Incidence, risk factors and prevention of stoma site incisional hernias: a systematic review and meta-analysis

D. P. V. Lambrichts*†, G. H. J. de Smet*†, R. D. van der Bogt†, L. F. Kroese* ‡, A. G. Menon‡, J. Jeekel§, G-J. Kleinrensink§ and J. F. Lange*‡

*Department of Surgery, Erasmus University Medical Center, Rotterdam, The Netherlands, †Department of Gastroenterology, Erasmus University Medical Center, Rotterdam, The Netherlands, ‡Department of Surgery, IJsselland Ziekenhuis, Capelle aan den IJssel, The Netherlands, and §Department of Neuroscience, Erasmus University Medical Center, Rotterdam, the Netherlands

Received 8 May 2018; accepted 16 July 2018; Accepted Article Online 9 August 2018

Abstract

Aim Stoma reversal might lead to a stoma site incisional hernia. Recently, prophylactic mesh reinforcement of the stoma site has gained increased attention, supporting the need for accurate data on the incidence of and risk factors for stoma site incisional hernia and to identify high-risk patients. The aim of this study was to assess incidence, risk factors and prevention of stoma site incisional hernias.

Method Embase, MEDLINE, Web of Science, Cochrane and Google Scholar databases were searched. Studies reporting the incidence of stoma site incisional hernia after stoma reversal were included. Study quality was assessed with the Newcastle–Ottawa Scale and Cochrane risk of bias tool. Data on incidence, risk factors and prophylactic mesh reinforcement were extracted.

Results Of 1440 articles found, 33 studies comprising 4679 reversals were included. The overall incidence of incisional hernia was 6.5% [range 0%–38%, median follow-up 27.5 (17.54–36) months]. Eleven studies assessed stoma site incisional hernia as the primary endpoint, showing an incidence of 17.7% [range 1.7%–36.1%, median follow-up 28 (15.25–51.70) months]. Body mass index, diabetes and surgery for malignant disease were found to be independent risk factors, as derived from eight studies. Two retrospective comparative cohort studies showed significantly lower rates of stoma site incisional hernia with prophylactic mesh reinforcement compared with nonmesh controls [6.4% vs 36.1% (P = 0.001); 3% vs 19% (P = 0.04)].

Conclusion Stoma site incisional hernia should not be underestimated as a long-term problem. Body mass index, diabetes and malignancy seem to be potential risk factors. Currently, limited data are available on the outcomes of prophylactic mesh reinforcement to prevent stoma site incisional hernia.

Keywords Stoma site incisional hernias, incidence, risk factors, prevention

Introduction

Temporary stomas are frequently constructed to defunction a low colorectal anastomosis and during surgery for acute complicated diverticulitis, inflammatory bowel disease and traumatic intestinal injury [1–8]. Subsequent stoma reversal is associated with surgical site infection (SSI), anastomotic leakage, postoperative ileus and development of stoma site or midline incisional hernia (MIH) [9–13]. Stoma site incisional hernia (SSIH) can cause pain, disfiguration, incarceration and strangulation [14,15].

Recent research has shown that prophylactic mesh reinforcement (PMR) in midline laparotomies in high-risk patients significantly decreases the incidence of MIH [16,17], and PMR at the stoma site during permanent stoma construction has been considered to reduce rates of parastomal hernia [18–21]. Considering the largely comparable pathophysiology, PMR during temporary ostomy takedown to prevent SSIH could also be beneficial by potentially obviating complications and re-operations, and has gained increased attention amongst surgeons [17]. Accurate data on incidence and risk factors for the development of SSIH are of importance to correctly assess the clinical value of PMR to prevent SSIH, to facilitate selection of high-risk patients and to aid clinical and shared decision-making [22].
Therefore, the aims of this study were to systematically investigate the literature regarding the incidence of SSIH after stoma reversal, to evaluate potential risk factors for SSIH and to assess the effectiveness of PMR in preventing SSIH.

**Method**

The protocol of this study was registered in Prospero (CRD42016053347). This study was conducted following the MOOSE guidelines and PRISMA statement [23,24]. Furthermore, decisions on the content were based on items proposed by Wille-Jørgensen et al. [25].

**Study design and participants**

Randomized controlled trials (RCTs) and prospective or retrospective cohort or case-control studies providing data on the incidence of SSIH were included. Case reports, reviews, letters, abstracts or comments were excluded. Studies were included if they met the

---

**Figure 1** Preferred items for reporting of systematic reviews and meta-analyses (PRISMA) flow diagram.
| Author          | Year | Design | LOE | NOS | Number | Male gender (%) | Age (years) | BMI (kg/m²) | Smoking (%) |
|-----------------|------|--------|-----|-----|--------|-----------------|-------------|-------------|-------------|
| Bakx [29]      | 2004 | R      | 2b  | 6   | 69     | 53.6 (28–83)    | 57 (28–83)  | –           | –           |
| Bhangu [30]    | 2012 | R      | 2b  | 6   | 59     | 76 (13.4)       | 62.7 (13.4) | –           | –           |
| Brook [5]      | 2016 | R      | 2b  | 8   | 193    | 59.6 (20–92)    | 66 (20–92)  | 25 (16–44)  | 16          |
| Cingi [31]     | 2008 | P      | 2b  | 6   | 31     | 48.4 (11.0)     | Hernia: 69.9 | No hernia: 68.1 | –           |
| De Keersmaeker [32] | 2016 | R      | 2b  | 6   | 153    | 60.1 (11.6)     | 67.1 (11.6) | –           | –           |
| D’Haeninck [33] | 2011 | R      | 2b  | 6   | 197    | 54.8 (15.4)     | 62.7 (15.4) | 25.3 (16–44) | 16          |
| Edwards [34]   | 2001 | RCT*   | 1b  | –   | 36     | 79.4 (32–90)    | 54 (32–90)  | –           | –           |
| Fiscon [36]    | 2014 | P      | 2b  | 6   | 20     | 75 (53.1–72.1)  | 65.4 (53.1–72.1) | –           | –           |
| Giannakopoulos [37] | 2012 | R      | 2b  | 6   | 159    | 67.3 (39–88)    | 65 (39–88)  | 24 (16–44)  | 16          |
| Guzman-Valdivia [38] | 2012 | R      | 2b  | 6   | 70     | 59 (14.3)       | 61 (14.3)   | 23.6 (16–44) | 16          |
| Hasegawa [39]  | 2017 | R      | 2b  | 8   | 316    | 56.7 (37–86)    | 67 (37–86)  | –           | –           |
| K€ohler [40]   | 2014 | R      | 2b  | 6   | 119    | 57.1 (11.0)     | 55 (11.0)   | 24.4 (22–26.8) | –           |
| Krand [41]     | 2013 | P      | 2b  | 7   | 50     | 68 (25–35)      | 61 (25–35)  | –           | –           |
| Lewis [42]     | 1990 | P      | 2b  | 6   | 50     | 50 (17–71)      | 35 (17–71)  | –           | –           |
| Li [43]        | 2017 | R      | 2b  | 9   | 82     | 57.8 (13.4)     | 54.7 (13.4) | –           | –           |
| Liang [44]     | 2015 | CM     | 3b  | 9   | 30     | 61 (9.3)        | 64 (9.3)    | No SSI: 27 (6.3) | –           |
| Luglio [45]    | 2011 | P      | 2b  | 5   | 944    | 59 (10.9)       | SSI: 59 (10.9) | SSI: 31 (6.1) | –           |
| Maggiore [46]  | 2015 | CM     | 3b  | 9   | 30     | 61 (9.3)        | 64 (9.3)    | Control: 12 patients > 30 | –           |
| Mala [47]      | 2008 | R      | 2b  | 6   | 56     | 66 (39–89)      | 65 (39–89)  | –           | –           |
| Mishra [48]    | 2014 | R      | 2b  | 6   | 51     | 50.2 (23.3)     | Lap: 68.2 (23.3) | –           | –           |
| Oriel [49]     | 2017 | R      | 2b  | 8   | 114    | 50.2 (38.8)     | Open: 68.5 (38.8) | –           | –           |
| Rosen [50]     | 2005 | R      | 2b  | 6   | 22     | 54 (33–73)      | 54 (33–73)  | –           | –           |
| Rutegard [51]  | 1987 | R      | 2b  | 6   | 56     | 51.6 (26–89)    | Li: 67 (26–89) | –           | –           |
| Saeed [52]     | 2012 | R      | 2b  | 6   | 79     | 72 (29–79)      | 66 (29–79)  | –           | –           |
| Saha [53]      | 2009 | R      | 2b  | 6   | 325    | 53 (16–90)      | 59 (16–90)  | –           | –           |
| Schreyer [54]  | 2011 | P      | 2b  | 8   | 111    | 50.5 (28–83)    | 62 (18–84)  | < 25 (40.5); > 25 (39.6) | –           |
| Seo [55]       | 2013 | R      | 2b  | 6   | 836    | 66.7 (11)       | 56 (11)     | –           | –           |
| Vermeulen [56] | 2009 | R      | 2b  | 6   | 139    | 56.6 (11)       | HP: 61 (23–85) | –           | –           |
| Welten [57]    | 1991 | R      | 2b  | 6   | 30     | 63.3 (38–82)    | PA: 63 (38–82) | –           | –           |

Continuous data are median (interquartile range), mean (standard deviation) or mean (standard deviation, range).

A, delayed closure group; B, early closure group; BMI, body mass index; C, clinical diagnosis; CM, case matched; CT, computed tomography diagnosis; d, days; HP, Hartmann’s procedure; Lap, laparoscopic; LC, loop colostomy; LI, loop ileostomy; LOE, level of evidence; m, months; MRI, magnetic resonance imaging; NOS, Newcastle–Ottawa scale; NSSE, nonstoma site extraction; P, prospective; PA, primary anastomosis with diverting ileostomy; R, retrospective; RCT, randomized controlled trial; SSI, surgical site infection; SSIH, stoma site incisional hernia; SSE, stoma site extraction; US, ultrasound; y, years.

*Data on risk of bias are given in Figure S1.
### Follow-up details

| Chemo (%) | Total duration | Time to closure | Time since closure | Method of closure | Method of SSIH detection |
|-----------|----------------|----------------|-------------------|------------------|-------------------------|
| –         | 24 w (2-124)   | 72 w (1-219)   | –                 | –                | –                       |
| 18.7      | 6 m (0.36)     | 20.5 m (0-69)  | –                 | Primary          | C, US, CT               |
| –         | 5.7 m (1-14)   | –              | –                 | Secondary        | C, US                   |
| –         | 66 d (25-356)  | 2.56 y (1.62)  | –                 | –                | CT                      |
| –         | 18.2 w (11.3-35.0) | –         | Primary          | –                | –                       |
| –         | 7.2 d (28-141) | 36 m (6-48)    | –                 | Primary          | –                       |
| –         | 18 w (8-137)   | 9.8 m (6.9-11.9)| –               | Primary          | –                       |
| –         | 9.1 m (18.6)   | 18.9 m (5.2)   | –                 | Primary          | –                       |
| –         | 106d (69-174)  | > 2 m          | –                 | Primary          | –                       |
| –         | 28 m (2-87)    | –              | Primary          | –                | –                       |
| –         | 4 m           | –              | Primary          | C                | –                       |
| –         | 272 d (55-1142)| –              | –                | –                | –                       |
| –         | 10.4 d (8-14)  | –              | Primary          | –                | –                       |
| –         | 9 w (5-53)     | 0.5-2 y        | Primary          | –                | –                       |
| –         | 4.7 m (3.0-9.0)| SSE: 16.4 m (7.7-30.6)| – | – | – |
| –         | 5.4 (3.1-7.4)  | NSSE: 25.6 m (12.3-41.8)| – | – | – |
| –         | 10 m (7.0)     | –              | No SSI: 49 open; | C, CT            | 20 closed; 13 loose      |
| –         | 9.2 m (4.1-15.0)| –             | Mesh: onlay, skin defect open | C, CT | – |
| Mesh: 16.8 m | –            | 38d          | –                 | –                | –                       |
| Control: 39.2 m | –             | –            | Control: primary | CT               | –                       |
| –         | 4 m (1-11)     | 36 m (2-118)   | –                 | –                | –                       |
| –         | 9 m (3-33)     | –              | C, CT            | –                | –                       |
| –         | 5.7 y (0.5-14) | 5.7 y (0.5-14)| –                | –                | –                       |
| –         | 14.7 m         | 160d (69-385)  | 14.7 m           | –                | –                       |
| –         | 36-60 m        | –              | –                 | –                | –                       |
| –         | 6 m (2-22)     | 1 y (n = 43), 2 y (n = 28), 3 y (n = 12) | –                | CT               | –                       |
| 15.7      | 34 w (19-57)   | 67 m (12-96)   | –                 | Primary = 99Sc  | C, US                   |
| –         | 6 m (1-48)     | 35 m (5-77)    | –                 | condary = 12    | C                       |
| –         | 7 m (3)        | –              | –                 | C, US, CT        | –                       |
| –         | 18-150 m       | –              | –                 | –                | C                       |
| –         | 25 m (6-52)    | 3.5 m (1-7)    | –                 | –                | –                       |
Table 2: Stoma characteristics.

| Author       | Year | Stomas formed | Stomas closed |
|--------------|------|---------------|---------------|
| Bakx [29]    | 2004 | 69            | 60            |
| Bhangu [30]  | 2012 | 59            | 59            |
| Brook [5]    | 2016 | 193           | 193           |
| Cingi [31]   | 2008 | 31            | 31            |
| De Keersmeecker [32] | 2016 | 153           | 153           |
| D’Haenick [33] | 2011 | 197           | 197           |
| Edwards [34] | 2001 | 70            | 63            |
| El Hassouna [35] | 2012 | 159           | 158           |
| Fiscon [36]  | 2014 | 20            | 20            |
| Garcia-Botello [6] | 2004 | 127           | 109           |
| Giannakopoulos [7] | 2009 | 119           | 119           |
| Guzman-Valdeia [37] | 2008 | 70            | 70            |
| Holzinger [38] | 2017 | 273           | 229           |
| Kohler [40]  | 2014 | 14            | 14            |
| Krand [41]   | 2008 | 50            | 50            |
| Lewis [42]   | 1990 | 50            | 40            |
| Li [43]      | 2017 | SSE: 139      | SSE: 139      |
| Liang [44]   | 2013 | No: SSE: 599  | NSSE: 599     |
| Liu [45]     | 2013 | Med: 47       | Mesh: 47      |
| Luglio [8]   | 2011 | 944           | 944           |
| Maggiori [46] | 2015 | Med: 30       | Mesh: 30      |
| Mala [47]    | 2008 | 72            | 72            |
| Mishra [48]  | 2014 | Lap: 35       | Lap: 12       |
| Oriel [4]    | 2017 | 114           | 114           |
| Rosen [49]   | 2005 | 22            | 22            |
| Rutgeert [50] | 1987 | 61            | 61            |
| Saeed [3]    | 2009 | 325           | 325           |
| Schreinemacher [82] | 2011 | 111           | 111           |
| Seo [53]     | 2013 | 246           | 245           |
| Vermeulen [54] | 2009 | HP: 139       | HP: 63        |
| Witten [55]  | 1991 | PA: 19        | PA: 14        |

**Indications for stoma formation**

|            | CRC | DIV | IBD | Trauma | Other |
|------------|-----|-----|-----|--------|-------|
| Bakx [29]  | 36  | 12  | 12  | 0      | 9     |
| Bhangu [30]|      |     |     |        |       |
| Brook [5]  | 102 | 20  | 47  | 0      | 24    |
| Cingi [31] |     |     |     |        |       |
| De Keersmeecker [32] | 153 | -   | 0   | 0      | 0     |
| D’Haenick [33] | 138 | 0   | 41  | 0      | 18    |
| Edwards [34] | 70  | 70  | 0   | 0      | 0     |
| El Hassouna [35] | 159 | 159 | 0   | 0      | 0     |
| Fiscon [36] | 20  | 3   | 12  | 0      | 5     |
| Garcia-Botello [6] | 109 | 72  | 5   | 32     | 17    |
| Giannakopoulos [7] |     | 49  | 10  | 33     | 25    |
| Guzman-Valdeia [37] | 12  | 43  | 0   | 3      | 12    |
| Holzinger [38] | 0   | 0   | 0   | 0      | 0     |
| Kohler [40] | 14  | 10  | 4   | 0      | 0     |
| Krand [41] | 50  | 46  | 2   | 0      | 2     |
| Lewis [42] | 40  | 0   | 0   | 50     | 0     |
| Li [43]    | SSE: 139 | SSE: 139 | SSE: 23 | SSE: 106 | SSE: 10 |
| Liang [44] | No: SSE: 599 | NSSE: 597 | NSSE: 119 | NSSE: 449 | NSSE: 31 |
| Liu [45]   | Mesh: 47 | Control: 36 | Mesh: 47 | Control: 36 |
| Luglio [8] | 944  | 944  | 279 | 64     | 507   | 0     | 94    |
| Maggiori [46] | 30  | Mesh: 30 | Control: 64 | Mesh: 30 | Control: 64 |
| Mala [47]  | 72   | 72   | 72  | 0      | 0     | 0     |
| Mishra [48] | Lap: 35 | Lap: 12 | Lap: 35 | Lap: 35 | Lap: 35 |
| Oriel [4]  | 114  | 114  | Hernia: 2 | No hernia: 33 | Hernia: 6 | No hernia: 37 | Hernia: 0 | No hernia: 8 | Hernia: 3 | No hernia: 25 |
| Rosen [49] | 22   | 22   | 19  | 15     | 0     | 1     | 4     |
| Rutgeert [50] | 61  | 23   |     | 3      | 0     | 19    |
| Saeed [3]  | 2012 | 59   | -   | -      | -     | -     |
| Saha [3]   | 325  | 325  | 160 | 25     | 118   | 0     | 22    |
| Schreinemacher [82] | 111 | 111  | 53  | 0      | 33    | 0     | 25    |
| Seo [53]   | 246  | 246  | 246 | 0      | 0     | 0     |
| Vermeulen [54] | HP: 139 | HP: 63 | 0   | 0      | 0     | 0     |
| Witten [55] | 30   | 23   | -   | -      | -     | -     |

C, colostomy; CRC, colorectal carcinoma; DIV, diverticular disease; EC, end colostomy; EI, end ileostomy; IBD, inflammatory bowel disease; HP, Hartmann’s procedure; Lap, laparoscopic; LC, loop colostomy; LI, loop ileostomy; NSSE, nonstoma site extraction; PA, primary anastomosis with diverting ileostomy; SSI, surgical site infection; SSE, stoma site extraction.

Following criteria: (1) patients ≥16 years of age, (2) participants underwent stoma reversal via laparotomy, laparoscopy or local surgery, (3) study outcome included data on the occurrence of SSIH and (4) follow-up duration. Studies reporting on >10% of patients with abdominal wall trauma; only reporting on duodenal/gastro-/oesophago- or urostomies; and only including stoma revisions or re-siting were excluded.

**Systematic literature search**

A systematic search was performed by a biomedical information specialist. On 4 July 2017, the Embase, MEDLINE, Cochrane, Web of Science and Google Scholar databases were searched. Full search syntaxes and results per database are shown in Appendix S1 in the online Supporting Information. There was no limit on publication date. Identified articles were reviewed independently by two reviewers (GS and DL) after duplicates were removed on title and abstract, followed by full-text review using EndNote X7®. Differences in article selection were discussed and inclusion or exclusion was performed after consensus was reached between reviewers.

**Data extraction**

Data extraction was performed by two researchers (GS and DL) and checked by a third independent researcher.
Discrepancies were discussed amongst all three researchers, and decisions were made when consensus was reached. In case of uncertainties on reported study results, corresponding authors were contacted if possible. Two researchers (GS and DL) independently assessed the quality of included studies by assessing level of evidence [26], Newcastle–Ottawa Scale (NOS) criteria (nonrandomized studies) [27] and risk of bias (RCTs) [28].

### Primary and secondary outcomes

The following outcome variables were extracted: study characteristics (author, year, design, level of evidence, risk of bias, NOS, SSIH detection methods), baseline characteristics [number of patients, gender, age, body mass index (BMI), smoking status, chemotherapy, surgical type and approach, indication, follow-up duration], stoma characteristics [numbers constructed and closed, stoma type (loop colostomy (LC) or ileostomy (LI) and end colostomy (EC) or end ileostomy (EI)), time to closure, closure method and surgical site infection (SSI) after closure] and SSIH characteristics (number of SSIH, SSIH per stoma type and SSIH repairs). Median follow-up for reported cumulative SSI and SSIH rates was calculated based on available follow-up data.
A Mantel–Haenszel random-effects model was used to calculate pooled odds ratios (ORs), while taking between-study variance and within-study variance into account. ORs with 95% CIs were calculated to assess outcome differences after ileostomy or colostomy reversal. $Q$ statistics and $I^2$ were calculated to evaluate heterogeneity. All analyses were performed with RevMan 5.3 (Cochrane Centre, Denmark), except for the cumulative meta-analysis, which was performed using R (version 3.4.1.).
Results

Search

A PRISMA flow diagram of the full search results is shown in Fig. 1. After fulfilling the search, a total of 2458 articles were identified, of which 1440 remained after removal of duplicates. After screening on title and abstract and full-text reading, 33 articles were included for qualitative and quantitative analyses [3–8,29–55]. Four articles provided data on outcomes after PMR for prevention of SSIH [45,46,56,57], of which two had a nonmesh control group and could therefore be included in quantitative synthesis [45,46].
Study characteristics

Study characteristics are shown in Table 1. Two articles were RCTs, 7 were prospective, 23 were retrospective cohort studies and 1 study was case-matched. A total of 6594 nonmesh and 77 mesh patients were available. The majority of studies (20/33) did not specify the SSIH detection method. Two studies specifically mentioned the use of clinical examination and 11 reported on imaging [ultrasound (US), CT or MRI].

Stoma characteristics

An overview of stoma characteristics is shown in Table 2. Overall, 5289 stomas were constructed, of which 4679 (88.5%) were closed. In three studies, the type of colostomy or ileostomy was not clearly described and was therefore reported as total number of colostomies or ileostomies. In all other studies, LI was the most investigated stoma type (28/30), followed by LC (8/30), EC (6/30) and EI (5/30).

Hernia rates

Table 3 provides data on the number of closures, SSIH, SSI and SSIH repairs in individual studies for different stoma types. The rate of SSI after stoma closure ranged from 0% to 18.3% [median follow-up 28 (21.08–36) months]. SSIH rates per stoma type are given in Table 4. The total SSIH rate was 6.5%, with a range from 0% to 38.5% [median follow-up 27.5 (17.54–36) months]. Eleven studies assessed SSIH rate as the primary outcome, whereas the other studies recorded SSIH as a secondary outcome. The SSIH rate of all 11 studies with SSIH rate as the primary outcome was 17.7% [172/970; range 1.7%–36.1%, median follow-up 28 (15.25–51.70) months]. Of these studies, nine used imaging to detect hernias, also leading to a 17.7% rate (139/786; range 1.7%–36.1%). From the 22 studies which did not have SSIH as the primary outcome, an overall rate of 3.6% [129/3622; range 0%–38.5%, median follow-up 27 (16.56–36) months] was found. As calculated from 11 studies (11/33) that used imaging to detect hernias, the SSIH rate was 15.3% [173/1134; range 1.2%–36.1%, median follow-up 28 (15.25–51.7) months]. In contrast, an incidence rate of 3.7% for SSIH [128/3458; range 0%–38.5%, median follow-up 27 (16.56–36) months] was derived from all studies (22/31) that did not use or did not mention the use of imaging for detection of SSIH.

Figure 2 shows a forest plot of seven studies from which data could be used to compare SSIH rates after ileostomy and colostomy reversal. No difference in SSIH risk was found (OR 0.82, 95%CI 0.40–1.69, I² 0%). Publication bias seemed unlikely, because the study distribution was justifiably symmetrical in an additional funnel plot (Fig. 3). In addition, no differences were found in cumulative meta-analysis (cumulative OR 0.87, 95%CI 0.44–1.75), as shown in Figure S2.

SSIH operation rates

SSIH operation data are shown in Table S1. No data on SSIH operations were available for LC and EI. Of all patients undergoing stoma closure, 6.1% (0%–38.4%) needed an operation for SSIH. Of the patients with SSIH, 51.4% (0%–100%) were operated. In the total ileostomy group, these percentages were 5.6% (0%–12.5%) and 56.4% (0%–100%), respectively, as derived from 10 studies.

Risk factors

Eight studies reported on risk factors for development of SSIH (Table S2) [3–5,30–32,45,52]. In univariate

| Table 4 | Hernia rates (subdivided by stoma type). |
|---------|-----------------------------------------|
| Stoma group | Number of stomas closed | Number of SSIH detected | Percentage SSIH detected (%) | Range (%) | Median follow-up (IQR)† |
| Loop colostomy | 3 | 54 | 9 | 16.7 | 6.7–37.5 | 36 (36–36) |
| Loop ileostomy | 21 | 2837 | 150 | 5.3 | 0–50 | 23.75 (14.92–43.75) |
| End colostomy | 4 | 131 | 13 | 9.9 | 0–40 | 12.35 (10–12.35) |
| End ileostomy | 1 | 3 | 0 | 0 | – | – |
| Colostomy | 9 | 302 | 48 | 15.9 | 0–40 | 28 (12.35–52.20) |
| Ileostomy | 26 | 3776 | 175 | 4.6 | 0–36.1 | 27 (18.53–51.50) |
| Total | 33 | 4602 | 301 | 6.5 | 0–38.5 | 27.5 (17.54–36) |

Only control patients were included; patients with prophylactic mesh placement were excluded.

SSIH, stoma site incisional hernia; IQR, interquartile range.

*Range of SSIH percentages reported in studies.
†Median (IQR) of available information on reported median study follow-up since closure (months).
analysis, Brook et al. [5] found a significantly higher BMI in patients who developed SSIH compared with patients without SSIH (mean 28.4 kg/m² vs 24.7 kg/m²). Moreover, they found a significantly higher percentage of clinically obese patients (BMI ≥ 30 kg/m²) in the SSIH group (42.3% vs 15%, P < 0.001). From a logistic regression model, an OR of 1.2 was found for BMI. Furthermore, from a nonparametric correlation test of Stage 1 hypertension (≥ 140/90 mmHg), a Spearman’s rho of 0.183 was found (P = 0.01). In addition, malignant disease was found to be associated with a higher likelihood of hernia in logistic regression analysis (OR 18, P = 0.009) and, albeit in univariate analysis, postoperative complication rates were higher in patients with SSIH (27% vs 22%, P < 0.001).

Liu et al. [45] investigated the influence of PMR versus no mesh in ileostomy closures and assessed potential risk factors. From univariate analyses, the following significant factors were found: age > 60 years, malignant disease, diabetes, hypertension, chronic steroid usage and chronic kidney injury. A multivariate analysis was performed and showed malignancy (OR 20.98, 95% CI 3.23–21.93, P = 0.001) to be independent risk factors for SSIH.

Bhangu et al. [30] found no significant differences in age or gender for patients with SSIH versus no SSIH. Moreover, no difference in MIH between patients with and without SSIH was found (50% vs 41%, P = 0.51). Age, SSI, stoma type, gender, BMI and time to closure did not significantly increase the risk of SSIH in the study by Cingi et al. [31]. However, patients with a MIH had an increased risk (OR 4.4) of SSIH.

De Keersmaecker et al. [32] assessed a number of potential patient- and surgery-related risk factors but did not find any significant differences in univariate analysis.

Oriel et al. [4] showed that myofascial release was performed more often in the SSIH group (18.2% vs 2.9%, P = 0.02) and more SSIH patients had superficial incisional SSI (27.3% vs 5.8%, P = 0.01).

From univariate analyses, Saha et al. [3] found the development of SSIH to be significantly associated with reoperation after LI reversal (3% vs 25%, P < 0.001) and emergency surgery (4% vs 13%, P = 0.01).

Lastly, Schreinemacher et al. [52] performed a multivariate analysis for risk factors, which only showed that BMI (≥ 30 kg/m² vs < 25 kg/m²) was a significant risk factor (OR 5.53, 95% CI 1.72–17.80), whereas a time to closure of < 6 months did not appear as risk factor (OR 2.38, 95% CI 0.96–5.99, P = 0.06).

**Prophylactic mesh reinforcement**

Four studies provided data on PMR outcomes, of which details are given in Table 5. Bhangu et al. [56] used biological mesh (Strattice™) and intraperitoneal onlay mesh (IPOM) placement in a case series of seven patients. During 30-day follow-up, only one adverse event was seen (a SSI with subsequent superficial wound breakdown) while the mesh was still in situ (on US).

![Figure 3](image-url)
In the case series by Van Barneveld et al. [57], 10 patients received a Parietex Composite Parastomal mesh during creation of a temporary stoma for parastomal hernia prophylaxis (IPOM placement). At stoma reversal, mesh continuity was restored to serve as SSIH prophylaxis. No serious mesh-related or other serious complications were observed during 12 month’ follow-up. After a median follow-up of 26 months [interquartile range (IQR) 14–29], no SSIH was found during physical and US examination in nine patients.

Two other studies, by Liu et al. and Maggiori et al., were comparative cohort studies, including 83 and 94 patients, respectively [45,46]. In the retrospective study by Liu et al. [45], consecutive patients undergoing ileostomy closure were included, of whom 47 (56.6%) had PMR with polypropylene mesh (Ultrapro, Ethicon Inc.) placed in an onlay position by the same surgeon in all patients. During median follow-up of 18.2 months (IQR 11.7–30.8), three SSIHs (6.4%) were detected in mesh patients, whereas 13 SSIHs (36.1%) were found in control patients (OR 8.29, 95% CI 2.14–32.08, P = 0.001). SSIH in the mesh group was small and asymptomatic, and did not require repair, compared with 28% SSIH repairs in control patients.

In the matched case–control study by Maggiori et al. [46], 30 consecutive patients were individually matched to patients from a prospective database. In these patients, a biological mesh (noncross-linked collagen, porcine dermal matrix; Meccellis, Biotech) was placed in a retromuscular position. At 1-year CT follow-up, SSIH incidence was lower in mesh patients than the control group (3% vs 19%, P = 0.04), while postoperative morbidity was similar in both groups (17% vs 11%, P = 0.51). SSIH repair was needed in eight control patients (13% vs 0%, P = 0.05).

### Discussion

This study shows an overall incidence of SSIH of 6.5% [range 0%–38.5%, median follow-up 27.5 (17.54–36) months], which is in accordance with the review by Bhanu et al. [58], who reported an overall hernia rate of 7% (range 0%–48%, median follow-up 36 months). However, this study was based on a smaller number of patients (n = 2698) than the present study (n = 4602). Both previous studies, by Bhanu et al. and Nguyen et al., reported on significant heterogeneity between studies and difficulties in interpretation and combining.

---

**Table 5** Overview of studies reporting on prophylactic mesh placement for the prevention of SSIH.

| Author     | Year | Design | Mesh or control | Mesh type | Control group | Outcome measure               | SSIH detection method |
|------------|------|--------|-----------------|-----------|---------------|-------------------------------|-----------------------|
| Bhangu     | 2014 | CS     | Mesh            | Biological (Strattice<sup>TM</sup>) | IPOM          | None                          | 30-day outcomes –     |
| Liu        | 2013 | R      | Mesh            | Polypropylene (Ethicon Ultrapro<sup>®</sup>) | Onlay –       | Rate of SSIH C and/or CT      |
| Maggiori   | 2015 | CM     | Mesh            | Bioprosthetic, noncross-linked collagen, porcine dermal matrix (Meccellis, Biotech) | Sublay, retromuscular | Skin defect open               | CT                    |
| van Barneveld | 2013 | CS     | Mesh            | Parietex<sup>TM</sup> Composite Parastomal mesh + AbsorbaTack<sup>TM</sup> (Covidien/ Medtronic) | IPOM None | SSIH and mesh complications | C and US               |

Continuous data are mean (standard deviation), mean (standard deviation, range), or median (interquartile range).

C, clinical diagnosis; CT, computed tomography diagnosis; CS, case series; EI, end ileostomy; LC, loop colostomy; LI, loop ileostomy; m, months; R, retrospective; CM, case matched; IPOM, intraperitoneal onlay mesh; SSI, surgical site infection; SSIH, stoma site incisional hernia; US, ultrasound.
study results [58,59]. To reduce this heterogeneity, several inclusion and exclusion criteria were used during our systematic literature search (Fig. 1). Most importantly, to be included, studies had to mention follow-up duration, since hernia rates increase over time and might vary between different durations. Furthermore, studies with >10% of patients with abdominal trauma were excluded, as earlier reports showed these patients to be more prone to hernia development [60,61].

To compare the SSIH rate between ileostomy and colostomy reversal, seven studies were eligible for analysis. Whereas the previous review of Bhangu et al. [58] showed a significantly different lower SSIH rate after ileostomy (OR 0.28, 95% CI 0.12–0.65), this review found no significant difference in the risk of SSIH between ileostomy and colostomy (OR 0.82, 95% CI 0.40–1.69), which was also not found in an additional cumulative meta-analysis (cumulative OR 0.87, 95% CI 0.44–1.75).

In this study, only one-third (11/33) of included studies assessed SSIH incidence as the primary outcome. Twenty studies did not mention detection methods and, therefore, it seems likely to assume that imaging was not used in these studies. To investigate potential underestimation, the overall incidence of SSIH from the 11 studies with SSIH as the primary outcome was calculated (17.7%, range 1.7%–36.1%) [4,5,30–32,37,45,46,48,51,52]. These rates indeed support the hypothesis that the overall incidence of hernia from all included studies (6.5%), as from those only reporting on SSIH as a secondary outcome (3.6%), is an underestimation. The potential risk of underestimation by not using imaging for detection of SSIH is further supported by the higher incidence in studies that used imaging, compared with studies that did not use, or did not mention the use of imaging as a detection method (15.3% vs 3.7%, respectively). Indeed, from the literature on incisional hernias it is known that prevalence rates vary substantially, through differences in diagnostic modalities, observer, definition and diagnostic protocol [62]. The use of imaging, which led to higher SSIH rates, might have identified asymptomatic or occult hernias. Therefore, the overall SSIH rate of 6.5% seems to be lower but more clinically relevant, and thus it remains debatable if PMR might even be necessary at all. Hence, it is important to identify high-risk patients,
in whom PMR might still be of added value and if in these patients its risks outweigh its benefits.

Eight studies were identified that reported on potential risk factors for development of SSIH. Three studies [5,45,52] performed a multivariate analysis, from which BMI, primary surgery for malignant disease and diabetes mellitus were identified as potential risk factors. BMI is known to affect midline incisional and parastomal hernia rates [16,63–66], which might be explained by higher intra-abdominal pressure and consequent higher abdominal wall tension [16,67]. Additionally, obesity and diabetes are associated with wound healing complications due to local hypoxia, caused by a decreased vascularization of adipose tissue and other microvascular changes, impairing collagen synthesis and having a negative effect on the overall healing process [16,68]. Smoking has a comparable negative effect on wound healing and is considered a risk factor for incisional hernia [69]. However, none of the included studies has shown a significant effect on occurrence of SSIH. Moreover, with regard to primary surgery for malignant disease, factors as malnutrition, poor general health and immunosuppressive effects of chemotherapy are thought to negatively affect the normal healing process [45,68,70]. Wound infections are known to increase the risk of hernia formation [63,71]; however, in the present literature review SSIs were not found to be independently associated with an increased risk of SSIH. Overall, the study by Oriel et al. [4] was the only study to identify superficial SSI as a factor contributing to future SSIH formation. The data on risk factors in this review might help with the selection of high-risk patients and therefore help guide clinical decision-making, potentially involving PMR. Moreover, since factors such as obesity and smoking can potentially be minimized, it might be of interest to focus not only on PMR but also on lifestyle interventions such as preoperative weight loss, smoking cessation and nutritional optimization for the prevention of SSIHs. However, to date no evidence is available on the efficacy or effectiveness of these lifestyle interventions with regard to incidence of SSIH.

Four studies reported on PMR for SSIH prevention [45,46,56,57]. These studies had several methodological limitations that made it difficult to draw conclusions about the potential added value of PMR. Two of the studies reported on a very limited number of patients \( (n < 10) \), decreasing their generalizability [56,57]. Furthermore, these studies had no control (nonmesh) group. Two other studies on PMR were of better quality because they included larger numbers of patients and as well as control patients [45,46]. Liu et al. [45] stated that mesh placement significantly reduced the incidence of SSIH following ileostomy closure, without an increase in complications. Maggiori et al. [46] reported a significant difference in SSIH on 1-year follow-up CT in favour of PMR. Nevertheless, all four studies recognized the need for RCTs to further evaluate the beneficial effects, safety and (cost-)effectiveness of PMR. Efforts have already been made by several research groups, and further trial results are awaited. A feasibility study by the Reinforcement of Closure of Stoma Site (ROCSS) Collaborative has recently been published and reported their study protocol to be feasible, without early safety concerns [72]. Based on their data, progression towards their ROCCS trial (ClinicalTrials.gov identifier NCT02238964) has continued [72,73]. Several other trials have been initiated, such as the MEMBO trial (NCT02576184), the ILEOCLOSE trial (NCT02226887) and the LISTO-trial (NCT02669992). Next to ileostomy closure, only the ROCCS trial also includes patients undergoing colostomy closure, and none of these trials focuses on a specific risk group, such as obese patients. However, since obesity seems to increase the risk of SSIH after stoma closure, this group of patients might potentially benefit more from PMR, although, paradoxically, these patients, especially in case of diabetes, might at the same time also be at higher risk of developing mesh-related complications [74,75]. Therefore, it would be interesting to see the results of PMR in these patients specifically. With regard to the efficacy and (cost-)effectiveness of PMR, it is still debatable as to what would be a clinically significant reduction in SSIH rates. In the case of the ROCCS trial, sample size calculation of the full Phase III study was based on a 40% reduction (25% to 15%) in the 2-year clinical hernia rate [72]. In the study by Maggiori et al. [46], a 16% difference was found (19% vs 3%, \( P = 0.043 \)), which might have been used for the sample size calculation of the MEMBO trial. However, further data on sample size calculations and risk reduction were not available. Unfortunately, robust conclusions cannot yet be drawn on its risks and benefits from the available literature on PMR. If PMR is proven to be beneficial in these studies, further implications for practice should be made sufficiently clear (e.g. patient selection) in order to overcome the barriers of implementing these findings [76].

The low level of evidence and the vast heterogeneity of the included studies are two important limitations of this study. Nevertheless, inclusion of these studies was still deemed necessary as they allowed a more comprehensive overview of potential risk factors, as well as more detailed analyses of SSIH and repair rates. The lack of a predefined time period from which studies could be included might also have been a limitation of this review, because important changes in operative and
perioperative care of patients have been introduced in recent decades (e.g. laparoscopy). However, this effect is presumably largely negligible since the majority of included studies were published in the previous decade (Table 1).

In conclusion, this review shows an overall incidence of SSIH of 6.5% (range 0%–38.5%), as well as an incidence of 17.7% (range 1.7%–36.1%) from 11 studies assessing SSIH as the primary outcome. Furthermore, potential risk factors have been identified, of which BMI, malignant disease and diabetes were considered to be the most important. Lastly, early results from four studies on PMR were identified, but no robust conclusions could be drawn. Results of ongoing trials are awaited.

Acknowledgements

The authors thank Wichor Bramer, biomedical information specialist at the Erasmus Medical Center, for his assistance with the search strategy and syntax.

Conflict of interests

None to disclose.

References

1 Edwards DP, Chisholm EM, Donaldson DR. Closure of transverse loop colostomy and loop ileostomy. Ann R Coll Surg Engl 1998; 80: 33–5.
2 Rufler E, Goffre B, Bonnel C, Zerbib F, Caudry M, Saric J. Preoperative radiochemotherapy and sphincter-saving resection for T3 carcinomas of the lower third of the rectum. Ann Surg 2001; 234: 633–40.
3 Saha AK, Tapping CR, Foley GT et al. Morbidity and mortality after closure of loop ileostomy. Colorectal Dis 2009; 11: 866–71.
4 Oriel BS, Chen Q, Itani KMF. Incidence, recurrence and risk factors of hernias following stoma reversal. Am J Surg 2017; 214: 232–8.
5 Brook AJ, Mansfield SD, Daniels IR, Smart NJ. Incisional hernia following closure of loop ileostomy: the main predictor is the patient, not the surgeon. Surgeon 2016; 16: 20–6.
6 Garcia-Botello SA, Garcia-Armengol J, Garcia-Granero E et al. A prospective audit of the complications of loop ileostomy construction and takedown. Digest Surg 2004; 21: 440–6.
7 Giannakopoulos GF, Veenhof AA, van der Peet DL, Sietsema C, Meijerink WJ, Cuesta MA. Morbidity and complications of protective loop ileostomy. Colorectal Dis 2009; 11: 609–12.
8 Luglio G, Pendlimari R, Holubar SD, Cima RR, Nelson H. Loop ileostomy reversal after colon and rectal surgery: a single institutional 5-year experience in 944 patients. Arch Surg 2011; 146: 1191–6.
9 Knox AJ, Birkett FD, Collins CD. Closure of colostomy. Br J Surg 1971; 58: 669–72.
10 Pittman DM, Smith LE. Complications of colostomy closure. Dis Colon Rectum 1985; 28: 836–43.
11 Salley RK, Bucher RM, Rodning CB. Colostomy closure. Morbidity reduction employing a semi-standardized protocol. Dis Colon Rectum 1983; 26: 319–22.
12 Khoury DA, Beck DE, Opelka FG, Hicks TC, Timmcke AE, Gathright JB Jr. Colostomy closure. Ochsner Clinic experience. Dis Colon Rectum 1996; 39: 605–9.
13 Antoniou SA, Agresta F, Garcia Alamino JM et al. European Hernia Society guidelines on prevention and treatment of parastomal hernias. Hernia 2017; 22: 183–98.
14 Read RC, Yoder G. Recent trends in the management of incisional herniation. Arch Surg 1989; 124: 485–8.
15 Snyder CW, Graham LA, Vick CC, Gray SH, Finan KR, Hawn MT. Patient satisfaction, chronic pain, and quality of life after elective incisional hernia repair: effects of recurrence and repair technique. Hernia 2011; 15: 123–9.
16 Jairam AP, Timmermans L, Eker HH et al. Prevention of incisional hernia with prophylactic onlay and sublay mesh reinforcement versus primary suture only in midline laparotomies (PRIMA): 2-year follow-up of a multicentre, double-blind, randomised controlled trial. Lancet 2017; 390: 567–76.
17 Muysoms FE, Jairam A, Lopez-Cano M et al. Prevention of incisional hernias with biological mesh: a systematic review of the literature. Front Surg 2016; 3: 53.
18 Odensten C, Strigard K, Rutegard J et al. Use of prophylactic mesh when creating a colostomy does not prevent parastomal hernia: a randomized controlled trial-STOMA-MESH. Ann Surg 2017, https://doi.org/10.1097/SLA. 0000000000002542.
19 Shabbir J, Chaudhary BN, Dawson R. A systematic review on the use of prophylactic mesh during primary stoma formation to prevent parastomal hernia formation. Colorectal Dis 2012; 14: 931–6.
20 Lopez-Cano M, Brandsma HT, Bury K et al. Prophylactic mesh to prevent parastomal hernia after end colostomy: a meta-analysis and trial sequential analysis. Hernia 2017; 21: 177–89.
21 Brandsma HT, Hanson BM, Aufenacker TJ et al. Prophylactic mesh placement during formation of an end-colostomy reduces the rate of parastomal hernia: short-term results of the Dutch PREVENT-trial. Ann Surg 2017; 265: 663–9.
22 Smart N. Stomas: time for a closer look. Colorectal Dis 2017; 19: 1049.
23 Stroup DF, Berlin JA, Morton SC et al. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in...
Review of stoma site incisional hernias

D. P. V. Lambrichts et al.

Epidemiology (MOOSE) group. JAMA 2000; 283: 2008–12.
24 Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. J Clin Epidemiol 2009; 62: 1006–12.
25 Wille-Jorgensen P, Rencehan AG. Systematic reviews and meta-analyses in coloproctology: interpretation and potential pitfalls. Colorectal Dis 2008; 10: 21–32.
26 Howick JC I, Glasziou P, Greenhalgh T et al. Oxford Centre for Evidence-Based Medicine. The Oxford 2011 Levels of Evidence. [Available from: http://www.cebm.net/index.aspx?o=5653].
27 Wells G, Shea B, O’Connell D et al. Newcastle-Ottawa Scale. Hospital Research Institute Ottawa (http://www.wohncr/programs/c clinical_epidemiology/nosgenpdf). 2006.
28 Higgins JP, Altman DG, Gotzsche PC et al. The Cochrane Collaboration’s tool for assessing risk of bias in randomised trials. BMJ 2011; 343: d5928.
29 Baxk R, Busch OR, Remelman WA, Veldink GJ, Slors JF, van Lanschot JJ. Morbidity of temporary loop ileostomies. Dig Surg 2004; 21: 277–81.
30 Bhangoo A, Fletcher L, Kingdon S, Smith E, Nepogodiev D, Januja U. A clinical and radiological assessment of incisional hernias following closure of temporary stomas. Surgeon 2012; 10: 321–5.
31 Cingi A, Solmaz A, Artaallah W, Aslan A, Akta AO. Enterostomy closure site hernias: a clinical and ultrasonographic evaluation. Hernia 2008; 12: 401–5.
32 De Keersmaecker G, Beckers R, Heindryckx E et al. Retrospective observational study on the incidence of incisional hernias after reversal of a temporary diverting ileostomy following rectal carcinoma resection with follow-up CT scans. Hernia 2016; 20: 271–7.
33 D’Haeinnick A, Wolthus AM, Penninckx F, D’Hondt M, D’Hoore A. Morbidity of a defunctioning loop ileostomy. Acta Chir Belg 2011; 111: 136–41.
34 Edwards DP, Leppington-Clarke A, Sexton R, Heald RJ, Moran BJ. Stoma-related complications are more frequent after transverse colostomy than loop ileostomy: a prospective randomized clinical trial. Br J Surg 2001; 88: 360–3.
35 El-Hussauna A, Lauritsen M, Bulow S. Relatively high incidence of complications after loop ileostomy reversal. Dan Med J 2012; 59: A4517.
36 Fison V, Portage G, Mazzeo A, Migliorini G, Frigo F. Laparoscopic reversal of Hartmann’s procedure. Updates Surg 2014; 66: 277–81.
37 Guzman-Valdivia G. Incisional hernia at the site of a stoma. Hernia 2008; 12: 471–4.
38 Hasegawa H, Yoshikoa K, Keighley MR. Randomized trial of fecal diversion for sphincter repair. Dis Colon Rectum 2000; 43: 961–4; discussion 4–5.
39 Holmgren K, Kverneng Hultberg D, Haapamaki MM, Matthiessen P, Rutegard J, Rutegard M. High stoma prevalence and stoma reversal complications following anterior resection for rectal cancer: a population-based multi-centre study. Colorectal Dis 2017; 19: 1067–75.
40 Kohler G, Spaun G, Luketina RR, Antoniou SA, Koch OO, Emanuel K. Early protective ileostomy closure following stoma formation with a dual-sided absorbable adhesive barrier. Eur Surg 2014; 46: 197–202.
41 Krond O, Yalti T, Berber I, Tellioglu G. Early vs. delayed closure of temporary covering ileostomy: a prospective study. Hepato-Gastroenterol 2008; 55: 142–5.
42 Lewis P, Bartolo DC. Closure of loop ileostomy after restorative proctocolectomy. Ann R Coll Surg Engl 1990; 72: 263–5.
43 Li WL, Benlice C, Stocchi L, Kessler H, Gorgun E, Costedo M. Does stoma site specimen extraction increase post-operative ileostomy complication rates? Surg Endosc 2017; 31: 3552–8.
44 Liang MK, Li LT, Avellaneda A, Moffett JM, Hicks SC, Awad SS. Outcomes and predictors of incisional surgical site in stoma reversal. JAMA Surg 2013; 148: 183–9.
45 Liu DS, Banham E, Yellapu S. Prophylactic mesh reinforcement reduces stomal site incisional hernia after ileostomy closure. World J Surg 2013; 37: 2039–45.
46 Maggiori L, Moszkowicz D, Zappa M, Mongin C, Panis Y. Bioprosthetic mesh reinforcement during temporary stoma closure decreases the rate of incisional hernia: a blinded, case-match studied in 94 patients with rectal cancer. Surgery 2015; 158: 1651–7.
47 Mala T, Nesbakken A. Morbidity related to the use of a protective stoma in anterior resection for rectal cancer. Colorectal Dis 2008; 10: 785–8.
48 Mishra A, Keeler BD, Maxwell-Armstrong C, Simpson JA, Acheson AG. The influence of laparoscopy on incisional hernia rates: A retrospective analysis of 1057 colorectal cancer resections. Colorectal Dis 2014; 16: 815–21.
49 Rosen MJ, Cobb WS, Kercher KW, Sing RF, Heniford BT. Laparoscopic restoration of intestinal continuity after Hartmann’s procedure. Am J Surg 2005; 189: 670–4.
50 Rutegard J, Dahlgren S. Transverse colostomy or loop ileostomy as diverting stoma in colorectal surgery. Acta Chir Scand 1987; 153: 229–32.
51 Sageed ZM, Lloyd-Evans J, Reid TD et al. CT evaluation for ‘quiescent’ herniation following closure of diverting loop ileostomy. Colorectal Dis 2012; 14: 1528–30.
52 Schreinemacher MH, Vigen GH, Dagnelie PC, Bloemen JG, Huizinga BF, Bouvy ND. Incisional hernias in temporary stoma wounds: A cohort study. Arch Surg 2011; 146: 94–9.
53 Seo SI, Yu CS, Kim GS et al. The role of diverting stoma after an ultra-low anterior resection for rectal cancer. Ann Coloproctol 2013; 29: 66–71.
54 Vermeulen J, Coene PP, Van Hout NM et al. Restoration of bowel continuity after surgery for acute perforated diverticulitis: should Hartmann’s procedure be considered a one-stage procedure? Colorectal Dis 2009; 11: 619–24.
55 Welten RJ, Jansen A, van de Pavoorrdt HD. A future role for loop ileostomy in colorectal surgery? Neth J Surg 1991; 43: 192–4.
56 Bhangu A, Futaba K, Patel A, Pinkney T, Morton D. Reinforcement of closure of stoma site using a biological mesh. *Tech Coloproctol* 2014; 18: 305–8.

57 van Barneveld KW, Vogels RR, Beets GL *et al.* Prophylactic intraperitoneal mesh placement to prevent incisional hernia after stoma reversal: a feasibility study. *Surg Endosc* 2014; 28: 1522–7.

58 Bhangu A, Nepogodiev D, Futaba K, West Midlands Research C. Systematic review and meta-analysis of the incidence of incisional hernia at the site of stoma closure. *World J Surg* 2012; 36: 973–83.

59 Nguyen MT, Phatak UR, Li LT *et al.* Review of stoma site and midline incisional hernias after stoma reversal. *J Surg Res* 2014; 190: 504–9.

60 Carne PW, Robertson GM, Frizelle FA. Parastomal hernia. *Br J Surg* 2003; 90: 784–93.

61 Cingi A, Cakir T, Sever A, Aktan AO. Enterostomy site hernias: a clinical and computerized tomographic evaluation. *Dis Colon Rectum* 2006; 49: 1559–65.

62 Kroese LF, Sneider S, Kleinrensink GJ, Muyssoms F, Lange JF. Comparing different modalities for the diagnosis of incisional hernia: a systematic review. *Hernia* 2018; 22: 229–42.

63 Iatsu K, Yokoyama Y, Sugawara G *et al.* Incidence of and risk factors for incisional hernia after abdominal surgery. *Br J Surg* 2014; 101: 1439–47.

64 Veljkovic R, Protic M, Gluhovic A, Potic Z, Milosevic Z, Stojadinovic A. Prospective clinical trial of factors predicting the early development of incisional hernia after midline laparotomy. *J Am Coll Surg* 2010; 210: 210–9.

65 Aquina CT, Iannuzzi JC, Probst CP *et al.* Parastomal hernia: a growing problem with new solutions. *Dig Surg* 2014; 31: 366–76.

66 Nastro P, Knowles CH, McGrath A, Heyman B, Porrett TR, Lunniss PJ. Complications of intestinal stomas. *Br J Surg* 2010; 97: 1885–9.

67 Seiler CM, Bruckner T, Diener MK *et al.* Interrupted or continuous slowly absorbable sutures for closure of primary elective midline abdominal incisions: a multicenter randomized trial (INSECT: ISRCTN24023541). *Ann Surg* 2009; 249: 576–82.

68 Riou JP, Cohen JR, Johnson H Jr. Factors influencing wound dehiscence. *Am J Surg* 1992; 163: 324–30.

69 Sorensen LT, Hemmingsen UB, Kirkeby LT, Kallehave F, Jorgensen LN. Smoking is a risk factor for incisional hernia. *Arch Surg* 2005; 140: 119–23.

70 van Ramshorst GH, Nieuwenhuizen J, Hop WC *et al.* Abdominal wound dehiscence in adults: development and validation of a risk model. *World J Surg* 2010; 34: 20–7.

71 Singh R, Omiccioli A, Hegge S, McKinley C. Does the extraction-site location in laparoscopic colorectal surgery have an impact on incisional hernia rates? *Surg Endosc* 2008; 22: 2596–600.

72 Reinforcement of Closure of Stoma Site. C, the West Midlands Research C. Feasibility study from a randomized controlled trial of standard closure of a stoma site vs biological mesh reinforcement. *Colorectal Dis* 2016; 18: 889–96.

73 Reinforcement of Closure of Stoma Site (ROCSS) Collaborative and the West Midlands Research Collaborative. Randomized controlled trial of standard closure of a stoma site vs biological mesh reinforcement: study protocol of the ROCSS trial. *Colorectal Dis* 2018; 20: O46–54.

74 Falagas ME, Kasiakou SK. Mesh-related infections after hernia repair surgery. *Clin Microbiol Infect* 2005; 11: 3–8.

75 Mavros MN, Athanasiou S, Alexiou VG, Mitsikostas PK, Peppas G, Falagas ME. Risk factors for mesh-related infections after hernia repair surgery: a meta-analysis of cohort studies. *World J Surg* 2011; 35: 2389.

76 Knops AM, Vermeulen H, Legemate DA, Ubbink DT. Attitudes, awareness, and barriers regarding evidence-based surgery among surgeons and surgical nurses. *World J Surg* 2009; 33: 1348–55.

**Supporting Information**

Additional Supporting Information may be found in the online version of this article:

**Figure S1.** Risk of bias assessment.

**Figure S2.** Cumulative meta-analysis of studies reporting on SSIH rates of ileostomies and colostomies.

**Table S1.** SSIH repair rates (subdivided by stoma type).

**Table S2.** Risk factors for SSIH.

**Appendix S1.** Details of the search strategy.