Institutional Analysis of Elective Inguinal Hernia Repair in Alcoholic Cirrhosis with Ascites

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BACKGROUND

- Hernias management in patients with alcoholic cirrhosis is complex
- For the non-emergent inguinal hernia, the decision when to operate is nuanced in this population
- We aim to understand which clinical characteristics can help identify which patients are appropriate for inguinal hernia repair

METHODS

- Retrospective review of adult patients with alcoholic cirrhosis of liver with ascites (ICD 10: K70.31) who underwent elective hernia repair at at single institution from 2018 to 2024 was performed
- Variables collected were MELD 3.0, CTP score, ascites, if controlled, with what methods (medications, paracentesis, TIPS), actively drinking, type of repair (open vs. MIS), ligation or reduction of hernia sac, mesh used, LOS, complications

RESULTS

- 22 transplant-naïve patients
- All abstinent from alcohol at time of surgery
- Ascites was manageed pre-operatively by diuretics (91%), TIPS (14%), or paracentesis (9%)
- Mesh was used in all cases
- Post-op surgical drain use was uncommon (3/22)
- Hernia repair was done mostly by general surgeons (91%) followed by transplant surgeons (9%)

Patients Male Female	n = 22 21 1
Median MELD 3.0 (range)	11 (7 – 21)
Median Child-Pugh score (range), grade	6 (5 – 9), A and B
Diuretic regimen Furosemide range Spironolactone range	 20mg to 80mg / day 25mg to 400mg / day
Time from last paracentesis to surgery	1 day to 4 years
Patients underwent TIPS before surgery	3
Hernia sac Ligation Reduction	 15 7
Surgical technique Open Laparoscopic Robotic-assisted	Total (by ligation / reduction) 18 (14 / 4) 2 (0 / 2) 2 (1 / 1)
Complications Seroma Hematoma Decompensation	Total (by ligation / reduction) 3 (2 / 1) 2 (1 / 1) 1 (1 / 0)
Outpatient/Overnight observation Inpatient LOS range	17 5 2 to 20 days
30-day mortality Overall mortality	0% 18% (4 of 22)

DISCUSSION

- Ascites requiring perioperative paracentesis for control was associated with worse outcomes
- The patient with decompensation required pre-op paracentesis and had high post-op ascitic output, thrombocytopenia, hepatic encephalopathy, and hepatorenal syndrome and was discharged to SNF after 20-day LOS
- Ligation of hernia sac was more common than reduction at surgery but had similar rates of seroma formation
- MELD and CTP are useful but imperfect markers for predicting surgical complications.

CONCLUSIONS

- Inguinal hernia repair in patients with alcoholic cirrhosis with ascites is safe in patients with controlled disease
- Decision to operate was dependent on symptom severity, history of incarceration, and approval by hepatology