



Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

A case report of a double port site hernia and their laparoscopic repair with intra corporeal suturing of the hernia necks and an underlay mesh repair

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ARTICLE INFO

Article history:

Received 11 July 2018

Accepted 31 July 2018

Available online 9 August 2018

Keywords:

Port site hernia

Laparoscopic herniorrhaphy

Intracorporeal suturing

ABSTRACT

INTRODUCTION: Port site hernias (PSH) are a potential postoperative complication in laparoscopic surgery. It is difficult to estimate their true incidence given the discrepancy in published reports.

PRESENTATION OF CASE: This is a case report of a 42-year-old lady who developed two separate PSH requiring a laparoscopic repair. This is also the first reported case of multiple PSH in a single patient in the English literature.

DISCUSSION: This report highlights the need for further research in establishing well defined incidence rates in order to properly discuss future surgical risks when consenting a patient for laparoscopic surgery. It is our belief that future research should be directed towards determining the risk associated with different trocar types, in the setting of various pre-morbid patient factors, to help surgeons decide on relevant instrument use and the most appropriate closure for port sites.

CONCLUSION: The growing incidence of PSH has brought about significant changes in the practice of laparoscopic surgery which behoves us as practicing clinicians to stay abreast of these changes so as to decrease the incidence of PSH.

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1. Introduction

Laparoscopic surgery is now sine qua non in the majority of abdominal surgical procedures. Laparoscopy allows quick access to the abdominal cavity, while avoiding large incisions, which often require a lengthy recovery period. A potential late complication of any abdominal surgery is a port site hernia (PSH). Despite smaller incisions with a laparoscopic approach, the fascia is breeched and there remains the risk of future herniation through the fascial defect. PSH are relatively uncommon, with reported incidences in the English literature of 5.4% [1]. They may result in poor cosmesis, such as an unappealing bulge on the abdominal wall or have the potential for serious complications such as incarcerated or strangulated bowel. Risk factors for PSH include the increased port size, patient's age, body mass index (BMI), excessive tissue manipulation and operative time [1].

2. Case report

A 42-year-old female, was referred by her family physician with two PSH as a result of a laparoscopic cholecystectomy performed 15 years previously. She reported vague periods of right upper quadrant pain with an intermittent bulge over the past two years. Clinical examination revealed a palpable mass in the right upper quadrant, just to the right of midline, as well as a second mass over the umbilicus with concomitant scar tissue from the previous laparoscopic cholecystectomy. She had recently lost 25 kg of weight intentionally and noticed that the swellings over the two incision sites had become more clinically apparent. There were no other hernias noted. Her surgical history included a laparoscopic cholecystectomy, laparoscopic hysterectomy, open appendectomy, and an exploratory laparotomy to investigate her chronic pelvic pain. Medical history included fibromyalgia, idiopathic angioedema, and gastroesophageal reflux disease. She is an ex-smoker with a 10-pack year history but had not smoked for the past decade.

A computerised tomography (CT) scan of her abdomen was performed to assess the location and extent of the abdominal wall hernias (Figs. 1–4). After an extensive discussion of the risks and benefits of hernia surgery she consented to a laparoscopic repair under general anesthetic. A four-port technique was employed as the distance between the hernia necks on the abdominal wall

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Fig. 1. CT Scan sagittal view of the umbilical hernia (blue arrow).

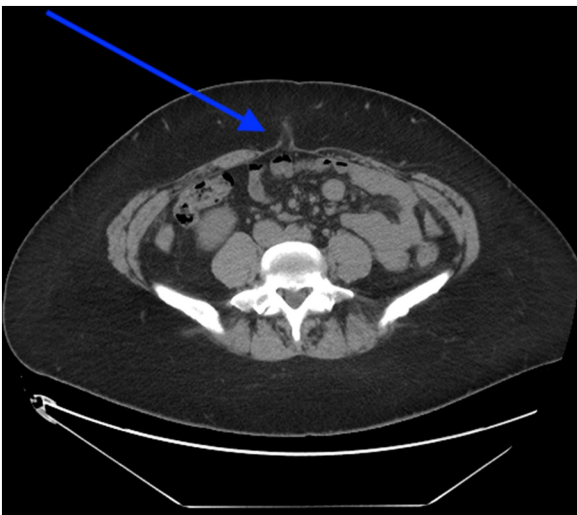


Fig. 2. CT scan axial view of the umbilical hernia (blue arrow).

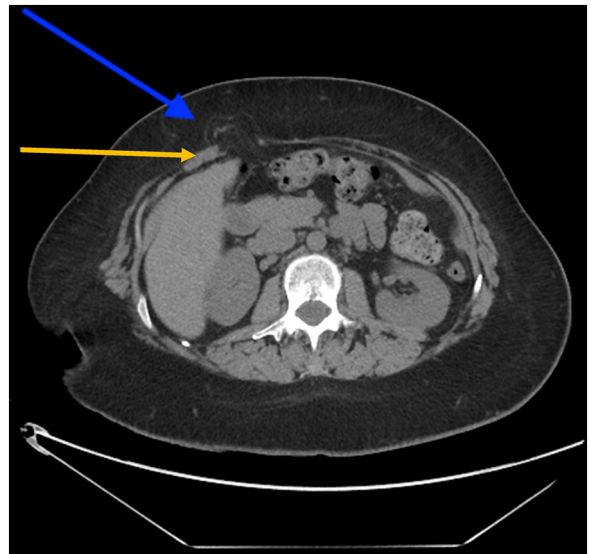


Fig. 3. CT scan axial view of the right upper quadrant incisional hernia (blue arrow) through the right Rectus abdominis muscle (orange arrow).



Fig. 4. CT Scan sagittal view of the right upper quadrant incisional hernia (blue arrow).

was greater than 30 cm. The right upper quadrant hernia was initially identified (Fig. 5) and the hernia neck exposed (Fig. 6). A V-Loc[®] non-absorbable suture was used to close the hernia neck laparoscopically and the suture was subsequently secured to the abdominal wall with gallbladder clips (Fig. 7). A 10 × 15 cm dual layer Ventralite[®] mesh was then applied to cover the tissue repair. It was secured to the abdominal wall using AbsorbaTack[®] absorbable tacks (Fig. 8). The umbilical hernia was subsequently visualized (Fig. 9) and the neck closed with a V-Loc[®] suture. The suture was also secured to the abdominal wall with gallbladder clips (Fig. 10) to prevent suture slippage. A Ventralite[®] mesh was applied over the tissue repair with AbsorbaTack[®] sutures (Fig. 11). Postoperatively, the patient made an uneventful recovery and was discharged home the same day.

3. Discussion

Following an extensive PubMed and Medline search this appears to be the first case report in the English literature of a patient with two simultaneous PSH. PSH are a late complication that may require symptomatic patients to undergo further surgery. This complication should be considered in the determination of port placement and trocar type.

We were unable to ascertain whether the two PSH developed simultaneously or at different times in the post-operative period following the laparoscopic cholecystectomy. The patient could not furnish us with this information as she was unable to remember. Simultaneous PSH formation may indicate that the patient has a connective tissue defect which may impair wound healing leading to the PSH. She did not develop hernias from her other abdominal

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