

Lateral Incisional Hernia

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Lateral Incisional Hernia (LIH)

Aim

The aim of the paper is to present the operative technique for the correction of lateral abdominal wall incisional hernias (LAWIH). We are presenting two case reports: the first with recurrent left-sided LAWIH in a patient already operated on four times, and the second with a right-sided LAWIH with liver herniation through incisional postnephrectomy hernia.

Material & Methods

Case 1

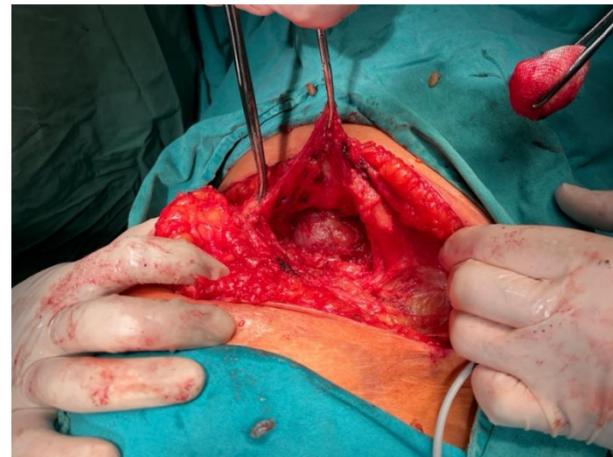
An elective operation of a recurrent left-sided LAWIH in a 59-year-old female
 Comorbidities: hypertension, LBBB, ureteric stenosis, CKD and severe nephrolithiasis.
 The patient has undergone three previous operations: two open left-sided nephrolithotomies and replacements of renal stents due to reinfection.
 The fourth procedure involved the repair of an ipsilateral incisional hernia.

Case 2

The patient, a 64-year-old female, was diagnosed with an incisional post-nephrectomy hernia.
 She presented with comorbidities such as hyperlipidaemia, xerostomia, thoracic spine syndrome, and lumbar syndrome without a history of smoking or alcohol use.
 Her medical history was further complicated by the presence of chronic pain.



Figure 1: Important landmarks and incisional hernia.



Figures 2 and 3: Hernial sac with retracted flank muscles and set suture for Mesh anchoring.



Figures 1 and 2: LAW postnephrectomy IH and landmarks.



Figures 3 and 4 : LAW hernia with Mesh in situ.



Figure 5. After 12 months with Mesh in situ.

Discussion

In the first case, the patient's history of multiple surgeries complicated the repair due to extensive scar tissue and altered anatomy. In both cases the mesh has been placed sublay in Taco formation with a wide (over 10 cm) overlap. Attachment to bony structures, including the costal margin and iliac crest, guarantees the stability of the mesh, as emphasized in Baumann's recommendations. Without drilling the bone, open mesh sublay repair with costal margin fixation is possible and functional. This outcome indicates that the surgical intervention was effective in achieving long-term stability and strength in the abdominal wall. Recurrences are most often attributed to insufficient mesh overlap and inadequate fixation. Hernia-Related Quality of Life Survey and pain intensity scores improved significantly as predicted.

References

1. Muysoms FE, Miserez M, Berrevoet F, et al. Classification of primary and incisional abdominal wall hernias. *Hernia* 2009;13:407–14
3. Baumann DP, Butler CE. Lateral abdominal wall reconstruction. *Semin Plast Surg* 2012;26(1):40–48.

Conclusions

After 36 months, the repaired lateral abdominal wall hernias (L2-4) showed no clinical recurrence or bulging. For the obese patients the abdomen should be re-entered through the previous incision. In non-obese patients, re-entry is performed through a median laparotomy. The ideal place for mesh placement is preperitoneally, or in space, as in reverse TAR. The extent of the overlap, in our opinion, should be at least 10 cm in the Taco formation.

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4. Moreno-Egea A, Vílchez J, Ruiz-Moral R, et al. Surgical techniques for abdominal wall reconstruction. *Arch Surg*. 2008;143(11):1095–1102.