Ventral Hernia Should be Treated Surgically and No One Should Die From It

Rifat Latifi, MD, FACS, FICS, FKCS
The Felicien Steichen Professor and Chairman of Surgery,
New York Medical College,
School of Medicine
Director,
Department of Surgery
Westchester Medical Center Health
Valhalla, New York

EDITORIAL

It happens again and again, all over the country: patients with giant, recurrent, neglected, and body-deforming ventral hernias, which prevent them from enjoying their lives, walk or often get wheeled from one surgeon's office to another, from one doctor to another, from one emergency department to another, trying to find a surgeon who will operate on them, but with no success. Disappointed in the healthcare system and hopeless for their future, they live with a hernia that continues to get worse, causing pain and obstructive signs and symptoms. Both elderly men and women, and particularly those with comorbidities, are in an even worse situation.

It may start with a simple cholecystectomy, hysterectomy, sigmoid colectomy for diverticulitis, appendectomy, treatment of an umbilical hernia, or laparoscopic weight-loss surgery; they develop a hernia, and their odyssey begins. They undergo laparoscopic or open repair, often primary repair, or repair with a large "blanket" of synthetic mesh or a newer biologic/hybrid mesh, sometimes just once or twice, but often many more times. Then they develop a new recurrence, bowel obstruction, and undergo emergency surgery with bowel resection with some sort of stoma (colostomy, diverting ileostomy, or end ileostomy). This is followed by another recurrence, abscess or leaking sinus tract, an infected mesh, with or without an entero-cutaneous or entero-atmospheric fistula, small or large. Morbidly obese patients are asked to lose weight, and we know that this almost never happens.

Some surgeons tell their patients, "*Many patients live with hernia; this is considered cosmetic surgery*". Worse, patients are told by their surgeons, who, to be clear, have failed to treat them, "*Don't ever let anyone operate on you; you will die on the table…", "Your abdomen is frozen", "Your case is too complex for me", "Your hernia is too big, too complex, you have no abdominal wall domain, go and follow-up with primary care, but if you have an operation, you may die…"*

Desperate, in pain, in and out of small and large emergency departments and hospitals (often managed with pain medications, instead of surgery), patients and their families continue to suffer. Patients are lost in follow-up by the medical system, and they wait and wait to find a surgeon. Worse, one day they end up in the emergency department with an intra-abdominal catastrophe, with intestinal necrosis of large segments of the large and/or small bowels, and undergo an emergency operation by whoever happens to be on-call that night. The results are not good: open abdomen, stoma, fistulae, ICU, multiple organ failure, tracheostomy, and, if they eventually leave the hospital, patients can spend months in rehab or a nursing home. At some point, they die.

The profile of ventral hernia patients varies, from post major abdominal trauma to post intra-abdominal catastrophe, post intra-abdominal organ transplant, or cirrhosis with massive ascites. Most are recurrent complex hernia, most of which require complex abdominal wall reconstruction (CAWR). Many require emergency surgery with significant complications, and CAWR in acute settings.[1-7] In patients with massive and debilitating hernia, with most of their intestines, large and small, hanging in their laps, or on the side, unable to enjoy life, unable to wash themselves, unable to move, surgery can be life-changing. Although it is not merely a cosmetic procedure, at such a late stage it can be risky. Patients who present late, with bowel obstruction, skin changes on hernia or leaking ascites, sometimes even with the small bowel liquefied and necrotic, do not do well. Yet, the satisfaction from seeing patients happy and returning to normal life is enormous.

Ventra hernias, or often inguinal hernias, particularly in obese and/or elderly patients, and in patients with cirrhosis with or without ascites and other major

comorbidities, are the new neglected disease on an epidemic scale. Hernia should be treated surgically and early by those who understand the anatomy and dynamics of the abdominal wall.

In this issue of Surgical Technologies International, Smiley et al. analyze a large national database in which they demonstrate that, in patients with ventral hernia who are admitted emergently, delayed time to surgery, age, male sex, obstruction and gangrene at the presentation are the main risk factors for mortality.[8] Once admitted, due to high rates of comorbidities, there is often a delay in surgery. If not operated upon within the first few days, each additional day of delay in performing surgery increases the odds of mortality by 3 percent. The message is clear: we need to operate early, before it becomes an emergency, and once admitted emergently, these patents should be operated upon at once.

In summary, we need to educate our primary care providers and patients alike that hernia should be treated surgically, not medically. It should not be neglected. And to those who say, "*Watch and see,*" I say, hernia does not get smaller, it gets bigger, and may someday kill the patient.

Finally, as surgeons, we should also not neglect hernia. If we are uncomfortable, or if CAWR is not in our domain of expertise, we should send patients to those who do know and can perform the required repair in a timely manner, before it becomes an emergency. We have to ask ourselves, why would someone with incarcerated hernia not be operated upon in a timely fashion? Moreover, why not operate on these patients before they get incarcerated and truly sick? No one in any hospital should ever die from ventral hernia because we, the doctors (not the patients themselves), have neglected it.

No one. Period.

REFERENCES

1. Gogna S, Latifi R, Choi J, et al. Early versus delayed complex abdominal wall reconstruction with biologic mesh following damage-control surgery. J Trauma Acute Care Surg 2021 Mar 1;90(3):527-34. doi: 10.1097/TA.0000000000003011.PMID: 33507024
2. McGuirk M, Kajmolli A, Gachabayov M, Samson D, Latifi R. Timing and type of bacteria in surgical site infections following complex abdominal wall reconstruction. Surg Technol Int 2020 Nov 28;37:27-34.PMID: 33245557
3. Gogna S, Latifi R, Choi J, et al. Predictors of 30- and 90-day readmissions after Complex Abdominal Wall Reconstruction with biological mesh: a longitudinal study of 232 patients. World J Surg 2020 Nov;44(11):3720-8. doi: 10.1007/s00268-020-05714-9. Epub 2020 Jul 30.PMID: 32734453
4. Latifi R, Samson DJ, Gogna S, Joseph BA. Perioperative complications of complex abdominal wall reconstruction with biologic mesh: A pooled retrospective cohort analysis of 220 patients from two academic centers. Int J Surg 2020 Feb;74:94-9. doi: 10.1016/j.ijsu.2019.12.035. Epub 2020 Jan 8.PMID: 31926327
5. McGuirk M, Kajmolli A, Gachabayov M, Smiley A, Samson D, Latifi R. Independent predictors for surgical site infections in patients undergoing complex abdominal wall reconstruction. Surg Technol Int 2021 May 20;38:179-85. doi: 10.52198/21.STI.38.HR1431. PMID: 33823057
6. Latifi R, Samson D, Haider A, et al. Risk-adjusted adverse outcomes in complex abdominal wall hernia repair with biologic mesh: A case series of 140 patients. Int J Surg 2017 Jul;43:26-32. doi: 10.1016/j.ijsu.2017.05.031. Epub 2017 May 16.PMID: 28526657
7. Samson DJ, Gachabayov M, Latifi R. Biologic mesh in surgery: a comprehensive review and meta-analysis of selected outcomes in 51 studies and 6079 patients. World J Surg 2021 Jan 8. doi: 10.1007/s00268-020-05887-3. Epub ahead of print. PMID: 33416939.
8. Smiley A, Levy L, Latifi R. et al. Risk Factors for Mortality in Patients with Ventral Hernia Admitted Emergently: An Analysis of 48,539 Adult Patients. Surg Technol Int 2021.

Surg Technol Int. 2021, November 23;39. pii: sti39/1513