



Letter: Prophylactic Use of Biologic Mesh in Ileal Conduit (PUBMIC): A Randomized Clinical Trial

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To the Editor: We read with interest the article by Djaladat et al published in the June issue of The Journal, "Prophylactic Use of Biologic Mesh in Ileal Conduit (PUBMIC): A Randomized Clinical Trial," on prevention of parastomal hernia (PSH) after radical cystectomy with ileal conduit urinary diversion.¹ Despite their negative results, the authors must nevertheless be congratulated for succeeding in completing this randomized prospective trial (RCT) that provides interesting information that should be taken into account in further investigations on this important subject. Incisional hernia is a very frequent complication that may occur after any abdominal surgery. This complication is somehow neglected by surgeons but significantly impairs the patient's post-operative quality of life, especially as it often requires surgical repair. It is therefore important to evaluate means to decrease the rate of incisional hernia after any abdominal surgery, and particularly in PSH as it is quite frequent after radical cystectomy.² The Djaladat study confirmed this high rate of PSH, being radiologically detected in between 30% to 40% of the cases after a follow-up of 2 years in both groups.¹ Only 3% of patients who underwent radical cystectomy needed PSH surgical repair in the Djaladat study, but this is likely due to the short follow-up of 2 years and the fact that repair of PSH after ileal conduit is rarely indicated due to a low risk of strangulation and the technical difficulties linked to this repair.²

The negative results of the Djaladat RCT should not discourage further trials on the subject as they might be in part attributed to the trial design that dates from 10 years ago, and to the technique they used for PSH prevention, namely a peritoneal absorbable biologic mesh used as a keyhole. The use of an absorbable mesh, either synthetic or biologic, has never proven to be effective in incisional hernia prevention or repair.³ We recently demonstrated the efficacy of a retromuscular permanent polypropylene mesh on prevention of incisional hernia after aortic aneurysm repair,⁴ and it is likely that permanent mesh might also be necessary for PSH prevention. In addition, the PUBMIC trial studied the keyhole technique for PSH prevention, a technique that is based on passing the stoma through a central hole of

the (biologic) mesh, herein placed in intraperitoneal position.¹ In PSH repair, meta-analyses suggested that the recurrence rate after keyhole might be as high as 30%.² In PSH repair after radical cystectomy, we recently published our successful experience using the Sugarbaker technique, consisting of passing bowel laterally through the permanent mesh side.⁵ The Sugarbaker technique is considered more efficacious than the keyhole in PSH repair and deserves to be tested in PSH prevention.

In conclusion, the negative results of the PUBMIC RCT trial reported by Djaladat should not end research on this important topic of PSH after radical cystectomy, and the Sugarbaker technique using a permanent intraperitoneal mesh deserves to be tested as it seems efficient and safe in PSH repair both on colostomy and on ileal conduit.

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Ethics Statement:

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