Expert Commentary on Diagnosis and Management of Perineal Hernia

Pieter J. Tanis, M.D., Ph.D.1,2

1 Department of Surgery, Amsterdam UMC, University of Amsterdam, Cancer Center Amsterdam, Amsterdam, the Netherlands
2 Department of Surgical Oncology and Gastrointestinal Surgery, Erasmus MC, Rotterdam, the Netherlands

Perineal hernia after abdominopерineal resection (APR) is an underemphasized problem that often significantly interferes with most daily activities, such as sitting, walking, and cycling. Surgeons have not paid much attention to this long-term complication. Literature on surgical repair is scarce, with small case series that report on all kinds of techniques with often short follow-up. Recurrence rates seem to be much higher than reported based on my own experience with extended follow-up and several failures that were referred to me.

Perineal hernias are often associated with functional problems. In women, the vagina might be angulated in a dorsal direction with even prolapse of the uterus (or top of the vagina after a hysterectomy) as part of the perineal herniation. If female patients were sexually active before APR, this is often no longer the case postoperatively due to anatomical changes that make vaginal penetration impossible. Therefore, some patients specifically ask if pelvic floor reconstruction with correction of the angulated vagina might restore their sexual function. However, these expectations should be tempered according to my personal experience. Prolapse of the bladder into the perineal hernia results in inadequate emptying and overflow incontinence.

Regarding surgical repair, there is no real advantage of biological mesh in the absence of contamination. Therefore, synthetic mesh is preferred because of lower costs. Noncoated polypropylene mesh is appropriate in case of full coverage by omentoplasty, while any potential

REFERENCES


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Correspondence: Pieter J. Tanis, M.D., Ph.D., Department of Surgical Oncology and Gastrointestinal Surgery, Erasmus MC, Doctor Molewaterplein 30, 3015 GD, Rotterdam, the Netherlands. E-mail: p.tanis@erasmusmc.nl

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contact with the bowel requires a dual mesh. The mesh has to be placed in a bridging configuration, likely explaining the high recurrence rates. The mesh should sufficiently overlap the coccyx/distal sacrum and lateral pelvic side walls. Positioning the mesh on the ventral side is less straightforward. Following the previously transected levator muscle and puborectal sling, the mesh should ventrally be positioned behind the posterior vaginal wall or prostate. But then, the mesh is not overlapping the top of vagina or seminal vesicles and bladder, with a potential risk of ventral recurrence. Alternatively, one might create an overlap of the mesh on top of the bladder, as is often performed using a (laparoscopic) abdominal approach. However, in such cases, the mesh does not anatomically reconstruct the pelvic floor, and intra-abdominal pressure will result in dorso-caudal displacement and prolapse of the urogenital organs.

Personally, I prefer a transperineal approach with anatomical reconstruction of the pelvic floor. This means ventrolateral fixation alongside the posterior vaginal wall or prostate with fixation in the anterior midline to the perineal body. With this approach, the mesh will reposition and support the urogenital organs, potentially improving function. The top of the vagina or seminal vesicles can be fixed to the mesh to prevent ventral recurrence. Dorsally, one can consider drilling some holes in the sacrum for transosseous sutures that pull the mesh toward the inner side of the sacrum. On the lateral sides, the mesh should not be stitched to the medial edge of the gluteal muscles, but to the remnants of the levator muscle more inward. My current practice is to create a small unilateral gluteal turnover flap for better soft tissue coverage of the mesh and prevention of perineal seroma formation. Such a combined mesh and flap technique seems to reduce the risk of recurrent hernia.