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SRB's Surgical Operations: Text & Atlas
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 • iliopubic tract repair is done

Fig. 19-42: Nyhus iliopubic tissue repair. Same plane after similar dissection mesh can be placed.

Condon Procedure

It is anterior iliopubic tract repair wherein the transversus abdominis is sutured to iliopubic tract from pubic tubercle to deep ring; then extending lateral to the cord. In direct sac relaxing incision is made on the lower rectus before tying all placed sutures.

Shouldice Repair

Even though transversalis fascia is thin, it is a tough layer and so double breasting of this fascia using continuous sutures (with nonabsorbable material) strengthens the posterior wall of the inguinal canal.

It is a multilayered repair. Continuous sutures provide *even distribution of tension* throughout the repair. It was originated at *Shouldice hernia clinic in Toronto* by Shouldice (EE Shouldice, 1930) where it was usually done under local anaesthesia. Often cremasteric resection is done in Shouldice in order to have proper revelation of the posterior inguinal wall. Cremasteric vessels (located at lateral part of the cord along with genital branch of genitofemoral nerve) need ligation during cremasterectomy. After doing herniotomy as in any other inguinal hernia, transversalis fascia is incised along the line of the wound from deep ring to pubic tubercle. Upper medial flap is elevated without elevating lower lateral flap. If there is redundant part of the transversalis fascia it should be excised to leave adequate amount of clean cut edges. Superior pubic vein is located on the deeper surface of the iliopubic tract which should not be injured while operating. Cribriform fascia of thigh is incised deep to the inguinal ligament to free the lateral flap of external oblique aponeurosis and also to visualize femoral opening.

First suture line: Lower lateral flap of fascia is sutured to posterior deep part of the elevated upper flap using continuous sutures from

closure of the external oblique aponeurosis without any additional two-layered repair of conjoint tendon to inguinal ligament.

Desarda Tension Free Tissue Repair

Desarda no mesh tension free tissue repair (Professor Mohan Desarda, Pune, India): It is live external oblique tissue flap reconstruction of the posterior wall of the inguinal canal. He proposed that strength of the inguinal canal depends on the aponeurotic extensions from the transverse abdominis aponeurotic arch normally which is physiologically dynamic and strong and his repair supports this effectively with least complications and recurrence. Inguinal canal is approached like usual hernia repair surgery. Indirect sac is dissected and ligated high using vicryl. Direct sac is not opened but buried by placing purse string sutures or interrupted mattress sutures over the transversalis fascia. Edge of upper leaf of the cut external oblique aponeurosis is sutured to the inguinal ligament below using continuous or interrupted polypropylene sutures. Cord should be outside this suture line. Upper leaf of sutured external oblique aponeurosis is incised horizontally around 1.5 cm above the sutured line; this incision extends laterally up to the internal ring level and medially up to the rectus sheath near midline. Lower edge of this newly cut part of the upper leaf of the external oblique is sutured to the conjoint tendon underneath using interrupted polypropylene sutures adequately. New upper cut part of the upper leaf of the external oblique is sutured to the edge of the original lower leaf in front of the cord structure. So live transposed external oblique acts as natural tissue prosthesis to support the posterior part of the inguinal canal. This technique said to have low recurrence rate with avoiding the placement of mesh (foreign body) with minimal complications (Figs 19-44 to 19-47).

Repair of Sliding Hernia