The Issues of Post-Lichtenstein Chronic Groin Pain

B. Ramana¹ · Brijesh Dube²

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Post-inguinal herniorrhaphy pain is a topic on which there is no clear consensus among surgeons about its definition, prevalence and causes. Among patients, it may be perceived to be a mesh-related complication, with serious medicolegal implications in different countries. For example, in Australia, regulators have classified hernia mesh as Class III (high risk) [1].

The varied incidence of chronic postoperative inguinal pain (CPIP) is reflected in the published literature, as reported by the authors, from 0 to 53 percent [2].

There are multiple etiological factors leading to this often-distressing condition involving the patient, the mesh and the surgeon, often in some combination.

We do not have clarity on the causation, prevention and management of CPIP from published literature on the subject, one reason being that studies have tested pain in different ways, as shown by the authors. The Lange paper has shown that CPIP after Lichtenstein may be related to surgical expertise, one example of a variable that might affect assessed outcomes [3].

The surgeons' ability to identify the IIN intraoperatively also varies significantly, which contributes to the difficulty in assessing CPIP. Previous studies have documented that the Ilioinguinal component may be distributed in the genitofemoral nerve at the level of the first and second lumbar nerves. Several studies have shown that the IIN may be missing in up to 22% of cases [4].

A previously published prospective multicentric study has shown that the surgeon who can identify all 3 nerves in a Lichtenstein is likely to have the least incidence of CPIP, while the surgeon who does not do so is likely to have a greater incidence [5].

IIN division may not prevent CPIP, as shown in the Lange paper, but it might lead to numbness or paresthesia as a trade-off. However, as the authors show, the data are not clear on this.

The authors make a valuable point in highlighting the importance of surgeons adopting the DMT (Dermatome Mapping Test) in the assessment of CPIP patients. This may be a common template in which all CPIP data are compared. However, this is possibly more utopian than utilitarian in the present world of surgery.

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✉ Brijesh Dube
brijeshdube74@gmail.com

¹ Department of Minimal Access, Bariatric, Hernia and GI Surgery, Calcutta Medical Research Institute, 7/2, Diamond Harbour Road, Kolkata, West Bengal 700027, India

² General and Minimal Access Surgery, Wockhardt Hospitals, Mumbai, India