

LETTER TO THE EDITOR

Modified three-stitch hernioplasty technique

Editor,

We read with great interest the article by Patchayappan *et al.*, concerning the three-stitch hernioplasty, where the prolene mesh is fashioned as in Lichtenstein's repair, placed, and fixed only by three prolene stitches. We agree with the authors as we are using a similar technique with some technical differences.

Our technique suggests an alternative anatomical site for mesh fixation. We evaluated iliopubic tract as a possible alternative site for it. Several studies have confirmed that the iliopubic tract can be identified readily as thickening of the transversalis fascia, running parallel and deep to the inguinal ligament.^[1] Lichtenstein's avoids it in his technique because although iliopubic tract is always present, it is considered to be of variable strength.^[2] However, other open hernia repair techniques support the use of the iliopubic tract.^[3,4] Our aim is to highlight the anatomical importance of the iliopubic tract for tension-free hernia repair.

Our modified technique is performed under local anesthesia and all patients received antibiotic prophylaxis (second-generation cephalosporin Cefuroxim, 750mg IV, 1 h before incision). We prefer a field block with multiple injections along the incision. The incision we make is parallel to the inguinal ligament, the same way as in Lichtenstein's procedure.^[3,5] Following the same steps with the authors, we reach the external oblique aponeurosis after ligating the three named superficial subcutaneous veins. External oblique aponeurosis is opened in a direction parallel to its fibers down through the external ring. A plane of cleavage is created between the external oblique aponeurosis and the conjoint tendon superiorly. The inguinal ligament is well defined by dissecting the floor of inguinal canal. The cord structure is encircled with a Penrose drain. Ilioinguinal nerve is preserved to avoid entrapment and chronic pain in the postoperative period.

After the completion of the investigation for the presence of a direct and an indirect hernia, we reduce the sac of the hernia without opening, regardless of the hernia type. We always use polypropylene mesh, usually 7 cm × 15 cm, which is placed over the transversalis fascia. The difference of our

technique compared with the one that the authors presented lays on this step. We fix the lower edge of the mesh to the iliopubic tract with a 4-0 continuous prolene suture instead of using the inguinal ligament.^[3]

Tension-free hernia repair has reduced the incidence of recurrences.^[4] Using the iliopubic tract as the place of mesh fixation, we are trying to achieve even less tension compared to the original Lichtenstein's technique. The disadvantages of our technique are that the operating time is slightly longer because of the different placements of the mesh and the higher risk of injury of iliac or femoral vessels, especially the femoral vein, during the mesh fixation. This technique is performed the last 5 years in our clinic with no recurrences or hematoma. Further research and more studies are necessary to reach safer conclusions.

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Conflicts of interest

There are no conflicts of interest.

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