Pre peritoneal mesh hernioplasty for incisional hernias

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Dear Sir,

We read with interest the article titled “Pre peritoneal mesh repair of incisional hernias: A seven year retrospective study.” [1] Unfortunately the authors have made many conflicting statements in the paper, which has made it lose the relevance.

1. The abdominal wall anatomy discussed in the material and methods and the accompanying Fig. 1 is depicting that the mesh was placed in the space between the posterior rectus sheath and the posterior surface of the rectus muscle. However in the results section the authors document that they had 77% cases of incisional hernia in lower abdomen (64% lower midline and 13% in pfannenstiel incision). As is well known the posterior rectus sheath is missing below the arcuate line in the lower abdomen. Hence, in majority of cases the mesh was placed in preperitoneal space in front of fascia transversalis and not in front of the posterior rectus sheath.
2. The authors have not documented the size of the hernial defect as it has a direct relationship with the proposed repair. Incisional hernias with smaller defects can be managed quite successfully by anatomical repairs. Mesh is required in defects which are wide and the resultant repair would be under tension.

3. In the results section both in the abstract and the main document the total number of patients shown is 105, out of which the details have been available for 95 patients only. However when the sex distribution is documented the authors provide the figures as 90 females and 10 males making it a total of 100 patients. The authors seem to have either subtracted or added 5 patients unwittingly. The authors should provide the exact number.
4. Out of 105 patients the number of patients who attended the follow up was 65 only. In absence of details of follow up for 40 patients (38%) is it justified to conclude that there was no recurrence? Instead of showing the number of patients as 105 in Table 1 the authors should have documented a zero recurrence in 65 patients only.
5. No details have been provided for the 14 patients who had a recurrent incisional hernia. Had any of them undergone a mesh repair in the past?

The learned authors and reviewer of the manuscript seem to have been in a hurry and have not bothered to check the relevant details and figures provided. This can harm the image of the Indian Journal of Surgery in the international medical community.

References

1. Bhat MG, Somasundaram SK (2007) Preperitoneal mesh repair of incisional hernias: A seven year retrospective study. *Indian J Surg* 69:95–98

Author response

We thank you for the interest shown on our article, Pre-peritoneal mesh repair of incisional hernias: a 7-year

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retrospective study Ind J Surg 2007;69:95–98. We submit our response to your comments.

1. The mesh is placed in the pre peritoneal area as per the title of the article. We do agree and appreciate that the posterior rectus sheath is absent in the area below the arcuate line. The posterior rectus sheath is dissected from the muscle in the upper area and in the lower area it is dissected from the peritoneum. The peritoneum along with the posterior rectus sheath is closed with continuous prolene sutures. The mesh is then placed over the sutured peritoneum and the posterior rectus sheath in the pre peritoneal area. The mesh lies over the posterior rectus sheath in the upper area and over the peritoneum in the lower area. This is the pre peritoneal placement of mesh.
2. Yes, we have not mentioned the size of the hernia defect. The size of the mesh used ranging from 15×7.5 to 30×20 cm is mentioned. The size of the mesh indicates the weak area. The series is about large in-

cisional hernia and thus the mesh used is larger and covers the large weak areas. The mesh is not used to close the defect, so we did not consider giving the size of the defect. The pre peritoneal placement of the mesh to cover the weak area makes the repair tension free. The linea alba is closed over the muscle without tension.

3. The sex ration in the total number of 105 cases is 95 (90.5%) females and 10 (9.5%) males. We regret the typical error of females mentioned as 90 instead of 95. The percentage mentioned within the brackets is correct.
4. Yes, we agree we have zero recurrence in the 65 cases followed up by us. It would be proper to read this in the table.
5. Yes, the details of the previous repair in the 14 recurrent hernias were not mentioned because we did not have them.

We will be happy to respond to any further queries.