ОСОБЛИВОСТІ ГЕРНІОПЛАСТИКИ ПРИ ЗАЩЕМЛЕНИХ ГРИЖАХ ЖИВОТА

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Актуальність. Не дивлячись на рекомендації WSES (2017), дискутабельним залишається питання можливості застосування сітки при защемлених грижах [1,2].

Review

Guidelines for treatment of umbilical and epigastric hernias from the European Hernia Society and Americas Hernia Society

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Background: Umbilical and epigastric hernia repairs are frequently performed surgical procedures with an expected low complication rate. Nevertheless, the optimal method of repair with best short- and long-term outcomes remains debatable. The aim was to develop guidelines for the treatment of umbilical and epigastric hernias.

Methods: The guideline group consisted of surgeons from Europe and North America including members from the European Hernia Society and the Americas Hernia Society. The Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach, the Scottish Intercollegiate Guidelines Network (SIGN) critical appraisal checklists, and the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument were used. A systematic literature search was done on 1 May 2018, and updated on 1 February 2019.

Results: Literature reporting specifically on umbilical and epigastric hernias was limited in quantity and quality, resulting in a majority of the recommendations being graded as weak, based on low-quality evidence. The main recommendation was to use mesh for repair of umbilical and epigastric hernias to reduce the recurrence rate. Most umbilical and epigastric hernias may be repaired by an open approach with a preperitoneal flat mesh. A laparoscopic approach may be considered if the hernia defect is large, or if the patient has an increased risk of wound morbidity.

Conclusion: This is the first European and American guideline on the treatment of umbilical and epigastric hernias. It is recommended that symptomatic umbilical and epigastric hernias are repaired by an open approach with a preperitoneal flat mesh.

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Introduction

Umbilical and epigastric hernia repairs are frequently performed surgical procedures with an expected low complication rate of 3·5 per cent[1]. The optimal repair method with the best short- and long-term outcomes remains debatable. The choices are many. For instance, is it necessary to use a mesh and, in the case of mesh repair, is a preformed patch better than a flat mesh, and in which anatomical layer should it be placed? Furthermore, when is a laparoscopic approach preferable to an open approach?

In recent decades, the European Hernia Society (EHS) has facilitated the creation of a number of guidelines on the treatment and prevention of hernias, aiming at improving and standardizing hernia care[2,3]. The International Endohernia Society (IEHS)[4–6] published guidelines on laparoscopic treatment of both primary ventral and incisional hernias in 2014, but did not address open ventral

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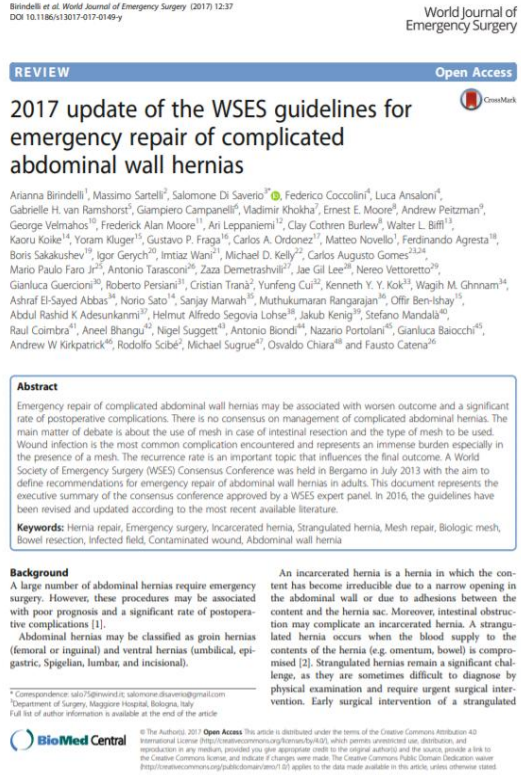

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REVIEW Open Access

2017 update of the WSES guidelines for emergency repair of complicated abdominal wall hernias

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Abstract

Emergency repair of complicated abdominal wall hernias may be associated with worsen outcome and a significant rate of postoperative complications. There is no consensus on management of complicated abdominal hernias. The main matter of debate is about the use of mesh in case of intestinal resection and the type of mesh to be used. Wound infection is the most common complication encountered and represents an immense burden especially in the presence of a mesh. The recurrence rate is an important topic that influences the final outcome. A World Society of Emergency Surgery (WSES) Consensus Conference was held in Bergamo in July 2013 with the aim to define recommendations for emergency repair of abdominal wall hernias in adults. This document represents the executive summary of the consensus conference approved by a WSES expert panel. In 2016, the guidelines have been revised and updated according to the most recent available literature.

Keywords: Hernia repair, Emergency surgery, Incarcerated hernia, Strangulated hernia, Mesh repair, Biologic mesh, Bowel resection, Infected field, Contaminated wound, Abdominal wall hernia

Background

A large number of abdominal hernias require emergency surgery. However, these procedures may be associated with poor prognosis and a significant rate of postoperative complications [1].

Abdominal hernias may be classified as groin hernias (femoral or inguinal) and ventral hernias (umbilical, epigastric, Spigelian, lumbar, and incisional).

An incarcerated hernia is a hernia in which the content has become irreducible due to a narrow opening in the abdominal wall or due to adhesions between the content and the hernia sac. Moreover, intestinal obstruction may complicate an incarcerated hernia. A strangulated hernia occurs when the blood supply to the contents of the hernia (e.g. omentum, bowel) is compromised [2]. Strangulated hernias remain a significant challenge, as they are sometimes difficult to diagnose by physical examination and require urgent surgical intervention. Early surgical intervention of a strangulated

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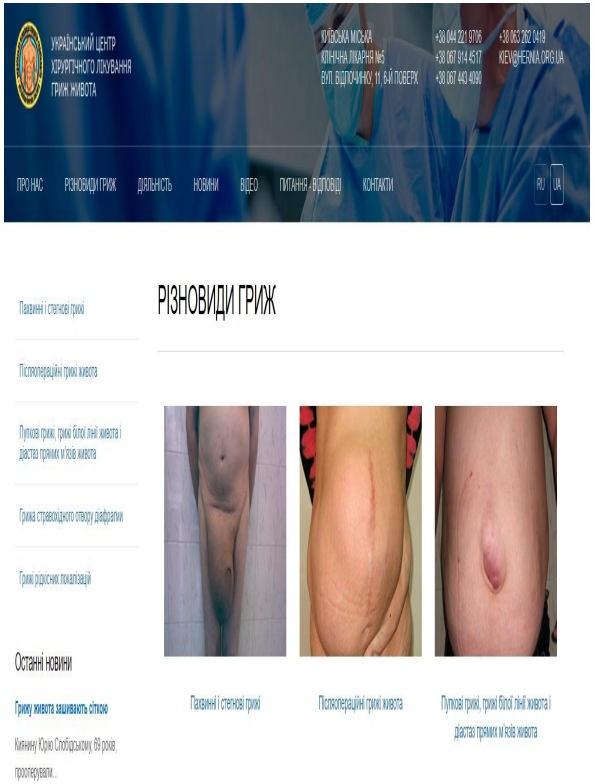


УКРАЇНСЬКИЙ ЦЕНТР ХІРУРГІЧНОГО ЛІКУВАННЯ ГРИЖ ЖИВОТА

ПРО НАС | РІЗНОВИДИ ГРИЖ | ДІЯЛЬНІСТЬ | НОВИНИ | ВІДЕО | ПИТАННЯ ВІДПОВІДІ | КОНТАКТИ | RU | UA

Останні новини

Грижу живота зашивають сіткою

РІЗНОВИДИ ГРИЖ

Пахвинні і стегнові грижі

Післяопераційні грижі живота

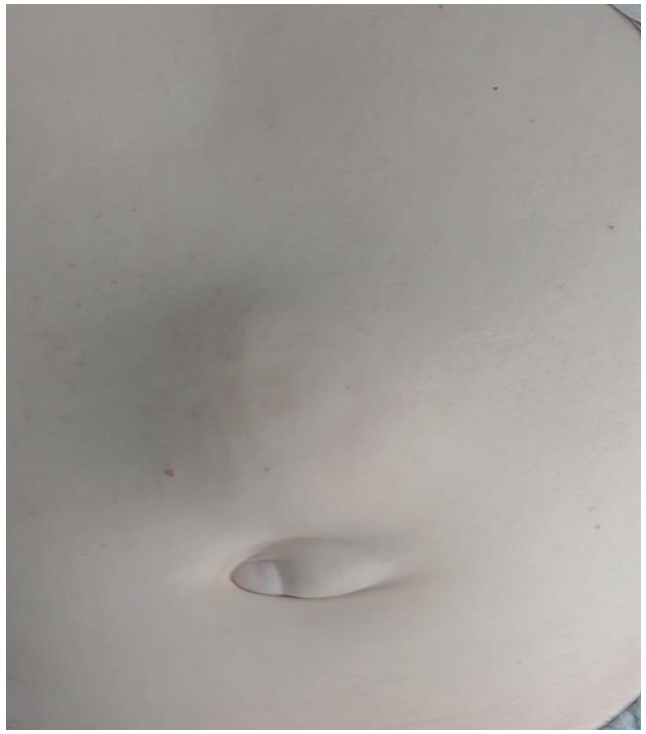
Пупкові грижі, грижі білої лінії живота і діастаз прямих м'язів живота

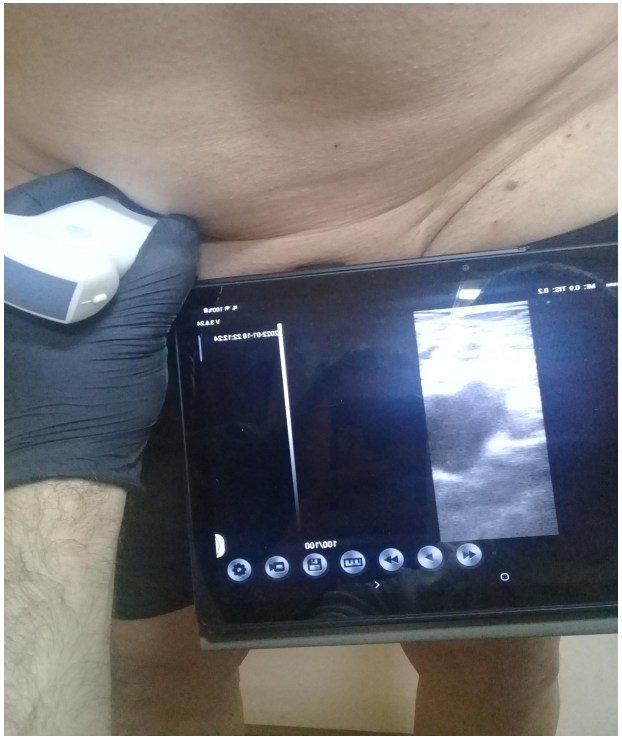
Мета. Проаналізувати особливості проведення аллогерніопластики при защемлених грижах живота.

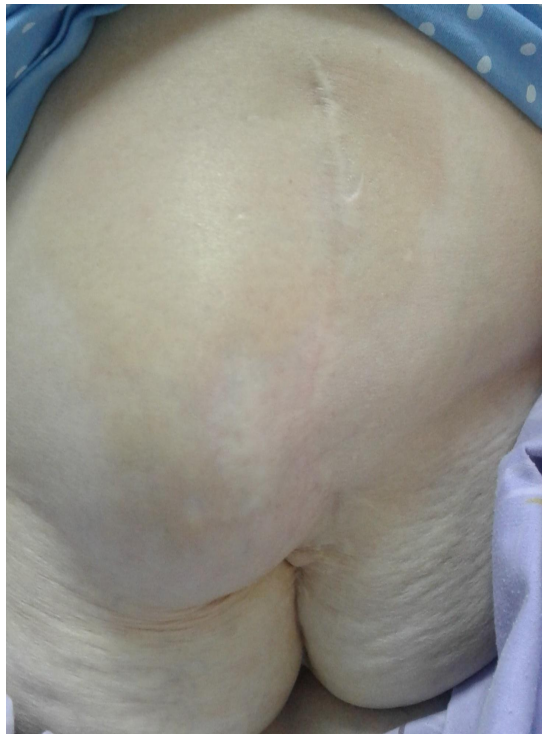
Матеріали і методи. В основу дослідження покладено аналіз 26 медичних карт стаціонарних пацієнтів. Критеріями включення у дослідження були:

- ✓ госпіталізація в ургентному порядку з клінікою защемленої грижі живота;
- ✓ відсутність онкологічного захворювання;
- ✓ відсутність летальності протягом 30 діб після оперативного втручання.

У хворих верифіковані: пахвинна грижа - 18 (69,2%) хворих, серед них L_1 - 10 (38,4%) хворих L_2 - 8 (30,8%) за EHC-класифікацією; первинна грижа живота - 6 (23%) хворих, серед них M medium - 4 (15,4%) хворих, M large - 2 (7,6%); інцизійні грижі 2 (7,6%) хворих з шифрами за EHC-класифікацією: $M_3W_2R_0$ та $M_3W_3R_0$.







Показаннями для проведення аллогерніопластики були:

- ✓ відсутність некрозу защемленого органу;
- ✓ відсутність клініки гострої кишкової непрохідності, перитоніту;
- ✓ відсутність явищ гіповолемії, гіповолемічного шоку;
- ✓ імуносупресії.

Результати дослідження. Всім пацієнтам за 30 хвилин до початку операції проведена антибіотикопрофілактика (цефтріаксон 1000 мг). Виконані оперативні втручання:

- ✓ операція за Ліхтенштейном - 18 (69,2%) хворих;
- ✓ аллогерніопластика за методикою sub lay - 8 (30,8%).

Серед ранніх післяопераційних ускладнень у 2 (7,6%) хворих були сероми. Нагноєння післяопераційної рани не було. В пізньому післяопераційному періоді відмічено рецидив грижі у 1 (3,8%) хворого.

Висновоки. При індивідуальному підході можливо проведення аллогерніопластики при защемленій грижі без ризику нагноєння післяопераційної рани.

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