Figure 2 Anterior view of the right mandibular ramus

the traditionally described position. It is essential to make the osteotomy as far lateral as possible, usually approximately 3–4mm more lateral than the traditional position (Figs 1 and 2). The mandibular nerve is thereby much more likely to remain in the distal segment of the osteotomised mandible.

When creating the sagittal split, the anterior aspect of the proximal (ramus) segment will be quite thin following this modified osteotomy. It is essential to use light force, while gently spreading the segments apart, using two thin osteotomes to avoid fracturing the antero-lateral aspect of the mandibular ramus.

DISCUSSION

This technical modification has reduced the incidence of postoperative labiomental paraesthesia by over 60% (at postoperative day one) in our practice. The efficacy of the technique now needs to be assessed in a randomised controlled clinical trial.

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Open intraperitoneal onlay mesh repair for medium–large lateral abdominal wall herniae

L Hendra¹, A Shrestha², M Joshi², S Basu²

¹Isle of Wight Healthcare NHS Trust, UK

²East Kent Hospitals University NHS Foundation Trust

CORRESPONDENCE TO

Sanjoy Basu, E: sanjoy.basu@nhs.net

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The surgical management of medium-to-large (transverse defect >5cm) lateral incisional abdominal wall herniae can be technically challenging due to the absence of sheath and lack of ‘give’ for a tension-free closure. The results can be disappointing, especially when the defect lies in close proximity to bony landmarks, such as the iliac crest or costal margin.^{1,2} Here we describe our approach to these challenging cases.

Figure 1 The introduction of a composite mesh over the defect with a 4/5cm overlap and a 4/5cm rolled-over edge on each side

TECHNIQUE

An open approach to the abdominal wall is made, customising the skin incision and excising excess skin, if necessary. The sac is opened, adhesiolysis is performed as necessary and the contents are reduced. A composite mesh of appropriate size is introduced intraperitoneally and rolled inwards, corresponding the free edge of the mesh to the defect margin (Fig 1).

The mesh is then secured to all layers of the anterior abdominal wall with interrupted prolene (2–0) sutures at 2cm intervals under direct vision, using a parachute technique at the point at which the mesh folds inwards (approximately 4/5cm from the edge of the defect).

This is further reinforced with an inner round of Securestrap (Ethicon, Cincinnati, OH, USA)/ ProTack (Covidien, Dublin, Ireland) medial to the sutures (Fig 1). The hernial sac is trimmed and closed

over the mesh with polydioxanone sutures. Two size 20 Robinson drains are left in the subcutaneous layers.

CONCLUSION

Our technique of intraperitoneal onlay mesh repair with composite mesh is a safe and effective way of treating medium–large lateral abdominal incisional herniae.

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