

# Inguinal Direct Hernia Surgical Repair without Cremaster Resection

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## ABSTRACT

preservation of the cremaster muscle while the direct inguinal hernia is surgically repaired. preserving the cremator's function. The major functions of the cremaster muscle, which surrounds the inguinal cord, are to elevate the testicles and to protect the inguinal cord's components.

**Idea :** The Hesselbach triangle in the inguinal area is where the direct inguinal hernia is located. The Poupart inguinal ligament is one of the triangle's components. The external border of the rectal muscle and the deep inguinal ring are in close proximity to the epigastric blood veins. That is the Hesselbach triangle, and the transversalis fascia is the primary wall component there. This makes it the abdominal wall's weakest spot. Historical Analysis Over the years, inguinal hernia repair has advanced significantly. The field of surgery has advanced quickly since Eduardo Bassini's initial treatment was proposed. Analyzing original articles from the sixteenth century reveals that there are two straightforward surgical approaches that form the foundation for all inguinal hernial orifice repair procedures.

principles of repair. The first involves tightening the external inguinal ring and strengthening the anterior wall of the inguinal canal (Stromayr 1559, Purmann 1694, Czerny 1877). The second involves tightening the internal inguinal ring and strengthening the posterior wall of the inguinal canal, either internally (Lucas-Championnière 1881, Bassini 1889, Lotheissen 1898, McVay 1942, Shouldice 1945, Lichtenstein 1987, Stoppa 1989) or externally (Lucas-Championnière 1881, Bassini 1889, Lotheissen 1898, McVay 1942, Shouldice 1945, Lichtenstein 1987, Stoppa 1989) or by laparotomy (Tait 1891) or laparoscopically (Ger 1990, Velez and Klein 1990).

We have made an effort to arrange the various inguinal

hernia surgical methods in a methodical manner based on the principles of their repair. We also highlight how they have evolved historically.

The patient has an inguinal hernia if there is a palpable, painful mass that gets worse with physical exertion or when performing the Valsalva maneuver. The hernia can be direct if it originates from the Hesselbach triangle or indirect if it arises into the inguinal canal; in either case, surgery is required to fix the problem.

**Procedure :** The most common procedures to repair the direct hernia are the Zimmerman and Mc Vay, but most of the surgeons actually prefer just to close the posterior wall (fascia transversalis) repairing the Hesselbach triangle. can be manually using non absorbible suture open surgery with a small incision or laparoscopic procedure, how the laparoscopic procedure dont perform dissection of the cremaster muscle, we start to perform the open procedure the same way, and this approach was who show, that doing this kind of closing of the posterior wall we can preserve the funtion of the cremaster muscle. Ralph Ger described the first potential laparoscopic inguinal hernia repair in 1982. He describes a metallic clip applying device to close the hernia sac during laparotomy for other operations.

## INTRODUCTION

In the end, he provides a similar account of a single laparoscopic inguinal henria repair using iron lips only [1-5]. He applied his method to hernia sacs that had abnormalities smaller than 1.25 cm. His method was not appropriate for direct inguinal hernias, and he did not discuss repairing the inguinal floor. McKernon and Laws (1993) described the first total extraperitoneal technique (TEP) to repair inguinal hernias. Similar to the transabdominal approach (TAPP), the open preperitoneal repair of a large The main tenets of the laparoscopic technique to inguinal hernia repair were mesh that covered all defects, distributed intra-abdominal pressure over the broad mesh region, and required minimal fixing. The indications for open inguinal hernia repair and laparoscopic inguinal hernia repair, TAPP or TEP, are the same. When the surgeon is satisfied with the procedure, they can also be used for unilateral primary hernias.

They may be best suited for bilateral inguinal hernias and recurrences following anterior methods. In youthful, energetic men with primary hernias, it frequently results in less discomfort and an early restart of operations. Strong relative

contraindications include radiation to the pelvis or previous lower abdominal surgery, as these conditions may make entry to the preperitoneal area challenging.

## CONCLUSION

It is worth noting that the open surgery, which preserves the cremaster muscle, has identical outcomes to the laparoscopic treatment. When performed by a skilled surgeon, it can be completed quickly and at a lower cost because it does not require specialized tools, unlike the laparoscopic approach. The patient recovered in the same amount of time and was able to return home the same day. Local anesthesia and sedation were other options.

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