Parastomal hernia

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When surgeons create a stoma, such as a colostomy or ileostomy , they are e ff ectively creating a hernia by bringing bowel out through the abdominal wall. The muscle defect created tends to increase in size over time and can ultimately lead to massive herniation around the stoma. The rate of parastomal hernia is over 50%. For patients, it is very di ffi cult to manage a stoma that is lying adjacent to or atop a large hernia. The stoma may intermittently obstruct and appliance bags fit poorly leading to leakage. The ideal surgical solution for the patient is to rejoin the bowel and remove the stoma altogether, but this is not always possible. The stoma may be re-sited but parastomal hernia will occur at the same ra te at the new location, so it is no longer recommended. Numerous techniques have been described to repair parastomal hernia but failure rates remain high. Mesh repairs are associated with a lower recurrence rate but also with occasional bowel erosion and infection. Meshes are best placed in the retromuscular space but intraperitoneal mesh placement is also popular (Sugarbaker). Laparoscopic repair is also possible, using a modified Sugarbaker technique or by using a large mesh with a central hole (‘keyhole’ technique). Recent reports have described the use of prophylactic mesh insertion at the time of formation of the stoma. A large-pore polypropylene mesh is inserted in the retromuscular space so that the bowel passes through a hole in the centre of the mesh. Using this technique, parastomal hernia rates may be reduced significantly .

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