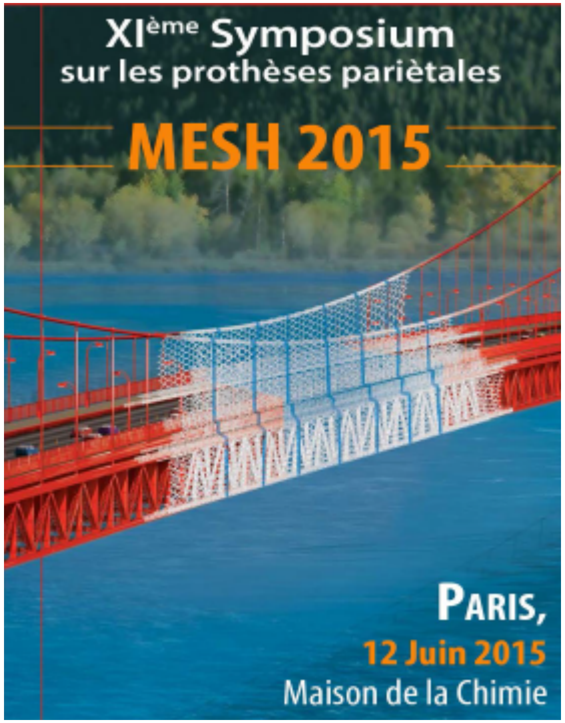

XI$^{\text{ème}}$ Symposium
sur les prothèses pariètales
MESH 2015

PARIS,
12 Juin 2015
Maison de la Chimie

Session n°5 : jeunes Chirurgiens en collaboration avec AJCV

Eventrations Lombaires et lombo-fessières

Y. RENARD, C. AVISSE, J.P. PALOT

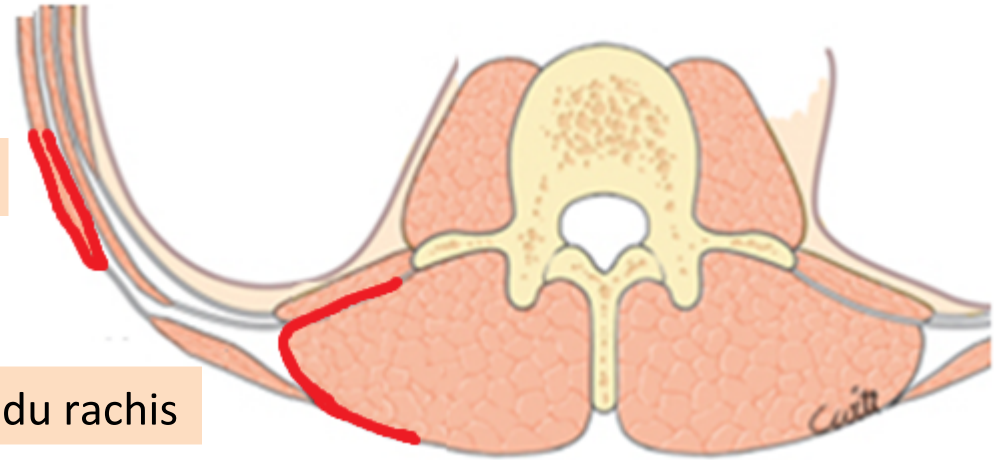
CHU DE REIMS

CENTRE HOSPITALIER UNIVERSITAIRE DE REIMS
SERVICE DE CHIRURGIE GÉNÉRALE,
DIGESTIVE ET ENDOCRINIENNE

UNIVERSITÉ
DE REIMS
CHAMPAGNE-ARDENNE

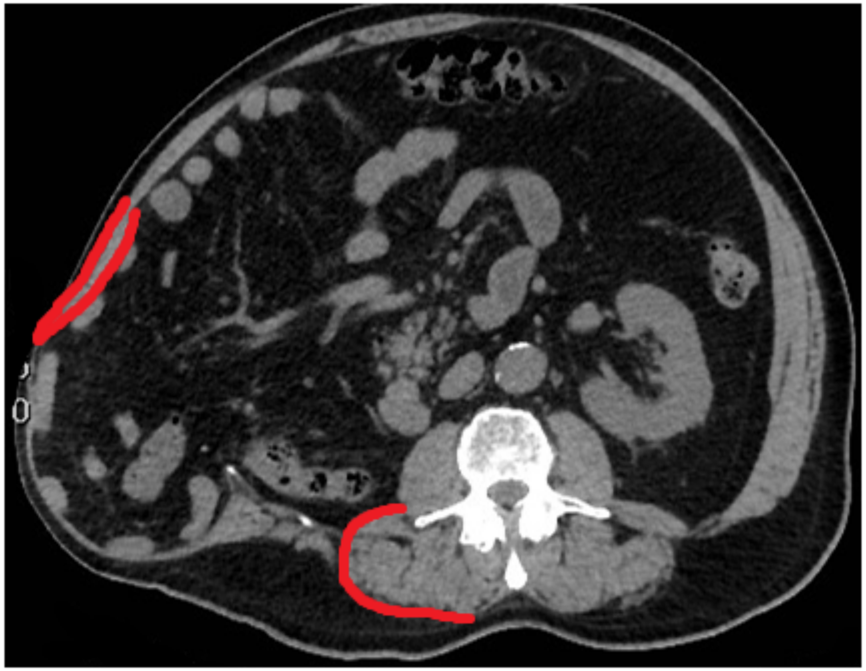
Laboratoire d'Anatomie
Faculté de Médecine de Reims

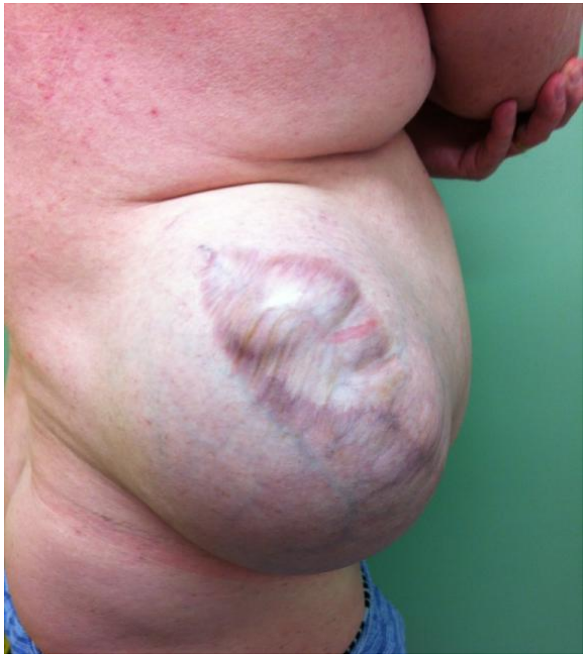
Anatomie



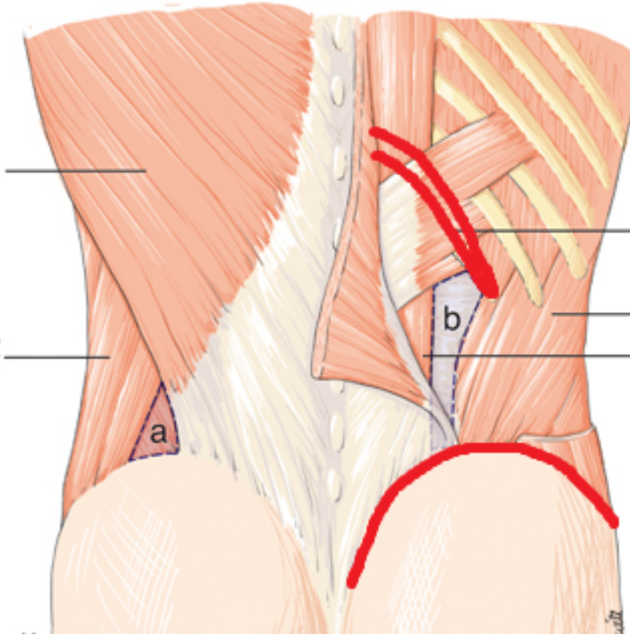
DH/Av : muscle oblique externe

DD/Arr : muscle érecteur du rachis





Anatomie

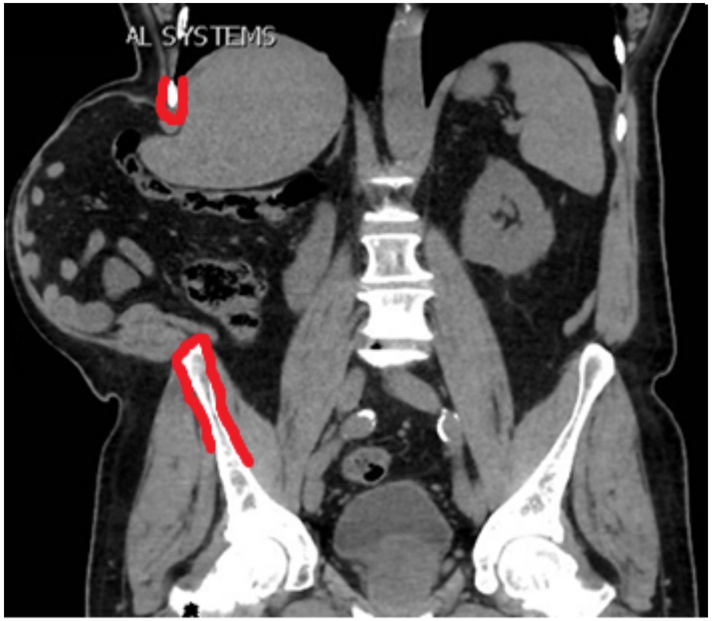


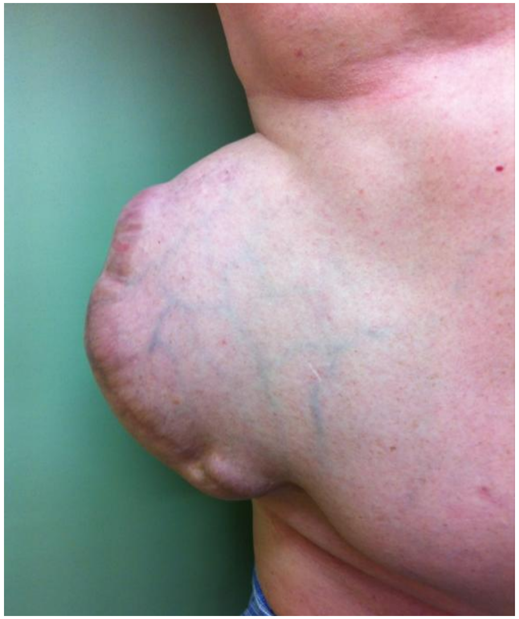
Ht : 12ème côte

Bas : crête iliaque

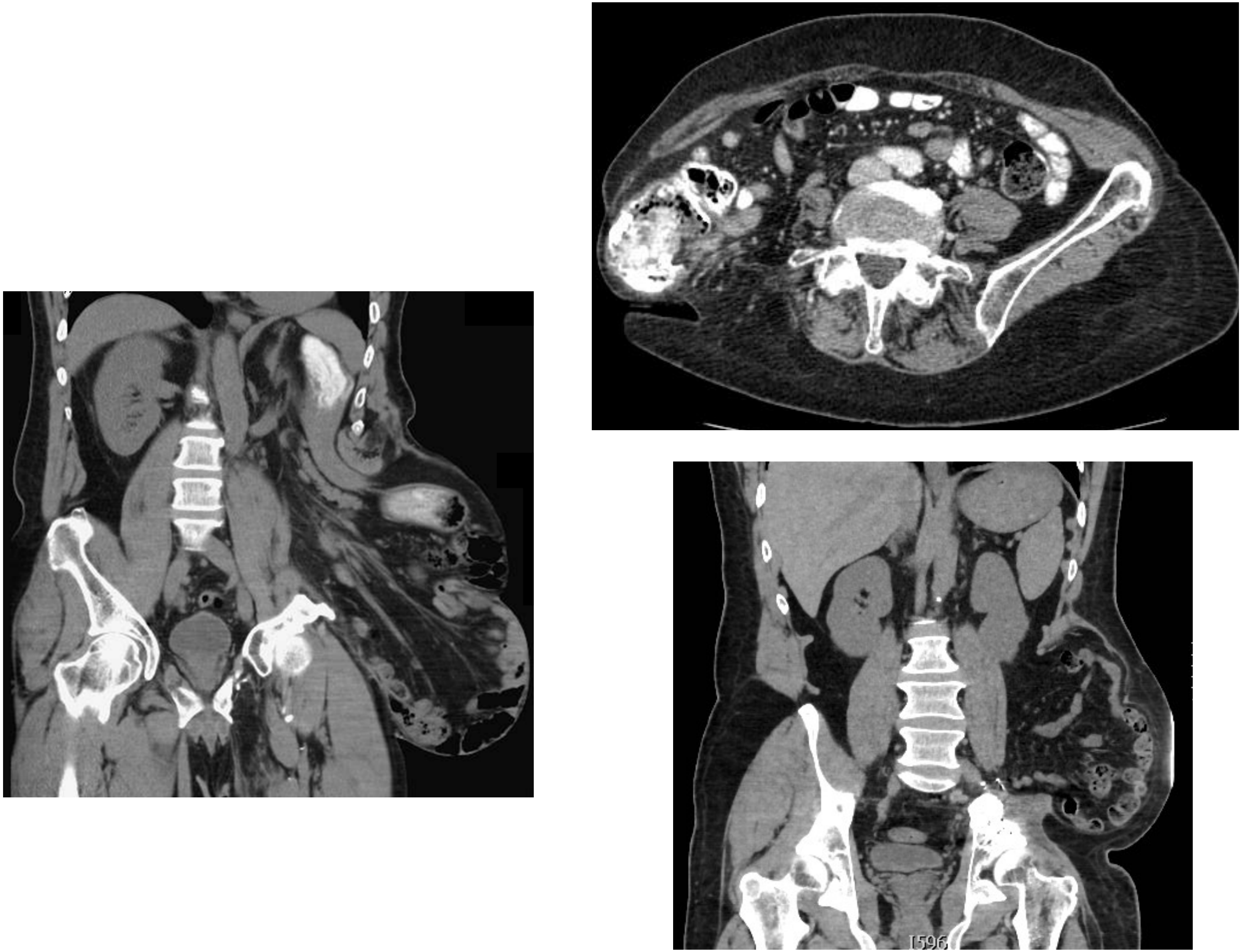
Triangle lombaire inférieur
(Jean-Louis Petit)

Triangle lombaire supérieur
(Quadrilatère de Grynfelt)

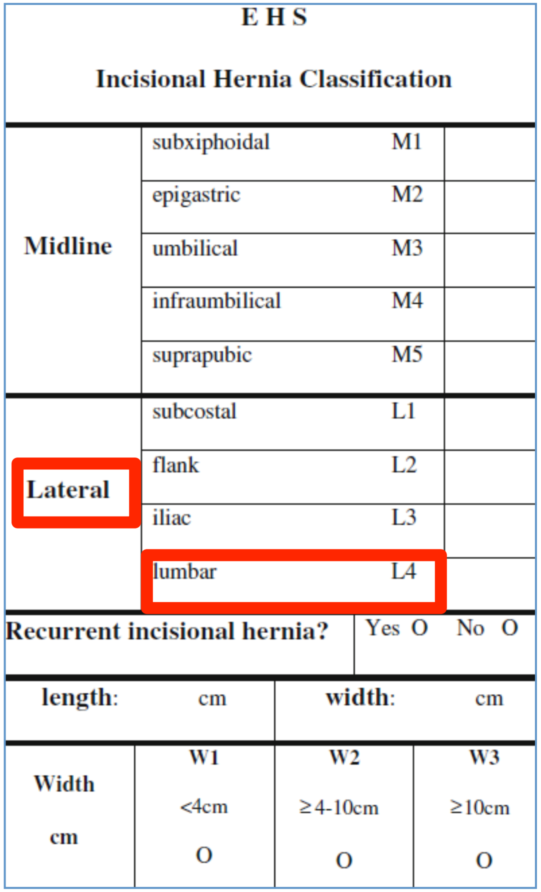




Anatomie



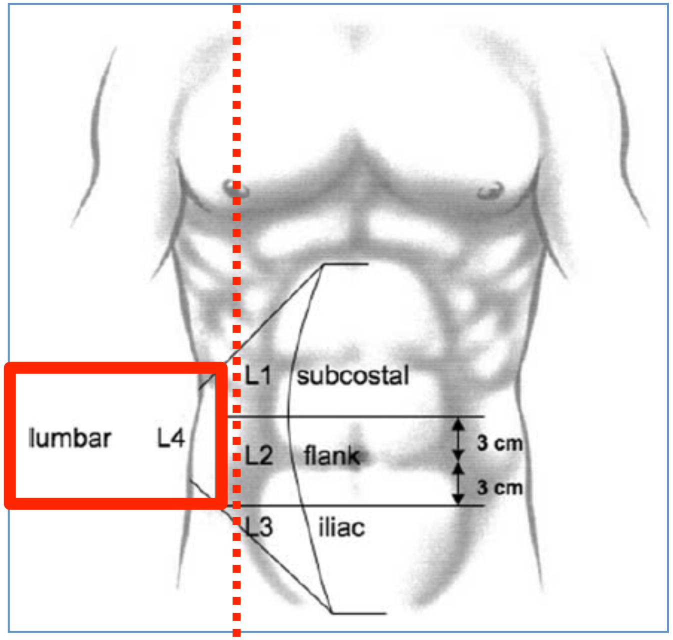
Introduction

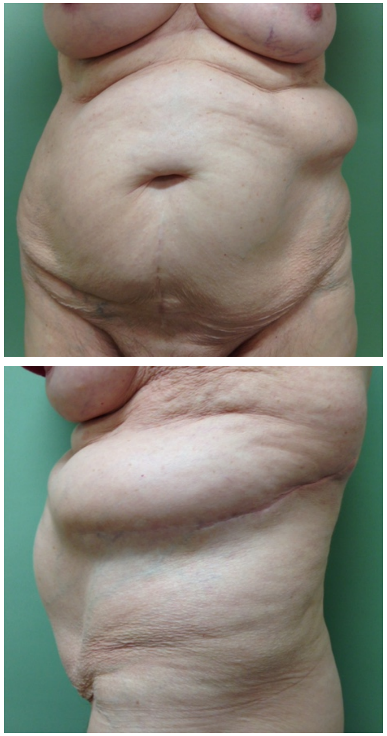


E H S

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


L1 subcostal
lumbar L4
L2 flank
3 cm
3 cm
L3 iliac

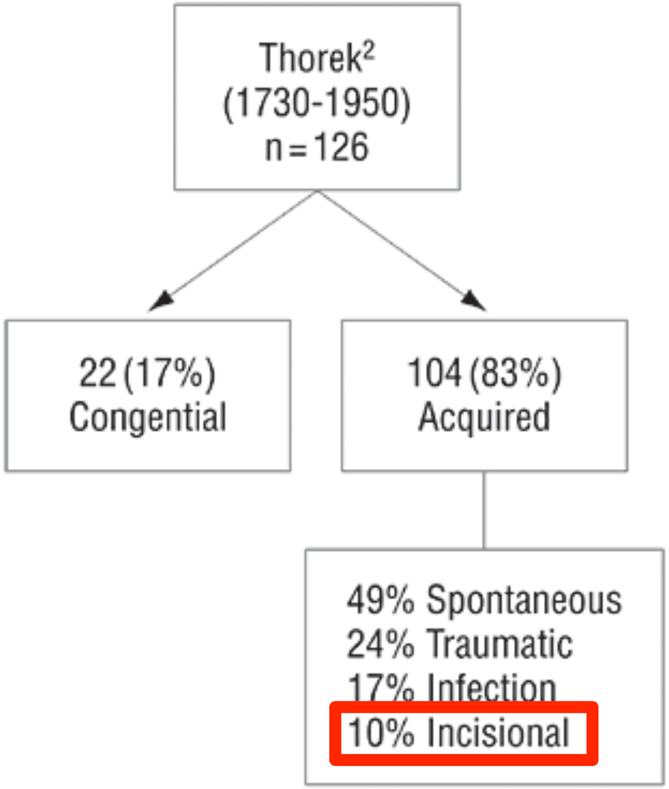


"latéro-dorsal de la ligne axillaire antérieure"
"defect of the posterolateral abdominal wall"

Muysoms FE. Hernia. 2009.

Littérature

Avant 1950 :



Thorek[2]
(1730-1950)
n=126

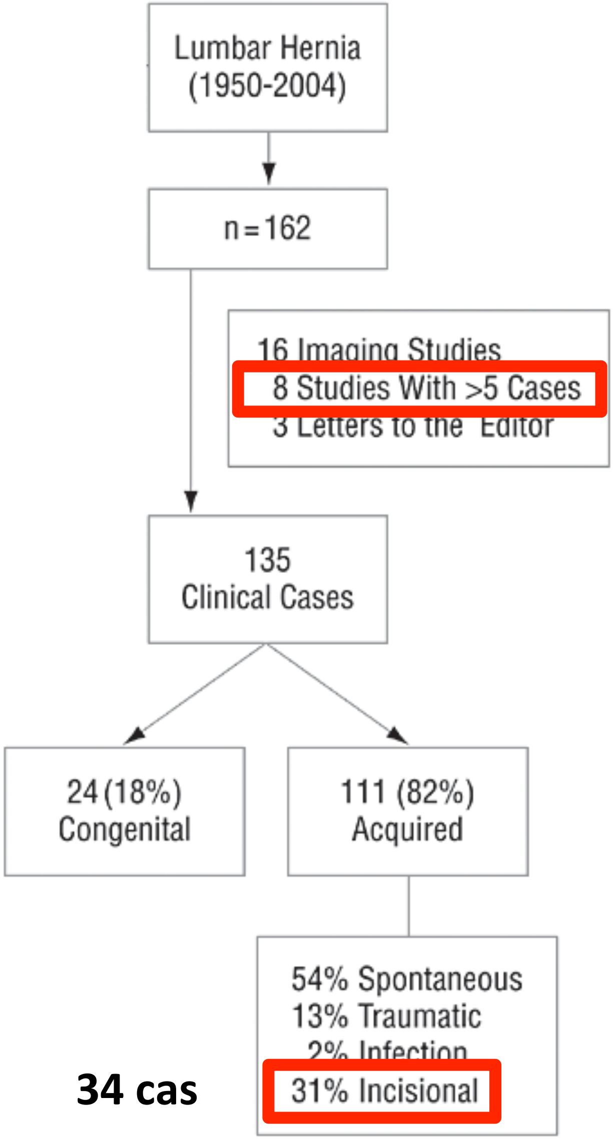
22 (17%)
Congential

104 (83%)
Acquired

49% Spontaneous
24% Traumatic
17% Infection
10% Incisional

10 cas

Après 1950



Lumbar Hernia
(1950-2004)

n=162

16 Imaging Studies
8 Studies With >5 Cases
3 Letters to the Editor

135
Clinical Cases

24 (18%)
Congenital

111 (82%)
Acquired

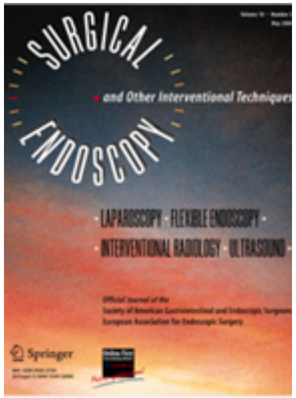
54% Spontaneous
13% Traumatic
2% Infection
31% Incisional

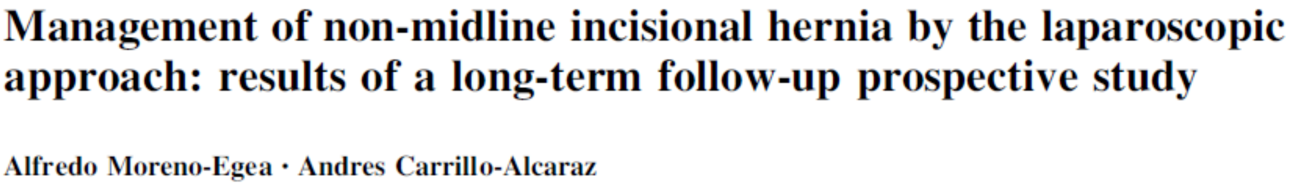
34 cas

Alfredo Moreno-Egea. JAMA. 2007

Littérature

Lal R. J Laparoendosc Adv Surg Tech A. 2014.	Etude rétrosp. → 5 lombaires / 185 latérales
Veyrie N. World J Surg. 2013	61 Ev lat. → “Lumbar I.H. was excluded”
Do MV. Ochsner J. 2012.	Etude rétrosp. → 5 cas
Yavuz N. Hernia. 2009.	Etude rétrosp. → 7 cas
Palanivelu C. Hernia. 2008.	Etude rétrosp. → 11 cas sur 10 ans


SURGICAL
and Other Interventional Techniques
ENDOSCOPY
LAPAROSCOPY · FLEXIBLE ENDOSCOPY ·
INTERVENTIONAL RADIOLOGY · ULTRASOUND
Springer

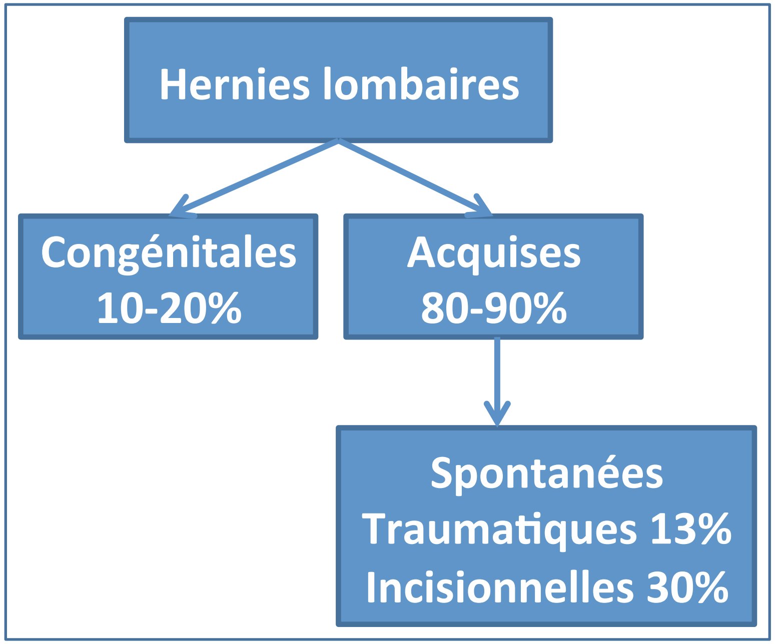


Management of non-midline incisional hernia by the laparoscopic approach: results of a long-term follow-up prospective study

Alfredo Moreno-Egea · Andres Carrillo-Alcaraz

Seule étude prospective, coelio, 33 lombaires / 73 patients

Classification et épidémiologie



Hernies lombaires

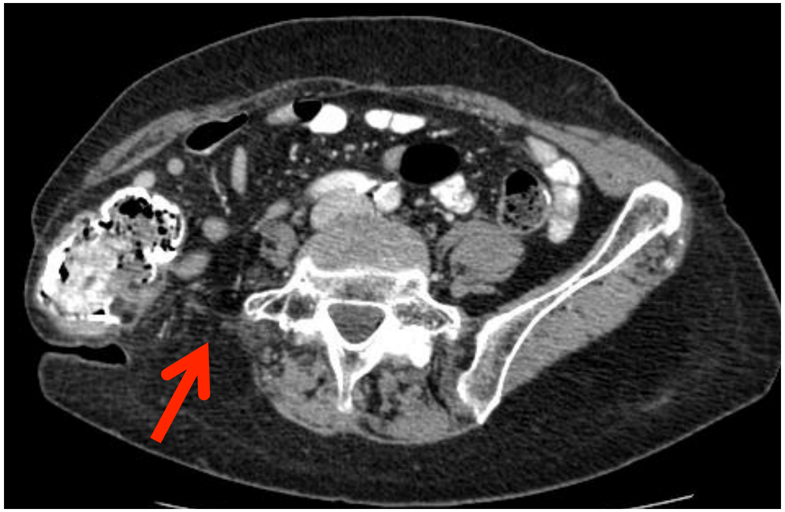
Congénitales 10-20%

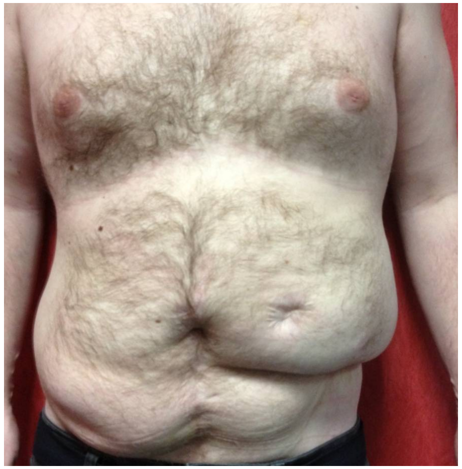
Acquises 80-90%

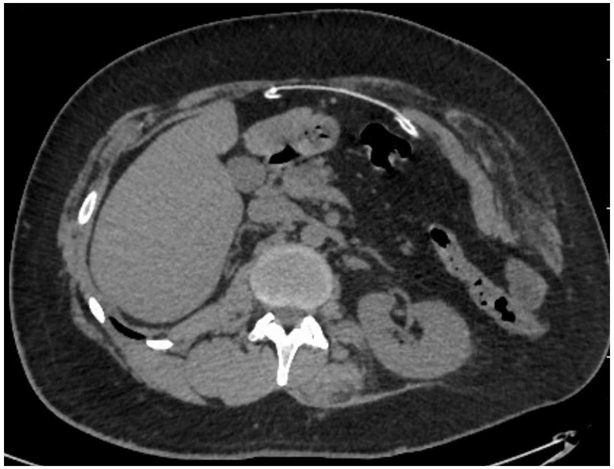
Spontanées
Traumatiques 13%
Incisionnelles 30%

Prévalence après lombotomie 20-30%

- Néphrectomie
- Rupture traumatique
- Greffon d’os iliaque
- Résection de tumeur pariétale abdo.
- Anévrisme aortique abdo.
- Reconstruction par lambeau de grand dorsal

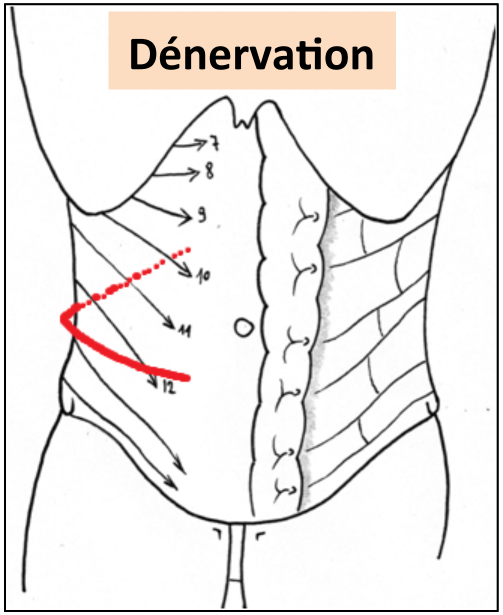


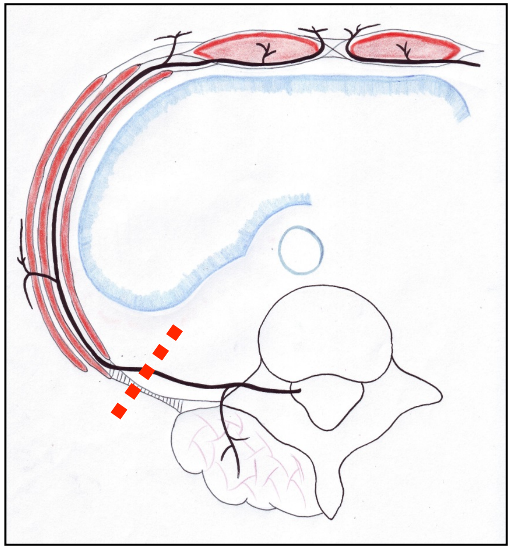


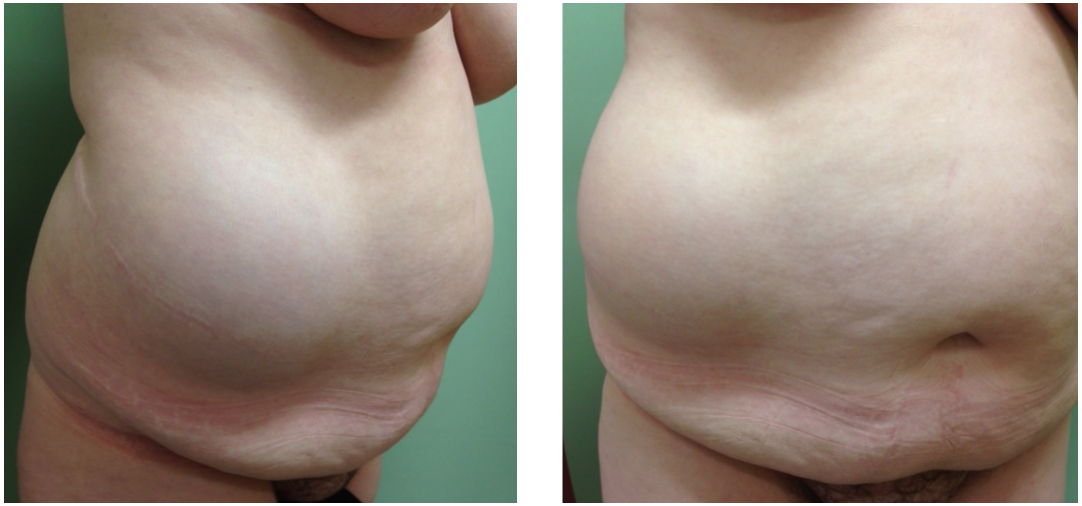


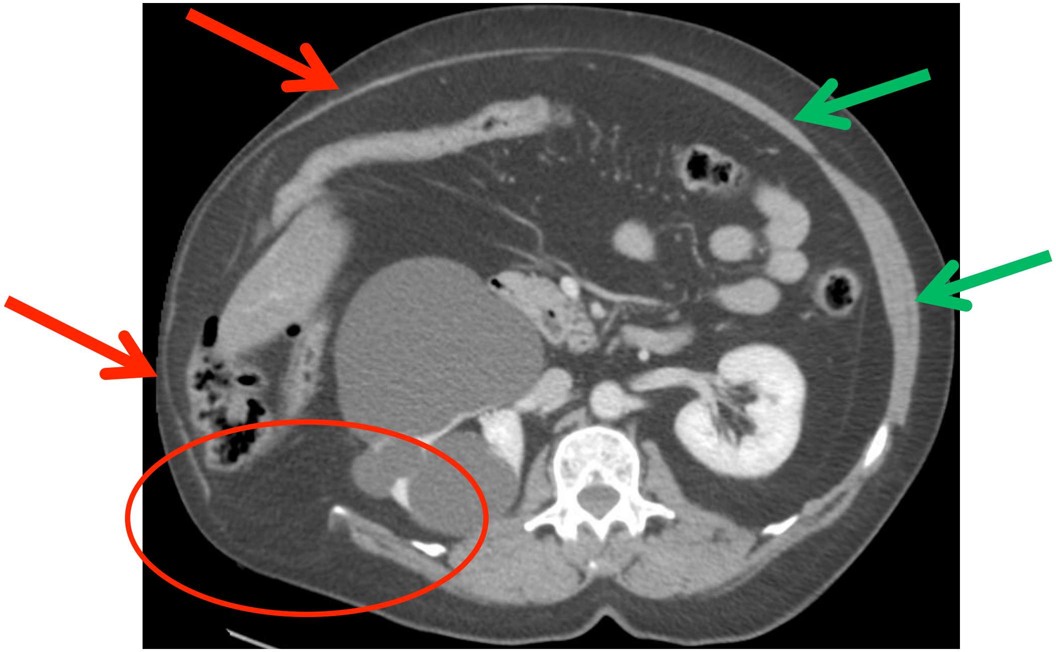
Shekarriz B. J Urol. 2001.
Sakarya A. Surg Endosc. 2003.
Alfredo Moreno-Egea. JAMA. 2007.
Palanivelu C. Hernia. 2008.

Physiopathologie (prev: 20-30%)


Dénervation
7
8
9
10
11
12







Physiopathologie (prev: 20-30%)

UROLOGIC ONCOLOGY

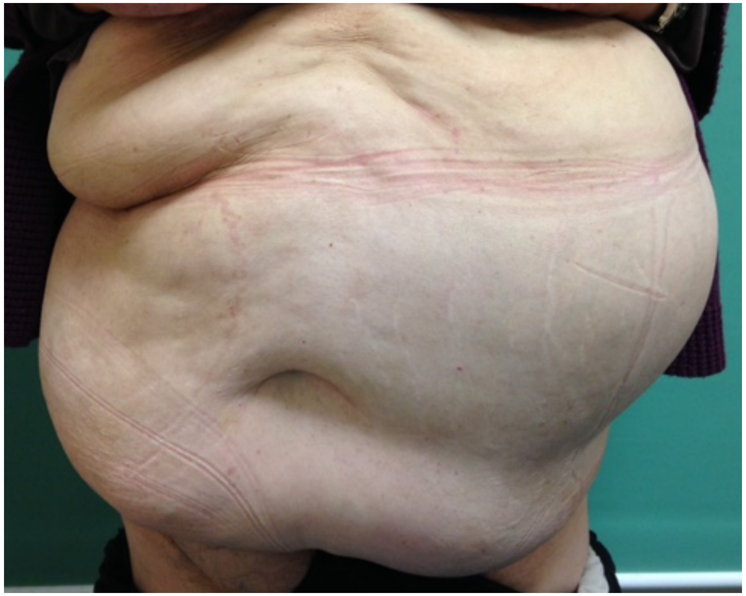
SUO

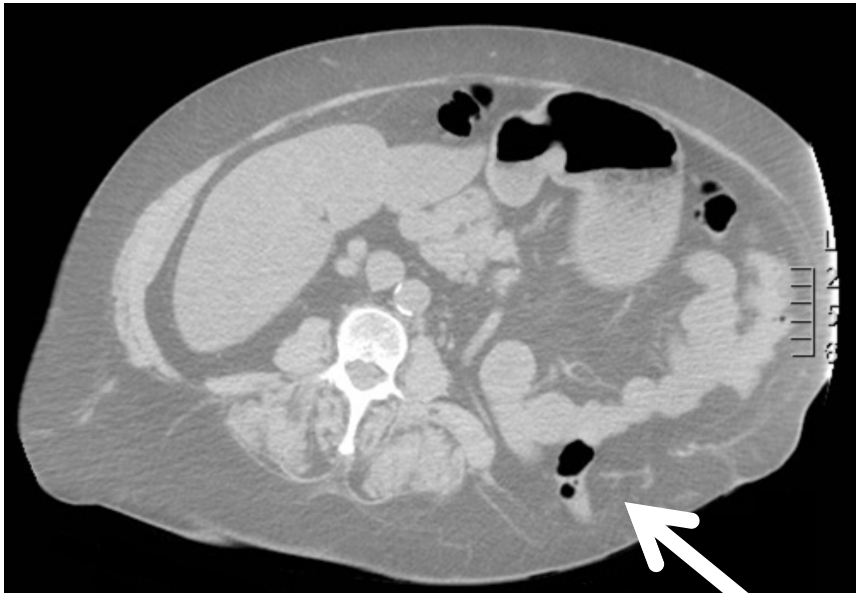
Urol Oncol. 2004 Jan-Feb;22(1):36-9.

Permanent flank bulge is a consequence of flank incision for radical nephrectomy in one half of patients.

Chatterjee S[1], Nam R, Fleshner N, Klotz L.

Dénervation
"flank bulging"



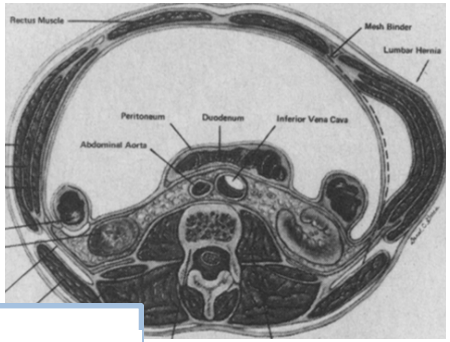


Variable selon les séries
13 – 50 %

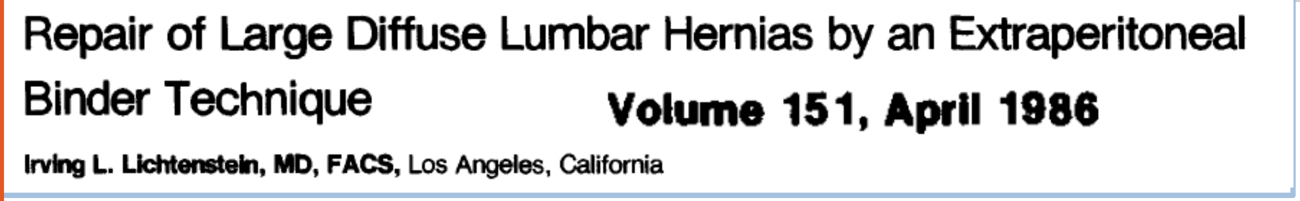
Technique chirurgicale

Eventration rare : **pas de technique standard**

Voie médiane ou lombaire ?
Quel plan ?
Quelle prothèse ?
Quelle marge ?
Quelle fixation et où fixer ?

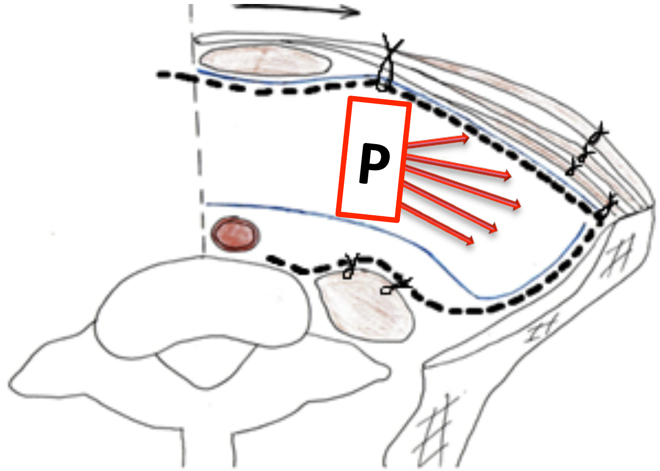

Rectus Muscle
Mesh Binder
Lumbar Hernia
Peritoneum
Duodenum
Inferior Vena Cava
Abdominal Aorta

The American Journal of Surgery


Repair of Large Diffuse Lumbar Hernias by an Extraperitoneal Binder Technique

Volume 151, April 1986

Irving L. Lichtenstein, MD, FACS, Los Angeles, California



Principes

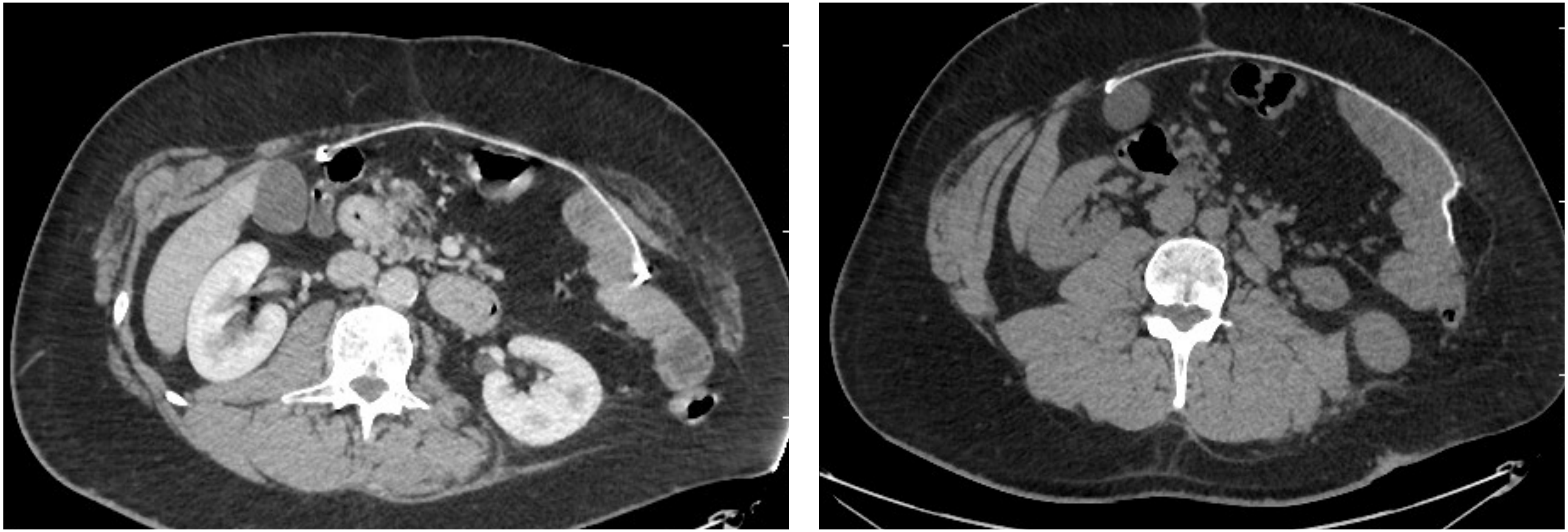
Large prothèse qui dépasse largement

Fixation : loin en arrière, sur le muscle psoas

Principe de Pascal

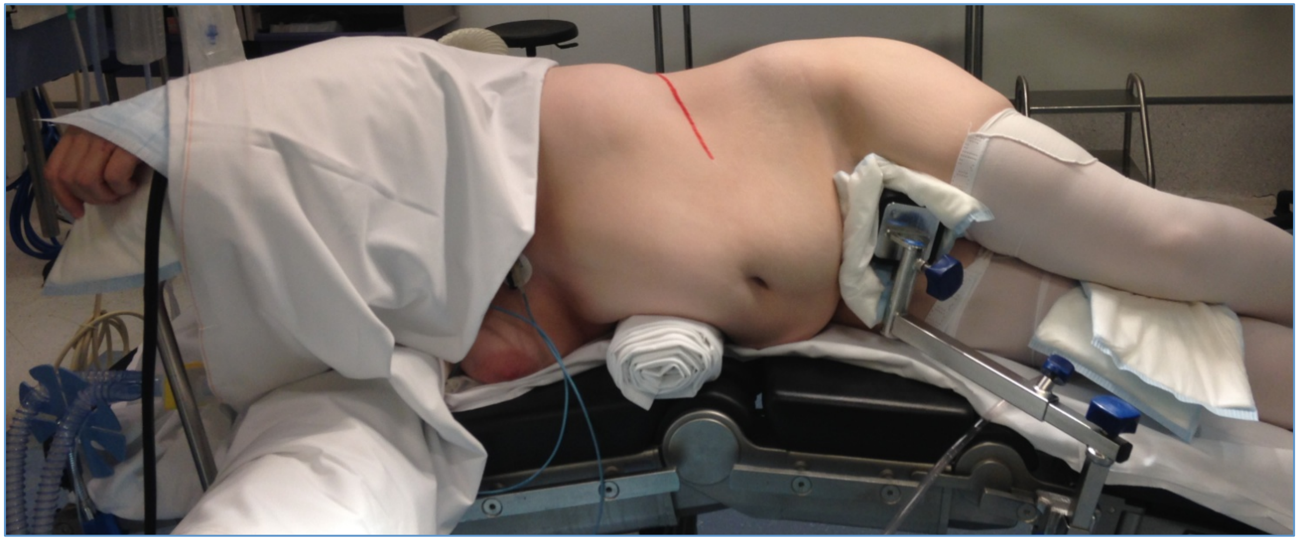
Atul KM. Am Surg. 2006.

Technique chirurgicale



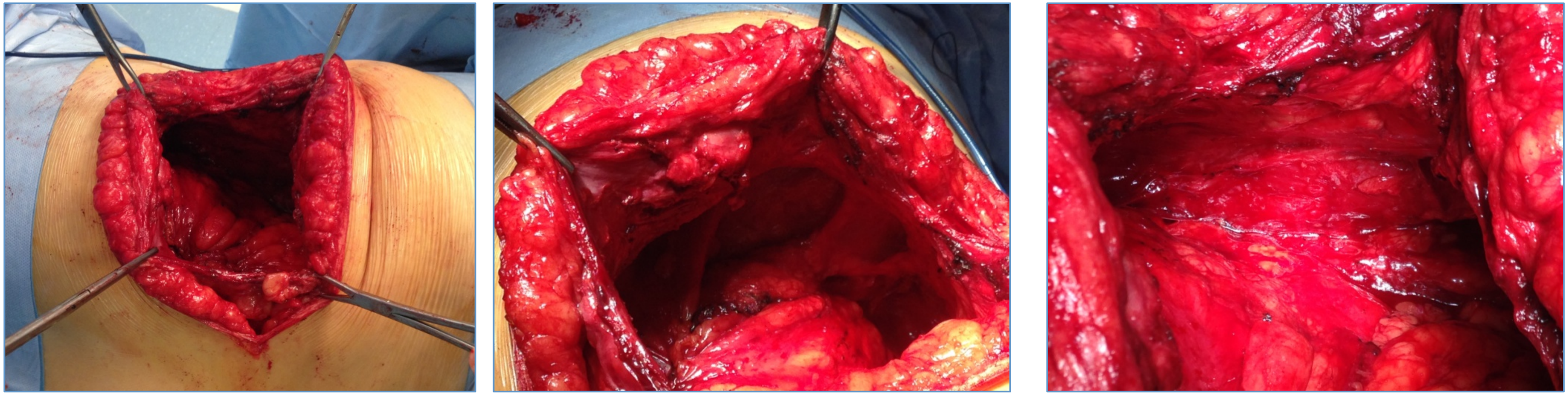
En arrière et en bas

Technique chirurgicale

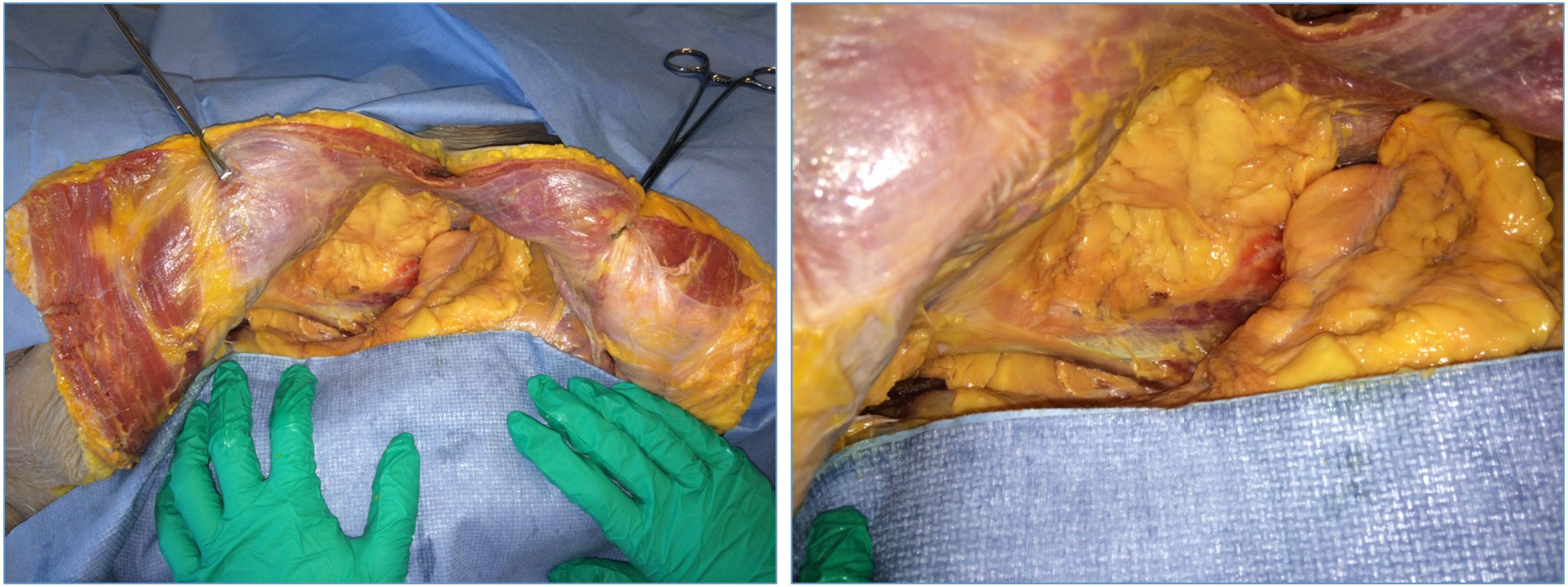


Patient sondé. DL cassé. Billot flanc. Sanglage.

Pas d'ouverture du péritoine, passage rétro-péritonéal.

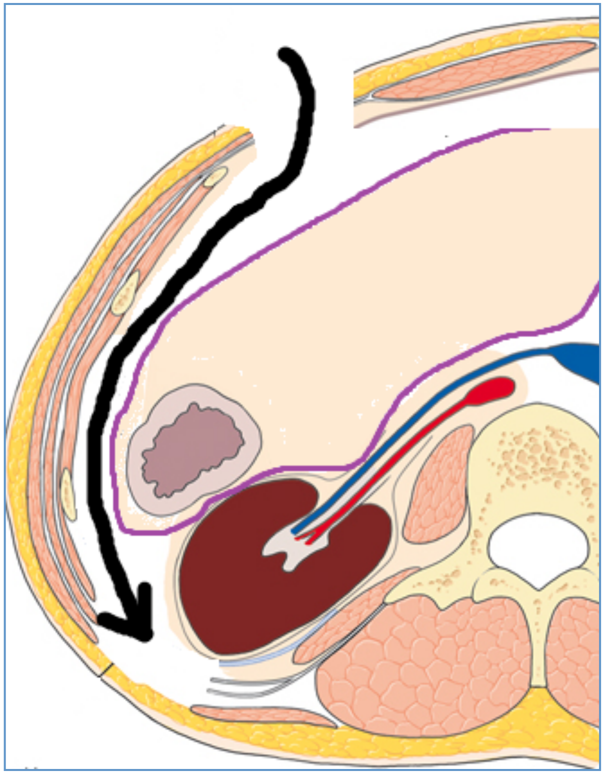


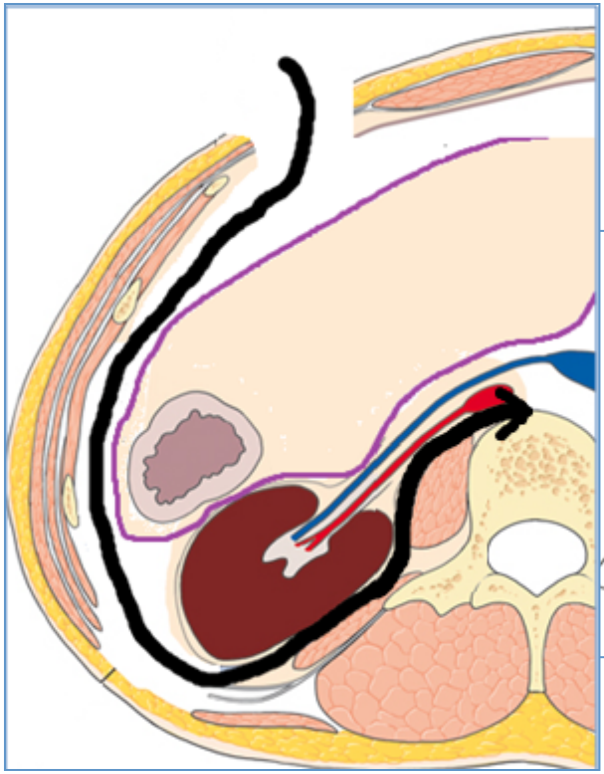
Technique chirurgicale

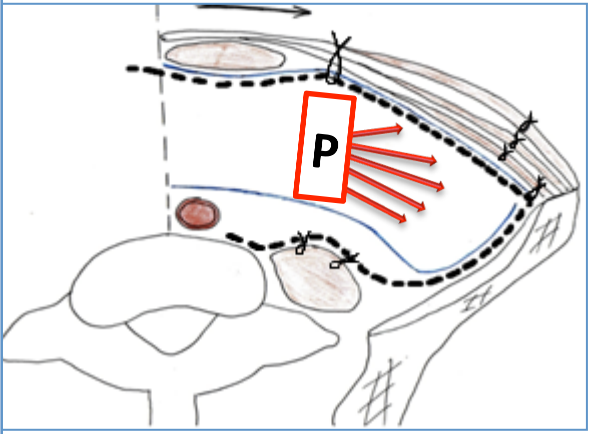


Exposition du muscle psoas.
En bas, exposition espace de Bogros et Retzius.
En haut, jusqu'aux dernières côtes.

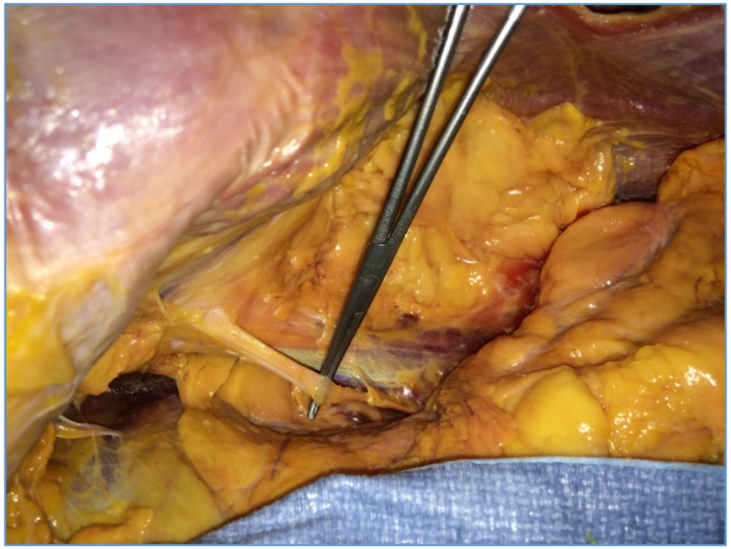
Technique chirurgicale

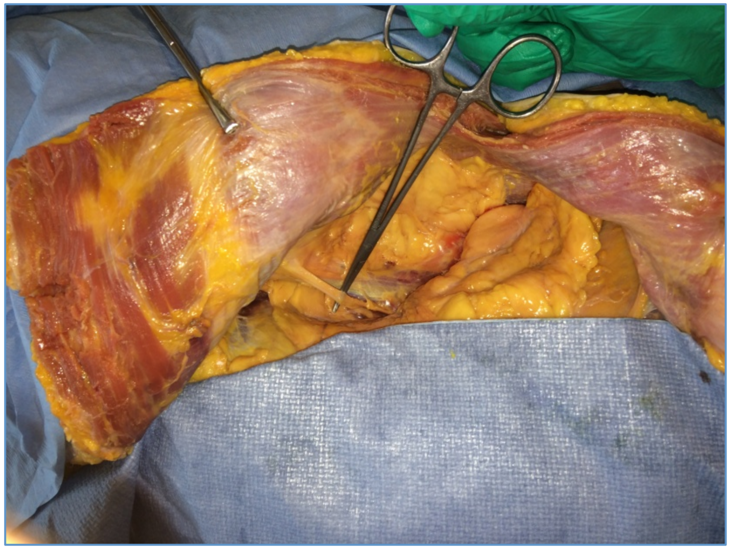


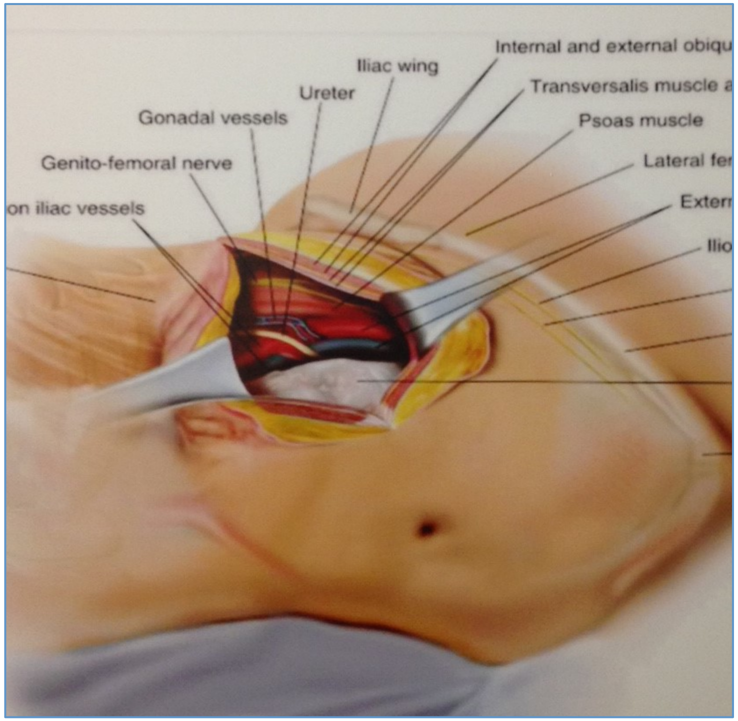




Technique chirurgicale



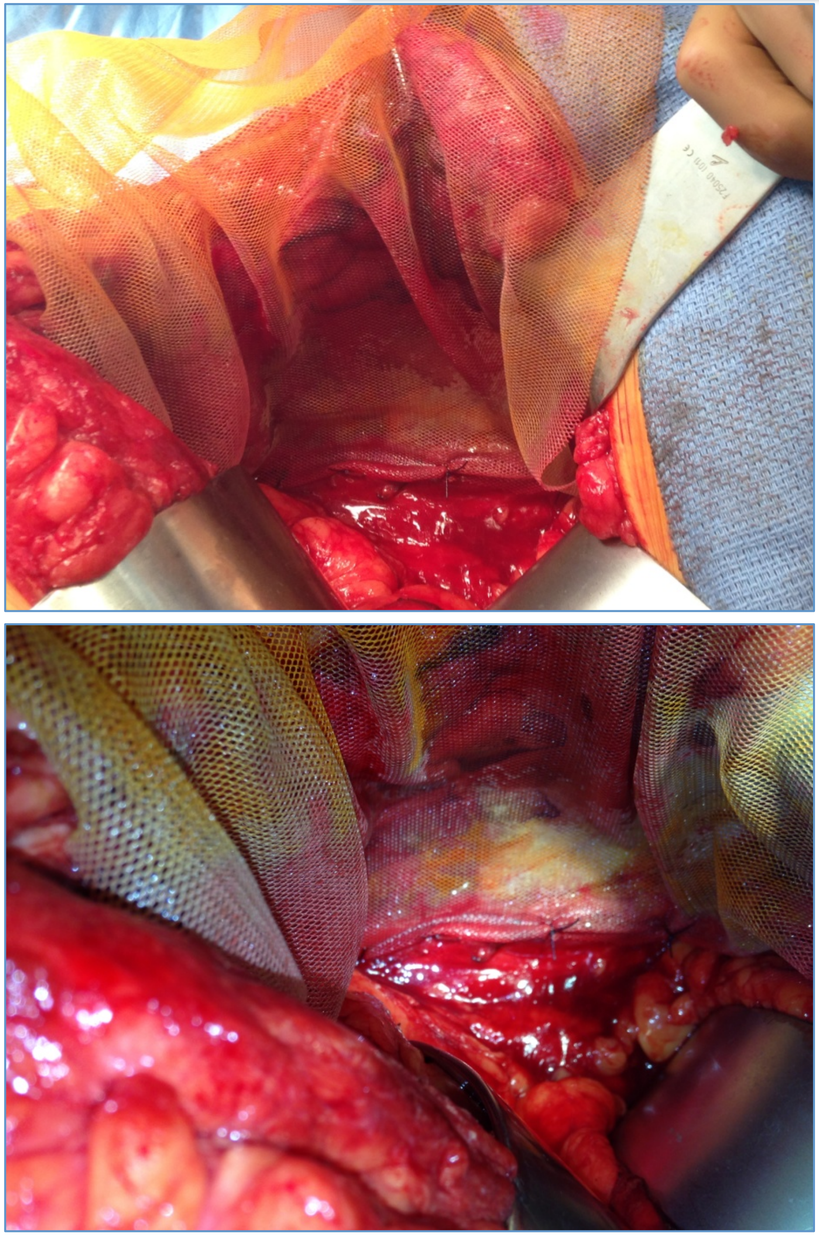


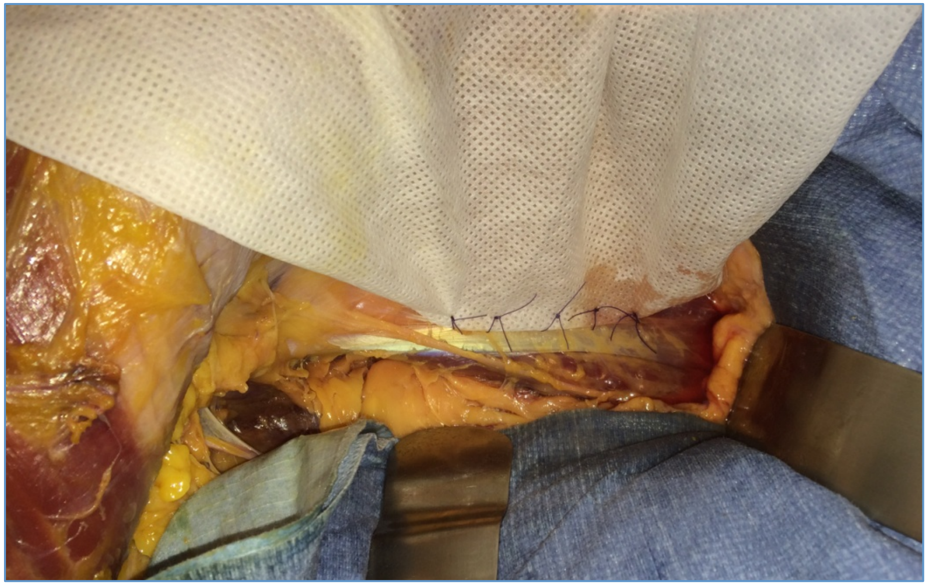

Internal and external obiqu
Iliac wing
Ureter
Transversalis muscle a
Gonadal vessels
Psoas muscle
Genito-femoral nerve
Lateral fe
on iliac vessels
Extern
Ilio

Repérage :

- Uretère
- Vaisseaux gonadiques
- Nerf fémoral

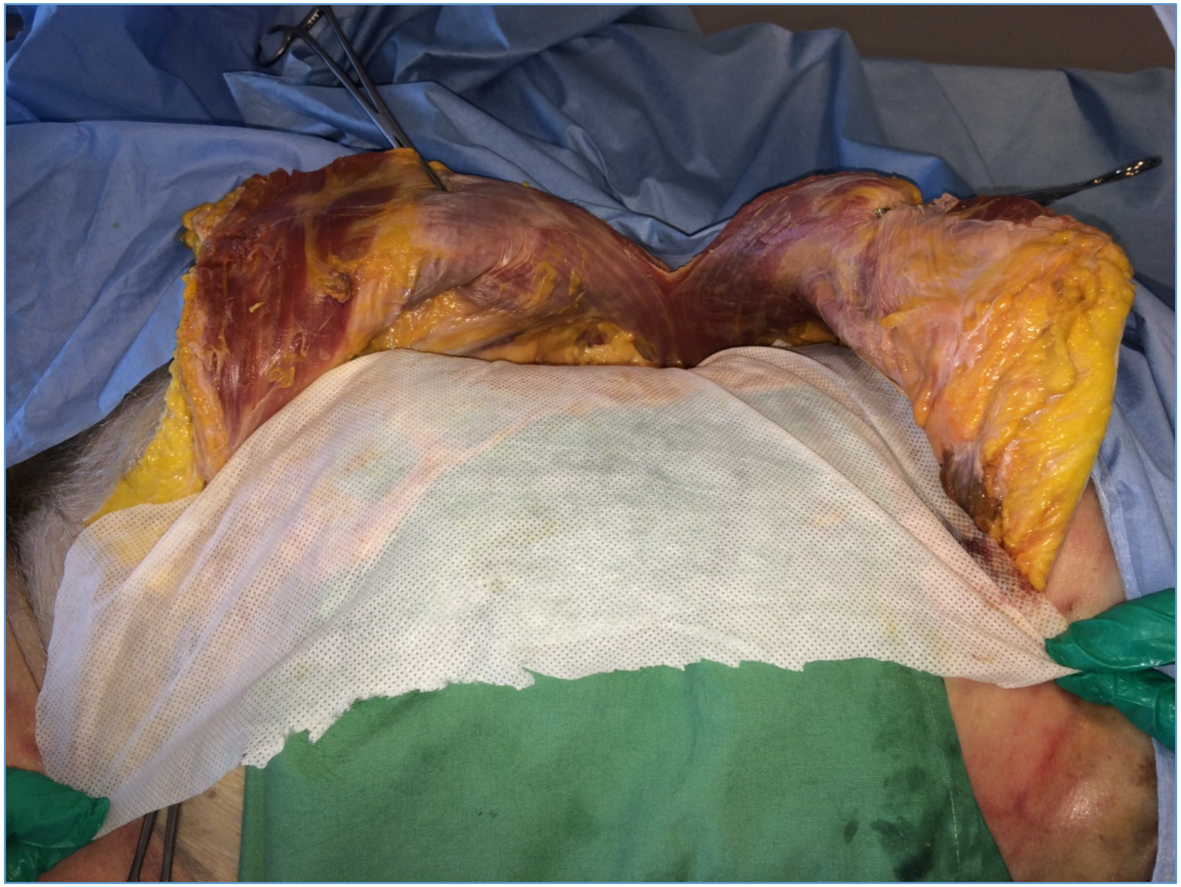
Technique chirurgicale





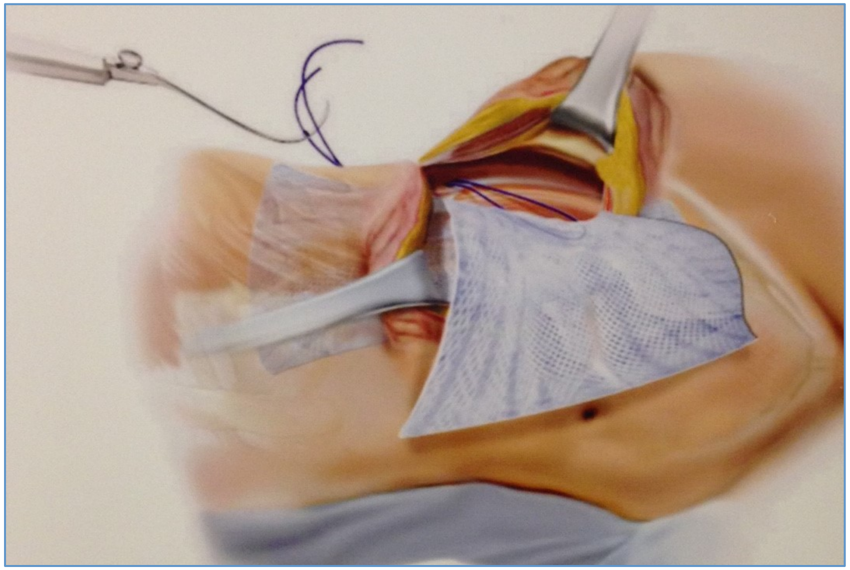
Fixation de la prothèse
au muscle psoas en arrière.

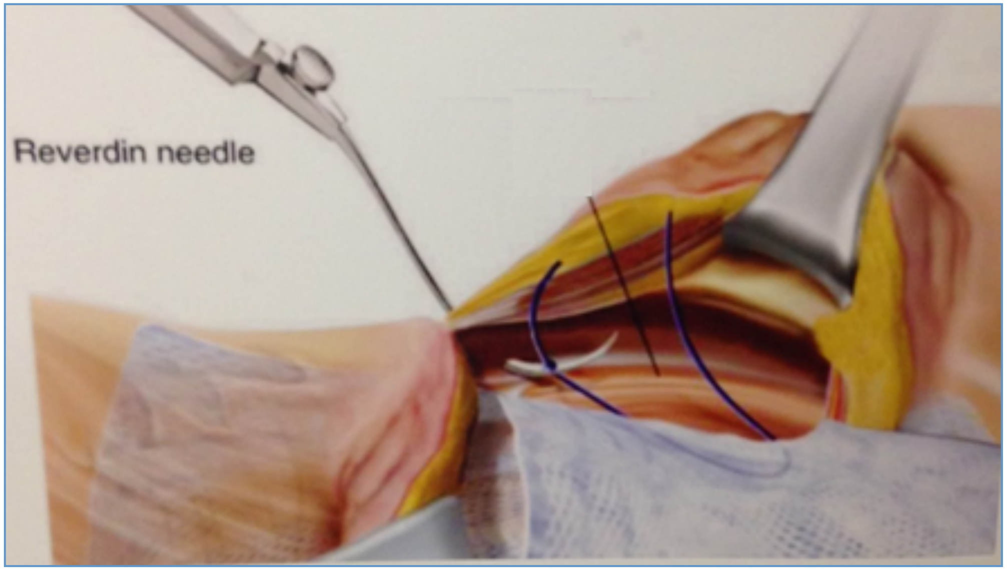
Technique chirurgicale

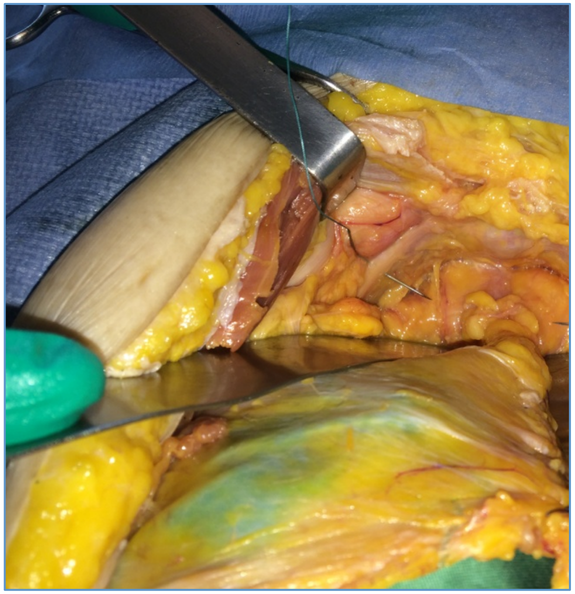


Roulis contro-latéral pour couvrir et fixer la prothèse par la masse viscérale.

Technique chirurgicale





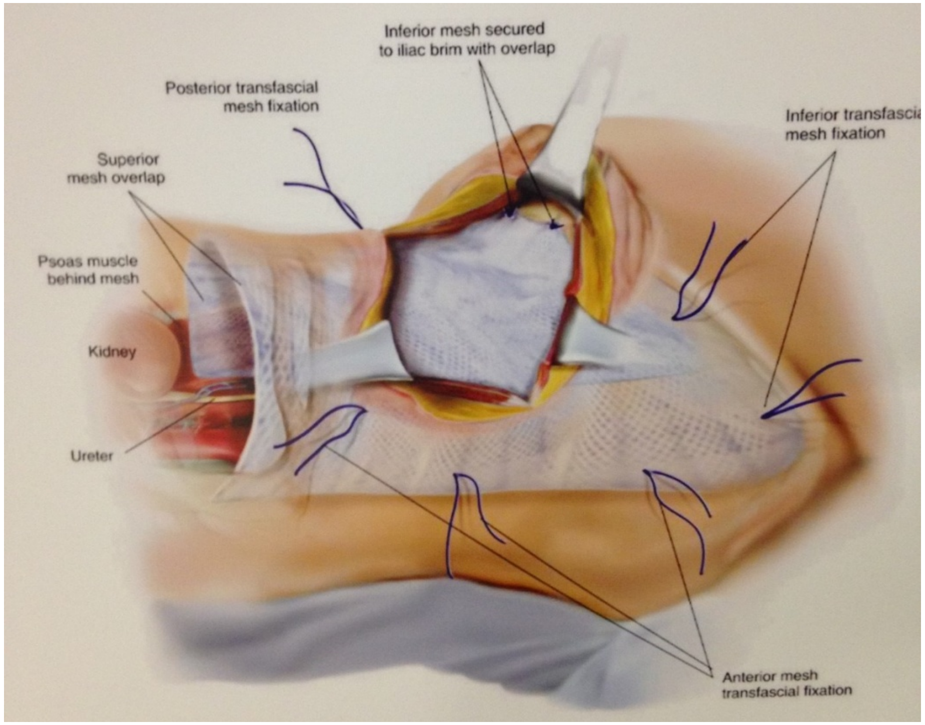


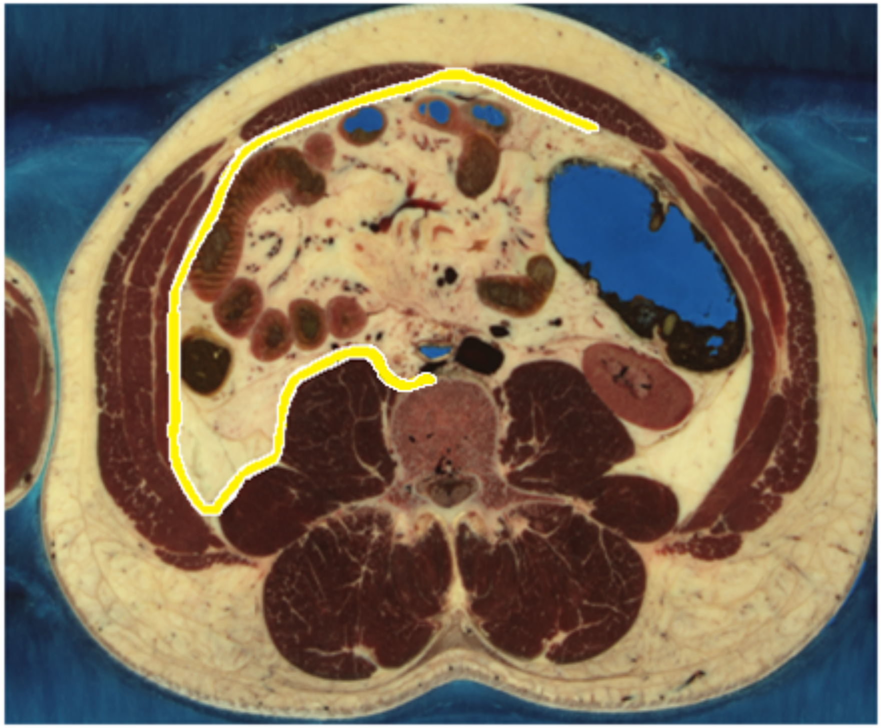
Fixation postérieure trans-musculaire à l’aiguille de Reverdin.

Au ligament de Cooper si nécessaire.

A travers les dernières côtes en haut.

Technique chirurgicale


Inferior mesh secured to iliac brim with overlap
Posterior transfascial mesh fixation
Inferior transfascia mesh fixation
Superior mesh overlap
Psoas muscle behind mesh
Kidney
Ureter
Anterior mesh transfascial fixation



Position finale de la prothèse

Voie ouverte / Cœlioscopie ?

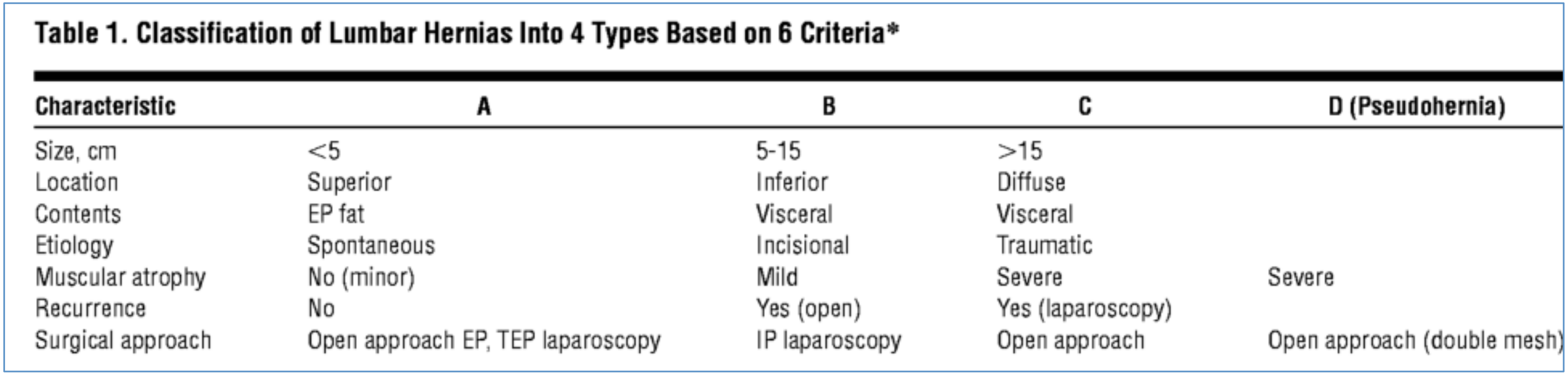
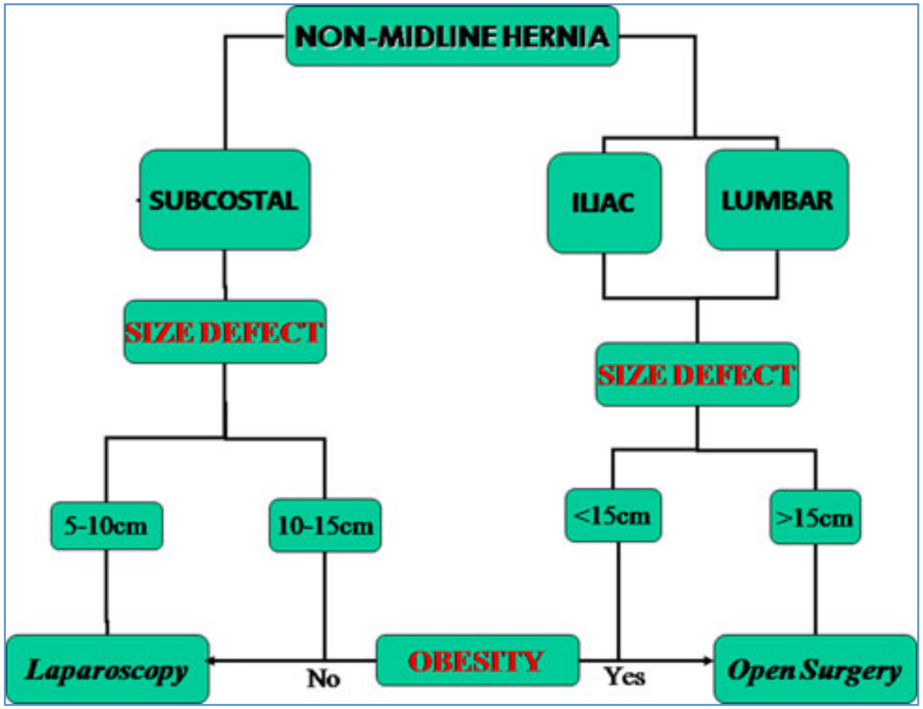


Table 1. Classification of Lumbar Hernias Into 4 Types Based on 6 Criteria*

Characteristic	A	B	C	D (Pseudohernia)
Size, cm	<5	5-15	>15	
Location	Superior	Inferior	Diffuse	
Contents	EP fat	Visceral	Visceral	
Etiology	Spontaneous	Incisional	Traumatic	
Muscular atrophy	No (minor)	Mild	Severe	Severe
Recurrence	No	Yes (open)	Yes (laparoscopy)	
Surgical approach	Open approach EP, TEP laparoscopy	IP laparoscopy	Open approach	Open approach (double mesh)


NON-MIDLINE HERNIA
SUBCOSTAL
ILIAC
LUMBAR
SIZE DEFECT
SIZE DEFECT
5-10cm
10-15cm
<15cm
>15cm
Laparoscopy
No
OBESITY
Yes
Open Surgery

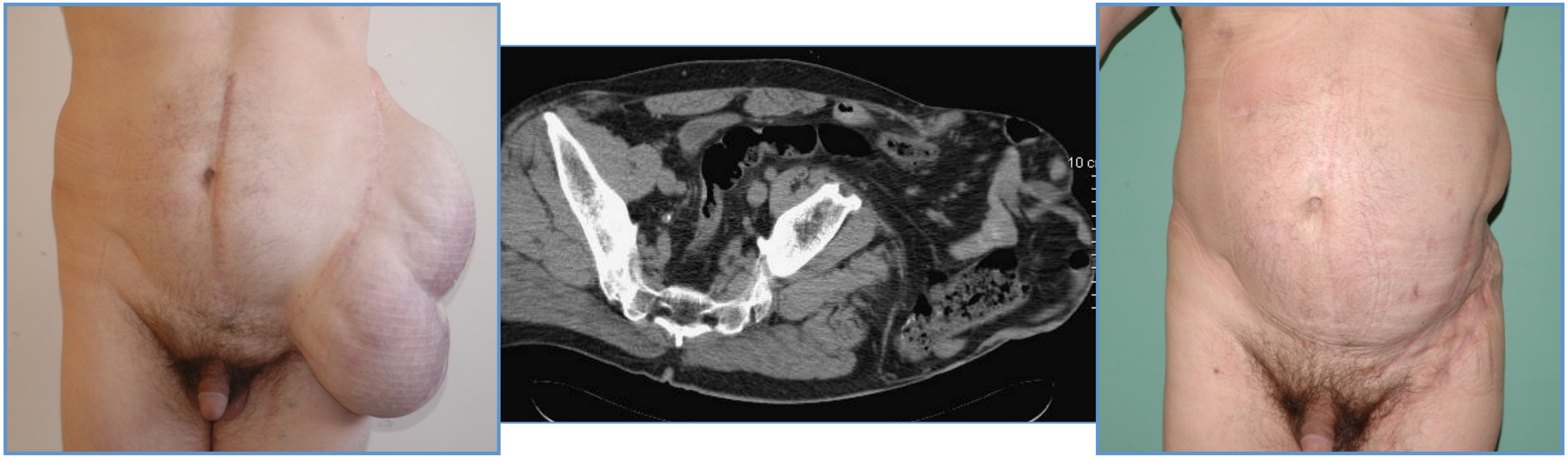
Retente des muscles
(surtout si dévervation)
➔ Voie ouverte !!

Moreno-Egea A. Arch Surg. 2007
Moreno-Egea A. Surg Endosc. 2012

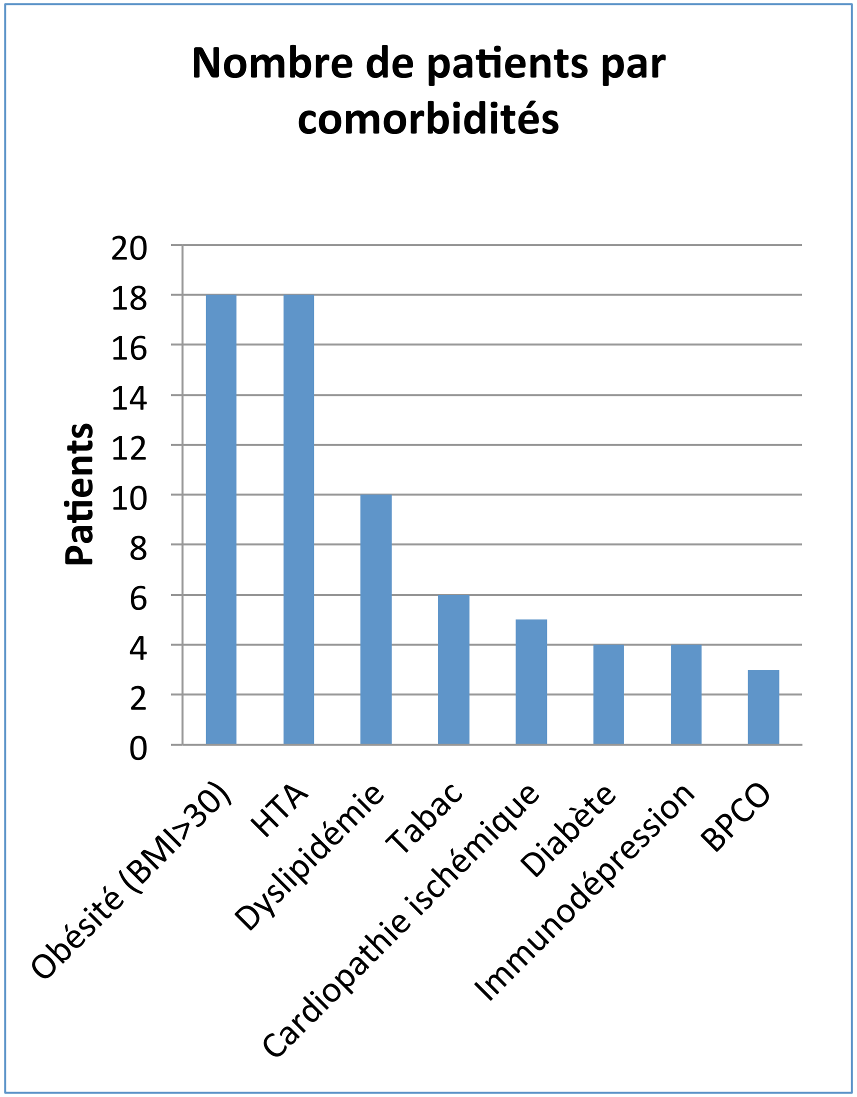
Série rémoise

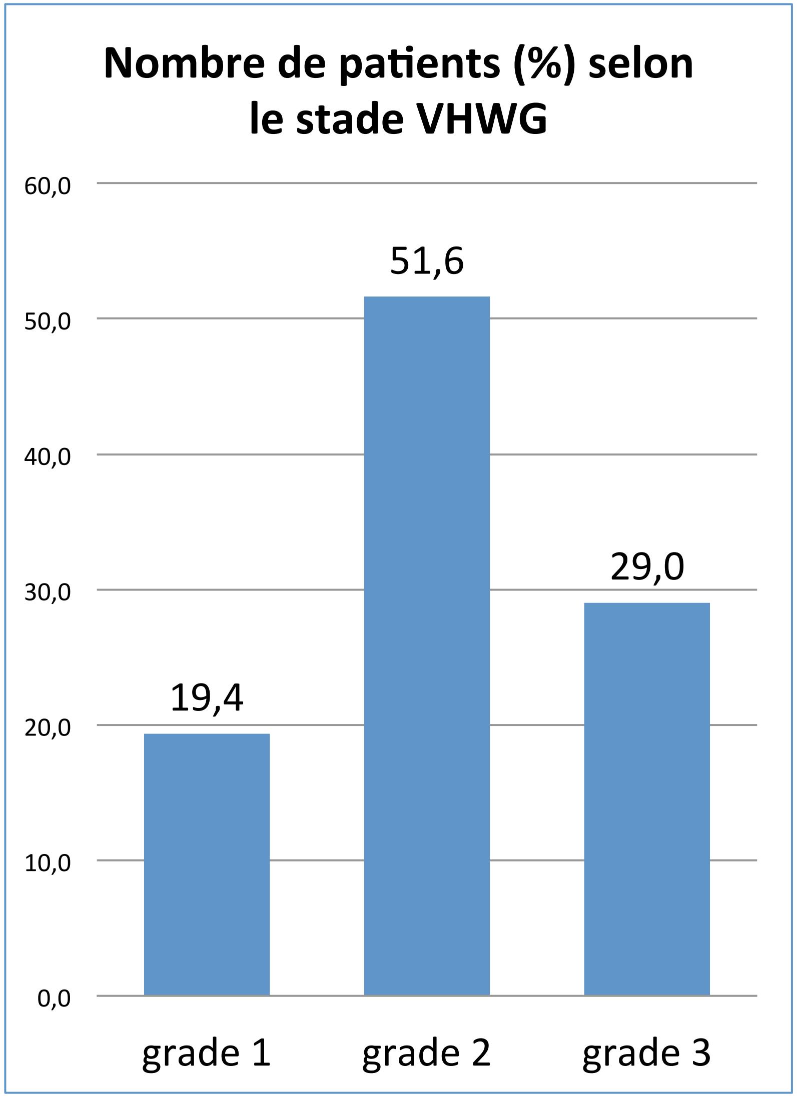
Rétrospective
Eventrations lombaires
Janvier 2009 – Janvier 2015
Technique identique, voie ouverte
31 patients
Suivi 17 mois

Série rémoise (moyenne, bornes)	
Patients	31
Age (an)	59,8 (23-77)
Sexe	16 H, 15 F
BMI (kq/m^2)	30 (20,7 – 46)

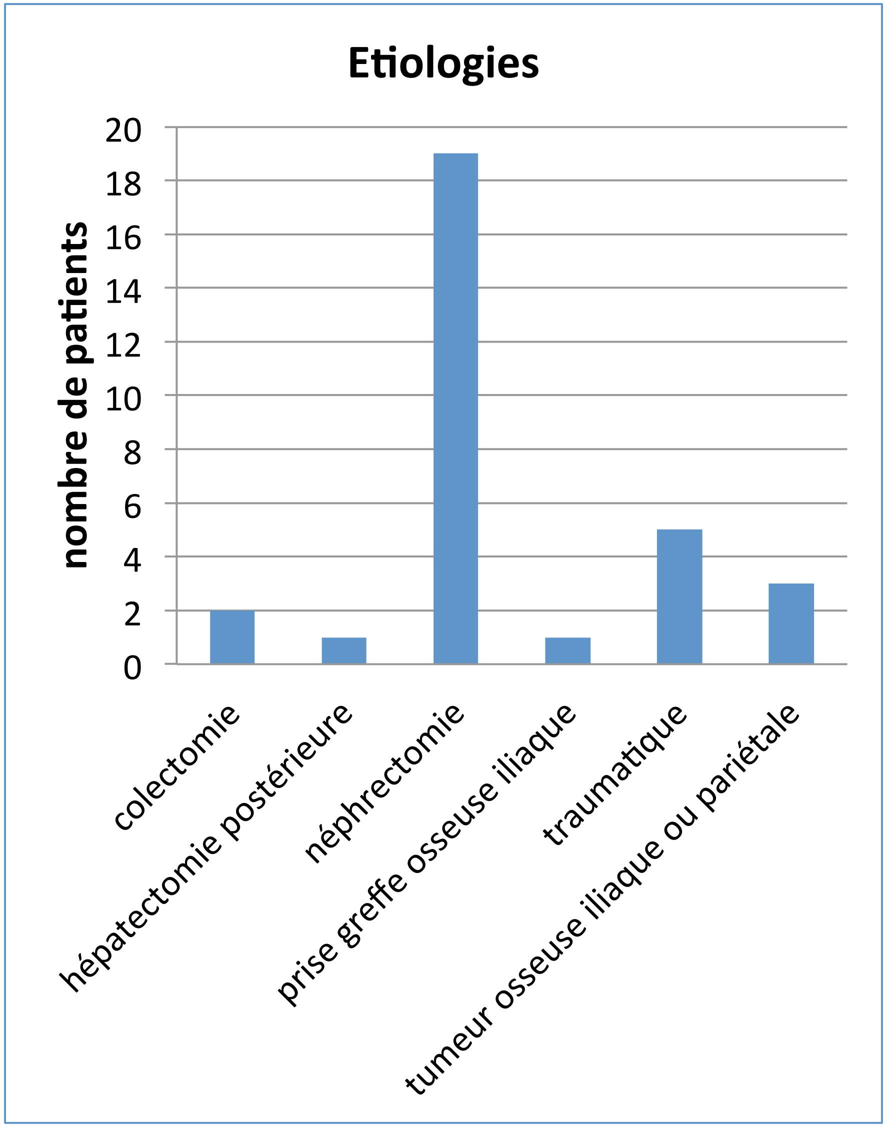


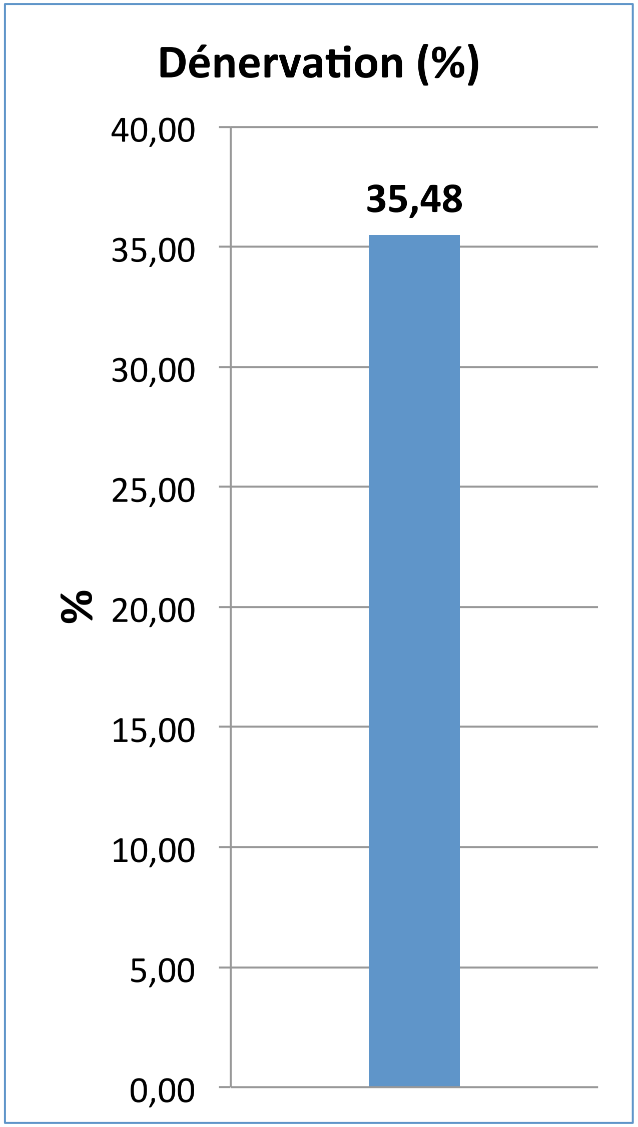
Série rémoise



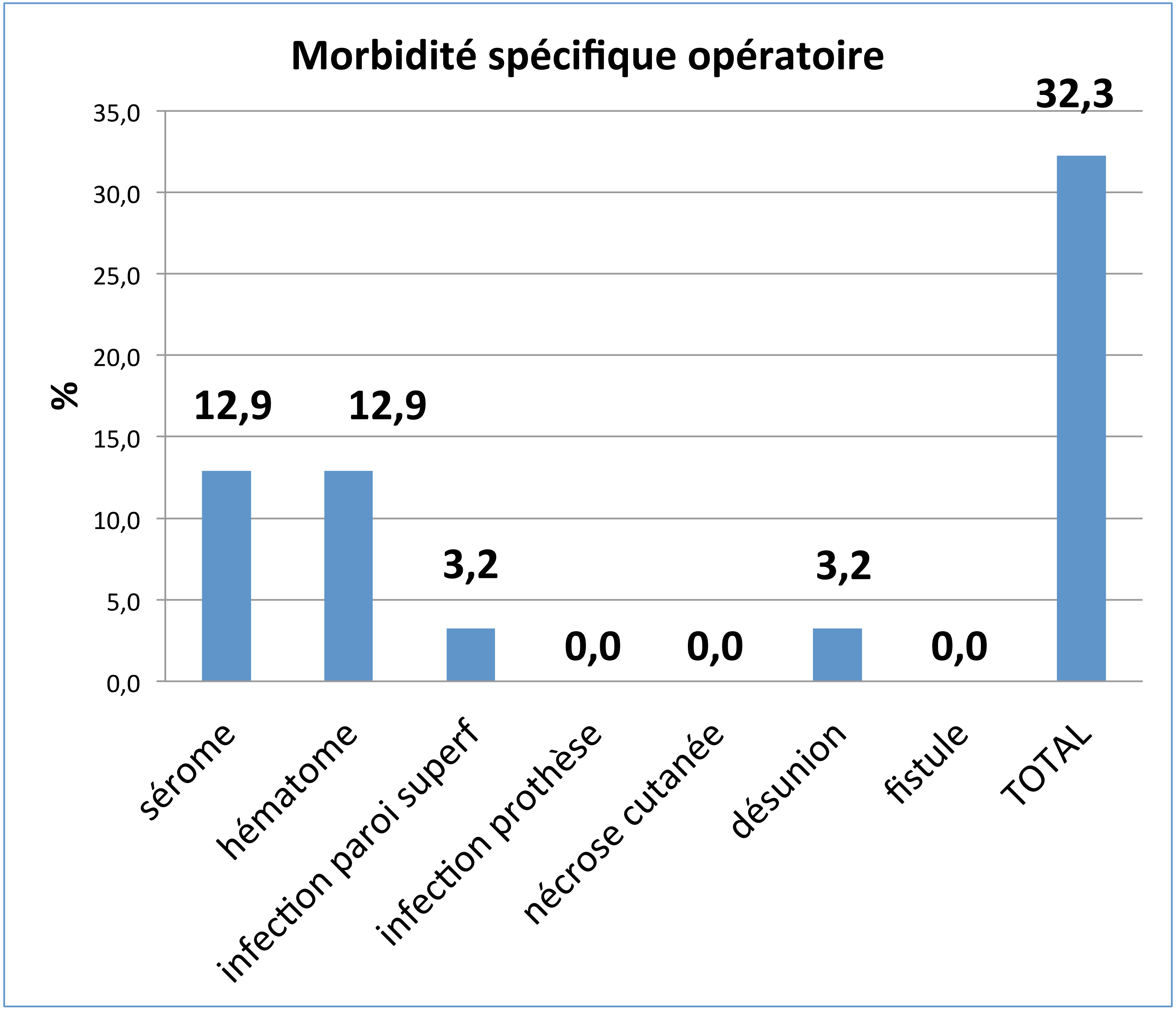


Série rémoise

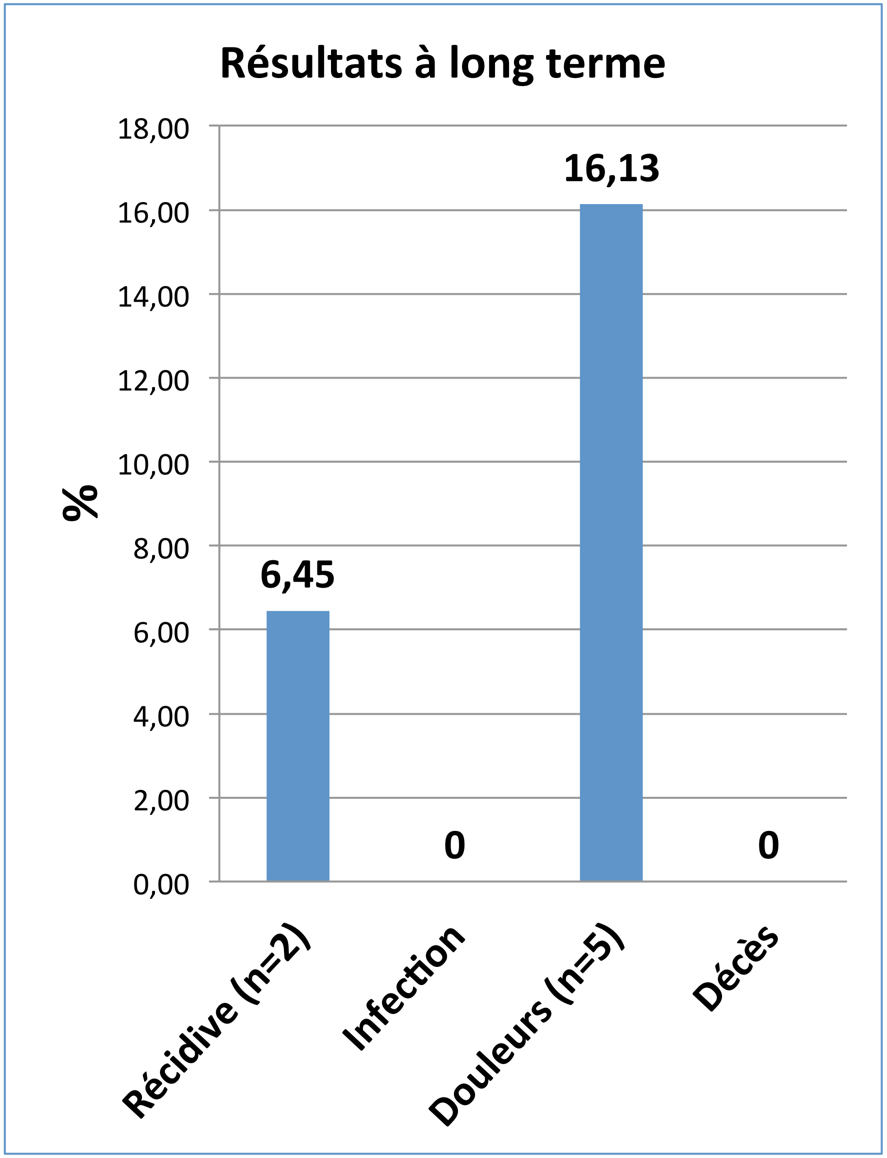

Etiologies

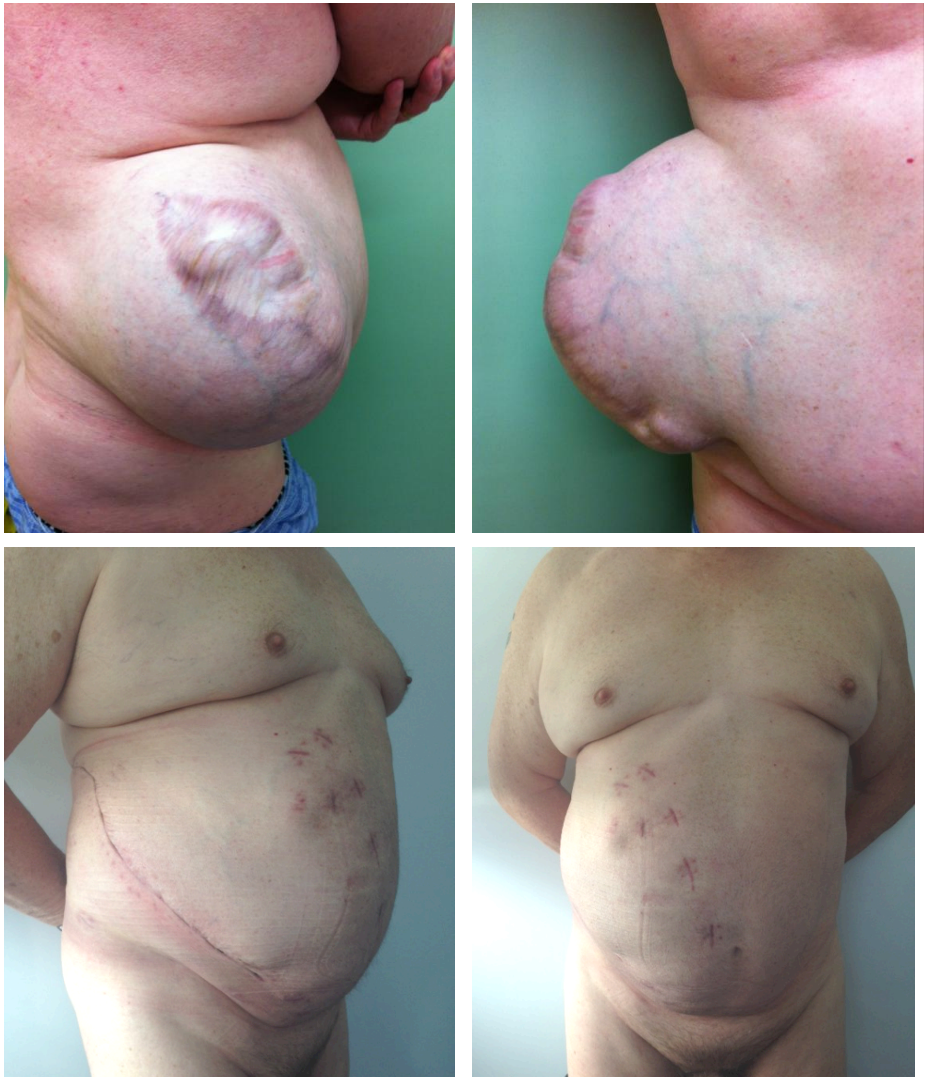

Dénervation (%)

Série rémoise



Série rémoise





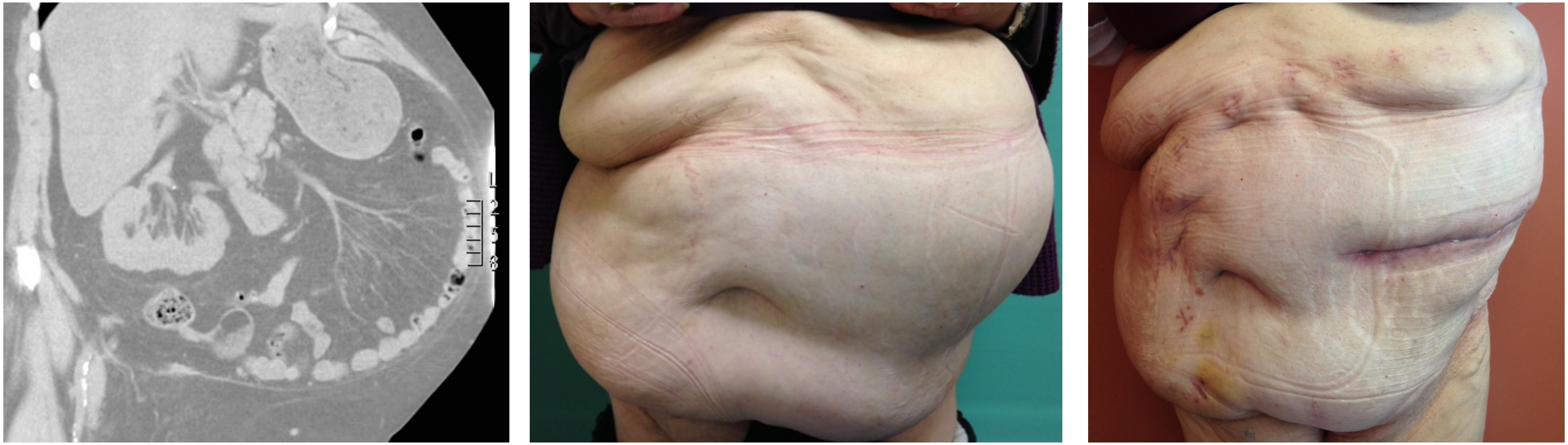
Conclusion

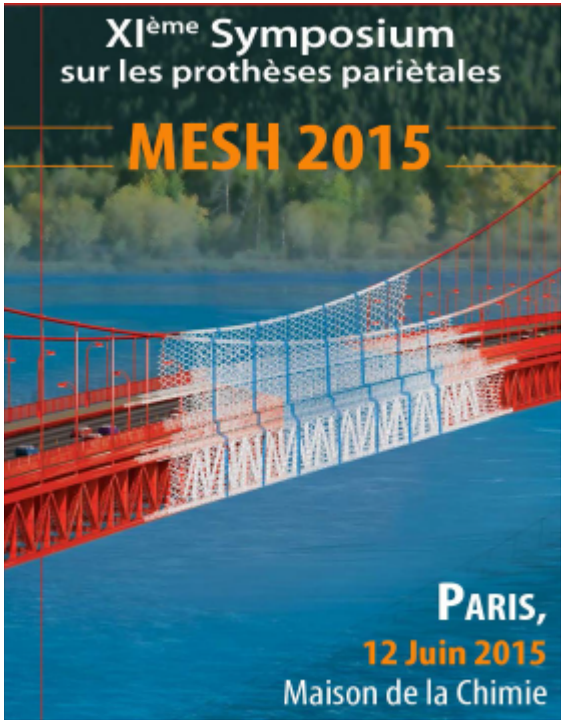
Rare (20% des éventrations latérales)

Le bon plan, prothèse large (5 cm en arrière)

Suture par apposition sur le psoas

Dénervation associée++ : traiter en même temps que l’éventration




XIème Symposium
sur les prothèses pariètales
MESH 2015
PARIS,
12 Juin 2015
Maison de la Chimie

Session n°5 : jeunes Chirurgiens en collaboration avec AJCV

Eventrations Lombaires et lombo-fessières

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