Is Laparoscopic Groin Hernia Repair Better Than Open Mesh Repair?
S Jain, C Norbu

Citation

Abstract
Laparoscopic Groin Hernia repair has gained popularity during the last decade. There is not enough literature to recommend its routine use in unilateral groin hernia repair. This article reviews the status of laparoscopic groin hernia repair in the present scenario.

INTRODUCTION
In 1984, Lichtenstein et al coined the term “Tension-Free Hernioplasty” and broke the convention by advocating routine use of mesh for hernia repair, thereby making tissue repair a thing of the past.

Real controversy started in 1990, when laparoscopic Tension-Free repair came into vogue and was routinely advocated and aggressively marketed by promising less pain and shorter recovery period, but the things in the small prints were completely ignored.

HOW TO DECIDE WHICH APPROACH IS BETTER
The most scientific way to come to conclusion over superiority of one method over other is on the basis of evidence-based medicine. The best evidences are in the form of Meta-analysis or randomized controlled trials.

Available literature was analyzed with regards to:
1. Recurrence Rate
2. Complications
3. Operating time
4. Cost effectiveness
5. Return to work and activity
6. Post operative pain

RECURRENCE RATE
An ideal approach to hernia repairs should have a low recurrence rate. Recurrence rates in various series are shown in table 1.

VA trial, concluded in 2004 involving 2164 patients in 14 centers in USA measured recurrence of hernia at two years as the primary outcome. Recurrence was found to be 10.1% in the laparoscopic group and 4.1% for open group in the repair of primary inguinal hernias, but rates of recurrence were similar in two groups after repair of recurrent hernias (10% and 14.1% respectively).
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Figure 1
Table 1: Studies comparing recurrence in laparoscopic versus open mesh repair

<table>
<thead>
<tr>
<th>First author</th>
<th>Laparoscopic</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRC Lap 5</td>
<td>1.9%</td>
<td>0</td>
</tr>
<tr>
<td>Champault et al</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Neumayer 5</td>
<td>10.1%</td>
<td>4.9%</td>
</tr>
<tr>
<td>NICE 2004 5</td>
<td>2.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Anderson 24</td>
<td>2.5%</td>
<td>1%</td>
</tr>
</tbody>
</table>

MRC laparoscopic hernia trial group found 1.9% recurrence rate in laparoscopic group and zero percent recurrence rates in open group at one year. This study involved 928 patients with groin hernias from 26 hospitals in UK and Ireland. Memon et al. found a trend towards an increase in the relative odds of short-term recurrence of 50% after laparoscopic repair compared with open repair. Champault et al. found recurrence rate of 6% in laparoscopic group versus 3% in open group in a series of 100 patients in a randomized trial. In a technology appraisal guidance 83 published by NICE, UK in 2004, showed recurrence rate of 2.3% after TEP repair and 1.3% after open repairs.

COMPLICATIONS

Incidence of serious visceral and vascular complications was found to be higher in laparoscopic group in most of the meta-analysis and randomized controlled trials comparing laparoscopic versus open mesh repair.

Figure 2
Table 2: Studies comparing complications between laparoscopic and open mesh repair of Inguinal Hernia

<table>
<thead>
<tr>
<th>First author</th>
<th>Laparoscopic</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. C. Cowell</td>
<td>8/2315 visceral</td>
<td>7/2499 visceral</td>
</tr>
<tr>
<td>Gram 5</td>
<td>15 serious complications</td>
<td>4 serious complications</td>
</tr>
<tr>
<td>MRC trial group 5</td>
<td>5.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Neumayer 5</td>
<td>39%</td>
<td>33.4%</td>
</tr>
</tbody>
</table>

Incidence of complications after laparoscopic inguinal hernia repairs can be seen in Table II. As evident from Table II, incidence of complications is significantly higher in laparoscopic group. Incidence of vascular and visceral injuries was found to be higher after laparoscopic repair (0.79% after lap repair versus 0% after open repair in NICE paper.). In MRC hernia trial group, all serious complications occurred in the laparoscopic group. In VA trial, complication rate was 39.1% in lap group including 2 deaths but 33.4% in open group. In an extensive review by Cochrane group 3 in conjunction with European Hernia trialist group, found serious vascular and visceral injuries more often in laparoscopic group (visceral injuries 8:2315 and vascular injuries 7:2498).

OPERATING TIME

Laparoscopic groin hernia repair takes longer than open mesh repair. In technology appraisal guidance 83, by National Institute for clinical excellence, Sept. 2004, it was stated that laparoscopic surgery was associated with a statistically significant increase in operation time compared with open methods of hernia repair. Meta-analysis of 16 randomized control trials of Trans abdominal pre peritoneal (TAPP) repair demonstrated on over all increase of 13.33 minutes compared with open repair. Metaanalysis of eight randomized control trial of trans extraperitoneal (TEP) repair demonstrated an over all increase of 7.89 minutes compared with open repair.

Memon and colleagues reviewed the data from 29 published randomized clinical trials and concluded that patients who underwent laparoscopic repair of groin hernia took longer time for surgery. In a Bringman trial operating time was found to be 5 minutes shorter in open mesh repair in comparison to laparoscopic group.

Comparison of operating time in various trials is shown in table III.

Figure 3
Table 3: comparing operating time

<table>
<thead>
<tr>
<th>First author</th>
<th>Laparoscopic</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCamack 22</td>
<td>14.8 minute longer (p &lt; 0.0001)</td>
<td></td>
</tr>
<tr>
<td>Memon 6</td>
<td>15.2 min longer (p &lt; 0.0001)</td>
<td></td>
</tr>
<tr>
<td>MRC trial group 6</td>
<td>58.4 minute</td>
<td>43.3 minute</td>
</tr>
<tr>
<td>Bringman 50</td>
<td>50 minute</td>
<td>45 minute</td>
</tr>
<tr>
<td>Pecora 39</td>
<td>49.6 minute</td>
<td>33.9 minute</td>
</tr>
<tr>
<td>Chung 24</td>
<td>Laparoscopic longer in all groups</td>
<td></td>
</tr>
<tr>
<td>Vaige 45</td>
<td>58 minutes</td>
<td>47 minutes</td>
</tr>
</tbody>
</table>

TIME TO RETURN TO NORMAL ACTIVITY

Majority of patients are able to perform normal activities at one week whether after open or laparoscopic surgery. Data regarding time to return to activity are rather subjective. Type of employment or profession, to which patient is returning will influence how long he needs to be away from work. Patient who is doing desk job in office will return to work earlier than a patent with a job that entails heavy lifting. Some patients will be getting paid sick leave, so they will have less incentive to go back to work early. Time to return to daily activities was found to be one day shorter for laparoscopic group than those undergoing open repair of hernia in a VA hernia trial group, but the time to resumption of sexual activity was similar in the two groups. However at 3 months of follow up, there was no difference.

2 of 5
in the activity level between the laparoscopic and open
group. Lawrence et al. did not find any significant
difference in return to normal activities in two groups.

COST EFFECTIVENESS
Technology appraisal paper 83 by NICE in Sept. 2004
concluded that laparoscopic groin repairs was associated
with an increased cost of between 100-400 sterling pounds
per procedure. Open preperitoneal method was found to be
most cost effective method of open repair. Hospital stay was
shortest with this method of repair. Laparoscopic hernia
repair in UK has additional cost of 300 pounds over open
repair, because of more operating time, time in hospital and
use of specialized equipments and obligatory need for
general anaesthesia. The argument that the additional cost
of lap hernia is offset by can earlier return of activity has
been questioned.

Figure 4
Table 4: Cost comparison

<table>
<thead>
<tr>
<th>First author</th>
<th>Laparoscopic ($)</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRC trial group</td>
<td>314 more pounds</td>
<td></td>
</tr>
<tr>
<td>Anderson</td>
<td>$ 1,001 higher</td>
<td></td>
</tr>
<tr>
<td>Jonsson</td>
<td>7063 SEK</td>
<td>417 SEK</td>
</tr>
<tr>
<td>Welwood</td>
<td>$ 505 more</td>
<td></td>
</tr>
<tr>
<td>Hildtinen</td>
<td>$ 446 more</td>
<td></td>
</tr>
</tbody>
</table>

A recent analysis concluded that laparoscopic repair was not
cost effective in terms of cost per recurrence avoided.

LEARNING CURVE OF LAPAROSCOPIC REPAIR
Laparoscopic groin hernia repair is a more complex
procedure with a steeper learning curve than open repair. It
requires different skills and a familiarity with preperitoneal
anatomy. Two large series concluded that 250-300 cases are
required to achieve expertise. This figure is hard to
achieve with current surgical programmes. Jacob et al. suggested that laparoscopic hernia repair should only be
carried out in specialist centres. All most all studies have
concluded that laparoscopic hernia repair should be carried
out by a surgeon who has a specialized training in
performing this procedure.

DAY CARE SURGERY
Open groin hernia can be performed as a day care procedure.
Day surgery provides a high quality, patient-centered
treatment that is safe, efficient and effective and is
accompanied by a lower incidence of hospital acquired
infection and early return to normal activity compared with
in-patient treatment.

POST OPERATIVE PAIN
Post Operative pain was found to be less in laparoscopic
hernia repair group across the board. VA group did not find
any difference in post operative pain after 14 days. Stoker et
al found less post operative pain for the first 4 hours after
open hernia repair probably due to effect of local anesthesia.

CONCLUSIONS
Laparoscopic hernia repair is more costly; difficult to learn
with a steep learning curve, carries the risk of serious
visceral and or vascular injuries. All cases of groin hernia
are not suitable for laparoscopic hernia repair as it is
contraindicated in strangulated hernia, sliding hernia,
irreducible hernia, and patients who are elderly or have co-
morbid conditions. Laparoscopic hernia repair can not be
performed as day care surgery or under local anesthesia.

Open mesh repair is economical, easy to teach and learn
without any steep learning curve. Open hernia repair does
not need any specialized training and results are some in
both specialist and non-specialist center. Open hernia repair
does not carry any risk of serious visceral or bowel injuries.
Open mesh repair is suitable for all types of groin hernias
including strangulated, irreducible, sliding hernia or in
elderly patients and patients with co-morbidity. Open groin
hernia repair is ideal for day-care surgery, especially under
local anesthia.

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90:1479-1492.
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