Canadian Association of General Surgeons
Association canadienne de chirurgiens généraux

Symposium on the management of inguinal hernias

1. Introduction

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It is estimated that approximately 70 000 hernia repairs are performed each year in Canada. Hernia repair ranks as the second most frequently performed surgical procedure in North America. Yet, the Rand Corporation, in a 1985 study,[1] concluded, arguably, that at least 10% of all primary repairs will fail, and there is little evidence that results from Europe are any different,[2] pointing to the fact that there may be differences between reality and the published short-term results. Surgeons understand that whereas a good portion of the recurrences appear in the first 2 years after repair, 40% to 50% appear after 5 years, and 20% are discovered as long as 25 years postoperatively. This makes extended follow-up mandatory for a definitive analysis of results. Good descriptive studies have also repeatedly identified that recurrences were more likely to occur after operation on femoral, direct and recurrent hernias,[2] indicating that their management may require a different approach.

It is no surprise, then, that there is continuous interest from the surgical community in trying to improve the results of this common affliction, especially in the present context of limited resources. It has been estimated, for example, that a 1% reduction of the recurrence rate of inguinal hernias in France would result in 1000 fewer operations per year.[3]

The interest in hernia management peaks from time to time with the arrival of new techniques, like laparoscopy or the rediscovery of important anatomic landmarks like the space of Bogros.

In this symposium, we have asked proponents of various surgical approaches to give us their view on the technique they advocate and their indications for various repairs. We realize that scientific outcomes analysis or long-term randomized studies are lacking to back up many of the current claims regarding hernia repair. However, we cannot ignore the good descriptive studies on the use of local anesthesia and the ambulatory environment setting as basic ingredients in producing good outcomes. Since there is not even a consensus on the classification of hernias, and there are so many individual variations in operating technique, it probably will be some time before we can determine the best management alternatives for primary, recurrent, femoral and direct hernias and even the proper attitude regarding return to strenuous activities. Finally, in the last decade, the use of mesh in the repair of primary or recurrent hernia has increased dramatically, raising questions about the justification of routine implantation of a foreign body for the cure of a benign condition, especially in young patients with a long life expectancy. This will also require more scrutiny.

Of course the appropriate treatment will have low morbidity, low recurrence rate, low cost, little or no hospital stay, the simplest form of anesthesia, minimal disruption of the patient activities and good patient acceptance. Easy, is it not?

References

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