AGREE II INSTRUMENT

Guideline assessed - EHS and AHS Guidelines for treatment of primary ventral hernias in rare locations or special circumstances.

Thank you very much for a thorough review of our paper. We have revised the manuscript accordingly and inserted comments below in this document.

DOMAIN 1. SCOPE AND PURPOSE

1. The overall objective(s) of the guideline is (are) specifically described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

The second paragraph of the introduction gives a general overview relating to umbilical and epigastric hernias, but spigelian and lumbar hernias are not explicitly mentioned. The problem I have though, is that to my mind, this is a confused document arising from a difficult marriage of two separate entities – common hernia in difficult situations & rare hernia.

Thank you for these comments. We have discussed it once again in the guidelines group. For us it does make sense to have a primary document including the 'simple questions' and what the majority of the surgical community needs to know. And then to have a second document with rare cases, which is for a minority of the surgical community

Firstly, the issue about common primary ventral hernia (i.e. umbilical and epigastric) repairs in those with liver and kidney problems, with rectus diastasis and in pre-menopausal women should unquestionably form part of the previous guideline. Salami slicing guidelines like this makes no sense. If the topics are clearly related (and they are), they should be kept together.

umbilical and epigastric hernias in patients with liver and kidney problems, in patients with rectus diastasis and in pre-menopausal women, are special cases, and we do believe that a guideline is more reader-friendly when it is not too long and addresses too many unanswered questions.

Secondly, if there is a desire to comprehensively evaluate the literature for rare hernias, why have obturator and primary perineal hernias not been included with spigelian & lumbar hernias? Why not have a stand alone guideline for all (not just some) rare hernias?

e a guideline on primary ventral hernias, where Spigellian and lumbar hernias are included. Your suggestion seems reasonable, but now this was the decision made, and we discussed once again, and decided to keep Spigellian and Lumbar hernias included.

2. The health question(s) covered by the guideline is (are) specifically described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Key questions clearly defined. Well laid out.

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Clear statement given in the methods section on page 3, lines 31-33.

We agree with the reviewer that no. 4 and 5 of the AGREE statement considering stakeholder involvement have not been full-filled. However, at this time in the process it is too late to change that. For an update of the guideline, this should be taken into account.

DOMAIN 2. STAKEHOLDER INVOLVEMENT

4. The guideline development group includes individuals from all relevant professional groups.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

This is similar to the other EHS / AHS guideline and has similar limitations. Surgeons (both open and lap) & those with guideline methodology expertise included. No primary care physicians were included, despite the intention for use by them (as started on page 3 line 33). Similarly, no "other physicians" – by which I presume they mean nephrologists, hepatologists, gastroenterologists – are involved and this must be considered a significant oversight when discussing some of these complex situations. We work in multidisciplinary teams and the composition up of the guideline group really MUST reflect this. A group of 12 surgeons giving their guidance on renal / liver failure patients with no physician input may be perceived as supreme arrogance and in effect makes this unpublishable in this form. I also note no involvement of anaesthetists, intensivists, nurses, physios and other allied health professionals who might be involved in the care of such patients, either in preoperative optimisation or perioperative care. I also note no involvement of healthcare funders / payors / regulators – they have a different perspective to offer from a population standpoint.

5. The views and preferences of the target population (patients, public, etc.) have been sought.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Again, similar to the previous EHS / AHS Guideline. No involvement of public or patients in the formulation of the guidelines (especially the formulation of the questions to be asked, i.e. what is important to them or in the evaluation of some of the evidence). Might I respectfully suggest that EHS & AHS convene a working group that sets out a policy document regarding the creation of guidelines and explicitly states the stakeholders / groups that need to be included from the inception of the process. It will help them create guidelines of higher quality, wider applicability and ultimately more relevant for patients. EHS / AHS are not alone in this - I note poor stakeholder involvement bedevils surgical guidelines (see Antoniou S et al Ann Surg 2019 Apr;269(4):642-651. doi: 10.1097/SLA.0000000000003036.)

6. The target users of the guideline are clearly defined.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Page 3 line 31-33

DOMAIN 3. RIGOUR OF DEVELOPMENT

7. Systematic methods were used to search for evidence.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Clearly described on page 4 in the literature search section

8. The criteria for selecting the evidence are clearly described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Clearly described in the methodology section on page 4

9. The strengths and limitations of the body of evidence are clearly described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Overall, the limited quality and quantity of evidence makes this a more clear-cut task, although again, recurrence dominates the discussion and this may not be the most appropriate outcome measure, especially for those on dialysis or with liver failure.

KQ1 & KQ2 – this is dealt with well. The issue not addressed is whether asymptomatic patients with cirrhosis & MELD < 15 should be offered planned surgery in light of the poor outcome (especially mortality) of emergency repair and the high failure rate of watchful waiting in that group.

This is a good question. However, there are no studies on watchful waiting on patients with cirhosis and umbilical hernia, why no recommendation can be given on asymptomatic hernias. We have commented on this in the manuscript.

KQ3 & KQ4 – the issue with preperitoneal synthetic meshes is that they may still cause intra-abdominal adhesions even if the peritoneum has not been opened. Might not be the best option here, where recurrence is less the concern, more what happens when the peritoneal catheter related peritonitis occurs. Are preperitoneal meshes more prone to infection? Do the adhesions cause problems. The other issue that isn’t addressed is whether the hernia (esp umbilical) should be used as the site for peritoneal dialysis catheter placement. Why close one hole and then create another to place the PD catheter?

Data is limited, but it seems safe to place the mesh preperitoneally. Nevertheless, in the recommendation, it is suggested to place the mesh onlay OR preperitoneally. Whether the dialysis cathether could be placed through the umbiical hernia defect is unknown. There are no studies available evaluating this method.

KQ5 – The authors should emphasize that rectus diastasis is a harbinger of connective tissue disorder and hence that is why suture repairs do not work for umbilical & epigastric hernias in this situation. What is not clear to me in reading this section is what was the indication for the repair of the diastasis in the series quoted. Is it cosmesis? Did patients have symptoms? If so

what? My concern is that without knowing the indication how can one judge what "success" is? Given the quality of the included series and the poor recording of complications, especially in the long term if non-absorbable suture material is used, I am not certain that it is wise to advocate simultaneous repair of diastasis as an option when the indications have not been delineated. It strikes me that it provides an opportunity for more complications with no defined, objectively measurable benefit. I would encourage the authors to be critical of the literature and to reconsider their comments. The comment "both open and endoscopic repair techniques for umbilical hernia in combination with rectus diastasis repair is feasible" is facile. Thank you for this comment, we have revised the section accordingly.

The evidence is so poor, that it is impossible to suggest a specific repair method. Only that mesh should be used.

KQ6 & KQ7 – this section is very well done and makes sensible recommendations. The evidence is discussed well in a balanced manner.

Thank you!

KQ8 – KQ10 – Overall this section is well done. The low numbers in the RCT should attract more criticism.

We have included a sentence emphasizing that the patient number is very small.

KQ11 & KQ12 – Appropriate discussion of very limited literature.

10. The methods for formulating the recommendations are clearly described.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Clearly described – GRADE / SIGN / AGREE on page 4.

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Only some of the KQ have explicitly addressed patient aspects from a non-hernia perspective, especially relating to liver & renal failure. I think this is where a wider MDT approach to the guideline committee would have been helpful.

12. There is an explicit link between the recommendations and the supporting evidence.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

True, partly because of the limited evidence base.

13. The guideline has been externally reviewed by experts prior to its publication.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Not applicable – this is the review.

14. A procedure for updating the guideline is provided.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Update in 2023 stated on page 16

DOMAIN 4. CLARITY OF PRESENTATION

15. The recommendations are specific and unambiguous.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Mostly – some have strayed into the nebulous territory of "optional" (KQ5).

16. The different options for management of the condition or health issue are clearly presented.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Overall this is done well.

DOMAIN 5. APPLICABILITY

17. Key recommendations are easily identifiable.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Clearly stated in boxes.

18. The guideline describes facilitators and barriers to its application.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

To some extent. There is an acknowledgement of the data quality limitation and of the methodological limitations of some studies. The need for MDT working is highlighted.

19. The guideline provides advice and/or tools on how the recommendations can be put into practice.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Not really covered.

20. The potential resource implications of applying the recommendations have been considered.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Uncertainty acknowledged

21. The guideline presents monitoring and/or auditing criteria.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7

Comments

Databases are discussed on page 15, but wider patient safety aspects are not.

DOMAIN 6. EDITORIAL INDEPENDENCE

22. The views of the funding body have not influenced the content of the guideline.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Fair and independent.

23. Competing interests of guideline development group members have been recorded and addressed.

Strongly Disagree					Strongly Agree	
1	2	3	4	5	6	7

Comments

Explicitly documented on page 16

OVERALL GUIDELINE ASSESSMENT

For each question, please choose the response which best characterizes the guideline assessed:

1. Rate the overall quality of this guideline.

Lowest possible quality					Highest possible quality	
1	2	3	4	5	6	7

2. I would recommend this guideline for use.

Yes

Yes, with modifications

No

NOTES

Overall, in its current form I think this lacks cohesion and structure. The early questions (KQ1 – 7) belong with the previous set of guidelines on umbilical and epigastric hernias – this would greatly enhance their wider applicability and quality. The rare hernias section should be expanded to include other rare subtypes. A more diverse group representative of the whole MDT would be useful in re-drafting / revising the guidelines.