Onlay Incisional Hernia Repair
“Tips and Tricks”

David Webb MD, FACS
Assistant Professor
Division of Minimally Invasive Surgery
University of Tennessee Health Science Center
Memphis, TN
Disclosures

- None relative to this talk
Patient Selection

- Hernia type and location
  - Versatile repair: can be applied to most midline primary ventral/incisional, flank, parastomal hernias
  - Avoid in patients where collateral blood flow to abdominal wall interrupted (i.e. previous AAA repairs)

- Hernia size
  - Repair is predicated on mesh-reinforcement of a primary fascial closure.
  - Select patients with a defect size that will allow a tension-free primary fascial closure.
  - Avoid with loss of domain
Preoperative Risk Reduction

- **Smoking Cessation:**
  - Mandated 6 weeks preop for elective repairs

- **Morbid Obesity:**
  - Ideally optimized to BMI<40 for elective repairs
  - Encourage lifestyle and dietary modifications
  - Refer to Outpatient Nutrition services
  - BMI>45: unable to lose weight=bariatric referral

- **Diabetes Mellitus:**
  - HgA1c<8
STEP ONE: CREATION OF MYOCUTANEOUS FLAPS
STEP TWO:
ASSESS FOR TENSION ON FASCIAL REAPPROXIMATION
STEP THREE:
POSTERIOR RECTUS SHEATH RELEASE
STEP FOUR:
EXTERNAL OBLIQUE
RELEASE
STEP FIVE:
FASCIAL CLOSURE
STEP SIX:
MESH PLACEMENT
STEP SEVEN:
MESH FIXATION
Technical Tips

- Tension-free fascial closure with selective components separation as needed
- Wide mesh coverage
- Conservative glue application
- Quilting stitches
- Running sub q skin closure
- Leave drains until dust is coming out
- Binder postop
Conclusions

- Appropriate patient selection
- Tension-free fascial closure is key
- Never is active smokers
- Avoid in morbidly obese and LOD