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RE: RECURRENCE OF INGUINAL HERNIAS REPAIRED IN A LARGE SURGICAL SPECIALTY HOSPITAL AND GENERAL HOSPITALS IN ONTARIO, CANADA

It is extremely rare, for an article dealing with the lowly hernia to provoke a tremor in the world of surgery. Malik and colleagues¹ have just managed that seismic quality and they are to be congratulated and celebrated.

For 20 years, synthetic meshes have become the mainstay of hernia surgery, thanks to an industry that fostered conferences, societies and free courses, but also flagrant and undaunted marketing. The drawbacks of meshes were always vague and nebulous.^{2,3} The current generation of surgeons can truly be said to have been formed by the industry!

Mesh-based repairs are touted as the ideal in the guidelines of the European, Danish and Swedish Hernia Societies.⁴ The American Hernia Society has found no reason to disapprove.

The Shouldice repair, a pure tissue repair, rated a mention only when infected mesh was removed! Sadly, no one performs or knows how to perform a Shouldice repair outside Thornhill. A repair which, barely 20 years ago, was considered the “gold standard.”

The world literature is now replete with publications on chronic postherniorrhaphy inguinodynia, a condition unknown before the introduction of mesh. In 1964, in Nyhus' classic hernia, postherniorrhaphy pain did not rate a mention in its index.⁵ In Ponka's equally excellent book, pain is mentioned in half a column as “uncommon” and due to “scar tissue” (1980).⁶

Copious publications are now firming up the statistics on postoperative complications of mesh: 11%

of patients will have a history of severe chronic postoperative inguinodynia severe enough to be detrimental to their quality of life. Another group of patients (3%–4%) will suffer irreversible dysejaculation, which only 20 years ago, without mesh, had an incidence of 1 in 2500 cases and was reversible! A hundred-fold (or 10 000%) increase. Another 10% will manifest severe testicular pain secondary to mesh erosion of the vas, which in some cases will require an orchidectomy. The specter of infertility has not been an issue, unless there is contact between mesh and vas (as in a Lichtenstein or laparoscopic approach) in a young adult with bilateral repairs and who may consider a family 10 years down the road. The delay in reaching the vas lumen is 7–10 years (unpublished data). Transmigration into adjacent organs are commonly reported but not systematically quantified with any accuracy through industrial surveillance. With such evidence, would a “duly informed” patient consent to mesh-based surgery?

To answer our respected authors, mesh is used in 3% of the cases at the Shouldice Hospital. Around the world, mesh is used in 90%–97%.⁷

The better results of the Shouldice repair are not due to legerdemain. Their surgeons truly know anatomy. More so than surgeons who do an average of 50 cases a year. In the Swedish registry, 50% of the surgeons did fewer than 7 cases a year. The hackneyed aphorism with vendors that... “with mesh, you do not need to know anatomy” is simply untrue.

Professor Volcker Schumpelick, Editor in Chief of the *Hernia*, in his address to the American Hernia Society (2005) stated that “despite the introduction of mesh and laparoscopy, there has been no reduction in the incidence of hernia recurrences in the last 30 years. That incidence worldwide is 14%.”⁸ Why are the European guidelines rushing to be launched as World guidelines?

This thorough, objective, generously followed, massive population-

based analysis by our Toronto colleagues has already reached *Hernia* and the European Hernia Society. The “tailored approach” concept is rather new. This paper will help nail that merciful concept. The figure estimated at 10%–20% could be brought to a mere 5% with simple emphasis of anatomy. The Shouldice Hospital already demonstrated, 20 years ago, that 1%–5% is the magic number depending on the type of hernia.⁹

This paper will become a classic, cited beyond the wildest dreams of its authors. It will awaken many residents to ask why it takes 4–6 years of surgical training if the industry can do it, through vendors, in a matter of minutes.

I would like to think that my learned and respected colleagues of the University of Toronto have revealed a good omen for a return to a saner algorithm and a harbinger of what I like to call a timely revival of a “greener operation.”

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