May 21, 2018

Regarding: A patient suffering mesh related pain

To whom it may concern,

The purpose of this letter is to inform doctors, employers and loved ones of patients suffering a condition broadly known as mesh related chronic pain of some essential facts that will help you to understand what is going on with your patient, employee or loved one. I am a board certified general surgeon who specializes in the care of patients with hernia mesh problems. I am frequently asked by my patients to write a letter like this because they have trouble making other people understand what they are going through. So I write this as an open letter to be used by any patient suffering mesh pain.

Patients with groin or abdominal pain lasting more than three months after mesh hernia surgery nine times out of ten have mesh related pain. This essential fact is not widely appreciated by the medical community. The medical literature about mesh related pain is sparse and confusing. But the problem is huge and for the individual patient with mesh pain can be devastating.

20% of patients who have mesh hernia surgery develop chronic pain. 5% develop pain so severe that it seriously adversely affects the quality of their lives. Effective treatment options are extremely limited. Most patients never get better and suffer social isolation, career ruin and financial loss in addition to their pain.

Typically patients with mesh pain will go back to their surgeons with their persistent complaints of pain. The surgeon will examine them and find nothing wrong. The surgeon will order some medical imaging tests and find nothing wrong. The surgeon realizing he has nothing to offer the patient will then refer them to a pain management specialist.

Mesh related pain is not due to surgical technical error or failure of the device to remain in proper position. Imaging studies are not helpful in making the diagnosis. There are no objective tests that will make the diagnosis. The diagnosis is a clinical diagnosis based on the patient's subjective complaints and the patient's history. A lack of objective findings can be very troubling for a doctor who does not have a lot of experience taking care of these patients.

The standard protocol for treating patients with mesh related pain includes narcotic pain medication, nerve stabilizing medications, nerve injections, nerve destruction, steroid injection of scar and to the extreme of spinal cord stimulators. None of these provide lasting relief and for many patients the side effects are intolerable. Mesh removal can help some patients but there are only a few surgeons in the world who have experience and good results. The decision to remove mesh should not be taken lightly.

Many mesh patients also relate symptoms other than pain to their mesh such as fatigue, weight loss, headaches, abdominal pain, skin rash, body aches, prostatitis, cystitis and other autoimmune like symptoms. These symptoms should not be dismissed out of hand. Mesh causes chronic inflammation which cause the production and systemic release of nerve growth factor and various other neurotrophs and tumor necrosis alfa and various other immune mediators.

Patients with chronic severe mesh pain develop a condition called central pain sensitization (CPS). Clinical features of CPS include allodynia, hyperalgesia and widening of the pain which can be very confusing to the patient and their doctor. In particular widening of the pain field creates a contradictory picture because it is a central nervous system phenomenon. The distribution of the pain fields does not correlate with peripheral pain pathways. Patients and doctors tend to think in terms of peripheral processes. Central pain sensitization is responsible for other well-known clinical pain syndromes such as phantom limb pain and complex regional pain syndrome (CRPS). Central pain sensitization is a prominent component of chronic hernia mesh pain.

Wasting time beyond three months doing nothing or doing ineffective treatments and useless imaging hoping the pain will go away is not advisable. The more time that goes by the more that central pain sensitization becomes instantiated and the less likely that the patient will be cured of their pain.

The last point that I would like to make for doctors specifically is that exploratory surgery is a bad idea. The diagnosis of mesh pain is not based on gross pathological/anatomical findings. Microscopic pathological examination will reveal chronic inflammation, neo-nerve sprouting and invasion of other organs and structures. Chronic inflammation is found in all mesh explant specimens and alone is sufficient pathology to cause pain. Operate if you clearly have a hernia recurrence. But not just because you suspect one. Operate if you have made the decision to take the mesh out. If you do though, take it all out and do not replace it.

For the friends, family and employers of mesh pain patients please understand that their pain is real and they are suffering a condition that there is not much help for but the greatest loss that they can suffer is the loss of your support.

Anyone who needs more information or advice may reach me at 1-702-256-7616.

Sincerely,

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