Orient yourself to the mesh by doing the following:

A. Review the diagram on the right showing the features and proper placement in relation to the patient’s anatomy.

B. The ML (Medial Line) marking helps to orient the mesh. When oriented correctly, the marking should be readable and placed towards the medial plane of the patient’s body.

Step 1

Dissect to obtain a critical view of the myopectineal orifice. To achieve that:

A. Enter the preperitoneal space via a conventional transabdominal preperitoneal (TAPP) or totally extraperitoneal (TEP) approach or using a robotic TAPP surgical approach.

B. Develop a surgical plane that extends 2 cm past the midline, at least 2 cm below Cooper’s ligament, and laterally beyond the anterosuperior iliac spine (ASIS).

C. Properly dissect the hernia sac and dissect the peritoneum and other tissue off of the spermatic cord to ensure that the mesh can lie flat.

D. Ensure you can visualize the critical landmarks shown in Fig. 2 prior to proceeding with mesh insertion.

Figure 1. Important features of Dextile™ anatomical mesh. Shown is a right-side large size mesh (15 × 10 cm).

Figure 2. The myopectineal orifice after a proper dissection has been completed.
Step 3

Introduce the mesh. To do so:

A. Select the size that best fits the patient’s inguinal area and provides ample coverage of the defect. Make sure the label (right or left) corresponds to the side of the patient where the hernia is located.

B. Pick a trocar that allows for a gentle introduction of the mesh. We recommend 10 mm trocars for M and L mesh sizes and 11 mm trocar for XL mesh size. Caution: Do not force the mesh through the trocar. Inappropriate force may lead to textile damage and/or impact self-deployment.

C. Grasp the medial edge and insert it directly into the trocar as shown in Fig. 3. Caution: It is recommended not to cut or reshape Dextile™ anatomical mesh as it may affect its effectiveness.

Step 4

Position the mesh. We recommend that you:

A. Place the medial edge of the mesh in a position that allows it to overlap the patient’s midline.

B. Gently direct the inferior flap laterally to align with the anatomy and guide the unsealed inferior edge down into the retropubic space as shown in Fig 4.

C. Dissect further medially and inferiorly if the mesh will not lie flat on the midline or the inferior edge.

D. Ensure that during space deflation the lateral and inferior edges stay flat against the abdominal wall and do not roll up as the inguinal space desufflates.

E. Finish the procedure per the TAPP or TEP technique you have used.

REFERENCES

1. Depending on the size of the defect, patient conditions, and procedure.
3. Based on internal test report #43008CR268, Design output file Merlin. February 2019

IMPORTANT: Please refer to the package insert for complete instructions, contraindications, warnings and precautions.

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