

whether it was representative of the systems error classification that is widely discussed in the literature.^{4,5}

The methodology of self-report used by the authors has just captured the errors in each category. Although the error classification was validated, the reliability of the surgical residents in reporting and classifying error is questionable because “no effort was made to educate and train the residents fully in error reporting.”

Our primary concern is that the conclusions of this paper may reinforce the thinking that surgical safety can be improved only by more clinical and technical training. Such a move will set us back by a decade, because it is only recently that we have begun to appreciate the role of systems issues such as teamwork and communication in surgery.^{6,7}

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Colocutaneous fistula after left inguinal hernia repair using the mesh plug technique

To the Editors:

The case illustrated by Ishiguro et al¹ is certainly educational; fortunately because of its rarity rather than for any other reason.

The authors suggest, however, as a consequence of this most unusual problem, that surgeons “should fully inform patients about possible complications from mesh plug and allow them to make an informed decision about the technique used for repair.” Surely

we need not scare patients about exceedingly rare scenarios. How common is this problem and should unwarranted attention really be focused on the initial surgery because rare and uncommon events happen at “St. Elsewhere”?

We scrutinized the literature regarding complications of mesh-plug hernioplasty and concluded that problems described as being a result of plug migration were commonly a result of poor “workmanship” at the time of the original surgery.² All published cases highlighted the need to perform a careful dissection and ensure adequate fixation. Furthermore, all holes in the peritoneal sac, irrespective of their size, should be sought and carefully closed. This is especially so in sliding hernias, as was possibly the case in this report.

One of the criticisms of mesh-plug hernioplasty is that it is a 3-dimensional prosthesis whereas hernial defects are 2-dimensional. Indeed, because of this we have “prepared” the plug prior to insertion in the preperitoneal plane. The outer layer of the plug is gently stretched, thus flattening its 3-dimensional shape prior to anchoring the prosthesis with sutures placed through its inner petals. This allows the outer layer to act as a sublay component in the repair. With this minor modification the “customized” plug manages each individual defect, and we have not experienced any migration in a consecutive series of over 1,500 plugs in 12 years.

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Complications after mesh plug inguinal hernia repair: There is no easy bypass to inguinal hernia surgery

To the Editors:

Ishiguro et al¹ have presented the 3rd case of a colonic fistula after mesh plug repair. Zubaidi et al² and Murphy et al³ reported earlier on colonic fistula secondary to mesh-plug hernia repair. These observations are important as they may lead us to a different thinking and analysis of inguinal hernia repair.

The reports on occurrence of complications after mesh plug hernia repair are in contrast to the results presented by Rutkow and Robbins⁴ and Millikan and

Doolas,⁵ who reported that they never saw any case of mesh migration or mesh infection or other complications related to mesh.

An explanation may be the marketing of the technique. Mesh plug repair is considered to be the easy hernia repair. Rutkow and Robbins⁶ emphasized in their preliminary report in 1993⁶ that they “believe that the ... decreased dissection” is important for lessened overall complication rates.

If it is true that the mesh plug repair is an easy-to-perform technique, then how come we see these complications when it is performed by other surgeons than the experts? And why should surgeons then participate in courses to learn how to do the technique?

Lo et al⁷ recommended the pre-peritoneal dissection be done carefully, to avoid tears in the peritoneum, not to place the mesh-plug deep within the defect, and to secure the mesh plug to reduce the possibility of mesh migration.

This report and others suggest that mesh plug hernia repair may not be such an easy technique to perform and that there is a risk for major complications associated with the technique, especially when poorly performed. After all, there is really a need to learn hernia repair, be it open or laparoscopic.

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