



ABDOMINOPLASTY AND SUMULTANE CURE OF A HUGE SUBUMBILICAL EVENTRATION

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CASE REPORT

ABSTRACT

Abdominal wall vents are musculo-aponeurotic continuity solutions secondary to a surgical incision or penetrating wound of the abdomen [1]. Their frequency, in series with sufficient decline, varies from 13 to 20% of laparotomy [2,3]. The incidence is correlated with the location and size of the incisions, the type of surgery, initial pathology and the patient's terrain [4]. Multiple repair techniques have been described in the literature; the combination of this cure with an abdominoplasty makes it possible to give a satisfactory result both functionally and aesthetically. In this work, we present the strategy adopted by our team in the management of a clinical case of subumbilical ventration.

INTRODUCTION

OBSERVATION:

The patient M.A, aged 48 years, with a history of 03 caesarean sections, followed in visceral surgery for recurrence of a huge subumbilical ventration.

The clinical examination showed a conscious patient, in good general condition, apyretic, with a stable hemodynamic state, presenting a subumbilical abdominal skin apron, aggravated by a ventration of intestinal contents whose round base clinically measures 16 cm of large diameter, on pre-existing caesarean section scar. Examination of the rest of the abdominal wall finds good quality skin, without stretch marks or other scarring; excess fat was demonstrated at the epigastric level and on both the right and left flanks. Examination of the muscle strap was hampered by the ventration; however, good muscle tone has been reported in supra-umbilical (Figure 1,2).



Figure 01: Front View



Figure 02: Left Profile View

The radiological assessment done (CT) was in favor of a ventration of 16.5 cm of major axis (collar), of intestinal contents sitting at the subumbilical level slightly to the right of the midline, associated with a supraumbilical diastasis of 5 cm wide.

Surgical technique:

The intervention begins with the realization of the preoperative drawing, this is the usual trace of anterior dermolipsectomies, it is carried out on the awake patient, standing. The midline is first drawn from the xiphoid appendix to the pubic symphysis. Multiple paths can be made; in our service, we use the one based on the rule of 7. The pubic lower point is placed 7 cm, skin tense, from the top of the vulva in women or from the root of the penis in men. We then mark a point on each side of the previous one and 7 cm from it. The suprapubic incision extends from one iliac spine to another, passing through these 3 points.

The areas of liposuction are marked largely avoiding those interested in ventration (Figure 03).



Figure 03: Preoperative plot showing the areas to be resected and lipospired (face, right profile and left profile)

The procedure begins with the infiltration of the areas to be sucked by adrenaline serum: 1mg/1000 cc, which is therefore followed by liposuction.

Skin incision according to the tracing. The detachment under supra-aponeurotic umbilical is done cautiously near the area of the vent until the exceedance of this region; the collar being detected, the visceral surgeon releases the entire extent of the ventration; the reinstatement of the content is made associated with a paritorraphy. The prosthetic parietoplasty was performed by bifacial plate

(Composite Parietex®) and the prosthesis was placed in preperitoneal retromuscular.

Circular cutaneous incision around the umbilicus, which is dissected along its entire length and then isolated.

Continuation of the supra-umbilical detachment, it is medial and is continued to the lower ribs and the xiphoid appendix.

Cure of supra-umbilical diastasis and respect for subumbilical enlargement.

Symmetrical subumbilical cutaneous-fatty resection.

Externalization of the umbilicus, 11 cm above the suprapubic incision, through a round or inverted V-shaped incision.

Sutures in 2 planes on 3 suction drains, including one intraperitoneal.

Compression dressing associated with an abdominal restraint sheath.

The surgical follow-up was simple with a favorable evolution in the short, medium and long term; no complications or recurrences were noticed with an 18-month setback (Figure 04).



Figure 04: Postoperative appearance (face and profile)

RESULT AND DISCUSSION

In abdominal surgery, large ventrations are a major complication whose treatment is responsible for a mortality of up to 10.4% in complicated forms [5]. The economic impact is considerable, aggravated by the frequency of recidivism, which can reach 51% [6].

It is common to find during pre-aponeurotic detachment one or more small orifices that are treated in

a simple way by reintegrating the contents and closing the fascia to the non-absorbable thread [130]. For larger vents, often detected during the consultation, simultaneous treatment does not result in additional skin detachment, so this is achievable without particular risk even if a plaque is needed.

The classic abdominoplasty procedure, supplemented by the placement of a pre-muscular, retromuscular pre-fascial plaque is increasingly practiced.

The prosthesis can be placed in four sites, pre-aponeurotic, pre-fascial retromuscular, pre-peritoneal retromuscular, intraperitoneal.

The technique restoring a normal anatomy (re-tensioning of the large straight muscles reinserted on the midline) with retro muscular prosthesis remains a preference.

Regarding risks; H.Le GALL *et al* [8] investigated the incidence of complications in patients receiving this combined procedure compared to those receiving abdominoplasty alone. They found no significant difference in infectious complications between the two groups. The cure of a parietal defect with placement of intraperitoneal prosthesis, associated with a tummy tuck with transposition of the umbilicus at the same time operative seems to them to be a beneficial intervention.

However, further studies are needed to confirm the absence of over-risk in terms of infectious complications of this technique compared to abdominoplasty alone.

In addition, the indication of a tummy tuck as a complement to a surgical course of ventration promises a very high satisfaction rate.

CONCLUSION

Plastic and abdominal wall repair surgery has evolved considerably in recent decades. Not only did it make it possible to propose appropriate therapeutic techniques and strategies, but also to correct the main functional and aesthetic damage posed by the abdomen.

Through this clinical case, it seems necessary to us to recommend the combination of an abdominoplasty with a parietal repair, since it is advantageous and well tolerated, when indicated.

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