Challenging Cases: Laparoscopic Repair Of Parastomal Hernia

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Parastomal hernias are difficult in general. The most common type we see are colostomy hernias, and those tend to be most difficult because, by definition, a colostomy is a hernia defect with the bowel going through the abdominal wall. So, you have to leave the hole, but repair the hernia.

For pre-operative evaluation, I like to get a CAT scan of the patient to assess the exact location of the hernia. If it’s a very obese individual, I like them to lose a little bit of weight. Intraoperatively, these are very difficult procedures. I laparoscopically take down all of the adhesions. Then, I close the defect as much as I can, especially lateral defects. Lateral-based hernias have higher incidence rates of recurrences, so I try to close them.

Once I do that, I use a flat sheet of the GORE® BIO-A® (W.L. Gore & Associates), cut a keyhole out of it, and put that over the defect and around the colon. This is then fixed with the SORBAFIX™ Absorbable Fixation System device. After that, I usually use a GORE® suture to loosely close the slit. The colon is then sewn to the abdominal sidewall using one or two sutures. Sometimes I’ll use the Suture Assistant or free-hand tie with a permanent suture.

Subsequent to that, I’ll do a Sugarbaker repair. The GORE® DUALMESH® PLUS Biomaterial is used to cover the entire area we just operated on – the colon, defect and BIO-A sheet – and secure it like any incisional hernia repair with the SORBAFIX

and transfascial sutures. Finally, I will free-hand sew the colon where it enters into and travels underneath the DUALMESH PLUS with a permanent suture to eliminate any defect.

This procedure is very time consuming and to get it all done right without compromising the lumen and getting enough overlap is very challenging. We're throwing everything possible at it. We are closing the defect, using an absorbable product and then a permanent product to repair it. Even for surgeons skilled at repairing incisional hernias, this operation is going to take a long time.

Notably, it has really made a significant impact in decreasing the recurrence rates. With a relocation of the hernia, the recurrence rate is 60 to 70 percent. Using mesh, it drops to around 25 to 30 percent. In my own experience doing the procedure I just described, I have not had a recurrence — not to say I won't. I have done some other methods without the BIO-A and just the Sugarbaker, and the recurrence rate was about 10 percent. So, this technique has made a difference in reducing recurrence rates.

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