Summary and conclusion

Surgical repair of the hernia is found to be the only definitive management. The of hernia surgery is highly surgeon dependent "no disease of the human body, belonging to the province of surgeons requires in its treatment a greater combination of accurate anatomical knowledge with surgical skill than hernia in all its varieties.

Since the first true herniorrhaphy was performed by Bassini over 100 years ago, all modifications and surgical technique have shared a common disadvantages, suture line tension, the anatomic, physiologic and pathologic characteristics of hernia recurrence are examined.

The prime etiologic factor behind most herniorrhaphy failure is the suturing together, under tension of structures that are not normally in apposition. With the use of modern mesh prosthetics, it is now possible to repair all hernia without distortion of the normal anatomy and with no suture line tension.

During the last two decades, tension free hernioplasties including Lichtenstein or mesh plug are the most effective and ideal method of inguinal hernia repair. Less than two decades ago, Lichtenstein described a tension-free onlay polyprolene mesh for inguinal hernia repair. In the late4 1980s, Gilbert reported the logical step in the evolution of mesh hernia

plugs by improving on the design through taking a flat piece of mesh and fashioning it by hand into a " cone " or an " umbrella " shape.

The mesh-plug technique is simple and can be utilized in the repair of any groin hernia. The peritoneal cavity is never entered and there is no postoperative ileus. Decreasing the amount dissection has lessened blood loss and resulted in diminished patient discomfort. The largest hernias have been repaired with excellent results through the use of a simple mesh-plug.

Various meshes have since been developed consisting of mainly of non absorbable materials, such as polypropylene, polyester and polytetra-fluroethylene. The tension-free hernioplasty with a sheet of prosthetic material is now a popular method for the treatment of inguinal hernias. It has been preferred by surgeons because the technique is simple, rapid, effective and safe with less postoperative pain, discomfort and low recurrence rate.

In preperitoneal hernia repair the transabdominal preperitoneal approach to expose the inguinal floor for hernia repair. Reinforcement in this area allows intra-abdominal pressure to assist in securing the inlayed prosthesis to the pelvic floor, after mesh placement, the peritoneum becomes nondistensible, thus; there is no need for hernia defect closure. This technique has met particular success in the repair of bilateral hernias, large scrotal hernias and recurrent or rerecurrent hernias in which conventional repair is difficult and carries a high morbidity and failure rate.

The prolene hernia system has 3 in 1 unique design. It is formed of three parts; each can be used as a separate type of tension free repair for inguinal hernias. It is formed of onlay patch, connector and underlay patch.

The increasing interest in minimally invasive surgery has encouraged development of techniques for performing hernia repair laparoscopically. Laparoscopic surgical approaches have several advantages over traditional open operations, including reduction in hospital stays, postoperative pain and time required for convalescence.

Laparoscopic inguinal hernia repair may cause a revolution in general surgery if it proves to be the best treatment for inguinal hernia. Today there are several laparoscopic techniques that have been to be feasible. However, no information concerning long-term recurrence rates and cost-effectiveness is available and it is still premature to advocate a transition from the preferred individualized conventional technique to a laparoscopic technique on a large scale.