Inguinal hernias have always been a favorite with me. Most patients are referred because of increasing pain as well as a bulge in the groin. I still see patients though who present with an incarceration and occasionally strangulation. Hernia repairs are fun to do and the patients are very appreciative. A good repair should last for the remainder of the patient's life.

For years patients underwent primary repair using adjacent tissues, The Shouldice repair was the best of the bunch and resulted in a low recurrence rate of about 1%. When a groin hernia recurred the initial repair used autologous fascia. Later in about 1986 polypropylene mesh was first used in recurrent groin hernias. This turned out to be a great innovation since it reduced the recurrence rate to about 0.1% and just as importantly it allowed the repair of these defects without tissue tension, the "tensionless repair or Lichtenstein repair." This resulted in a repair that was much more comfortable and relatively painless when compared to the previous tissue repairs. This in turn allowed for most hernia repairs to be performed under local and sedation anesthesia as an outpatient. Also patients were able to return to work within a few days of the procedure.

Since then the use of mesh in the repair of all hernias has become the standard. The concept of using mesh is that the spaces between the mesh, the interstices, allow for the in growth of capillaries and granulation tissue followed by collagen, thereby filling the defect with strong tissue. The initial discomfort is usually mild and resolves over about a week as tissue grows into the mesh and the repair stabilizes. Visualization of the three cutaneous nerves in the groin during repair is important and has resulted in reduced pain following repair.

Laparoscopy has allowed us to do many of our operations less invasively, laparoscopic cholecystectomy being the prime example, but laparoscopic hernia repair has remained controversial. Laparoscopic groin hernia repair requires general anesthesia and is probably not indicated for large hernias that extend into the scrotum. A study published in ***the New England Journal of Medicine*** vol 350, April 2004 found the open technique to be superior to the laparoscopic technique with regards to the rates of recurrence and complications in primary hernia repairs. The time to return to work was about the same in the two groups. I recommend the simpler open technique under local anesthesia for most patients and especially for older patients and those with underlying disease. Situations in which a

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laparoscopic repair could be considered are in those patients who can tolerate general anesthesia and who have small bilateral direct hernias or a recurrent hernia.

I always try to discuss the different methods of repair with each patient and together we decide which is the right repair for that particular patient.

I hope this has been informative, if you have any questions or if I can help you with a patient, who has a general surgical problem, please don't hesitate to call.

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