

INTRODUCTION

- Superior mesenteric vein thrombosis (SMVT) is rare in outpatient inguinal hernia repairs and is infrequently described in past literature.
- There are many hypercoagulable states, like malignancy and genetic predispositions, that increase the risk of VTE.
- Increased age and BMI also predispose patients to SMVT in the setting of surgery.

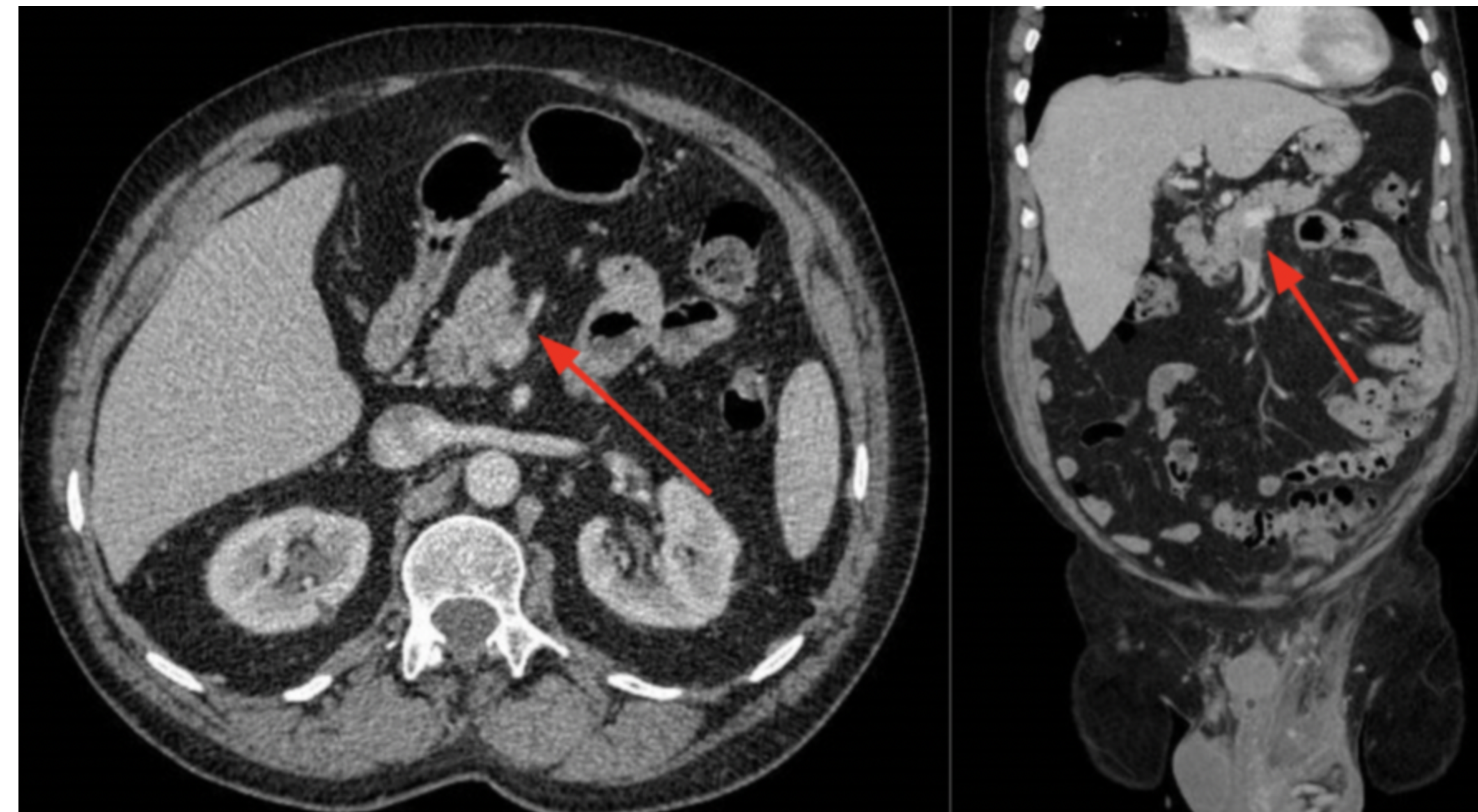
OBJECTIVE

We report a patient who developed a superior mesenteric vein thrombosis following omentectomy during a robotic inguinal hernia repair

CASE PRESENTATION

- Here we present a 63 year old male with obesity and no prior history of VTE who came to our office with a large left inguino-scrotal hernia. His imaging showed it contained a majority of omentum in it. He was taken electively for a robotic Trans-Abdominal Pre-Peritoneal inguinal hernia repair with mesh placement and partial omentectomy.
- The surgery was done as an ambulatory surgery and was technically difficult as the omentum could not be reduced. A bipolar electrocautery device was used to do a partial omentectomy and then reduced and extracted. He was discharged promptly.
- During the surgery the patient had mechanical DVT prophylaxis with sequential compression devices (SCDs), but was not given chemical prophylaxis.

IMAGING



RESULTS

- After 9 days postoperatively, he presented to the ER for mild scrotal ecchymosis where on CT no groin pathology was seen, but there was an acute middle colic vein thrombus extending to SMV on CT.
- He was started on Apixaban and discharged. He was seen 5 days later in the office and will get a repeat CT in 3 months.

CONCLUSION

- This case study highlights a potential gap in recommendations versus practice for DVT prophylaxis in routine outpatient inguinal hernia repairs.
- Currently, we routinely use mechanical but not chemical prophylaxis for DVT prevention in elective hernia repairs, however moving forward, giving chemical prophylaxis for patients with high Caprini scores and low bleeding risk, such as our patient (Caprini score of 1.8%), should become standard practice.
- This is especially important for patients with complex abdominal wall reconstruction or significant comorbidities.