INTRODUCTION

Inguinal hernias are common and continue to be one of the main challenges which surgeons face. Despite the advances in surgical technology and immunology in the last ten years, we are still faced as was Celses, in the first century B.C., with patients complaining of 'Protrusions' of the abdominal cavity. From the patients' perspective, hernia is a painful and uncomfortable disability which may prevent him working and fortunately these are relatively simple and safe to repair.

Throughout the history of modern surgery for groin hernia, several procedures have been presented with very good results, but the results have sometimes been difficult to reproduce. The relationship between the type of hernioplasty and recurrences have been a continuing matter of disagreement (Smedberg et. al. 1984).

No one, however, questions the necessity for surgery where the excision of that part of the sac that traverses the abdominal wall, back to the level of the parietal peritoneum, is an essential part of any type of surgical repair (Ferguson, 1978).

Additionally in order to prevent recurrences, the end of 'high ligation' of the sac been regarded as axiomatic. Recurrence of indirect inguinal hernia has often shown to be due to failure
to find and extirpate the sac (Ferguson, 1978) and due to various techniques of hernial wall repair, recurrence rates continue to range between 1 and 10% (Lichtenstein, 1987). Impersonal reviews indicate that the recurrence rate remains excessively high and fairly constant whatever method and material is employed.

The question at issue is whether, after the proximal sac is excised, the resulting peritoneal defect at the level of the parietal peritoneum should be closed by suture i.e should ligation of the hernial sac be done routinely in every case or whether simply excising the proximal sac and leaving the resulting defect open would make any difference in post-operative pain and recurrence rates?

If it can be proved that simply excising the hernial sac leads to no significant changes in the recurrence rates, then an unnecessary procedure which was hitherto being done can be omitted with the additional advantage of a significant reduction in the postoperative pain.

What remains after excision of the sac is a peritoneal defect. It has been demonstrated in animal studies and in clinical experience that the closure of laparotomy wounds without suture of the peritoneum has not affected healing. Clinical observation show that raw peritoneal defects heal rapidly (Ellis and Heddle, 1977). If leaving the peritoneum
open makes no difference to abdominal wound healing then an unnecessary routine can be given up and therefore also ligation of the hernial sac.

The hernial sac consists of a single layer of mesothelium. It is unreasonable to assign a crucial role to a structure of such insignificant strength in the repair of adult inguinal hernias. Co-existent fascial deficiency has been shown to always precede peritoneal protrusions (Lichtenstein, 1987). These findings suggest that peritoneum in recurrent hernias is nothing more than a passive space filler.

Traditional methods of hernia repair have varied little since the first description by Bassini. In 1884, he performed the first true inguinal floor reconstruction. Five years later, he documented a recurrence rate well under 10% (Sabistion Jr.). There has been little recorded since then to indicate marked improvement in these results. Newer concepts, modern materials and recent experimental evidence invite re-evaluation of established surgical tenets. Despite the certainty of iconoclastic criticism, it is time to challenge some of the myths surrounding hernia repair.

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