In the laparoscopic mesh repair of ventral hernias, the mesh is usually fixed by tackers, staples or sutures. Compared to suture fixation, the mesh fixation by tacker is relatively faster and easier. For the tacker fixation to be secure, the tacker must drive all the way into the abdominal wall fascia. Depending on the thickness of the mesh, the abdominal wall and the preperitoneal fat, the tackers sometimes are not long enough to have a good hold on the fascia to secure the mesh. Improper fixation can leave a loose tacker in the abdominal cavity or a sharp protruding end giving rise to complications.

Case Report

A 50 year old female patient was admitted for routine laparoscopic mesh repair of her recurrent ventral hernia. On laparoscopy, a part of the greater omentum was found inside the sac. After reducing the hernial content, the defect was repaired using a 15x15cm dual mesh plus biomaterial, (a two layered biomaterial composed entirely of polytetrafluroethylene, Gore-Tex USA). The mesh was fixed using a combination of sutures (Ethilon) and tackers (mesh fixation device, OMS-TTSD, 5mm titanium, single use instrument with 20 helical fasteners, Tyco healthcare, USA). Her postoperative recovery was uneventful apart from a small seroma in the hernial sac and she was discharged home on third day. She presented twenty days after the surgery with a swelling and redness of the skin at the previous hernial site. On examination, infection of the seroma was suspected and some 60ml of offensive-smelling pus was aspirated. She was put empirically on broad-spectrum antibiotics and the seroma cavity was laid wide open. The cultures grew Eschericia coli and Klebsiella. The wound was irrigated several times a day in the hope of salvaging the mesh. Over the course of weeks the wound healed slowly except for a persistent sinus in the middle of the wound which continued to discharge offensive pus which on culture grew intestinal organisms. Infection of the mesh was suspected and the possibility of its removal was discussed with patient. A sinogram performed through the sinus opening showed the contrast tracking to the site of a tacker and on further injection it filled a part of the proximal transverse colon. A tacker had eroded into the colon resulting in a fistula (Figure 1, 2).

Figure 1: Sinogram showing the fistulous tract leading to the tacker. Multiple tackers are seen at the site of fixation of mesh.
A barium enema did not show the fistulous tract or a leak or any irregularity.

A laparotomy was performed and showed adhesions between the mesh, omentum and bowel which were separated. The sharp end of a tacker was seen eroding into the proximal part of the transverse colon (hepatic flexure) making a fistulous communication to the skin. The colon was mobilized and a limited right hemicolectomy was performed. The mesh and all the tackers were also removed. She made an uneventful recovery and was discharged. She was seen six months after the surgery and there was no recurrence of hernia or fistula.

**Discussion**

The fixation of mesh in the laparoscopic repair of ventral hernia with tackers is a fairly standard technique among laparoscopic surgeons (Figure 3, 4). But there are rare reports of tacker related complications of adhesions, pain, hernia, intestinal obstruction, perforation of the bowel or urinary bladder and death. The

![Figure 2: Further injection of dye filling the ascending colon](image1)

![Figure 4: Helica (Spiral) tacker fixation device](image2)

![Figure 3: Intraperitoneal Tacker fixation of mesh](image3)

![Figure 5: Intraperitoneal sharp protruding end of the spiral tacker](image4)

![Figure 6: Spiral tacker used for intraperitoneal fixation of mesh in laproscopic repair of ventral and incisional hernia](image5)
length of a tacker is 4 mm long and depending on the thickness of tissue it may penetrate the neighboring structures with disastrous complications. If not carefully fixed these tackers could fall into the abdominal cavity or the sharp end of a tacker which is not buried properly may cause injury over a time even with normal patient movement (Figure 5, 6, 7, 8). Alternative techniques of suture fixation of mesh may avoid the tacker related complications. 5

References


