

“A new technique of inguinal hernia repair - neither similar to nor modification of Desarda’s repair”

AUTHOR: Professor Dr. Desarda M.P. M.S. (General Surgery), JIMA 2007

To the Editor,

I read with interest the article ‘Repair of inguinal hernia by a simple technique-A preliminary observation’ published by Dr. Parthasarathi Giri, Associate professor Mrinalkanti Das and professor Amita Giri in the January 2007 issue of the JIMA. I am thankful to them all for giving reference of my operation technique in their article. But I do not agree that the procedure followed in their technique of hernia repair is like that of “Desarda’s repair” with some modification. In my repair, a strip of the external oblique aponeurosis goes behind the cord to form a new posterior wall. After excision of the sac, a strip of the external oblique aponeurosis (EOA) is partially separated from its medial leaf, keeping its continuity intact at either end. This undetached strip of EOA is sutured to the inguinal ligament below and the arch of muscle above, behind the cord, to form a new posterior wall. This strip is put under tension by muscular contraction and works as a shield to prevent recurrence. External oblique muscle gives additional strength to the weakened muscle arch to keep this strip physiologically dynamic. I have recently published an article ‘Physiological repair of inguinal hernia-A new technique (Study of 860 patients) in ‘The World Journal of Hernia and Abdominal wall surgery’⁽¹⁾. The 0% recurrence rate, minimal pain, one night stay and complete recovery in 1-2 weeks time is seen because this repair is based on the physiological principle and not on the anatomical principle as seen in the mesh repairs. I also do not agree with the statement that the shutter mechanism, inter action of abdominal muscles and the positioning of the gut due to contours of the abdominal wall really plays effective role in the prevention of hernia formations. The presence or absence and the number of the aponeurotic fibers seen in the ‘Aponeurotic extensions’ from the Transversus abdominis aponeurotic arch in the posterior wall plays a real role in the prevention of hernia. Posterior wall of the inguinal canal is composed of two layers, aponeurotic extensions and the transversalis fascia, as against the general belief of only transversalis fascia. Shielding, compression and squeezing action of the strong musculo-aponeurotic structures around the canal also play an equally important role.⁽²⁾

The use of hernial sac for repairs just can not be considered in any way you suture it because the sac is nothing but protrusion of the peritoneum, which is papery thin and it does not have any strength per se to prevent the future herniation or recurrence. Whatever, postoperative protection is received by the patient in their study is probably because of the tightening of the internal ring (Marcy's repair) or the suturing of the conjoint tendon to the inguinal ligament (Bassini's repair). Therefore, this repair is neither similar to nor a modification of Desarda repair or even mesh repair. I will request the authors and the readers to try 'Desarda,s repair' which is simple, cost effective, without any recurrence, without any foreign body and based on the new concepts of the physiology of inguinal canal published by me in BMC Surgery 2003; 3:2.

REFERENCES: 1) Desarda MP-Physiological repair of inguinal hernia-A new technique (Study of 860 patients), Hernia 2006; 10:143-146

2) Desarda MP-Surgical physiology of inguinal hernia repair - a study of 200 cases, BMC Surgery 2003 3:2