

Original Research Article

Posterior inguinal wall reinforcement after mesh removal for infected mesh.

Abstract:

Background: Repair of the inguinal hernia either laparoscopic or open repair is one of the most common procedures worldwide. Prosthetic mesh for repair of inguinal hernia is widely used, it decreases the rate of recurrence, and however, infection of the mesh remains one of the challenging surgical management. Definitive treatment of infected mesh is removal of the infected mesh; posterior inguinal wall is reinforced using cremasteric apparatus; which is used as autogenous flap reconstruction for posterior inguinal wall.

Patients and methods: Twelve patients were included in the study, between January 2014 to January 2018. Those patients with refractory mesh infection after open repair of inguinal hernia, with either a sinus discharging pus or exposed mesh.

Results: All twelve patients (100%) recruited in our study get rid of their infection. Eleven patients (91%) had no recurrence after 3 years follow up, while one patient (0.08%) had recurrence after 2 months; which was supra vesical type of inguinal hernia. Operative time was 70±10 minutes, bleeding was minimal and no major complication was recorded.

Conclusion: Infected mesh removal and reinforcement of the posterior inguinal wall by cremasteric apparatus as autogenous flap is a safe and effective one step surgical treatment for infected mesh post repair of inguinal hernia.

Key words: cremasteric apparatus, inguinal hernia, reinforcement.

Introduction:

Open versus laparoscopic repair of inguinal hernia is one of the most common surgical procedures performed worldwide. Inguinal canal is 3.75 -4 cm long, directed anteroinferiorly and medially as a cylinder at the lower abdominal wall. ⁽¹⁾ Understanding of the anatomy and physiology of the inguinal canal improves the surgical techniques and outcomes. Synthetic mesh of various materials is widely used in the repair of inguinal hernias, it has a lower recurrence

rate than primary repair, however, complications related to mesh use includes; infection, extrusion, and enterocutaneous fistula. ⁽²⁾ Postoperative infection of the mesh is a difficult and challenging surgical task, it is usually refractory to medical treatment, and always the definite treatment necessitates mesh removal. Use of cremasteric apparatus after removal of an infected mesh is a new procedure for reinforcement of the posterior inguinal wall and decreases the rate of recurrence.

Patients and methods:

From January 2014 to January 2018, this prospective study was conducted in Zagazig university hospitals and Saudi German hospital. Ethical committee approval and a written consent for surgery and possible complications were done. Twelve patients were recruited in our study. Those patients presented with features of persistent mesh infection; either a sinus discharging pus, or exposed mesh, however, no enterocutaneous fistulae were recorded in our study post inguinal hernia repair. Medical treatment was tried for several weeks by different antibiotics according to culture and sensitivity tests, and multiple swaps from the infected mesh. Failure of medical treatment necessitates a definitive management in the form of mesh removal. Abdominal computed topography (CT) with oral contrast was done to exclude bowel fistulae. Prophylactic antibiotic, and in four cases antifungal was decided by a microbiologist, who also decided follow up with antimicrobial drugs as per guidelines.

mesh far from posterior inguinal wall, now the infected mesh is dissected and removed.

Debridement of the necrotic tissue located in the superficial fascia, and necrotic tissue of external oblique fibers. Irrigation of the wound with isotonic solution. Now, care is

Table (1): preoperative patient's characters

Sex	Male (11)	Female (1)	P value 0. 031
Age	22-58	32	0.064
Right	7 patients	1 patients	0.057
Left	4 patients	0 patients	0.059

Surgical intervention:

All patients had radiological investigation in the form of abdominal computed topography (CT), to exclude bowel fistulae. Antibiotic is given one hour before operation, antifungal is given for four patients and all was decided by a microbiologist. Intra operative; patients were in supine position, under general anesthesia, the wound is reopened, gentle dissection through infected granulation tissue. Careful dissection of the cord from the infected mesh, now, the cord is freed from the underneath infected mesh. Careful removal of the stitches fixing the infected mesh to the posterior wall, gentle and blunt dissection of the infected

taken to the cord; great care is needed during dissection of cremasteric muscle along the whole length of the cord in the inguinal canal, now the cremasteric muscle and fascia (cremasteric apparatus) is freed from cord structures, (Fig 1- 4).

Cremasteric apparatus is then incised at

the distal part of the inguinal canal, at the level of external ring. Narrowing of the internal ring using one or two simple stitches by 2/0 prolene. Now the sheet of cremasteric apparatus is fixed by 2/0 prolene to the posterior inguinal wall. Closure with suction drain.



Fig. (1) Mesh dissection.



Fig. (2) Cremasteric apparatus.



Fig. (3) Cremasteric apparatus.



Fig. (4) Cremasteric apparatus.

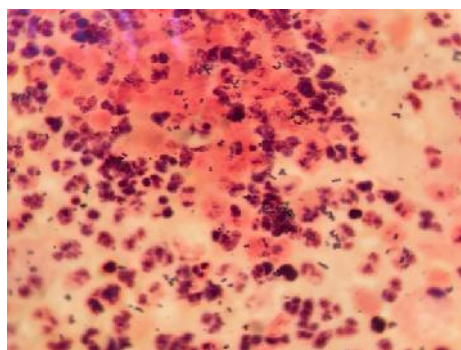


Fig.(5) Gram stained smear showing pus cells, gram positive cocci (staphylococcus aureus)

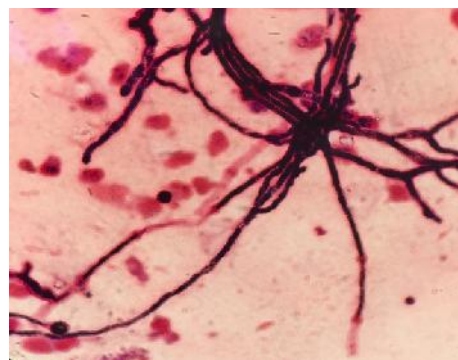


Fig. (6) Gram stained smear showing pus cells, budding yeast cells with pseudohyphae

Patient's outcome and statistical analysis:

All values are presented as mean, median, (range), or percentage. The primary outcomes of this study were to evaluate the success and complication rates after mesh removal and cremasteric apparatus use for reinforcement of posterior inguinal wall. Continuous data were compared using the unpaired *t*-test or Mann-Whitney tests. Categorical variables were evaluated using Chi-Square. Survival analysis was not performed, as the lesion was not a life-threatening condition. Statistical significance was determined *a priori* at ≤ 0.05 .

Microbiological studies:

Mesh-related infections are one of the mesh-related complications that have become increasingly important. Such other mesh-related complications (seromas, adhesions, chronic severe pain, migration and rejection of the mesh) ⁽⁸⁾. Mesh-related infection incidences after hernia repair have been reported up to 8% ⁽⁹⁾. Swabs were taken from infected mesh sites for culture and sensitivity. Specimen swabs are cultured on ordinary bacteriological media (Blood agar, Chocolate agar and MacConkey agar). Two sets were made for each sample swab. One incubated aerobically at 37°C, 5% CO₂ for 48 hours, other incubated anaerobically at 37°C for 5 days. The growth is identified by ordinary bacteriological methods (colony morphology, gram stains, biochemical tests like catalase (Oxid) and oxidase (Oxid), Staphytec latex agglutination kit (Oxid), and Streptococcal grouping latex kit (Biomerx). Antibiotic sensitivity was done for isolated organisms by modified Kirby-Bauer method using CLSI guidelines 2017. *Staphylococcus aureus* isolated from 5 patients (42%) (figure 5), three of them were methicillin-resistant *Staphylococcus aureus* (MRSA). Beta-haemolytic streptococci group B were isolated from 2 patients (16%). *Klebsiella pneumoniae* isolated from 1 patient (8%). Mixed infection with anaerobic peptostreptococci isolated from 1 patient (8%). *Candida albicans* were isolated from 3 patients (25%) (figure 6).

Results:

Table (1) demonstrates demographic data. Male to female ratio shows significant, however, no significant difference regarding age of the patient, and the site of the hernia (right or left). Operative time was 70 ± 10 minutes ($P = 0.07$), bleeding was minimal, and no major complication reported, except for three patients who had mild scrotal edema for two weeks ($P = 0.09$). Postoperative hospital stay was 2 ± 1 days, during patients' stay; follow-up of wound, scrotal edema, antimicrobial drugs, and suction drain. Drain is removed for all patients by 3rd postoperative day. After discharge, all patients had regular follow-up every week for the first month, every month for three months, every three months for the first year, and every year for 2-4 years. Of our twelve patients, only one patient (0.08%) had recurrence at the same side of previous hernia two months after operation, by local examination; it was suprapubic type ($P = 0.069$).

Discussion:

Our study demonstrates the feasibility of one-step surgical procedure to get rid of the prosthetic infected mesh and a surgical maneuver using autogenous muscle flap to decrease the rate of recurrence. Infected mesh always necessitates mesh removal, bowel resection as needed, however, using a new prosthetic mesh at the same sitting for reconstruction carries infection rate 50% to 90% due to heavily contaminated wound ⁽³⁾.

10% to 15% of all surgical procedures for inguinal hernia repair, this means that it is the most frequent procedure ⁽⁴⁾. Use of prosthetic mesh for reinforcement of inguinal wall significantly reduces the number of recurrence, yet it carries a number of

complications; infection, exposure, and bowel perforation with enterocutaneous fistulae ⁽⁵⁾.

Little attention in literature was given to management of infected mesh, and repair of incisional hernia after removal of infected mesh, patients all had a wound discharging pus, with continuous failure of medical treatment.

Herioplasty using a prosthetic mesh aims at reinforcement of the posterior inguinal wall, so, we did not faced with overlay mesh, nor mesh extrusion, this explains why we did not enter the peritoneum, with no chance of bowel injury, this is contrary to the study done by *Steven R* (2003), who faced a mesh extrusion, entry into peritoneum, with bowel resection ⁽⁶⁾.

Laparoscopic repair of hernia nowadays has increased prevalence over open repair. There is doubt if rate of infection is similar or it has a lower rate of infected mesh, yet it has a little role regarding operations for infected mesh, and for bowel fistulae ⁽⁷⁾.

Being of high incidence among surgical procedures, inguinal hernia repair has a considerable impact on quality of life, health care expenditure, and working disability, so, if complication is found, we have to think about the best solution.

Conclusion:

Removal of prosthetic infected mesh with the use of cremasteric apparatus as an autogenous flap for reconstruction and reinforcement of the posterior inguinal wall, is a safe, reliable, and effective method as

one step surgical procedure, for infected mesh removal and avoiding recurrence of the hernia.

References:

- 1- Adam M., Drake R., Gray H., David W, 2005, Gray's anatomy for students. Elsevier/Churchill Livingstone, p 260.
- 2- Luijendijk RW, Hop WCJ, Van Den Tol, 2000, A comparison of suture repair with mesh repair for incisional hernia, N Engl J Med; 343: 392-397.
- 3- Dayton MT, Buchele BA, Shirazi SS, 1986, Use of an absorbable mesh to repair contaminated abdominal wall defects. Arch Surg; 121: 954-960.
- 4- Sukkar SM, Dumanian GA, Szczerba MD, 2001, Challenging abdominal wall defects. Am J Surg;181: 115-21.
- 5- Kasperk R, Klinge U, Schumpelick V, 2000, The repair of large parastomal hernias using a midline approach and a prosthetic mesh in the sublay position. Am J Surg, 179;: 186-8.
- 6- Steven R, Gregory A, Definitive surgical treatment of infected or exposed ventral hernia mesh. Ann Surg 2003, 237(3);437-441.
- 7- Ramshaw BJ, Esartia P, Schwab J. 1999, Comparison of laparoscopic and open ventral herniorrhaphy. Am J Surg, 65: 827-832.
- 8- Heniford BT, Park A, Ramshaw BJ, Voller G. :laparoscopic ventral and incisional hernia repair in 407 patients .J.AM Coll Surg 2000;190:645-650.
- 9- Falag M.E and Kasikou S.K.:mesh related infections after hernia repair surgery ;clinical microbiology and infection journal ,11(1):p 3-8.

