THE TRUTH ABOUT INGUINAL HERNIAS

John Dunn, FRACS

Laparoscopy Auckland

SIGNS/SYMPTOMS (1)

- history is important
- comes and goes
- aggravated standing/lifting
- reduces overnight
- discomfort → pain

SIGNS/SYMPTOMS (2)

Indirect

- younger
- inguinoscrotal
- strangulation

Direct

- older

INVESTIGATION

- nil
- maybe ultrasound
  (can over-read)
- stand/cough examination
- 15% bilateral

DIFFERENTIAL

- nodal mass (constant)
- groin strain (athletes)

TREATMENT

- truss (belongs in MOTAT)
- herniorrhaphy

LAPAROSCOPIC

- totally extraperitoneal
- day stay
- short recovery (1 week)
- recurrence rare (<<1%)
- zero nerve entrapment

ARGUMENTS (1)

Cost – NO

- avoid disposables
- short operating time (20 mins)
- savings to society huge

ARGUMENTS (2)

Difficult to do – NO

- get trained
- “easier” than good open repair
- it IS specialised

ARGUMENTS (3)

High Recurrence – NO

- 9000+ repairs 20 years Laparoscopy Auckland
- recurrence <<1%

SPECIAL CONSIDERATIONS

- pain after open repair
  → re-repair laparoscopically
  and take out old sutures
- recurrence after open repair (10%)
  → re-repair laparoscopically
- bilateral hernias
  → definitely repair laparoscopically

ONLY EXCEPTIONS

- too sick for GA
  (open under LA)

- previous radical prostatectomy
  (plane undissectible)

OTHER HERNIAS

Treat the same way

- Femoral
  (less common, mainly females)
- Spigelian
  (rare, lateral edge rectus)

STATEMENT

"It is our firm belief that open herniorrhaphy should almost never be performed in this day and age.

"The laparoscopic extraperitoneal approach is unquestionably superior in terms of recovery, recurrence and nerve entrapment. This is proven with vast local experience.

"Ideal hernia management is now specialised."

John Dunn