SURGICAL ASSOCIATES OF PALM BEACH COUNTY

Newsletter

Volume 1, Issue 3 April 2010

Surgical Associates of Palm Beach County is the oldest and largest Multi-Specialty Surgical group practice in South Palm Beach County

INTRODUCTION

Surgical Associates of Palm Beach County (SAPBC) is a Multi - Specialty Surgical group practice with over 250 years of combined surgical experience. SAPBC has a reputation for leadership and innovation in the surgical community, and has built a reputation for excellence in surgical care over the past four decades.

Our mission is to provide the highest quality, state of the art, and personalized care possible for our patients. We take pride in our individual specialties and work hard to maintain our expertise. Our surgeons are proficient in the latest minimally invasive surgical techniques, including Laparoscopy, Thoracoscopy and Endovascular surgery.

SAPBC is capable of providing skilled care for most General Surgical, Colon and Rectal, Vascular, Thoracic, Breast and Surgical Oncologic conditions. The combined training, experience and technical skill of our surgeons has made our practice a true Center of Excellence. However, if any of us believes a patient would be better served with treatment elsewhere, we will gladly and honestly make that referral and help get a timely appointment.

Because of all the recent advances occurring in Medicine, especially within the field of Surgery, we feel that it is important for our referring physicians to have an understanding of the latest treatment modalities available to their patients and what we as a group have to offer.

With the above in mind, SAPBC will be sending you bimonthly newsletters informing you of the latest treatment modalities available to your patients for various surgical conditions. Our goal is to keep you informed so that you can make the most intelligent recommendation to your patients, and most of all, feel comfortable referring them to our group.

We appreciate the trust you have given us to care for your patientôs problems and will endeavor to provide them with the highest quality surgical care. When your patients need surgery, you need to know that they are getting experienced, fully capable care performed to the highest standards.

As always, thank you for your continued support.

For more information please visit our website

www.sapbc.net


Gerald N. Robinson, M.D.


Frederick B. Liebler. M.D.


Jonathan Wideroff, M.D.


Matthew A. Klein, M.D.


Joseph A. Colletta, M.D.


Angela Jones, M.D.


Manuel A. Molina M.D.


Robyn Moncrief, M.D.


David L. Wulkan, M.D.


John C. Motta, M.D.


Andrew S. Ross, M.D.

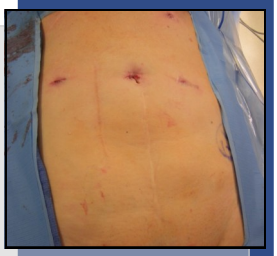

James R. Barron, M.D.


Jonathan Waxman, M.D.

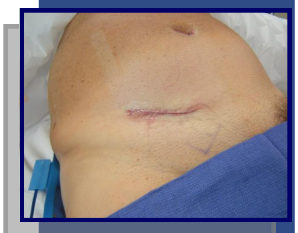

Jose F. Yeguez, M.D.

Laparoscopic Surgery for Inguinal Hernia

Volume 1, Issue 3 April 2010



LIHR in patient with two previous laparotomies.



Open inguinal hernia repair

Laparoscopic inguinal hernia repair (LIHR) has become increasingly popular in the last few years. However, the adoption of the laparoscopic technique has been controversial and the literature has been contradictory.

Early in the development of the technique, a large piece of mesh was placed on the inguinal canal on top of the peritoneum. This practice was abandoned because the high incidence of bowel obstruction and fistulae caused for exposure of the bowel to the mesh.

Actually, most of the LIHR are performed using either the total extra peritoneal (TEP) approach or the trans abdominal pre-peritoneal (TAPP) technique. TEP requires creating a space at the preperitoneal area, using most of the time a dissecting balloon. During TAPP the surgeon enters the abdominal cavity, the peritoneum is open on top of the hernia, the mesh is placed, and the peritoneum is closed again. In both cases the sac is reduced.

The preliminary studies have shown a steep learning curve, longer operative time and high costs. LIHR requires high laparoscopic skills and familiarity with preperitoneal anatomy. Two large studies concluded that 250-300 cases are required to achieve expertise (N Eng J Med 2004, 350: 1819-27 and Br J Surg 2002; 89: 1062-6). As a result, many surgeons abandoned the LIHR.

In the beginning laparoscopic repair was associated with a high recurrence rate. Early recurrence (less than 1 year) has been associated with technical errors, such as insufficient lateral preperitoneal dissection and further inadequate mesh placement, deficient anchoring of the mesh, undetected cord lipoma, inadequate hernia sac management, etc (N England J Med 1997; 336 (22).

However, bilateral hernias may be repaired simultaneously without increasing morbidity, and in recurrence cases LIHR allows to work in a previous untouched posterior space. For that reason, many trials have recommended laparoscopic surgery for inguinal hernia repair as the procedure of choice for bilateral and recurrent cases.

Advantages to the laparoscopic approach, include:

1. Quicker recovery and shorter hospital stay
2. Significantly reduced risk of infection and recurrence.
3. It is possible to check for, and repair, a second hernia on the opposite side at the time of the operation, without the need for a second large incision.
4. Better aesthetic results.

Evidence-based medicine has demonstrated that in the hands of expert surgeons, the LIHR is equivalent to open technique, with its additional benefits.

In actuality laparoscopic repair of primary unilateral inguinal hernia is an excellent procedure with outcomes comparable to open surgery. (Surgeon 2007; 5(4): 209-12).

In a study including 100 consecutive patients with primary inguinal hernia, the laparoscopic approach offers less pain and faster recovery at the expense of a longer operative time. TEP and TAPP techniques provided similar results (Int J Surg 2009, Epud ahead of print). Furthermore, in a retrospective review of 176 patients it proved comparable results (Mil Med 2009, 174(12): 1320-3

In a prospective study, 365 patients were randomized in 5 groups (Bassini,

670 Glades Rd, Ste 300 - Boca Raton, FL 33431 Ph: 561.395.2626 **http://www.sapbc.net**

Newsletter

Volume 1, Issue 3 April 2010

Patients with inguinal hernias who undergo laparoscopic repair recover more rapidly and have fewer recurrences than those who undergo open surgical repair. (N Engl J Med 1997; 336: 1541-7.)

Shouldice, Lichtenstein, TAPP and TEP). No significant difference in the recurrence rate and complications between laparoscopic and open methods was revealed. (Hernia 2008, 12(4): 385 -9.)

In an extensive review 4,231 patients were included in 23 trials. In 10 of 15 trials, TEP repair was associated with longer surgery time than open repair, shorter postoperative hospital stay, earlier return to work, and recurrence rates similar to those for open inguinal hernia repair (Surg Endosc 2007, 21(2): 161 -6.).

In conclusion the optimal surgical approach to inguinal hernia remains controversial. However, in the hands of an expert laparoscopic surgeon the minimally invasive approach is equivalent and may be considered the standard of care.

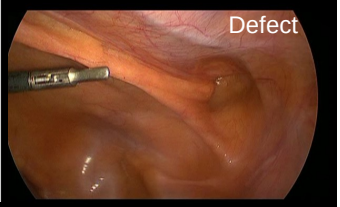
LIHR is the standard of care for patients with recurrence and bilateral hernias. In my opinion, laparoscopic surgery should be the first choice for repairing either of the inguinal hernias, with some exceptions. I prefer TAPP over TEP. A bigger piece of mesh can be used, and undetectable bilateral defect or other hernias can be identified. Similar outcomes are obtained in terms of recurrence while increasing patient satisfaction, with less scaring and less pain.

Laparoscopic surgery is limited to patients receiving anticoagulation, having an incarcerated or a strangulated hernia, large inguino -scrotal hernias, or those requiring to be done under local anesthesia. However, in select cases, we have performed TAPP repair for incarcerated cases, inguino -scrotal hernias, and electives patients on warfarin.

Chronic postoperative pain after LIHR has been considered a new complication. Adequate anchoring technique and device to avoid nerve injury has been evaluated.

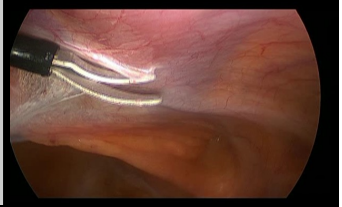
TAPP

Identification of indirect right inguinal hernia defect

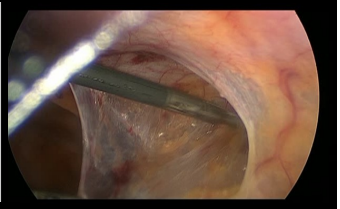


Opening of the

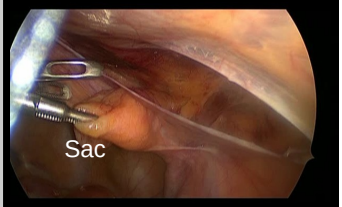
peritoneum above hernia defect



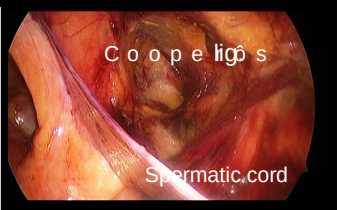
Creating a peritoneal flap



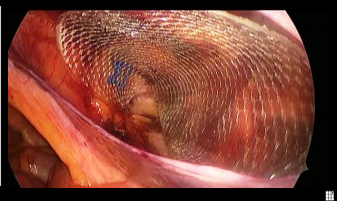
Reduction of the hernia sac



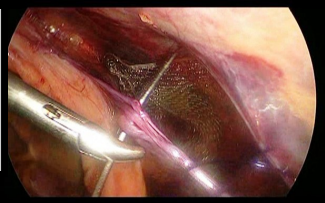
Identification of the Cooper's ligament and spermatic cord



3D Max light polypropylene mesh placement



Closing peritoneum with intraop-erative suture



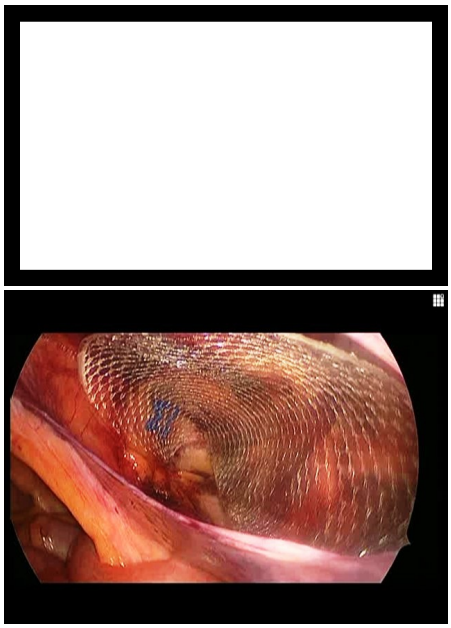
670 Glades Rd, Ste 300 - Boca Raton, FL 33431 Ph: 561.395.2626

Newsletter

Volume 1, Issue 3 April 2010

For surgeons without enough experience to perform LIHR, open technique still has been the ñGold Standar ever patient demand for minimally invasive surgery is escalating.

Jose F. Yeguez, MD



Jose F. Yeguez, MD.

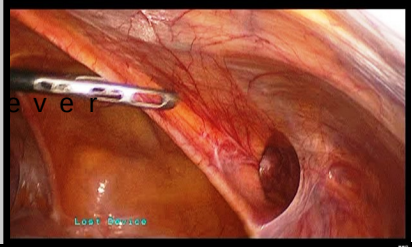
James Barron, MD

Angela Jones, MD.

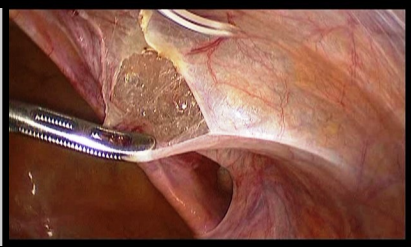
SAPBC has surgeons with extensive experience in performing LIHR. We prefer TAPP technique. We have interest in laparoscopic inguinal and incisional hernia repair.

TAPP

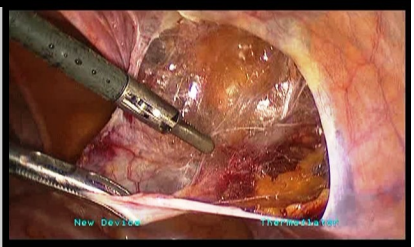
Identification of right inguinal hernia defect



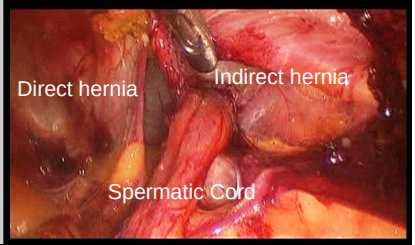
Opening of the peritoneum above hernia defect



Creating a peritoneal flap and dissecting the hernia sac

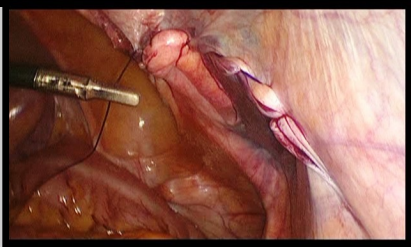


Hernia defect. Pantaloon hernia with direct and indirect component



Ultrapro mesh placement and anchoring mesh with Pro Tackers

Closing peritoneum with intraoperative suture



670 Glades Rd, Ste 300 - Boca Raton, FL 33431 Ph: 561561.395.2626 **http://www.sapbc.net**