

**Re: JSL 2007;11(3):389–393 Fatal Intestinal Ischemia After Laparoscopic Correction of Incisional Hernia**

Dear Dr. Kavic:

I found the article *Fatal Intestinal Ischemia After Laparoscopic Correction of Incisional Hernia* by Dr. E. B. Wassenaar et al (2007;11(3):389–393) very interesting and illuminating concerning mesenteric arterial atherosclerosis and its most severe end point. Their 47-year-old patient exhibited postlaparoscopy intestinal ischemia requiring visceral angiography and inferior mesenteric artery angioplasty (no stent despite some recoil/residual stenosis of this apparent single and vessel supply of the GI tract). Their patient, and 10 of another 14 patients in their review, did not survive.

Their specific patient presented with known aorto-iliac atherosclerotic disease requiring previous iliac angioplasty. At that time, I suspect that arteriographic definition of celiac/superior mesenteric/inferior mesenteric stenosis/occlusions could have determined that their patient was at high risk for mesenteric ischemia. Perhaps this ultimately fatal outcome could have been precluded had angioplasty/stenting been performed preoperatively rather than after ischemia had occurred?

Mesenteric vascular disease is a highly lethal/morbid process that many times is overlooked unless “classic” symptoms are present. Unfortunately, many times our patients present with much more soft/subtle signs and symptoms (intermittent dyspepsia, nonspecific weight loss, general malaise, and other things) and many times with no suspicious symptoms at all. Significant mesenteric arterial stenosis (at least 2 of 3 vessels) is now seen/found incidentally by MRA or CT angiography performed for other indications.

The therapeutic conundrum is what should be done for the elective, minimally symptomatic patient? I suspect that many of us have known at least several patients who developed serious mesenteric ischemic complications whilst in the conservative follow-up phase of their mesenteric arterial disease as demonstrated by radiologic studies.

There is somewhat of a divergence of opinion between some published material and what is discussed at vascular meetings regarding this problem. I do suspect that “forewarned is forearmed.” I would respectfully urge vigilance in the detection of significant (2 of 3 mesenteric vessel stenoses) and plea for early treatment of such PRIOR to the development of devastating visceral ischemia and its consequences.

Very sincerely yours,

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Board Certified – General Surgery  
Board Certified – Thoracic Surgery

**Authors' Response**

To the Editor:

We would like to thank Dr. Johnson for his interest in our recent article. In his correspondence, he raised a question about arteriographic evidence of stenosis or occlusion of mesenteric vessels in our patient. Unfortunately, we did not have any. Four years before our laparoscopic incisional hernia correction that took place in June 2005, the patient underwent an ultrasonographic duplex examination that only demonstrated significant stenosis in the right common iliac artery. Subsequently, the patient underwent a percutaneous transluminal angioplasty in October 2001 with a very good result. The last control duplex ultrasonography was performed one year before laparoscopic hernia repair (July 2004) and detected no hemodynamic signs of restenosis.

Unfortunately, the patient's medical history, the absence of signs and symptoms of mesenteric ischemia, and—probably the most important—the lack of suspicion, resulted in no investigation being performed preoperatively that was directed at evaluation of the mesenteric vasculature. Needless to say, we assume that preoperative detection of severe mesenteric vessel stenosis would trigger adequate therapeutic reaction before hernia repair or, at the least, help us in early recognition of the nature of the underlying problem.

E. B. Wassenaar, J.T.F.J. Raymakers, S. Rakic