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LETTER TO THE EDITOR

Internal Hernia in the Times of COVID-19: to Laparoscope or Not to Laparoscope?

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It almost feels like a dream. It is still hard to accept that this pandemic has crossed 400,000 cases at the time of writing this letter and by the time it reaches the editor, we would have unfortunately crossed half a million cases. The certainty of this statement is probably more disheartening than the statement itself. Medical fraternity across the world has launched into action as well as it can. Elective surgery has been deferred along with the non-urgent cancer cases. Even the cancer operations face a grim prognosis, firstly with the procedural-related mortality itself but more importantly, the added morbidity and mortality from the risk of contracting coronavirus.

For me, it started hitting home when we were drafting guidelines on how we manage acute surgical patients. For the last 10 years at my hospital, we have tried to establish a hot gall bladder service. To have this dismantled over a cup of coffee was to say the least, soul destroying. To add to this, we have a whole list of acute general surgical procedures (diagnostic laparoscopy, appendicectomy, incision and drainage) that at some point used to arouse the entire junior surgical team, now considered unnecessary. The Italian experience had already warned us to the dangers of aerosol-generating procedures and thus the discontinuance of elective endoscopies; however, we could have never imagined that laparoscopic surgery could fall a victim to this pandemic. The Intercollegiate General Surgery Guidance [1] has been more dogmatic as compared with the American College of Surgeons [2] and now recommends "Consider laparoscopy only in selected individual cases where clinical benefit to the patient substantially exceeds the risk of potential viral transmission in that particular situation" [1].

The IFSO Worldwide Survey 2016 reported that 191,326 primary Roux-En-Y gastric bypasses had been performed in 2016 [3]. Thus, taking into account the underreporting in registries vs. the growth of bariatric surgery, most of us would agree that roughly 500,000 Roux-En-Y gastric bypasses would have been performed worldwide over any 3 years in the last decade. The risk of small bowel obstruction following internal hernia between 30 days and 3 years is estimated to be between 2.14 and 7.13% depending on whether defects were closed or not respectively [4]. Thus, with even a modest mean incidence of 3% over 3 years, one would expect 15,000 internal hernias to present over 36 months. It is hard to calculate how many internal hernias would develop between April and October 2020, but most would agree that 2500 internal hernias worldwide would be a reasonable estimate. With the uncertainties surrounding laparoscopic surgery and aerosol generation, it has now been advised that all internal hernias would need a laparotomy for fixation. To make matters worse, the decision has been left to the surgeon's discretion in the super-obese category!

"Primum non nocere" is a phrase familiar to most surgeons and something that most surgeons have lived by. However, how do we define harm in the case of a super-obese post-bypass patient with a suspected internal hernia? Would the act of laparotomy be the harm itself? Needless to mention the risk of a long convalescence on the ward with thus an increased risk of contracting the coronavirus. How do we choose how much harm to cause and to whom?

I do not think we will ever be able to answer these questions. Our minds and the minds of the entire medical community will be scarred by the recollection of these events. I sincerely hope that soon these events are relegated to the past and we start forgetting the decisions we were forced to make and live by.

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