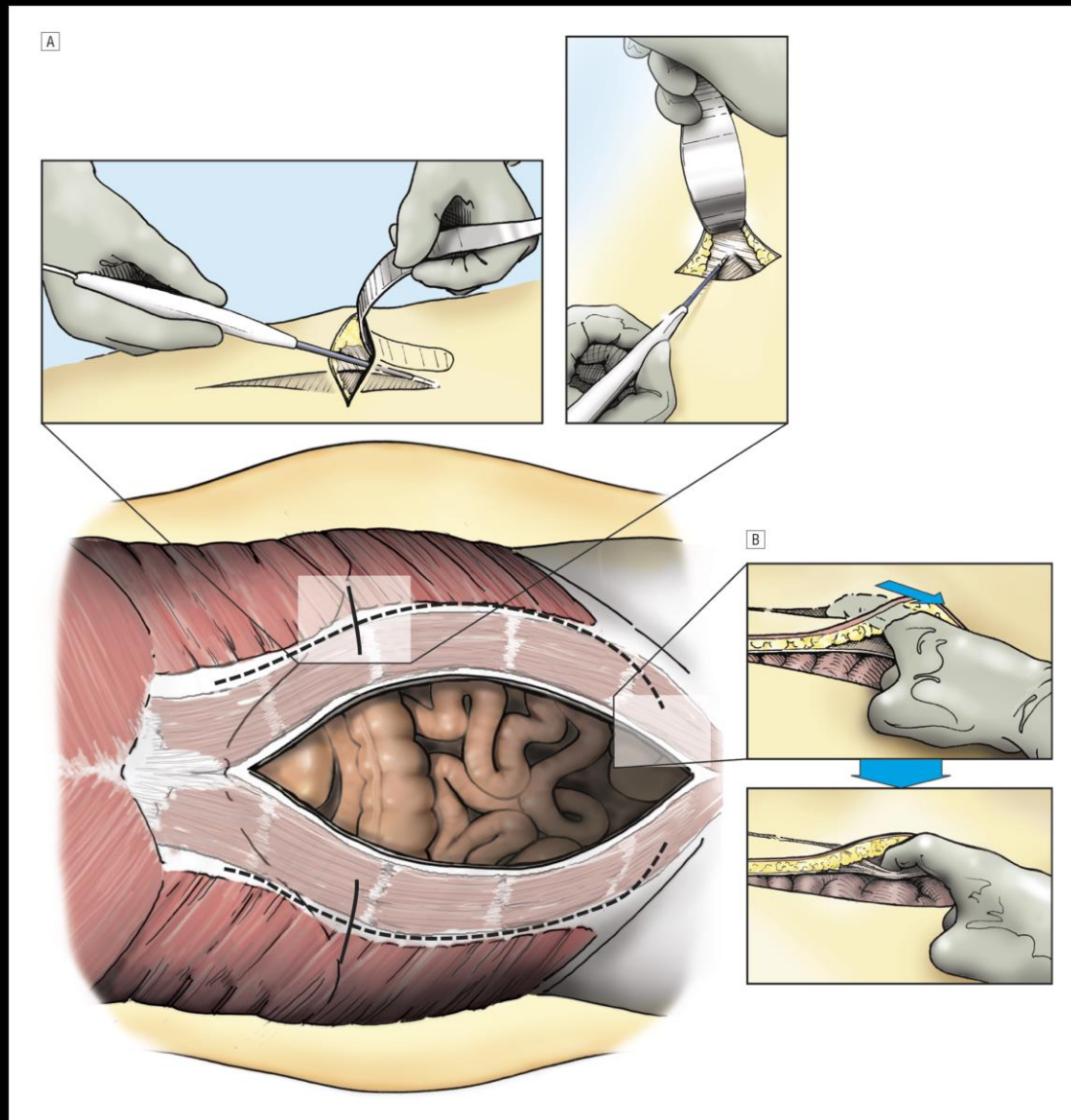




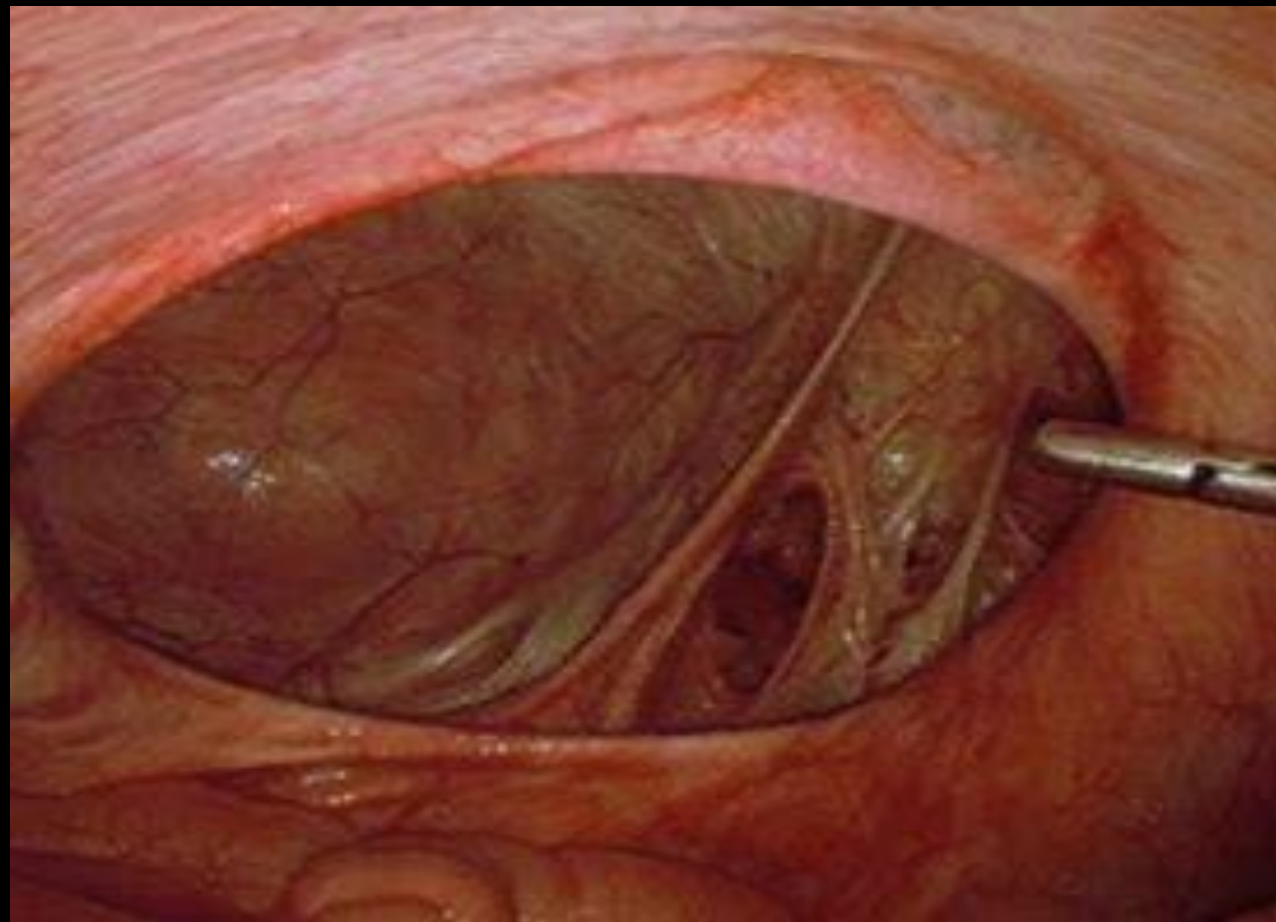
TAR PROCEDURE



ANT RECTUS
SHEATH
SEPARATION WITH
MINIMAL INCISION

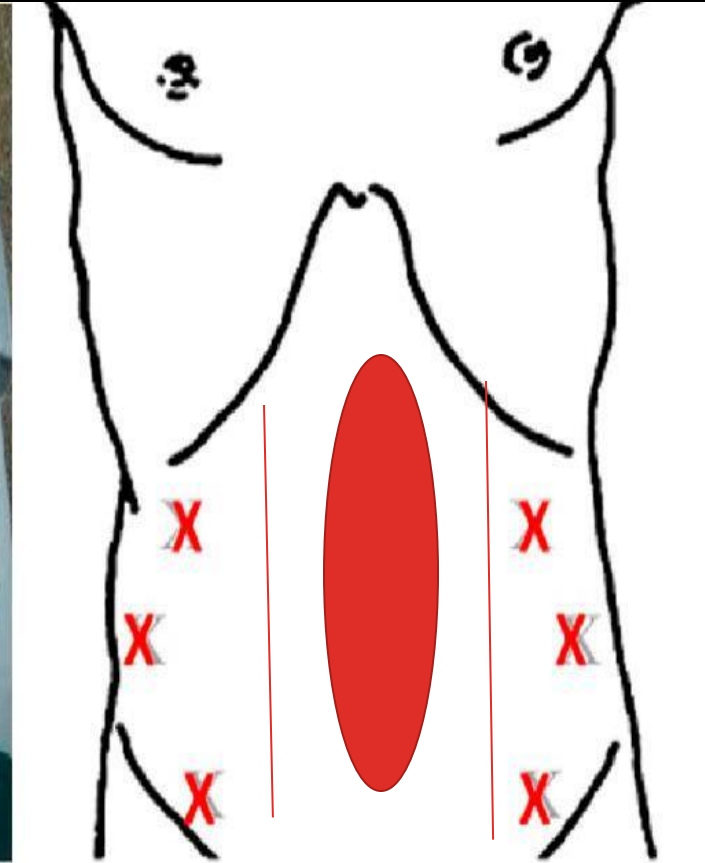


LAP
VIEW OF
A LARGE
HERNIA

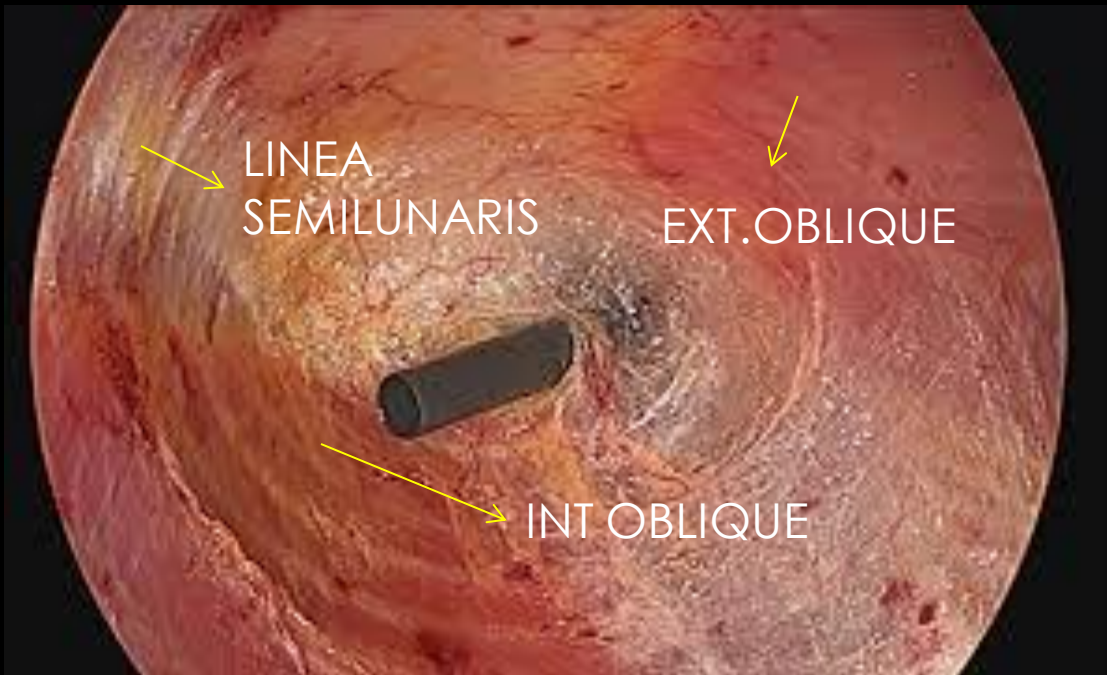


LAPAROSCOPIC
TECHNIQUE

PORT POSITIONS



LAP VIEW OF COMPONENT SEPARATION TECHNIQUE



COMPLICATIONS

FLAP NECROSIS

MESH INFECTION

ANASTAMOTIC LEAK

REEXPLORATION FOR ABDOMINAL COMPARTMENT SYNDROME

RECCURENCE OF HERNIA

CONCLUSION

A PROPER PRE OP EVALUTION

A PROPER PRE OP PREPARATION

COUNSELLING ...COUNSELLING...COUNSELLING THE PT AND ATTENDERS

KEEP TWO /THREE OTIONS IN PLACE AS EVERYTHING MAY NOT GO AS WE PLAN ALL THE TIME

BETTER TO DO AT PROPER CENTRE WITH BETTER FACILITIES TO DEAL WITH POST OP COMPLICATIONS

AN EXPERIENCED SURGEON

I DO FOLLOW THIS

NEVER CRITICISE
OTHER
SURGEONS/DOCTORS

