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Incarcerated hernia with colon perforation and skin necrosis after internal hemipelvectomy for G3 chondrosarcoma: report of a case

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Introduction: Chondrosarcoma of the pelvis is a rare malignant tumor needing radical resection if there is no evidence of metastatic disease. If an internal hemipelvectomy has to be performed it results in a weakness of the groin region with the consequence of an herniation in this new pelvic space. We present a case of a patient with acute incarcerated and perforated hernia with local skin necrosis to the right hemipelvic region six month after internal hemipelvectomy.

Case Report: We performed internal hemipelvectomy in a 54years-old male patient with a pelvic G3 chondrosarcoma. The postoperative course was uneventful and the patient was discharged 14 days after surgery. Six month later he developed acute abdominal pain and was transferred to the next hospital. CT scan revealed an incarcerated hernia which was managed in an open fashion with pelvic incision reduction of the herniated bowel and inferior onlay mesh closure. Soon after he developed peritonitis and re-incarceration with bowel perforation. After referral to our clinic median laparotomy was performed with ileocecal resection. The abdomen was left open with negative pressure system inside. At the pelvic site necrotic skin was removed along with the infected mesh and a second negative pressure system was applied on the outside. After three times of abdominal dressing changes an inlay mesh was peritoneally fixed (IPOM) and the abdomen was closed. The skin defect was reconstructed using a latissimus dorsi flap. Thereafter the postoperative course was uneventful and the patient could leave the hospital after 40 days. Now at one year-follow-up year he is able to walk with sticks and his oncological follow-up is uneventful.

Conclusion: Especially in obese patients a prophylactic mesh reinforcement after hemipelvectomy should be recommended to avoid pelvic herniation. This should be performed by a specialised hernia surgeon and could be done secondly after hemipelvectomy with a laparoscopically or with an open IPOM technique. An open onlay mesh fixation from the pelvic site however should be avoided because of difficult fixation and lack of peritoneal stabilisation as seen in our case. IPOM could avoid such fatal cases like ours with an extensive reconstruction.



Figure 1. Reconstruction