

THE LICHTENSTEIN REPAIR OF UNQUINAL HERNIA

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Inguinal hernia repair is one of the oldest operations ever documented. In fact, the first record of it dates prior to the Middle Ages. Today hernioplasty is one of the most common surgical procedures. Traditional (tension repair) hernia surgery involved cutting adjacent muscle, then pulling it together using suture.

This creates extreme tension on the muscle as it must be moved out of its normal anatomic location to cover the hernia defect. This produces swelling and pain. Most important, the tension inhibits full effective healing of the edges. The result of incomplete healing in the presence of this continued tension is the muscle edges which may pull apart causing a higher failure rate with recurrent hernia.

Today, some surgeons still use these “tension” methods, variation include the Bassini/Halsted, Cooper/Mc Vay and Canadian /Shouldice repair. In the mid eighties, hernia surgeon Irving Lichtenstein caused a stir among his colleagues when he proposed that using a piece of polypropylene mesh was the best way to repair all inguinal hernias. They felt that using a “foreign body” for repair increased the risk of infection. However Dr.Lichtenstein persisted and in 1989 published a study of 1,000 patients who received the Lichtenstein repair, experienced minimal complications and had a zero recurrence rate of after a follow up period of 1-5 years. The description of the Lichtenstein-free mesh repair, opened a new era in groin hernia repair. Most surgeons prefer tension free techniques, since mesh does not place tension on the sides of the abdominal wall and in majority cases does not pose any threat of infection. Surgery is usually performed under local anesthesia. The groin is prepared in the usual fashion. A polypropylene mesh is trimmed to fit the floor of the inguinal canal and its apex is first sutured to the pubic tubercle using propylene suture. Then suture lower border of the mesh to the free edge of the inguinal ligament. Interrupted propylene sutures, then suture the two cited edges of the mesh together around the spermatic cord. The inferio-medial corner of the mesh is then attached well overlapping the pubic tubercle. After meticulous hemostasis,a closed suction drain is placed beneath the external oblique aponeurosis. Regarding peri-operative care of the patient, prophylactic antibiotics is usually given for 48-72 hours postoperatively. The usual duration of the hospitalization is 2 days. When a closed suction drainage is used, it is removed the day of discharge. This technique is not only the safest procedure available but also associated with the least post-operative discomfort, most rapid return to normal activity and also associated with lowest rate of recurrence when compared with other technique.