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COMMENT

Comment to: Initial and recurrent management of parastomal hernia after cystectomy and ileal conduit urinary diversion

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Dear editor,
we read with interest the article by Roussel et al. recently published in the *Journal* and describing their retrospective experience with repair of parastomal hernia (PSH) after cystectomy and ileal conduit urinary diversion [1]. Amongst 35 PSH repairs in a 11-year period, they reported 13 Keyhole and 22 Sugarbacker techniques. The reported outcome of these PSH repairs was quite disappointing, with 30% (Keyhole) and 18% (Sugarbacker) symptomatic recurrences leading to necessary second repair after a median follow-up of 31 and 20 months, respectively. Their report did not provide imaging follow-up. Roussel et al. concluded that the Keyhole and Sugarbacker techniques should not be used in this indication [1], a statement that we do not share for the Sugarbacker technique. Particularly, these results are in opposition to our report published in the June 2024 issue of the *Journal*, in which we described our experience with 23 repairs of PSH after Bricker procedure (16 Sugarbacker and 7 Sandwich repairs) [2]. Our retrospective report described a low clinical recurrence rate of 4.5% after a median follow-up of 57 months. In addition, all but one patient in our series underwent at least one computed tomography (CT). These CTs were retrospectively reviewed with an objective radiological recurrence rate of 13% after a median imaging follow-up of 50 months. Our conclusion was totally different from Roussel et al., as we could show that in our experience, the Sugarbacker and the Sandwich techniques provided excellent results with low rate (4.5%) of symptomatic PSH recurrence [2].

This discrepancy between these two large experiences highlights the fact that the Sugarbacker technique of PSH repair might be challenging, and that several technical factors might influence the postoperative results [3]: the type of the used mesh, the size of this mesh related to the size of the defect, the length of the Sugarbacker tunnel, the use of a Sandwitch technique (a combination of Keyhole and Sugarbacker repairs in case of large PSH defects) [3], the mesh fixation method (single crown or double crown, permanent or absorbable). Furthermore, in our hands, the laparoscopic approach is ideal in the Sugarbacker repair despite the more difficult dissection of potential adhesions, compared to laparotomy. Particularly, during PSH repair phase, we consider that the mesh positioning and fixation is easier by laparoscopy than by open approach.

The type of mesh used in the Sugarbacker technique remains an important matter of further studies. To our view, as in all incisional hernia repair, this mesh should be permanent (higher recurrence rate of biologics or slowly absorbable meshes). In addition, in PSH repair, this mesh should be covered by anti-adhesive material on both sides, as both mesh surfaces are in potential contact with the bowel.

In conclusion, in opposition to the Roussel et al. report, our laparoscopic Sugarbacker experience in repairs of PSH after Bricker procedure showed excellent clinical and CT results after a median follow-up of more than 4 years [2]. Further prospective studies should establish what should be the preventive and therapeutic management of PSH after cystectomy and ileal conduit urinary diversion [4, 5].

Declarations

Conflicts of interest Olivier Detry declares that he has no conflict of interest.

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