La connaissance est le pouvoir, le pouvoir d'améliorer.

Filip Muysoms

AZ Maria Middelares
Gand, Belgique

8 min

AZ Maria Middelares

Scientia potentia est

Francis Bacon, London, 1561-1626

AZ Maria Middelares

Discours de la Méthode

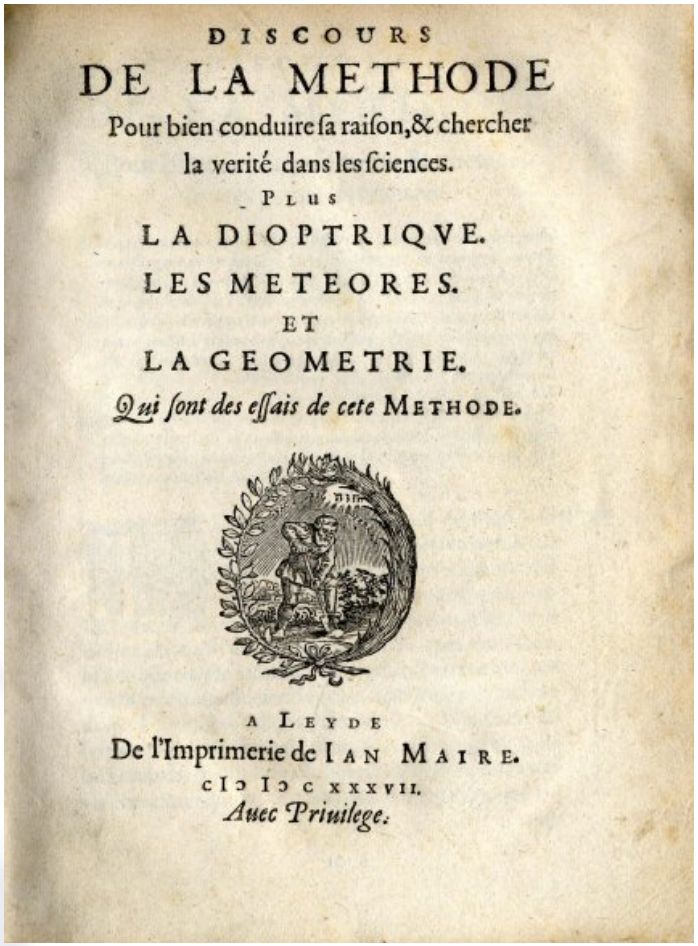
pour bien conduire sa raison, et chercher la vérité dans les sciences

René Descartes, 1596-1650

AZ Maria Middelares

Discours de la Méthode

pour bien conduire sa raison, et chercher la vérité dans les sciences



DISCOURS
DE LA METHODE
Pour bien conduire ſa raiſon,& chercher
la verité dans les ſciences.
PLUS
LA DIOPTRIQVE.
LES METEORES.
ET
LA GEOMETRIE.
Qui ſont des eſſais de cete METHODE.

A LEYDE
De l'Imprimerie de IAN MAIRE.
cIↃ IↃ c xxxvii.
Auec Priuilege.

René Descartes, 1596-1650

AZ Maria Middelares

The scientific method

- Inductive reasoning
  - Extracting general rules from observations

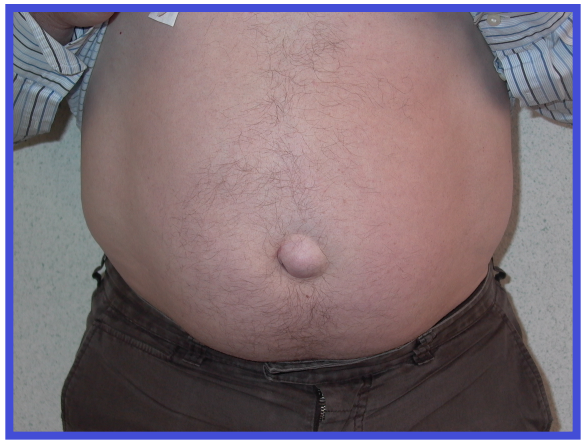
When we close an umbilical hernia with a mesh we have less recurrences.

- Guideline (EBM):
  - rule of conduct or principle

We have to use a mesh to treat an umbilical hernia.

AZ Maria Middelares

E H S Primary Abdominal Wall Hernia Classification		Diameter cm	Small <2cm	Medium ≥2-4cm	Large ≥4cm
Midline	Epigastric				
	Umbilical				
Lateral	Spigelian				
	Lumbar				



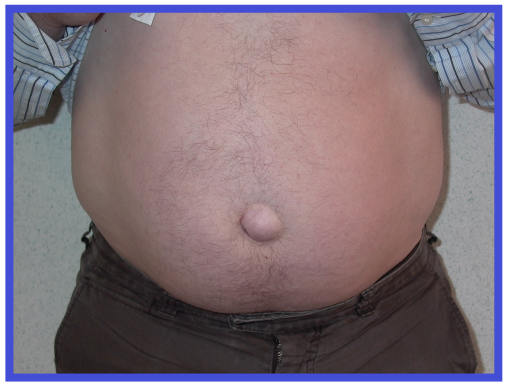
Classification of primary and incisional abdominal wall hernias.
Muysoms F. et al. *Hernia* 2009; **13(6)**: 407-414

AZ Maria Middelares

La connaissance est le pouvoir, le pouvoir d'améliorer.

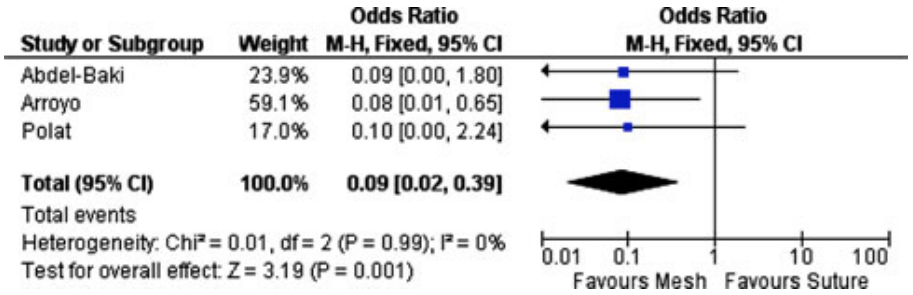
IX^{ème} Symposium
sur les prothèses pariétales
MESH 2013
Paris
14 juin 2013
Maison de la chimie

Quels sont nos résultats?

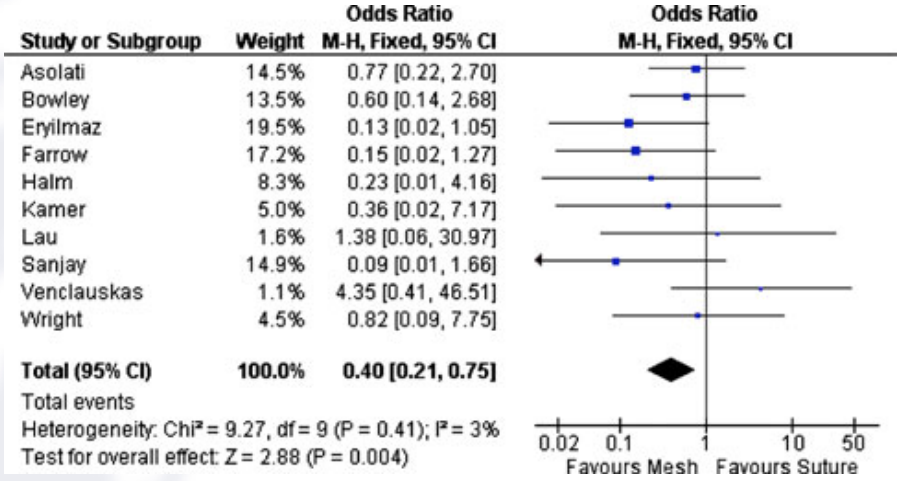


AZ Maria Middelares

RCT's



cohort studies



Does mesh offer an advantage over tissue in open repair of umbilical hernias? A systematic review and meta-analysis.
Aslani N, Brown CJ *Hernia* 2010; **14**: 455-462

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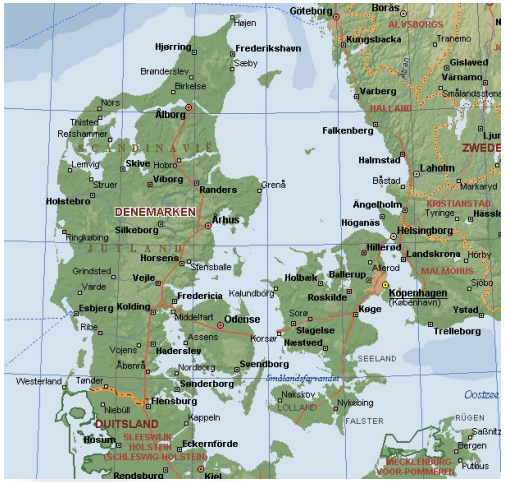

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Dansk Herniedatabase

- Forside
- *Grupper*
- *Downloads*
  - Årsrapporter
  - Vejledninger/Formularer
  - Litteraturliste
  - Instruktionsvideoer
- *Møder*
- Kontakt
- Til patienter

Dansk Herniedatabase er en klinisk database, oprettet for at forbedre behandlingen af lyske- og bugvægsbrok i Danmark. Databasen registrerer lyskebrok- og bugvægsbrok-operationer på patienter fyldt 18 år på operationstidspunktet. Region Hovedstaden er vært for databasen. Den daglige drift financieres fra Danske Regioner's pulje til kliniske databaser. Se i øvrigt årsrapport her på hjemmesiden, hvis du søger yderligere information om Dansk Herniedatabase.

Hvis du er patient og har spørgsmål om behandlingen af et brok skal du henvende dig til din egen læge - Herniedatabasen påtager sig ikke vejledning af enkeltpersoner.

Herniedatabasens styregruppe er organiseret med 2 arbejdsgrupper: en for ventralhernier og en for ingvinalhernier som hver er ansvarlige for databasen og projekter inden for deres område.

Online-inddatering

(Åbner i nyt vindue - login i boks til højre for midten)

Husk !

Herniesession til DKS årsmøde 15/6 - se evt. DKS hjemmeside for dagsorden

Herniedatabasens årsrapport 2009

Se kopi præsentationer

DKS/herniesession 10/6-2011

Se de nationale retningslinier for behandling af lyskebrok

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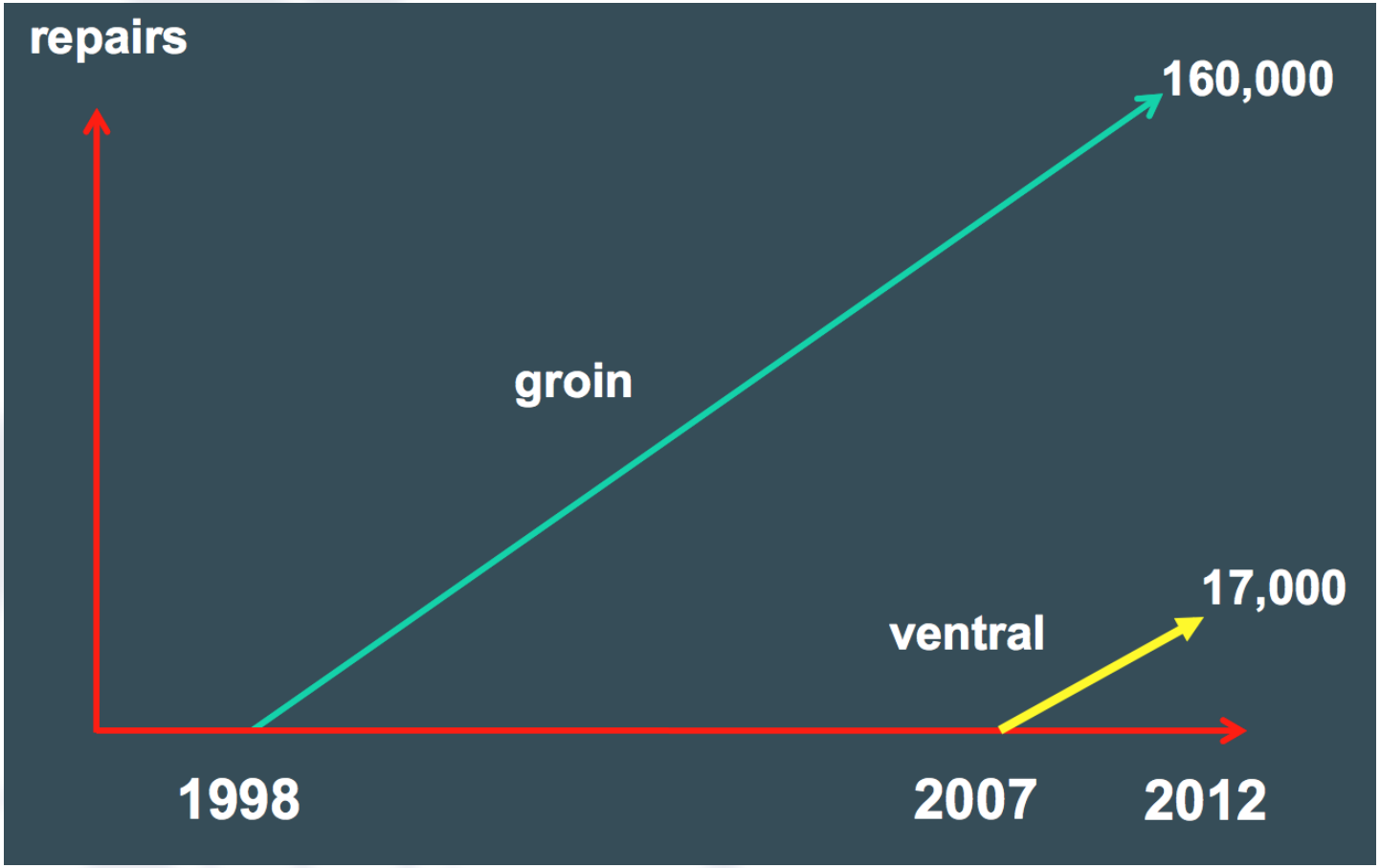
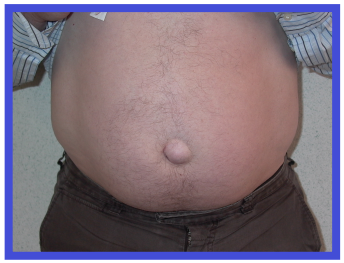

repairs
160,000
groin
17,000
ventral
1998
2007
2012



- ✓ all elective umbilical and epigastric hernias 2005-2006
  - ✓ 3431 operations
  - ✓ readmissions in 5.3% within 30 days
    - ✓ wound-related complications: infections, seroma, pain

A nationwide study on readmission, morbidity, and mortality after umbilical and epigastric hernia repair.
Bisgaard T, Kehlet H, Bay-Nielsen M, Iversen MG, Rosenberg J, Jørgensen LN. *Hernia* 2011; **15**: 541-546

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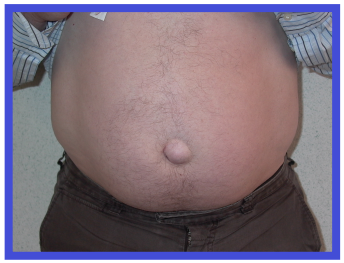

- ✓ elective primary umbilical and epigastric hernias
  - ✓ open repairs, single center: 139 patients
  - ✓ f.u 36 months
  - ✓ median defect size 1.0 cm
  - ✓ questionnaire and selective clinical investigation
    - ✓ moderate or severe pain and/or discomfort: 12%
    - ✓ cumulated risk of recurrence: 11.5%

Long-term complaints after elective repair for small umbilical or epigastric hernias
Erritzøe-Jervild L, Christoffersen MW, Helgstrand F, Bisgaard T *Hernia* 2013; **17**: 211-215

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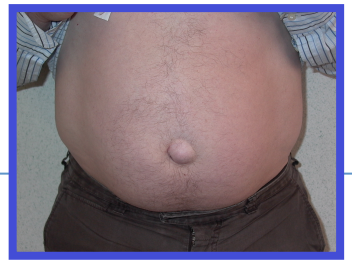

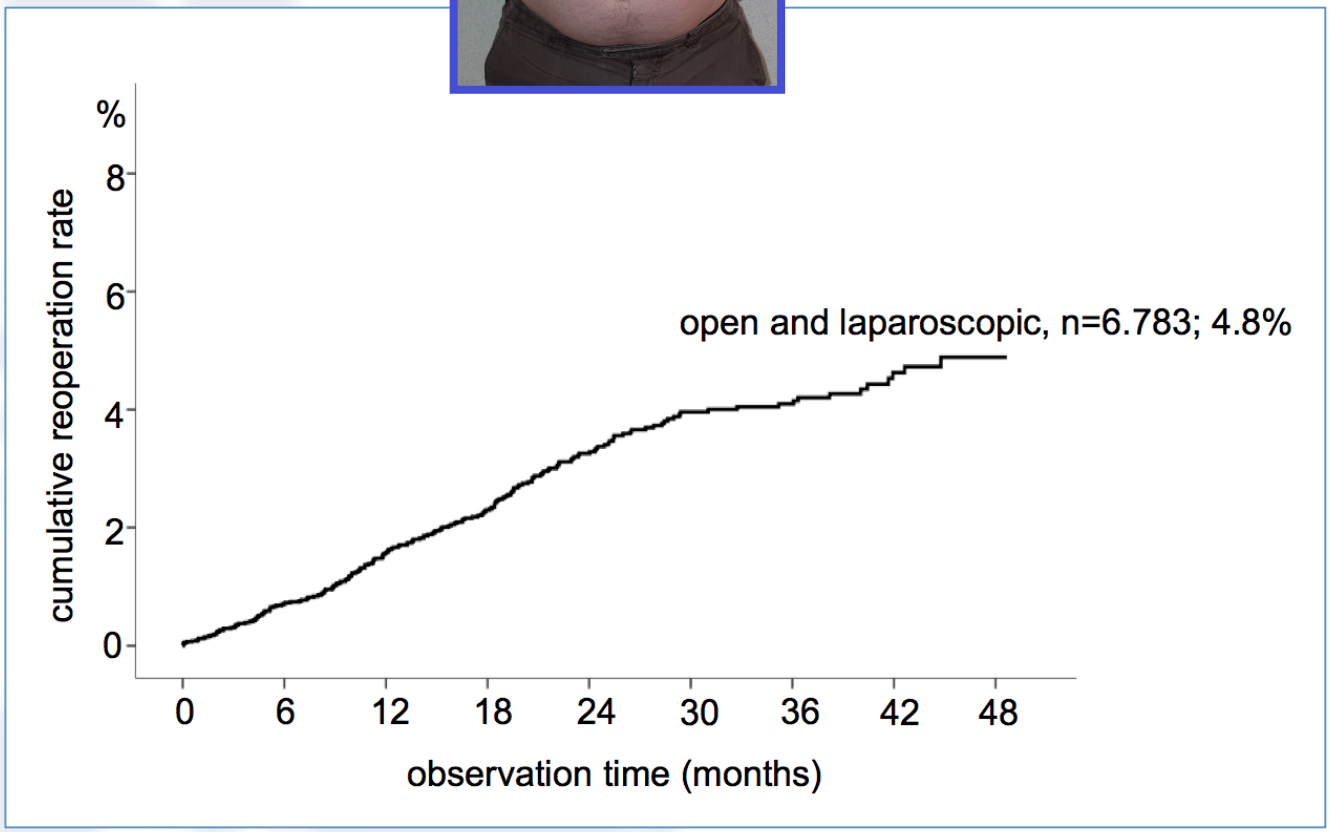

Danish ventral hernia database.
Unpublished data; courtesy of Thue Bisgaard

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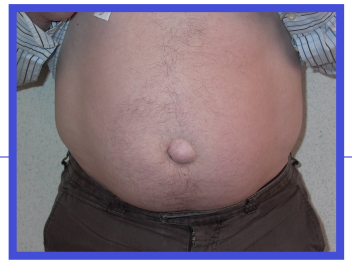

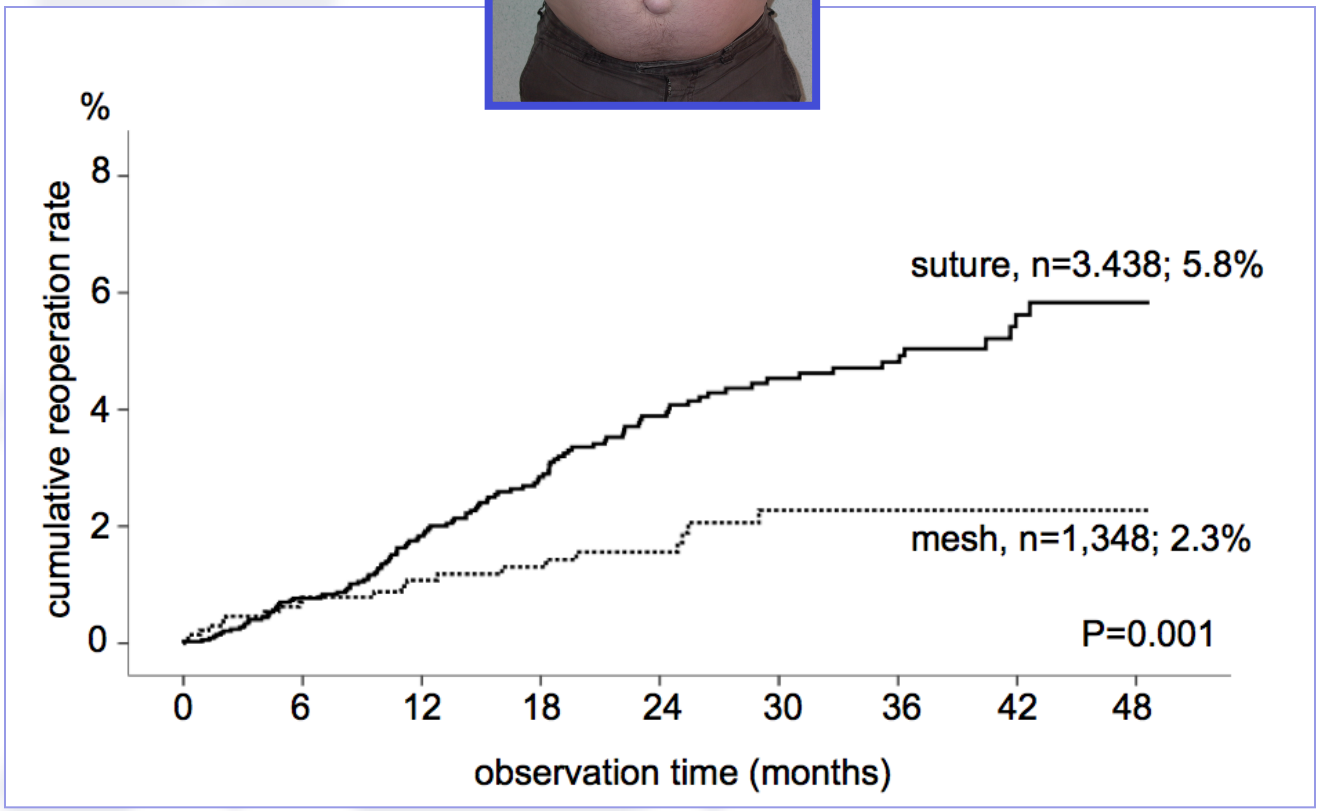

Lower reoperation rate for recurrence after mesh versus sutured repair in small umbilical and epigastric hernias. A nationwide register study.
Christoffersen MW et al. 2013 World J Surg; submitted.

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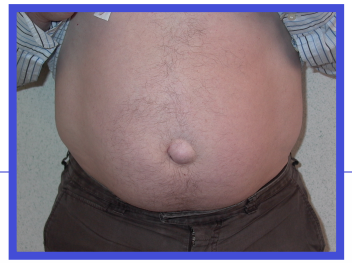

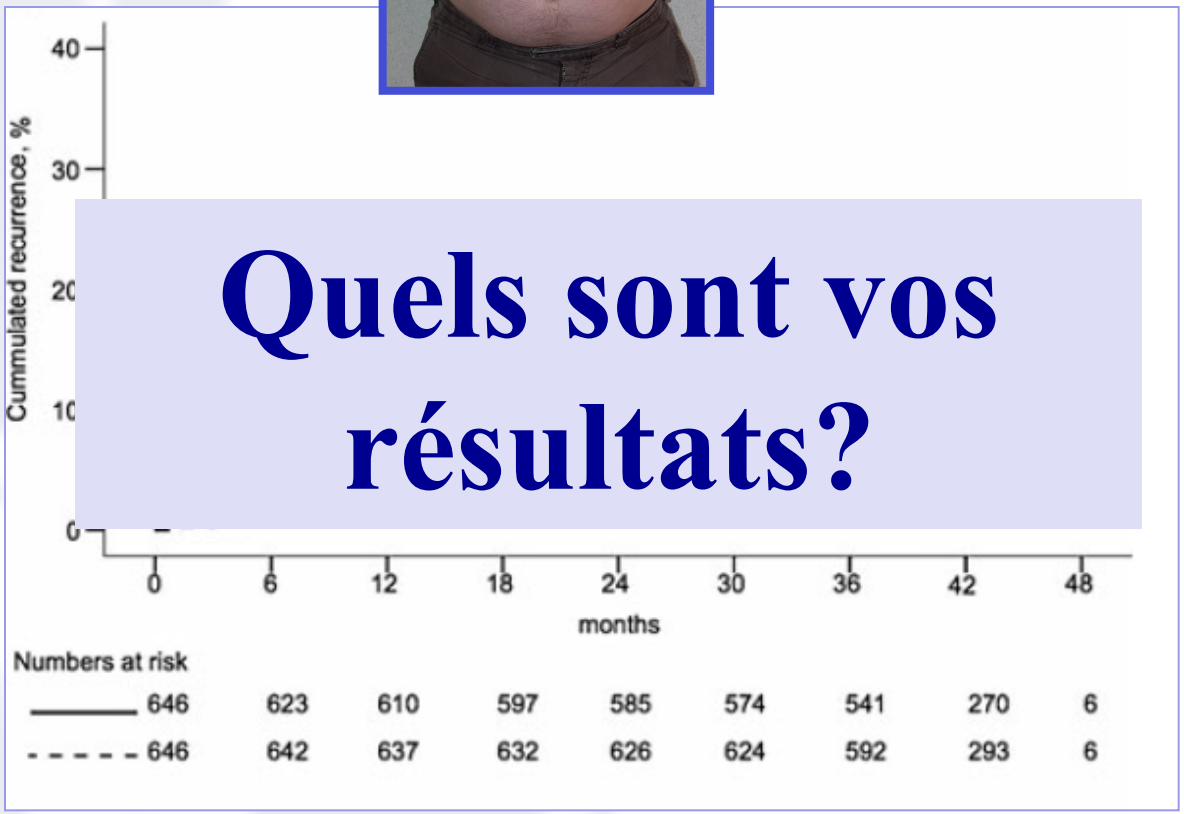

Quels sont vos résultats?

Reoperation versus clinical recurrence rate after ventral hernia repair.
Helgstrand F et al. *Ann Surg* 2012; 256:955-958

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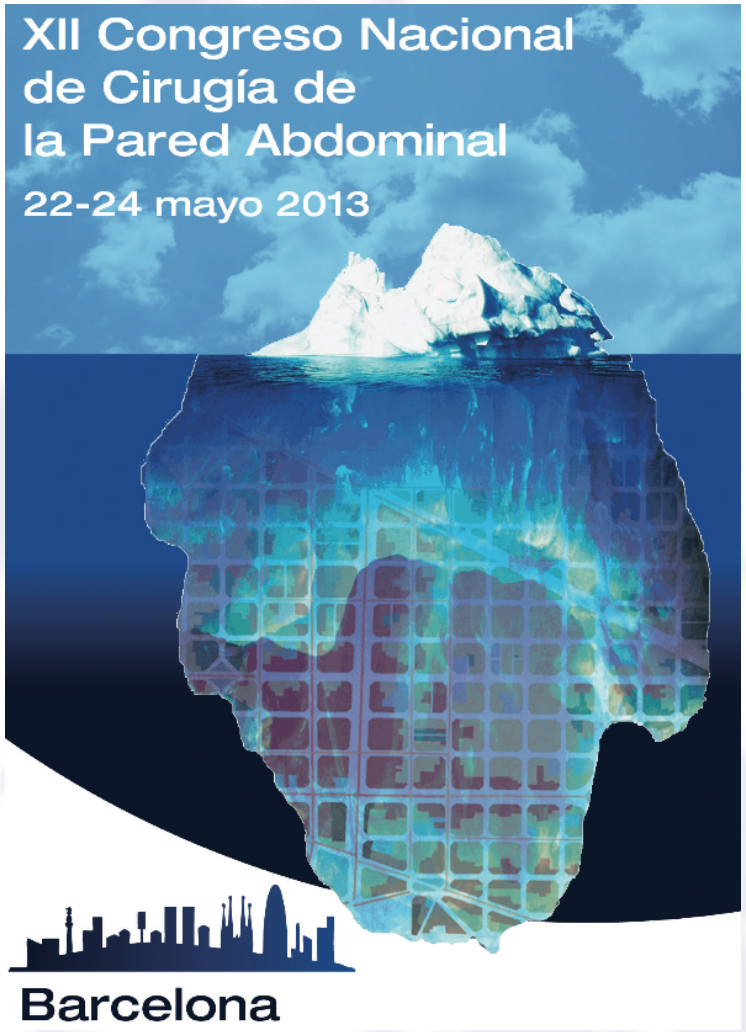
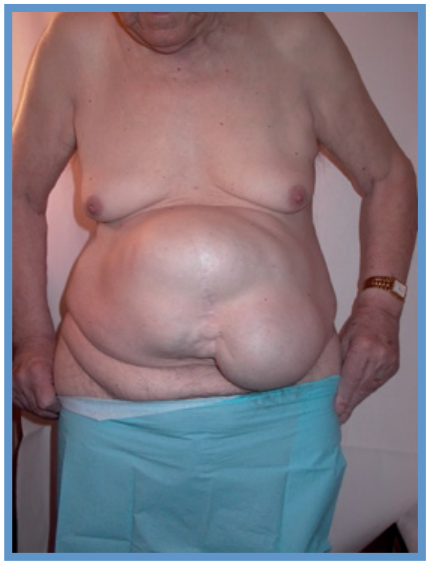
La punta del iceberg.



How good are we?
What are our results?



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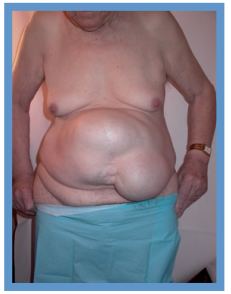
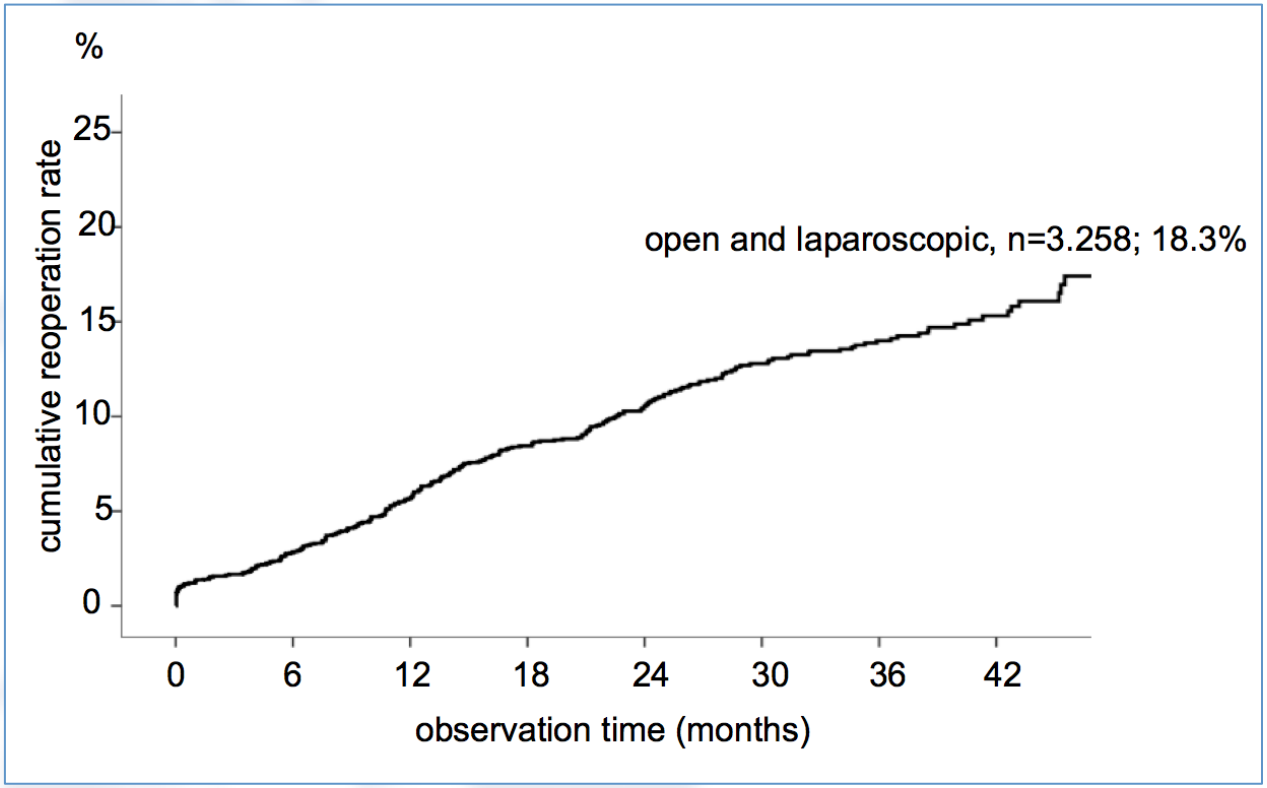
And incisional hernias?

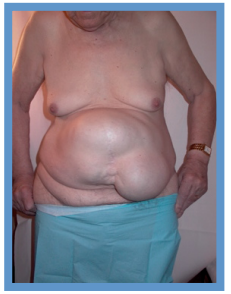


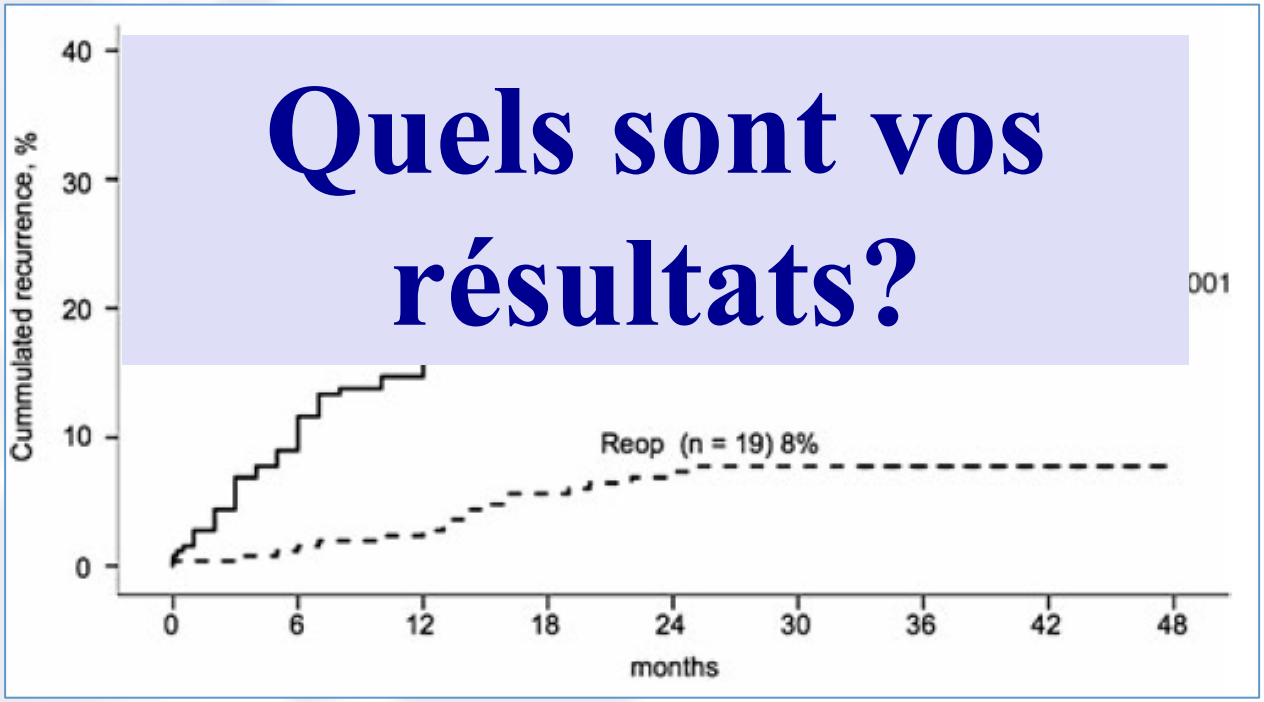


Danish ventral hernia database.
Unpublished data; courtesy of Thue Bisgaard

AZ Maria Middelares

And incisional hernias?





Reoperation versus clinical recurrence rate after ventral hernia repair.
Helgstrand F et al. *Ann Surg* 2012; 256:955-958

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Quels sont vos résultats?

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Quels sont vos résultats?

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EuraHS working group members

EuraHS mission

EuraHS wants to develop and provide for all EHS members

- an international online platform for registration and outcome measurement.

- an online platform for reporting early or late mesh complications, as a survey of implant materials.

- a set of definitions and classifications for use in clinical research on abdominal wall hernias.

- a uniform method of presenting outcome results in clinical studies on abdominal wall hernia repair.

EHS ventral hernia tryptic

Hernia
DOI 10.1007/s10029-009-0518-x

ORIGINAL ARTICLE

Classification of primary and incisional abdominal wall hernias

F. E. Muysoms · M. Miserez · F. Berrevoet · G. Campanelli · G. G. Champault · E. Chelala · U. A. Dietz · H. H. Eker · I. El Nakadi · P. Hauters · M. Hidalgo Pascual · A. Hoeferlin · U. Klinge · A. Montgomery · R. K. J. Simmermacher · M. P. Simons · M. Śmietański · C. Sommeling · T. Tollens · T. Vierendeels · A. Kingsnorth

Received: 9 February 2009 / Accepted: 7 May 2009

Abstract
Purpose A classification for primary and incisional abdominal wall hernias is needed to allow comparison of publications and future studies on these hernias. It is important to know whether the populations described in different studies are comparable.
Methods Several members of the EHS board and some invitees gathered for 2 days to discuss the development of an EHS classification for primary and incisional abdominal wall hernias.
Results To distinguish primary and incisional abdominal wall hernias, a separate classification based on localisation and size as the major risk factors was proposed. Further data are needed to define the optimal size variable for classification of incisional hernias in order to distinguish subgroups with differences in outcome.
Conclusions A classification for primary abdominal wall hernias and a division into subgroups for incisional

Results of a consensus meeting on the development of an EHS classification held in Ghent, Belgium, 2–4 October 2008.

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Hernia (2012) 16:239–250
DOI 10.1007/s10029-012-0912-7

REVIEW

EuraHS: the development of an international online platform for registration and outcome measurement of ventral abdominal wall hernia repair

F. Muysoms · G. Campanelli · G. G. Champault · A. C. DeBeaux · U. A. Dietz · J. Jeekel · U. Klinge · F. Köckerling · V. Mandala · A. Montgomery · S. Morales Conde · F. Puppe · R. K. J. Simmermacher · M. Śmietański · M. Miserez

Received: 19 November 2011 / Accepted: 24 March 2012 / Published online: 18 April 2012

Abstract
Background Although the repair of ventral abdominal wall hernias is one of the most commonly performed operations, many aspects of their treatment are still under debate or poorly studied. In addition, there is a lack of good definitions and classifications that make the evaluation of studies and meta-analyses in this field of surgery difficult.
Materials and methods Under the auspices of the board of the European Hernia Society and following the previously published classifications on inguinal and on ventral hernias, a working group was formed to create an online platform for registration and outcome measurement of operations for ventral abdominal wall hernias. Development of such a registry involved reaching agreement about clear definitions and classifications on patient variables, surgical procedures and mesh materials used, as well as outcome parameters. The EuraHS working group (European registry for abdominal wall hernias) comprised of a multinational European expert panel with specific interest in abdominal wall hernias. Over five working group meetings, consensus was reached on definitions for the data to be recorded in the registry.
Results A set of well-described definitions was made. The previously reported EHS classifications of hernias will

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Hernia
DOI 10.1007/s10029-013-1108-5

REVIEW

Recommendations for reporting outcome results in abdominal wall repair

Results of a Consensus meeting in Palermo, Italy, 28–30 June 2012

F. E. Muysoms · E. B. Deerenberg · E. Peeters · F. Agresta · F. Berrevoet · G. Campanelli · W. Ceelen · G. G. Champault · F. Corcione · D. Cuccurullo · A. C. DeBeaux · U. A. Dietz · R. J. Fitzgibbons Jr · J. F. Gillion · R.-D. Hilgers · J. Jeekel · I. Kyle-Leinhase · F. Köckerling · V. Mandala · A. Montgomery · S. Morales-Conde · R. K. J. Simmermacher · V. Schumpelick · M. Śmietański · M. Walgenbach · M. Miserez

Received: 22 December 2012 / Accepted: 29 April 2013

Abstract
Background The literature dealing with abdominal wall surgery is often flawed due to lack of adherence to accepted reporting standards and statistical methodology.
Materials and methods The EuraHS Working Group (European Registry of Abdominal Wall Hernias) organised a consensus meeting of surgical experts and researchers with an interest in abdominal wall surgery, including a statistician, the editors of the journal Hernia and scientists experienced in meta-analysis. Detailed discussions took place to identify the basic ground rules necessary to improve the quality of research reports related to abdominal wall reconstruction.

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The Netherlands

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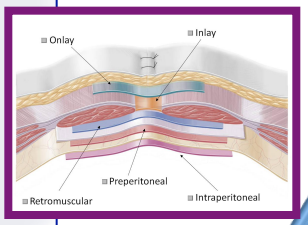
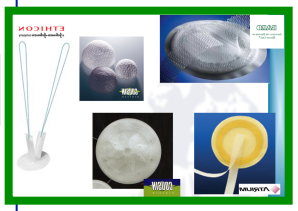
The triple-P triangle of abdominal wall hernia repair





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EHS consensus meeting on classification of ventral and incisional hernias, Ghent October 2008

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EHS consensus meeting on classification of ventral and incisional hernias, Ghent October 2008

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EHS consensus meeting on classification of ventral and incisional hernias, Ghent October 2008

E H S Primary Abdominal Wall Hernia Classification		Diameter cm	Small <2cm	Medium ≥2-4cm	Large ≥4cm
Midline	Epigastric				
	Umbilical				
Lateral	Spigelian				
	Lumbar				

E H S Incisional Hernia Classification			
Midline	subxiphoidal	M1	
	epigastric	M2	
	umbilical	M3	
	infraumbilical	M4	
	suprapubic	M5	
Lateral	subcostal	L1	
	flank	L2	
	iliac	L3	
	lumbar	L4	
Recurrent incisional hernia?		Yes O	No O
length: cm		**width**: cm	
Width **cm**	**W1** <4cm O	**W2** ≥4-10cm O	**W3** ≥10cm O

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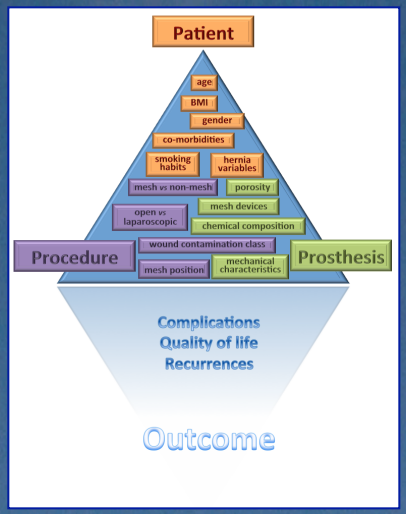
The abdominal wall	The *abdominal wall* is the musculo-fibrous covering of the abdomen containing the abdominal contents.
Abdominal wall hernia	An *abdominal wall hernia* is an abnormal protrusion of the contents of the abdominal cavity or of pre-peritoneal fat through a defect or weakness in the abdominal wall.
Ventral hernia	A *ventral hernia* is a hernia of the abdominal wall excluding the inguinal area, the pelvic area and the diaphragm.
Primary ventral hernia	A *primary ventral hernia* is a ventral hernia that was present at birth or that developed spontaneously without trauma to the abdominal wall as the cause of the hernia.
Umbilical hernia	A primary ventral hernia with its centre at the umbilicus.
Epigastric hernia	A primary ventral hernia close to the midline with its centre above the umbilicus.
Spighelian hernia	A primary ventral hernia in the area of the fascia Spigelian aponeurosis.
Lumbar hernia	A primary ventral hernia in the lumbar area.
Secondary ventral hernia	A secondary ventral hernia is a ventral hernia that developed after a traumatic breach of the integrity of the abdominal wall.
Incisional ventral hernia	An ventral hernia that developed after surgical trauma to the abdominal wall, including recurrences after repair of primary ventral hernias.
Traumatic ventral hernia	A ventral hernia that developed after non-surgical penetrating or blunt trauma to the abdominal wall.
Acute postoperative ventral hernia	An incisional hernia resulting from an abdominal wall dehiscence, either complete (with skin dehiscence) or incomplete (covered with intact skin) within 30 days after the operation.
Parastomal hernia	An incisional hernia through the abdominal wall defect created during placement of a colostomy, ileostomy or ileal conduit stoma.



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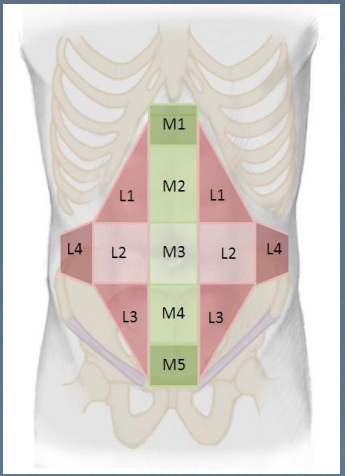
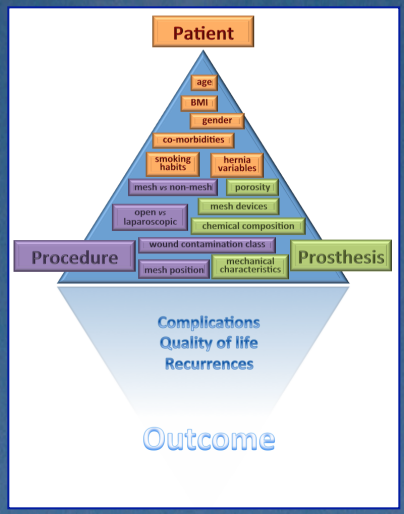


Severity Of Co-morbidity Score SOC-score	
SOC-score	**Definition**
0	No co-morbidities
1	Asymptomatic, no medical consultation needed in last 12 months
2	Stable disease, intermittent therapy and medical consultation needed ≤ 4x/year
3	Stable disease, continuous therapy with regular medical consultation > 4x/year
4	Progressive disease, with changing or intensified therapy and frequent medical consultation > 12x/year



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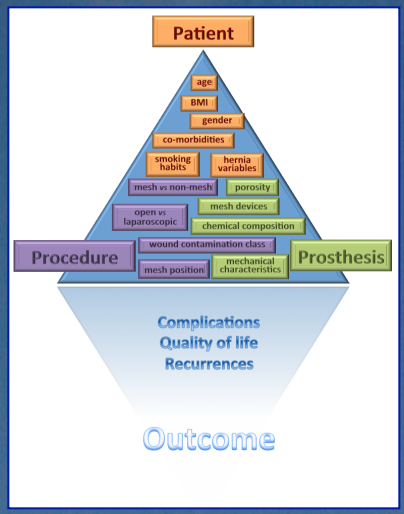
Class of operation and wound contamination	CDC-Definition	Example for abdominal wall hernia repair
Class I: Clean	These are uninfected operative wounds in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tracts are not entered.	- Elective repair of a hernia.
Class II: Clean-Contaminated	These are operative wounds in which the respiratory, alimentary, genital, or urinary tract is entered under controlled conditions and without unusual contamination.	- Bowel lesion during adhesiolysis, without gross spillage of bowel content. - Combined cholecystectomy and hernia repair. - Bowel resection for incarceration. - Presence of a colostomy.
Class III: Contaminated	These include open, fresh, accidental wounds, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, nonpurulent inflammation is encountered.	- Bowel lesion with gross spillage. - Enterocutaneous fistula.
Class IV: Dirty	These include old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.	- Perforation of strangulated bowel. - Presence of infected mesh



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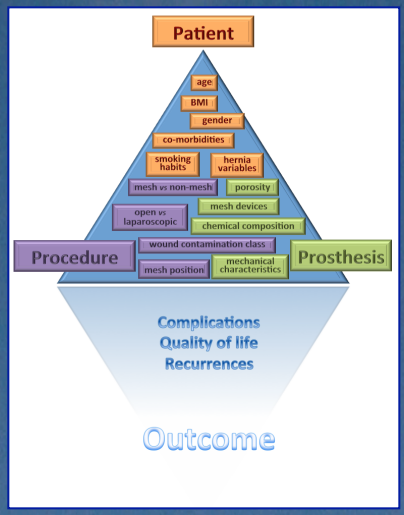
EuraHS-QoL Preoperative

Pain at the site of the hernia												
	0 = no pain										10 = worst pain imaginable	
In rest (lying down)	0	1	2	3	4	5	6	7	8	9	10	
During activities (walking, biking, sports)	0	1	2	3	4	5	6	7	8	9	10	
Worst pain felt during the last week	0	1	2	3	4	5	6	7	8	9	10	
Restrictions of activities because of pain or discomfort at the site of the hernia												
	0 = no restriction										10 = completely restricted	
Daily activities (inside the house)	0	1	2	3	4	5	6	7	8	9	10	X
Outside the house (walking, biking,driving)	0	1	2	3	4	5	6	7	8	9	10	X
During sports	0	1	2	3	4	5	6	7	8	9	10	X
During heavy labour	0	1	2	3	4	5	6	7	8	9	10	X
											X = If you do not perform this activity	
Cosmetic discomfort												
	0 = very beautiful										10 = extremely ugly	
The shape of your abdomen	0	1	2	3	4	5	6	7	8	9	10	
The site of the hernia	0	1	2	3	4	5	6	7	8	9	10	

EuraHS-QoL Postoperative

Pain at the site of the hernia repair												
	0 = no pain										10 = worst pain imaginable	
In rest (lying down)	0	1	2	3	4	5	6	7	8	9	10	
During activities (walking, biking, sports)	0	1	2	3	4	5	6	7	8	9	10	
Worst pain felt during the last week	0	1	2	3	4	5	6	7	8	9	10	
Restrictions of activities because of pain or discomfort at the site of the hernia repair												
	0 = no restriction										10 = completely restricted	
Daily activities (inside the house)	0	1	2	3	4	5	6	7	8	9	10	X
Outside the house (walking, biking,driving)	0	1	2	3	4	5	6	7	8	9	10	X
During sports	0	1	2	3	4	5	6	7	8	9	10	X
During heavy labour	0	1	2	3	4	5	6	7	8	9	10	X
											X = If you do not perform this activity	
Cosmetic discomfort												
	0 = very beautiful										10 = extremely ugly	
The shape of your abdomen	0	1	2	3	4	5	6	7	8	9	10	
The site of the hernia and the scars	0	1	2	3	4	5	6	7	8	9	10	



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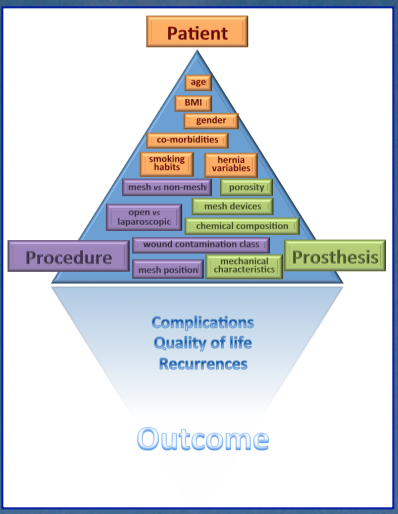
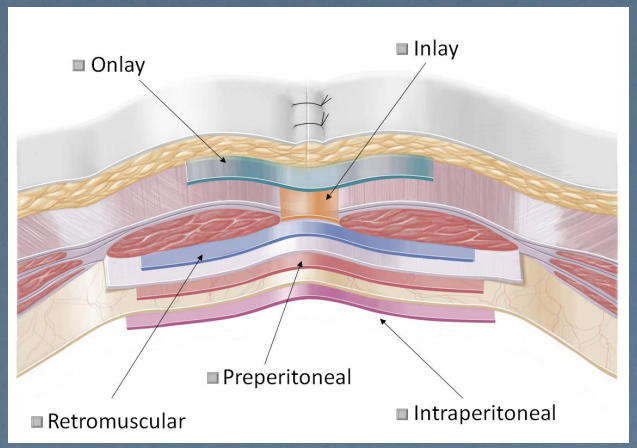
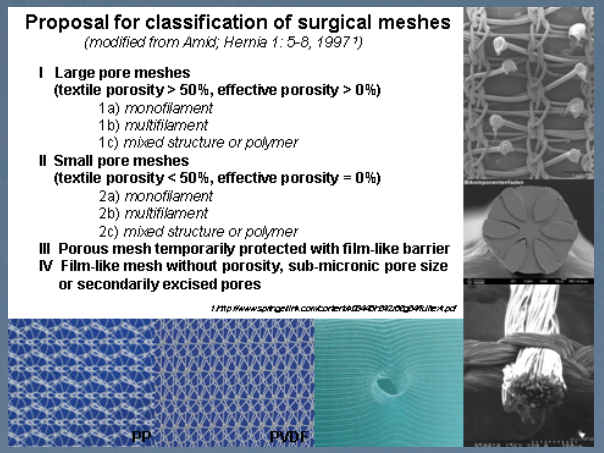
EuraHS
European Registry of Abdominal wall Hernias







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Intra-operative complications	Are complications occurring during the time of the patients' arrival in the operating room and the patient leaving the operating room
"Acute" or "early" postoperative complications	Are complications occurring during the hospitalisation or within 30 days postoperatively
Late postoperative complications	Are complications related to the hernia repair occurring after discharge and more than 30 days postoperatively
Operative morbidity	The percentage of patients treated who had at least one complication occurring during the operation, during the hospitalisation or 30 days postoperatively
Operative mortality	The percentage of patients treated who died during the operation, during the hospitalisation or within 30 days postoperatively

Grade 0
No complications

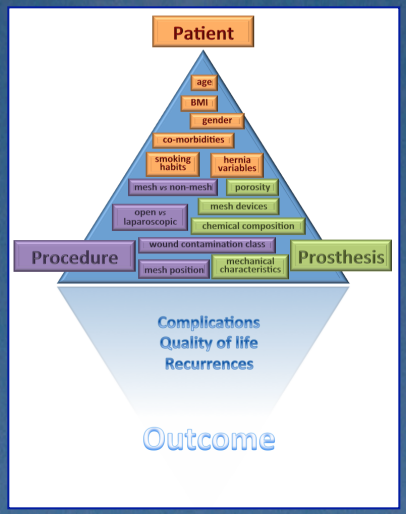
Grade I
Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions (are allowed: antiemetica, antipyretica, analgetics, diuretics, electrolytes and physiotherapy. This grade includes wound infections opened at the bedside *and a seroma requiring aspiration bedside*.)

Grade II
Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Blood transfusion and TPN are included.

Grade III
Requiring surgical, endoscopic and radiological interventions
IIIa intervention not under general anesthesia
IIIb intervention under general anaesthesia

Grade IV
Life threatening complication requiring IC/ICU management
IVa single organ dysfunction
IVb multiorgan dysfunction

Grade V
Death of the patient



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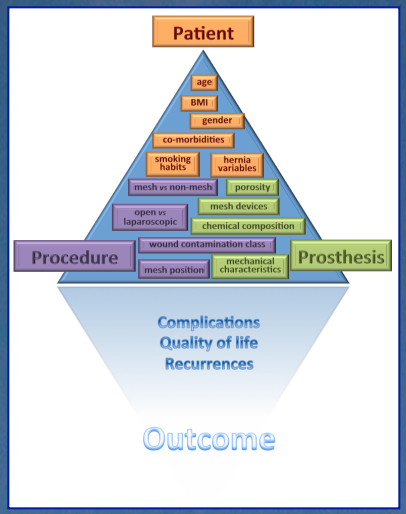
TYPE OF SEROMA	*Definition*	*Clinical significance*
0	*No clinical seroma*	*No clinical seroma*
I	*Clinical seroma lasting < 1 month*	*INCIDENT*
II	*Clinical seroma lasting > 1 month*	
III	*Minor seroma-related complications*	*COMPLICATION*
IV	*Major seroma-related complications*	



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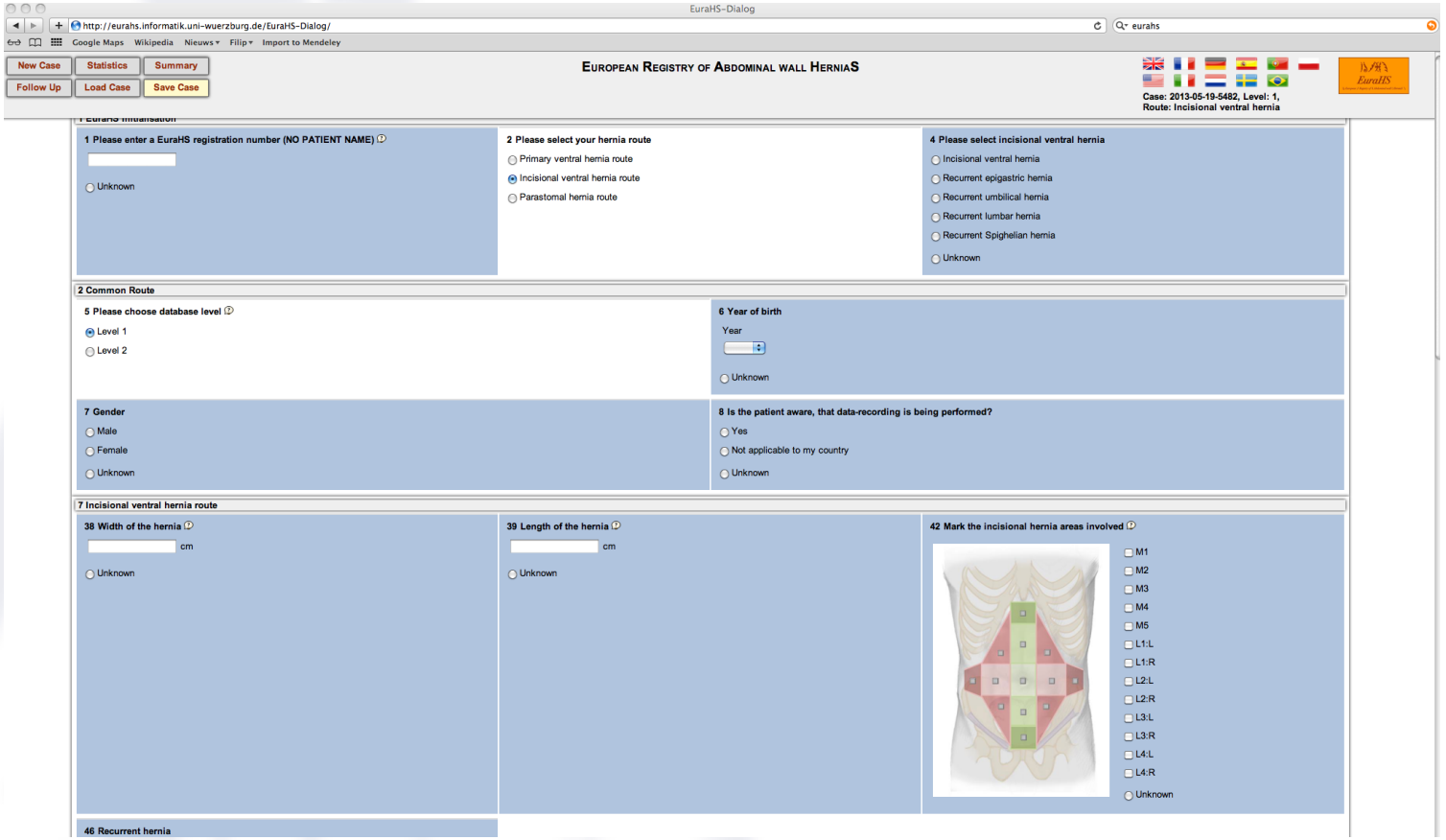

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DOKTER MUYSOMS LANCEERT BAANBREKEND PLATFORM BUIKWANDCHIRURGIE

Dr. Filip Muysoms en dr. Iris Kyle-Leinhase

Dokter Filip Muysoms is een autoriteit op het vlak van buikwandchirurgie en de aanpak van littekenbreuken. Als chapter president van de EHS (European Hernia Society) staat hij nu ook aan de wieg van een wetenschappelijk Europees platform in zijn vakgebied, EuraHS. De voordelen daarvan zijn legio. Een interview.

Het platform wordt boven de doopvont gehouden op het "EuraHS Launch symposium" in Brussel op 7 en 8 juni. Een congres met mondiale allure waarop wellicht zelfs de Chinezen afkomen. Dr. Muysoms legt uit wat de bedoeling is: "De wetenschappelijke literatuur over hernia, navelbreuken, lies- en littekenbreuken blijkt momenteel ondermaats. Er bestaan immers geen standaarden voor. Na ons zeer succesvolle congres vorig jaar in het ICC hier in Gent – met meer dan 1.000 geïnteresseerden - richtten we een Europese werkgroep op. Toen legden we de kiemen voor dat platform. Met EuraHS (voluit: European Registry for Abdominal Wall Hernias) hanteert iedereen altijd dezelfde classificaties en definities. Onze studies zullen we beter kunnen vergelijken."

"Het congres moet aan de doelgroep – zowel chirurgen, firma's als beleidsmensen van de EU – de kwaliteiten van het platform duidelijk maken. Ons platform verzamelt nauwgezet alle informatie over implantaten gebruikt bij buikwandchirurgie. Ontsporingen zoals bij de borstimplantaten zijn zo te vermijden."

"Het platform is ook puur als register inzetbaar, maar tegelijkertijd heeft het zoveel meer troeven. Je kunt er evidence-based mee werken, en dat voor een courante pathologie."

Sommige data zijn nogal straightforward, zoals leeftijd, geslacht, lengte enzomeer. Andere zijn dat minder. Hoe kun je subjectiviteit uitsluiten?

Filip Muysoms: "Dat is de volgende stap: hoe zullen we alles zo precies mogelijk meten en weergeven? Een navelbreuk meten met een echo kun je heel precies, maar een littekenbreuk meten is vaak nattevingerwerk, zelfs al zit je goed qua grootteorde. De rol van het platform bestaat er nu net in om in de mate van het mogelijke alles te stroomlijnen."

Er bestaan ook andere databanken zoals in de Scandinavische landen en in Duitsland. Willen jullie daarmee samenwerken?

"Dat zijn alleen registers, wij gaan dus iets breder, al kan ons platform ook als register gebruikt worden. Als ons platform betrouwbaar genoeg wordt, is het mogelijk dat Zweden bijvoorbeeld zijn register inruilt voor ons platform."

"De verspreiding van wetenschappelijke informatie is het grote doel van het platform. Daarom wordt mijn publicatie (Muysoms et al., 2011) enorm belangrijk; het gaat

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