

Laparoscopic Incisional Hernia Repair

CPT Code: Repair initial incisional or ventral hernia, reduceable 49560
Repair initial incisional hernia, irreducible or strangulated 49561
Repair recurrent incisional hernia, reduceable 49565
Repair recurrent incisional hernia, irreducible or strangulated 49566
Mesh implantation 49568

SAMA Code: 1835,1836,1807

Definition: Laparoscopic technique used to repair a defect at the site of previous surgical incision.
The principle is to have a tension free repair and good cosmetic result.
No single technique is the answer to all incisional hernias and at times multidisciplinary approach is required.
Most can be repaired with a sub-lay patch.
Conventional repair using own tissues have poor results.

Indication For Procedure: Most hernias will require surgical repair because of the poor life quality and continued enlargement.
The larger the size the more complicated the repair. This makes early repair advisable.
High risk patients may make conservative support more appropriate.

Contra indications: Coagulopathy, sepsis or open skin lesions, ascites

Pre-Operative Investigations: Diagnosis is clinical.
Consultation with multidisciplinary team may be required for complicated hernias.

HOSPITALISATION:

- **Pre-op admission days:** Nil
- **Theatre Requirements:** LOF 3
All cases will require general anaesthetic and most large hernias an epidural for pain relief.
- **Length of stay (LOS):** 2-8 days depending on complexity.

Complications: Infection- .25-1% (open 20-30%)
Haemorrhage- 1%
Seroma- 10-15%
Chronic pain- 2.5%
Port site hernia- <1%
Recurrence – 5-15% (open 20-50%)

Level of Care: 3

Ancillary Services: 0

Post Operative Investigations: 0

Certifications: Fellowship or Masters degree in general surgery.

References:

Reviewed by: Dr Jeremy Nel

Date reviewed: March 2009

Comments: Advanced laparoscopic training is not required and skills required should be within the ability of General Surgeon.
The laparoscopic placement of the mesh has decreased the incidence of wound complications drastically. The ease of surgery and decreased trauma to the patient has made this technique especially advantageous in the obese. The ongoing research into the best material is continuing. PTFE dualmesh with its internal smooth surface has the lowest incidence of adhesions but has the disadvantage of longterm exposure to infection and cost. Combination meshes are incorporated and this eliminates the infection rate.
The use of tissue glue will decrease the incidence of seroma and is not expensive.
The mesh should overlap the defect by 5cm as it also shrinks by 30%.
Fixation of the mesh by suture transfascially seems the most effective.
Decreased hospital stay and cost effectivity make this the technique of choice for most standard ventral hernias.