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LETTER TO THE EDITOR

Letter to the Editor concerning article by Morris-Stiff G, Hassn A (2008) Hernioscopy: a useful technique for the evaluation of incarcerated hernias that retract under anaesthesia. Hernia 12:133–135

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Dear Sir:

As we all know, groin hernias are very common problems but relatively easy to deal with in daily surgical practice. However, they may become life threatening when strangulation occurs. In this context, the article in *Hernia*, April 2008, entitled "Hernioscopy: a useful technique for the evaluation of incarcerated hernias that retract under anaesthesia" by Morris-Stiff and Hassn has great importance, and I read the article with great interest [1].

As the authors mentioned clearly, a small number of incarcerated hernias can reduce during the induction of general anaesthesia, and the surgeon may have to face the alternatives of close observation or exploratory laparotomy to see what happened to the intestine. Although the laparoscopic approach has appeared to be a good therapeutic option for strangulated hernias [2], it is certain that not every surgeon has enough experience with laparoscopic surgery outside of cholecystectomy and diagnostic laparoscopy; moreover, not every institution is fully equipped for that. Nevertheless, the technique described in the article may really be very useful for some cases in many centers. However, I would like to separate such incarceration cases by their type and anatomical location before drawing the treatment map. I agree with the authors that conducting a hernioscopy via hernia sac to evaluate the intestinal viability is a smart technique for incarcerated umbilical and incisional hernias. I expect more surgeons will do so after reading this interesting paper. Nevertheless, I prefer and would like to recommend an easy and safe method for incarcerated groin hernias: hernia sac content examination and repair with 'local anaesthesia'.

Local anaesthesia is a very good choice for most groin hernia repairs. It is well tolerated and associated with significant advantages compared to general and regional anaesthesia [3] and should especially be considered when the patient is old and not fit for general anaesthesia [4]. The authors already mentioned in the discussion section that incarcerated hernias were seen more frequently in the elderly, and some of the patients in their small series were old. In addition, Dr. Morris-Stiff previously cited a Medicare analysis showing a 10-fold higher death rate for incarcerated hernias [5] and referred to the availability of local anaesthesia in inguinal hernia repair in a very recent paper from another institution [6]. This is consistent with our previous report on emergency hernia repairs with high mortality rate in elderly patients [7]. In fact, in such cases, local anaesthesia could be a safer choice for the patient and the surgeon.

I personally prefer using local anaesthesia when starting the operation for an incarcerated groin hernia. This keeps the hernia content in place at the beginning since no muscle relaxant has been used. The surgeon can see what is in the hernia sac without any spontaneous reduction. Obviously, the sac content may be only omentum in many incarcerated cases, and these cases will not be different from other irreducible groin hernias repaired on an elective basis. When the sac contains intestine, the surgeon can evaluate the viability of the involved bowel loops for a while before a gentle reduction to the abdominal cavity. The operation then

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can be completed with a Lichtenstein repair. If the small bowel seems to be grossly ischemic or of very questionable vitality, it is also possible to do a limited resection and anastomosis via the inguinal incision. This may require a further induction of general anaesthesia but still avoids an unnecessary laparotomy. The choice of repair then can be a Bassini-Shouldice suture repair or even prosthetic repair again.

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