Laparoscopic cholecystectomy accompanied by simultaneous umbilical hernia repair

With this report, Kamer and colleagues[1] are to be congratulated for tackling a topic of extreme relevance to general surgeons everywhere. Symptomatic cholelithiasis and umbilical hernia are 2 very common clinical problems worldwide and so it is no surprise that they often confront the treating surgeon in conjunction with one another. While the gold standard for the treatment of bothersome gallstones (laparoscopic cholecystectomy) is well established, the optimal repair for the typically encountered umbilical fascial defect is less clear. Some surgeons favor primary closure of the fascia with suture alone, others prefer to always use mesh. The type of mesh, optimal location and manner of placement (open versus laparoscopic) are all additional variables to consider. Given the lack of consensus surrounding repair of the isolated umbilical defect, one can imagine that there is little uniformity in the recommended repair of these defects at the time of laparoscopic cholecystectomy.

In this retrospective review, the authors’ were able to identify 3 main methods of repair for fairly similar fascial defects: 1) simple interrupted closure of the fascia, 2) the Mayo double breasted technique of primary fascial closure or 3) mesh onlay assisted closure. Regardless of chosen technique, results were generally comparable with one another and compared favorably as well with reported results for isolated umbilical hernias.[2] Recurrence rates were lower in the mesh assisted group and, of note, the use of mesh did not seem to increase the occurrence of infection despite the synchronous cholecystectomy. Taken in total, these results are likely consistent with the experience of most surgeons whom perform frequent laparoscopic cholecystectomy — i.e., that the typical coincidental umbilical defect is easily reduced for peritoneal access and then repaired after trocar removal at the completion of the case, often with just a few simple interrupted sutures for small defects and with mesh assistance for somewhat larger hernias (greater than 2-3 cm).

As is often the case with an interesting topic like this, even as some questions are answered, others come to mind. Can mesh repair of the larger, incidental umbilical hernia be safely undertaken in the setting of laparoscopic cholecystectomy for acute cholecystitis or is the risk of infection prohibitive? Would larger defects (not included in this study) that preclude fascial closure be best repaired laparoscopically in conjunction with gallbladder removal, particularly now that the feasibility and success of laparoscopic umbilical hernia are well established.[3,4] Perhaps we can look forward to future studies from this same group of investigators targeting these questions and others. A final important point deserves emphasis and stands in contrast to the mesh technique described by the authors’ here. Although herniologist opinion varies widely about many details of hernia repair, most would agree on the importance of both mesh reinforcement on the underside of the fascia rather than atop it and primary fascial closure over the mesh whenever possible.

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References