Hernia (2004) 8: 402
DOI 10.1007/s10029-004-0252-3

LETTER TO THE EDITOR

**Edwin L. Nirdlinger**

# Causes of postoperative pain

Received: 12 February 2004 / Accepted: 10 May 2004 / Published online: 11 August 2004


Dear Editor:

In the article "Long-term follow-up after Lichtenstein hernioplasty in a general surgical unit" Verstraete and Swannet noted a fairly high level of chronic and occasional discomfort in patients following Lichtenstein hernia repairs. They suggested that further studies to prevent or cure chronic pain and occasional discomfort following a Lichtenstein hernioplasty are necessary, since the frequency of these complications is higher than the prevalence of recurrence. They went on to propose a theory that the origin of the chronic pain in their patients could be attributed to central neuroplasticity. They also stated that the dysjaculation that they observed in their patients could not be due to obstruction of the sperm core due to foreign-body reaction, since their patients were not sterile after the operation.

Before attributing chronic and intermittent postoperative pain to central nervous system dysfunction, we should consider some simple facts and the craftsmanship that a surgeon should display. Dr. Robert Bendavid has shown us that dysejaculation pain is caused by kinking of the vas deferens. We also know that having one patient vas deferens is certainly sufficient to father a child. The physicians at the Shouldice Hospital have always stressed division of the genital branch of the genitofemoral nerve to prevent the development of chronic postoperative pain. The Lichtenstein hernia repair, as it is usually done, places mesh directly on top of this nerve. The vas deferens is frequently lying on top of the mesh. Whether mesh is used in an opened hernia repair or not, division of the genital branch of the genitofemoral nerve is an important aspect of opened inguinal hernia repairs which is often overlooked. In my own practice, I have frequently operated (using local anesthesia) on patients referred to me for chronic inguinal pain after hernia repair only to find the genital branch of the genitofemoral nerve involved in scarring wither from direct suturing or from mesh being placed on top of the nerve.

It should be emphasized (especially at a teaching institution) that hernia repairs should be performed using local anesthesia. It is widely felt that hernia repairs done under local anesthesia have a much lower rate of chronic pain. This is understandable, since patients complain when a nerve whose presence is not appreciated by the surgeon is inadvertently incorporated into a repair. The surgeon can then adjust the placement of his suture, thus, saving the patient postoperative discomfort.

Those who teach hernia repair should stress the pertinent anatomy of the groin and a meticulous technique using local anesthesia and including division of the genital branch of the genitofemoral nerve. In addition, transposition of the spermatic cord above the aponeurosis of the external oblique muscle (as Dr. E. Trabucco has suggested) would prevent adherence of the vas deferens and the spermatic vessels to any mesh placed on the floor of Hesselbach's triangle.

E. L. Nirdlinger
Great Lakes Hernia Center, 5300 Harron Road,
Sylvania, Ohio 43560, USA
E-mail: csiedler@toledoclinic.com
Tel.: +1 419 885 4090