

nal ligament plicates easily, and this allows the transversus abdominis arch to descend to Cooper's ligament.

Of the total number of 406 Cooper ligament repairs in our trial, 303 (75%) had a relaxing incision and 103 (25%) did not. In a study to be published, we did look into the factors leading to recurrence. When we studied the influence of the relaxing incision on the 28 recurrences in the Cooper ligament repair, we found surprisingly that there were 24 recurrences among those with (24/303 = 8%) and 4 among those without (4/103 = 4%) the relaxing incision. However, this difference was not statistically significant ($p < 0.02$).

We thank Dr Rutledge for his comments.

JEAN MARIE HAY, M.D.
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April 24, 1996

Dear Editor:

Dr. Amid's technique for inguinal herniorrhaphy has yielded extraordinarily excellent results in his hands, and in fact, we have used this technique for our anterior approach to inguinal hernias for years. However, many surgeons have reported instances of neuropathies, recurrences, vascular injury, hematoma, and testicular problems when they use his technique.

In his publication,¹ Dr. Amid compares early laparoscopic results during the developmental stage with a method he has spent years perfecting. His comparisons are not fair, nor are they valid. We see both our Lichtenstein anterior approach patients and our laparoscopic hernia patients in our office and thus, we have a valid basis to compare the two. In addition, when we interviewed the more than 100 patients we have operated on laparoscopically who have had previous open herniorrhaphy, they tell you of their preference for the laparoscopic approach. Laparoscopic preperitoneal hernia repair is not for every patient and certainly not for every surgeon (because the learning curve is formidable), but it can be done very well in the proper hands.

For the past 3 years, we have performed through the laparoscope a procedure that has been time-tested for more than 30 years of open surgery. Adhering strictly to the principles formulated by Rives et al.,^{2,3} a large piece of mesh (no keyhole in the mesh) is placed in the preperitoneal space after the peritoneum is swept to the level of the umbilicus. We have repaired very safely and effectively more than 850 inguinal hernias using a totally laparoscopic preperitoneal approach. There have been no neuropathies, no recurrences, four hematomas, and one pulmonary embolism.

Until Dr. Amid develops an effective long-term experience with the laparoscopic approach or provides this journal's readers with a prospective evaluation of laparoscopic and his well-established open technique, he should avoid statements such as "... the procedure (Lichtenstein) can be performed with results that are superior to those of laparoscopic repair."¹

References

1. Amid PK, Shulman AG, Lichtenstein IL. Simultaneous repair of bilateral inguinal hernias under local anesthesia. *Ann Surg* 1996; 249-252.

2. Rives J, Nicaise H, Lardennois B. A propos du traitement chirurgical des hernies de l'aîne. *Therapeutique Ann Med Pharm Reims* 1965; 193-200.
3. Stoppa R, Verhaeghe P, Warlaumont C. Procédé original de plastique de l'aîne? L'interposition sans fixation d'une prothèse en tulle de dacron par voie médiane sousperitoneale. *Mem Acad Chir* 1983;119-123.

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June 13, 1996

Dear Editor:

I read the letter of Drs. Voeller and Mangiante with much interest. I would like to make the following comments.

I thank them for describing the results of open tension-free hernia repair in our hands as "extraordinarily excellent." However, had the doctors referred to a 1995 publication of ours,¹ in which we referenced a long list of surgeons who have achieved identical results, they would perhaps have understood that there in fact is nothing extraordinary about what we have achieved with this procedure. (There have been many subsequent articles published with the same information.) This certainly would demonstrate that, unlike laparoscopic repair which—in their own words—is not for "every surgeon," the open tension-free repair is viable universally.

The anecdotal complications Drs. Voeller and Mangiante claim have been associated with open tension-free repair are not consistent with documented, published reports by other authors. In fact, they are inconsistent with a recently published multicenter study that focused on that very issue.² In actuality, those complications frequently have been reported in association with the laparoscopic procedure, not with open tension-free repair.

The laparoscopic complications mentioned in our article are culled from reports published as recently as last year. More complications have been listed in reports published subsequent to submission of our article.

We agree that patients who have undergone laparoscopic surgery (provided no operative complications) and who have had previous open herniorrhaphies would state a preference for the laparoscopic approach. This also has been our experience with open tension-free repair on patients who had a previous herniorrhaphy. This is because both our procedure and the laparoscopic technique are tension-free hernioplasties *versus* herniorrhaphy, which is not.

I have no doubt that laparoscopic hernia repair "can be done very well in the proper hands." By the same token, it is possible to swim the English Channel. The important question, given all the available data, is why do it?² Should Drs. Voeller and Mangiante review the literature relative to the operation they justify as having been "time-tested for more than 30 years," they would find a recurrence rate of 1.5% to 26% associated with their model procedure. That figure is dramatically greater than the widely reported 0 to 0.5% recurrence rate of open tension-free repair.