# Introduction

The inguinal canal is the commonest site of recurrent hernation, possibly because inguinal hernias are seen more frequently and in part because that confidence in the procedure of repair is so high that it is often done by juniors . it is roughly estimated that recurrence of inguinal hernias in adults is in a range of ( 10 - 15% ) **(Donald and Edward; 1992).**

Since inguinal herniorraphy is required in about 2% of the population and accounts for 15% of general surgical procedures, it is now surprising that recurrence pauses a major surgical problem **(Abrahamason 1990).**

Once the primary repair fails it is more difficult to achieve success, moreover recurrence and rerecurrence require multiple procedures which may end with an incisional type of hernia especially in Hesselbach's Triangle **(Raymond and Rea; 1992).**

Any technique to be used for surgical repair of recurrent hernia should primarily eliminate any known risk factors (e.g chronic cough , prostatic obstruction, obesity, cigarette smoking , etc.).

Dealing with operative failure and recurrence, good surgical technique with proper judgement and choice of repair, should be of prime importance. Prosthetic replacement may become a necessity in some cases, however experience with different operations is considered by some authorities to be one reason why experts report fewer recurrence , so it is more better to individualize treatment and not to try to fit every patient to one procedure **(Raymond and Rea ; 1992).**

Recurrence may be identical one. (that is to say of the same type of the originally repaired hernia), or different recurrence (missed hernia , iatrogenic one, and incisional hernia add to the different types of recurrence) **(Ponka 1984).**

The failure of inguinal repair and subsequent recurrence may be ascribed to errors in judgement of the technique on the part of the surgeon and endogenous causes **(Ben david1994).**