

## Invited Commentary

# Concomitant bariatric surgery and component separation: Historical advance or a blunder?

It is well known how practices differ in the 'real' world and the world of surgical academia. In the field of bariatric surgery, synchronous surgery (for example, a cholecystectomy) is routinely practised in India (for example). It is natural for the surgeon and the patient to try and avoid a second surgery, especially if both fall within the core competence of the surgeon. However, this practice is strongly discouraged by evidence.<sup>[1]</sup> In the example cited, synchronous bariatric surgery and lap cholecystectomy have a higher rate of complications and mortality. Still, many surgeons do not think it applies to them.

In the field of hernia surgery, component separation, whether anterior or posterior, open or minimally invasive, is considered a major undertaking. It has systemic implications just like any other major gastrointestinal surgery.

To combine bariatric and complex hernia surgeries may be to put the patient in a double jeopardy. In practice, bariatric surgery is never an emergency, and the same may be said to be largely true for component separation techniques. Therefore, it seems that there can be little justification in doing both procedures together in the same sitting. In fact, the evidence in favour of concomitant ventral hernia repair by intraperitoneal onlay mesh (IPOM) (a lesser procedure than component separation) along with bariatric surgery itself is all over the place, with contradictory reports.<sup>[2,3]</sup> The reported literature supporting this cannot be (and is not) considered to be defining or even convincing, with the recent large study from Cleveland adding to our concerns over increased short-term morbidity.<sup>[4]</sup> I have personally known of patients dying after gastric bypass and IPOM for ventral hernia, from a leak. Bowel obstruction and strangulation at repaired port site hernias is also something some of us have seen. Once bitten, always shy!

It is, of course, well known that leaks and pulmonary embolism are the most important factors leading to mortality in bariatric surgery patients. In the setting of a prolonged combined surgery, a leak could have devastating implications for the patient with a repaired ventral hernia, as could an embolism.

I am personally troubled by this paper, as it may give both a false sense of security, as well as a so-called evidence-based

justification to a surgeon keen on doing combining surgery. Amongst the practical issues, in the patient who undergoes concomitant bariatric surgery and component separation, we have to deal with higher operative time and costs, higher pain scores, greater difficulty in detecting complications early on because of tachycardia and pain, as well as abdominal tenderness after an extensive abdominal wall procedure.

While both endoscopic anterior component separation and IPOM repair are well-established procedures, the current trend in most hernia centres across the world is to favour the posterior component separation (usually the transversus abdominis repair [TAR]) and the retromuscular placement of the mesh. Intraperitoneal mesh usage is increasingly being avoided, as the long-term complications of recurrence, bowel adhesions, obstruction and fistulisation are problematic.<sup>[5]</sup> We have tried to bridge the open posterior components separation technique/TAR and the minimally invasive procedures by establishing the endoscopic totally extraperitoneal retromuscular repair for ventral hernias.<sup>[6]</sup> The encouraging, albeit early, results have kindled enormous interest and discussion in the field of hernia surgery.

While surgery is a craft of skill, it is also more than mere carving and sewing of flesh. In surgery, there is a huge element of judgement, wisdom and consideration for the patient. It is because of these qualities that senior hernia surgeons advocate not combining component separation and bariatric surgery. It is important, in these difficult times of lawsuits and media trials of doctors, to remember that standard of care (SOC) is not about what the expert surgeon would do, but what a reasonable and prudent surgeon would have done. Doing component separation and bariatric surgery together is emphatically not SOC.<sup>[7]</sup>

It is perhaps a good time to remind ourselves of the old saying:

'Just because you can, doesn't mean you should.'

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**Balsubramanian: Concomitant bariatric surgery and component separation**

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