

Recurrent inguinal hernia: what is the best approach?

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Over the past fifteen years, traditional surgical correction of inguinal hernia has gradually given way to “tension-free” repairs. Benefits of the latter include a lower recurrence rate: from 10-15 percent, to less than one percent. Though traditional techniques have long been shelved, it is well known that the recurrence rate is approximately 50 percent five years after surgery, and 20 percent after 15-20 years. Therefore, inguinal hernia recurrence surgery is performed following both traditional hernioplasty (now declining) and the “tension-free” technique (rising, in line with the increase in hernia surgery reported over the last ten years).

Most of the recurrences that occur following “tension-free” hernioplasty are associated with an open anterior approach which, being considered the gold standard for inguinal hernia, is also the most widely used approach.

Since re-treatments should avoid using the same approach used for primary repair, it is reasonable to assume that the mesh is generally applied through a posterior approach, regardless of whether the repair is open or laparoscopic.

Consequently, several considerations are in order:

- as for the primary hernia, barring clinical or logistical contraindications, the recurrent hernia should also be treated in a day-surgery setting, which means that the anesthesiology and surgery must permit early discharge, readily controllable pain, minimal complications which, if present, can be treated on an out-patient basis, and last but not least, low costs;
- given today’s longer life expectancy, these pa-

tients are often geriatric and, as such, frequently suffer from concomitant pathologies which may increase surgical risks;

- in some cases, prior surgery in the space of Retzius may argue against using a posterior approach;
- even today, most surgeons are more comfortable with the traditional open anterior approach.

Based on the literature, recurrences can be treated just as effectively using either the posterior or the anterior approach; however, it should be noted that:

- the posterior approach requires spinal or general anesthesia, whilst the anterior approach can easily be performed under local anesthesia (which is better suited to day-surgery);
- posterior repair techniques have been associated with a small number of severe surgical complications involving the intraperitoneal and/or pelvic structures. No such complications are reported for anterior repair procedures, and, in addition, the costs appear to be lower.

The open anterior approach, always recommended for treating recurrences previously repaired using the posterior approach, also has a role in the treatment of anteriorly repaired recurrences, and is particularly effective in elderly patients who are at high anesthesiological risk and/or when the space of Retzius has already been surgically accessed.

The principle of avoiding an approach that has previously proved ineffective is doubtless correct, but in light of the foregoing this concept may, and, in some cases should be ignored in order to offer the patient the best possible treatment.