Original Research Article

Surgical sequale of transabdominal preperitoneal approach versus Lichtenstein open repair in a rural setting

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ABSTRACT

Background: The objective was to compare the outcomes perioperative outcomes of transabdominal preperitoneal approach (TAPP) versus Lichtenstein tension (open) free repair for adult unilateral uncomplicated inguinal hernia patients (including both direct and indirect hernias).

Methods: The prospective study was conducted between July 2018 to August 2020. A total of 60 patients, 30 in the Lichtenstein tension free repair group and 30 in the TAPP repair group data were collected and analysed.

Results: The mean age was 55 in our study. On comparing open versus TAPP, significant difference of p value ≤0.05 was observed in terms of surgical site infections, time to discharge, time to return to work and mesh related pain in TAPP. Operative time was shorter in open group.

Conclusions: Laparoscopic transabdominal preperitoneal repair is a valid alternative to open traditional method with lesser morbidity to the patients.

Keywords: Hernia, Laparoscopic repair, Open repair

INTRODUCTION

Inguinal hernias are one of the most common conditions encountered by a general surgeon, owing to their high lifetime risk of 27% in men and a prevalence of 47% above the age of 75. Inguinal hernias have been identified and a wide variety of treatment modalities have been proposed and attempted dating back to the bronze age.1,2 In the modern era, Lichtenstein tension free repair is considered to be the standard treatment modality. Laparoscopic methods such as the TAPP repair, have been proven to be safe, effective and reliable but have not been proven to be invariably better than the traditional Lichtenstein tension free repair.3 The objective of the present study was to compare the outcomes (operating time, surgical site infections, time to discharge, time to return to work, mesh related pain and recurrence) of TAPP and Lichtenstein tension free repair for adult unilateral uncomplicated inguinal hernia patients (including both direct and indirect hernias).

METHODS

Adult patients presenting with inguinal hernia (including both direct and indirect hernias) to Vinayaka Mission’s Kirupananda Varayar medical college and hospitals, Salem between July 2018 to August 2020. A total of 60 patients, 30 in the Lichtenstein tension free repair group and 30 in the TAPP repair group. It was a prospective COHORT study. The inclusion criteria was criteria men (18+ years) patients with unilateral inguinal hernia (including both direct and indirect inguinal hernias) Nyhus classification types I, II, IIIA and the exclusion criteria was patients with recurrent hernias, complicated
hernias (strangulation, obstruction), women, patients who were medically unfit or high risk for surgery (ASA class III and above) and patients with previous lower abdominal surgery or trauma.

The sample size was calculated using a formula that showed that 30 or more patients should be enrolled.

The following formula was used to calculate the sample size,

\[ N = \frac{Z^2 \times pq}{d^2} \]

where,

- \( N \) = sample size,
- \( Z \) = standard normal variate value = 1.96 (95% confidence interval),
- \( p \) = prevalence of VD deficiency in stone patients (33.7% according to Elkoushy et al),
- \( q = 100 - p \).
- \( d \) = allowable error (5-20% of \( p \)).

**RESULTS**

All of the participants in our study were men. Our study population included 5 (8.3%) patients in the 18-34 year range, 6 (10%) patients in the 35-44 year range, 14 (23.3%) patients in the 45-54 year range, 20 (33.3%) patients in the 55-64 year range, 11 (18.3%) patients in the 65-74 year range and 4 (6.7%) above the age of 75 as shown in Table 1 and 2.

The average length of open surgery was 61 minutes. The average length of a TAPP repair was 77 minutes. P value for this finding is <0.001 as shown in Table 3.

In open surgeries, patients were discharged, on average, 7.6 days after the day of surgery. In TAPP surgeries, patients were discharged, on average, 3.9 days after surgery. P value for this finding is <0.001 as shown in Table 4.

### Table 1: Distribution of patients by age.

| Age (in years) | Number | Open | Lap |
|---------------|--------|------|-----|
| 18-34         | 5      | 2    | 3   |
| 35-44         | 6      | 2    | 4   |
| 45-54         | 14     | 7    | 7   |
| 55-64         | 20     | 10   | 10  |
| 65-74         | 11     | 7    | 4   |
| 75+           | 4      | 2    | 2   |

### Table 2: Standard deviation, mean and median age.

| Mean | Median | Standard deviation |
|------|--------|--------------------|
| 55.97| 58     | 14.09              |

### Table 3: Average and median surgery time.

| Type | Average surgery time | Median surgery time |
|------|----------------------|---------------------|
| Open | 61                   | 59                  |
| TAPP | 77                   | 79                  |

### Table 4: Average and median time to discharge.

| Type   | Average time to discharge (in days) | Median time to discharge (in days) |
|--------|------------------------------------|------------------------------------|
| Open   | 7.6                                | 8                                  |
| TAPP   | 3.9                                | 4                                  |

### Table 5: Time to return to work (in days).

| Type   | Time to work (in days) |
|--------|------------------------|
| Open   | 31.1                   |
| TAPP   | 20.3                   |
Patients took an average of 31.1 days after open surgery, and 20.3 days after TAPP to return to work. P value for this finding is <0.001 as shown in Table 5.

There were no recurrences in the open group while there were 2 (6.7%) in the TAPP group 6 months after surgery. P value for this finding is 0.16 as shown in Table 6.

Reports of chronic pain and their severity decreased over time. At 1 month post operatively, the open group had an average reported value of 1.43, TAPP group at 0.23. At 3 months, it was 1.23 for the open group and 0.2 for the TAPP group. At 6 months it was 0.9 for the open group and 0.17 for the TAPP group. This is a significant decrease for the open group with p=0.0002. The TAPP repair group also showed a decrease in pain from 0.83 to 0.53. However it is not a significant finding as the p value is 0.16 as shown in Table 7.

**DISCUSSION**

Inguinal hernias are one the most commonly encountered surgical cases. Lifetime prevalence of the disease goes up to 47% in elderly male patients above the age of 75.4,3 Furthermore, management is almost always surgical in nature, with conservative management largely reserved for patients unfit for surgery.

Management of inguinal hernias has evolved significantly over the centuries, from the crude herniotomy with orchiectomy performed in ancient times, herniorrhaphies through most of the 20th century and finally to prosthetic mesh based repairs from the late 20th century to now.5-8 Laparoscopic repair was popularized at the beginning of this century and is becoming more common.9

Lichtenstein tension free repair, the most popular open prosthetic repair can be performed under local or regional anesthesia, a significant advantage over laparoscopic procedures.10,11 It is also a cheaper and shorter procedure than a laparoscopic procedure.12-14 These factors are conducive to performing the procedure as a day care procedure, though we did not do so in our patients as they tend to be from rural areas at significant distances from our hospital and tend not to be able to travel back to the hospital quickly if complications occur.

However, the open procedure increased the risk of hematomas and seromas.15-18 Furthermore, patients undergoing the open procedure took longer to be discharged on average.19 More disturbingly, a very significant portion of patients, up to 63%, developed chronic pain postoperatively.20 This also probably explained the longer periods of rest that patients required postoperatively before they can return to their occupations. This of special interest to us gave the demographics of our patients, who happened to be poorer patients from rural areas and financially less secure.

The laparoscopic TAPP repair required general anesthesia and took longer to perform than an open surgery. This might be because of surgeon experience and might change as more surgeons were trained in the procedure but was borne out in current studies.21 The need for laparoscopic instrumentation also increased the cost of the surgery but with falling costs of instruments, they were still viable alternatives to open surgeries even in cost sensitive environments like in our hospital and more generally, in the Indian scenario. Further, patients who underwent TAPP were able to return to work much earlier and this might offset at least part of the increased cost of surgery.22

In our own center, our patient population was typically rural, often performed physical labor and tended not to have disposable income. Many patients found a significant disruption in their occupations to put undue strain on their finances. Our own findings suggested that patients were able to return to work far sooner after TAPP repair when compared to open surgery. The present had its own limitations that included smaller sample size, entirely male patients and sample selection.

**CONCLUSION**

To conclude, TAPP repairs have been established as safe and effective. We cannot definitively declare one procedure to be better than the other as each procedure has its own advantages and disadvantages. However, an
individual patient might benefit more from one procedure than the other. Thus, we recommend that TAPP repair should be considered wherever possible and should be presented as an option to patients.

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**Ethical approval:** The study was approved by the Institutional Ethics Committee

**REFERENCES**

1. Abramson JH, Gofin J, Hopp C, Makler A, Epstein LM. The epidemiology of inguinal hernia. A survey in western Jerusalem. J Epidemiol Community Health. 1978;32(1):59-67.

2. Rutkow IM. Epidemiologic, economic, and sociologic aspects of hernia surgery in the United States in the 1990s. Surg Clin North Am. 1998;78(6):941-51.

3. Johnson J, Roth IS, Hazey JW, Pofahl WE. The history of open inguinal hernia repair. Curr Surg. 2004;61(1):49-52.

4. Bhandarkar DS, Shankar M, Udwadia TE. Laparoscopic surgery for inguinal hernia: Current status and controversies. J Minim Access Surg. 2006;2(3):178-86.

5. Memon MA, Cooper NJ, Memon B, Memon MI, Abrams KR. Meta-analysis of randomized clinical trials comparing open and laparoscopic inguinal hernia repair. Br J Surg. 2003;90(12):1479-92.

6. Shulman AG, Amid PK, Lichtenstein IL. A survey of nonexpert surgeons using the open tension-free mesh patch repair for primary inguinal hernias. Int Surg. 1995;80(1):35-6.

7. Ger R, Monroe K, Duvivier R, Mishrick A. Management of indirect inguinal hernias by laparoscopic closure of the neck of the sac. Am J Surg. 1990;159(4):370-3.

8. Mirilas P, Lee J, Skandalakis. Surgical Anatomy of the Hernial Rings. Fischer’s Mastery of Surgery. 7th ed. Wolters Kluwer; 2019: 187-92.

9. Susan Standing. Gray’s Anatomy. 41st ed. Philadelphia: Elsevier; 2016: 1079-81.

10. Liu N, Greenberg JA, Brooks DC. Inguinal Hernia, Maingot’s Abdominal Operations. 13th ed. McGraw-Hill Education; 2019

11. Desarda MP. Physiological repair of inguinal hernia: a new technique (study of 860 patients). Hernia. 2006;10(2):143-6.

12. Schmedt CG, Däubler P, Leibl BJ. Kraft K, Bittner R. Simultaneous bilateral laparoscopic inguinal hernia repair. Surgic Endosc Other Intervent Techniq. 2002;16:240-4.

13. Bassini E. Nouvo Metodo per la Cura Radicale dell’ Ernia Inguinale. Padua, Italy: Prosperini; 1889.

14. Jenkins JT, O’Dwyer PJ. Inguinal hernias. BMJ. 2008;336(7638):269-72.

15. Kang SK, Burnett CA, Freund E, Sestito J. Hernia: is it a work-related condition? Am J Ind Med. 1999;36(6):638-44.

16. Zollinger JRM. Classification systems for groin hernias. Surg Clin North Am. 2003;83(5):1053-63.

17. Rutkow IM, Robbins AW. Classification systems and groin hernias. Surgic Clinic North Am. 1998;78(6):1117-27.

18. Fitzgibbons RJ, Giobbe-Hurder A, Gibbos JO, Dunlop DD, Reda DJ, McCarthy JM, et al. Watchful waiting vs repair of inguinal hernia in minimally symptomatic men: a randomized clinical trial. JAMA. 2006;295(3):285-92.

19. Gilbert AI. An anatomic and functional classification for the diagnosis and treatment of inguinal hernia. Am J Surg. 1989;157(3):331-3.

20. Young DV. Comparison of local, spinal, and general anesthesia for inguinal herniorrhaphy. Am J Surg. 1987;153(6):560-3.

21. Nordin P, Zetterstrom H, Gunnarsson U, Nilsson E. Local, regional, or general anaesthesia in groin hernia repair: multicentre randomised trial. Lancet. 2003;362(9387):853-8.

22. Rutkow IM, Robbins AW. “Tension-free” inguinal herniorrhaphy: a preliminary report on the mesh plug technique. Surgery. 1993;114(1):3-8.

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