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Importance of making a diastasis smaller before hernia surgery

Tupler J
Diastasis Rehab

Abdominal hernia surgery is more successful if patients prepare for it before surgery just like any other surgery. This is the missing link in prevention of an incisional hernia. The patient must take responsibility for maintaining the integrity of the sutures.

Preparation for hernia surgery involves making a diastasis smaller with the Tupler Technique®. The goal of the Tupler Technique® is to heal the weakened linea alba. The program heals connective tissue by making both the abdominal muscles and connective tissue stronger. Stronger connective tissue is easier to sew and stronger muscles along with an awareness how to use them in the recovery process will maintain the integrity of the sutures thus preventing an incisional hernia.

The 4 step Tupler Technique® is both a research and evidence based program. Diastasis Rehab statistics using 1200 clients proves that within 6 weeks the program can make the diastasis 55 % smaller. The program heals connective tissue by:

1. Repositioning the muscles and connective tissue with a Diastasis Rehab Splint®. By approximating the connective tissue it takes the stretch off the weak connective tissue and continuously keeps it in this narrow position allowing it to heal. The recti muscles need to be approximated in order to move in a backwards not sideways direction. A backwards movement of the muscles strengthens it. A sideways movement not only does not strengthen it, it stretches the weakened connective tissue.
2. Protecting the connective tissue from movements and activities that stretch it. (Exercises in a hands and knees position, swimming, golf, tennis, crunches)
3. Strengthening the transverse muscle and learning how to use it with activities of daily living and then in week six of the program while exercising. Exercises also bring blood flow to the connective tissue.

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Single incision TEP hernioplasty for the patients who have previous history of lower midline incision

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Introduction: TEP hernioplasty is regarded as relative contraindication due to the possible damage of peritoneum for the patients who have previous history of lower midline incision. We have carried out single incision TEP for the patients who have previous history of lower midline incision.

Object and method: 12 patients of inguinal hernia (unilateral: 5, bilateral: 7) who have previous history of lower midline incision received single incision TEP hernioplasty. Break down of previous surgery was (Total hysterectomy: 5, Low anterior resection: 2, Sigmoid resection: 2, Prostatectomy: 2, Y graft replacement of aortic aneurysm) For bilateral lesion repair of each side was carried out through retro-muscular tunnel made each side of rectus muscle. Repair of the other side was carried out through the tunnel made at the other side. Both retro-muscular tunnels were achieved from single incision. (Bilateral approach for bilateral lesion)

Result: Among 12 patients 19 lesion, 15 lesion could be successfully treated by TEP while 4 lesions needed to conversion to open surgery. One patient after radical hysterectomy, 2 patients after low anterior resection, one patient after retropubic prostatectomy needed conversion. On the other hand for the patients who received sigmoidectomy, simple hysterectomy, replacement of abdominal aorta, TEP could be successfully completed.

Discussion: Previous lower midline incision was regarded as relative contraindication for TEP since due to the difficulty for dissecting preperitoneal space and possible injury of peritoneum. However our result demonstrated that lower midline incision itself was not contraindication for single incision TEP. Procedures without pelvic node resection single incision TEP repair could be completed without injury of peritoneum. For single incision TEP with our bilateral approach for bilateral lesion, dissection of pre-peritoneal space can be completed regardless of pre-peritoneal adhesion.

Conclusion: Single incision TEP can be feasible procedure for patients who have previous history of lower midline incision.