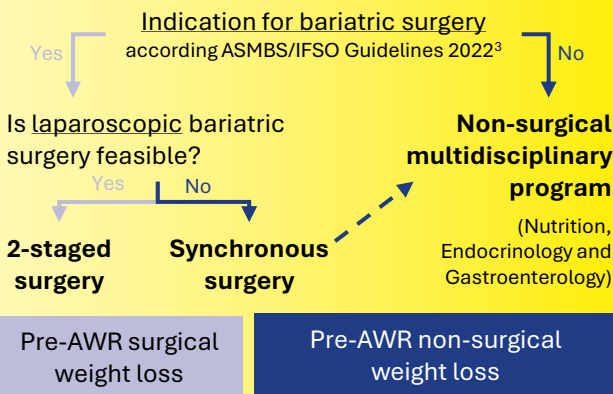


## Pre-operative optimization of patients with obesity and complex incisional hernia: how we do it and results

### Obesity and hernia

Hernias and obesity are often associated.<sup>1</sup>

Obesity is a chronic disease with high impact and negative influence in abdominal wall reconstruction (AWR).<sup>2</sup>



All AWR were performed by open approach with bilateral retrorrectus dissection and component separation on demand. For mesh reinforcement was used a large Bulevb®, Dipro Medical Devices.

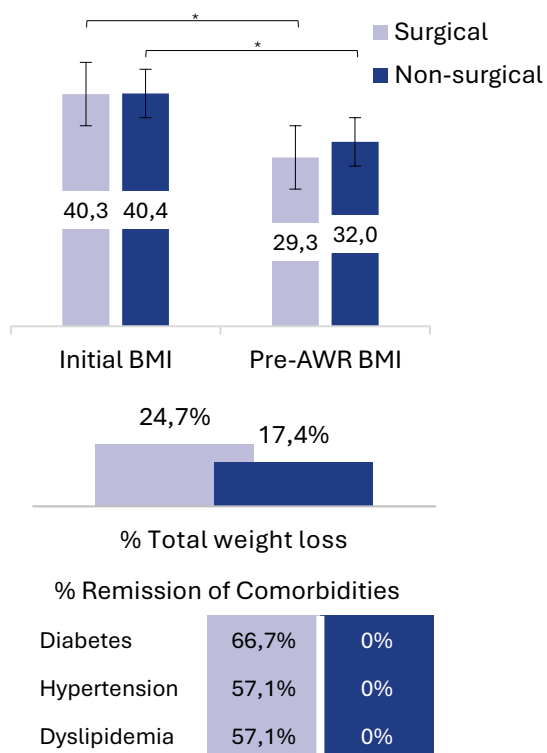
**Primary outcomes:** weight loss and remission of obesity associated comorbidities pre-AWR

**Secondary outcomes:** interval time till AWR, surgical morbidity and recurrence

### Results

\* p value < 0,05

	Surgical weight loss	Non-surgical weight loss
n	10	9
Age (median, years)	62 (44-65)	73 (49-77)
BMI (mean, kg/m <sup>2</sup> )	40,3 ± 5,2	40,4 ± 4,4
Diabetes	2 (22%)	6 (60%)
Hypertension	6 (67%)	7 (70%)
Dyslipidemia	7 (78%)	7 (70%)
Treatments	6 Sleeve 3 RYGB 1 SADIS	9 nutrition + 2 GLP-1 analogs + 3 intragastric balloon
Time to AWR* (mean, days)	696,2 ± 293,1	343,0 ± 143,3
Complications	1 case of intestinal obstruction	1 case of gastric outlet obstruction



Component separation	Dermolipectomy	Synchronous bariatric surgery	Overall morbidity	Surgical site occurrences	Recurrence	Follow-up (mean, months)
40%	40%	10%	10%	10%	0%	20,1 ± 10,5
55,6%	33,3%	22,2%	44,4%	33,3%	0%	26,7 ± 14,4

### Conclusions

Preoperative obesity management significantly reduced BMI. Comorbidities improved only with surgical weight loss.

Overall morbidity was 26.3%, with SSO accounting for 21.1%, showing no statistically significant difference between groups - though the non-surgical group had a higher incidence. These results are significantly better than AWR in patients with BMI > 35 kg/m<sup>2</sup>.<sup>4</sup>

### References

1. Zelicha, H. et al. Hernia. 2024
2. Novitsky, YW. et al. Hernia. 2013
3. Eisenberg, D. et al. Obes Surg. 2022
4. Somelevitz J. et al. Am J Surg. 2018