

MAAS

МАКЕДОНСКА АСОЦИЈАЦИЈА НА АБДОМИНАЛНИ ХИРУРЗИ
MACEDONIAN ASSOCIATION OF ABDOMINAL SURGEONS



ABSTRACT BOOK КНИГА НА АПСТРАКТИ

First Symposium of MAAS
&
"4th Meeting of WEB Chapter of E-AHPBA"



28-29.03.2025

Hotel DoubleTree by Hilton, Skopje, N. Macedonia

**First Symposium of the Macedonian
Association of Abdominal Surgeons (MAAS)
and the Fourth Meeting of the WEB Chapter
of E-AHPB**

**Прв Симпозиум на Македонската
асоцијација на абдоминални хирурзи
(MAAS) и Четвртиот состанок на WEB
Chapter на E-AHPBA**

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**28-29 March 2025 Skopje, RN Macedonia
DoubleTree by Hilton
28-29 март 2025 г. Скопје, РС Македонија**

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CRITICAL VIEW OF THE MYOPECTINEAL ORIFICE - OUR EXPERIENCE

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The critical view of the myopectineal orifice is a concept established in 2016 by the International Hernia Collaboration Facebook Group, and it is comprised of several recommendations for safe minimally invasive inguinal hernia repair. Using this concept and contemporary understanding of the posterior anatomy of the inguinal region in 2020, Claus et al. proposed the ten golden rules to fully standardize the technique of laparoscopic inguinal hernia repair. These rules are currently essential steps that every surgeon must follow.

The goal is to present our experience with the use of contemporary concepts and recommendations for minimally invasive inguinal hernia repair.

We retrospectively analyzed a single surgeon's experience in Clinical hospital Shtip, with elective inguinal hernia repair from 2016 to 2024 using medical documentation.

Out of 309 elective inguinal hernia repairs performed by a single surgeon in the same number of patients over the nine-year period, 222 (72.08%) were open according to Lichtenstein, and 86 (27.92%) were laparoscopic performed by Transabdominal preperitoneal approach (TAPP). The laparoscopic approach was used for relatively younger patients with an average age of 48.76 vs 57.18, and mostly for bilateral inguinal hernia in 72 (83.72%) patients.

After completing the long-term learning curve, careful follow-up of modern recommendations is of basic importance for a safe laparoscopic inguinal hernia repair.

Key words: laparoscopy, inguinal hernia, safety.



Critical view of the myopectineal orifice - our experience

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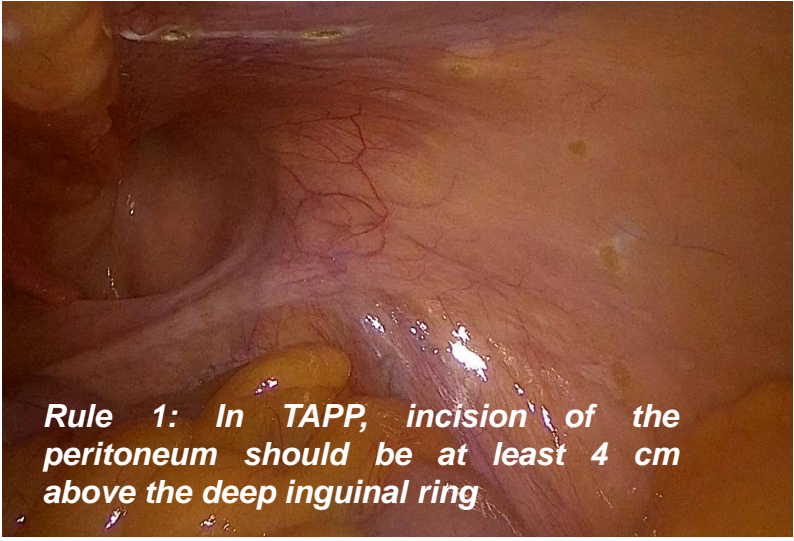
Ilija Milev^{1*}, Aleksandar Veselinov¹, Nikola Arsovski¹, Aleksandar Longurov¹,
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International guidelines for groin hernia management (EHS)

- **Statement:** When the surgeon has sufficient experience in the technique, laparo-endoscopic techniques do not take longer than Lichtenstein operations (level of evidence – Strong)
- **Statement:** When the surgeon has sufficient experience, no significant differences are observed in the perioperative complications needing reoperation between the laparo-endoscopic and Lichtenstein techniques (level of evidence – Strong)
- **Statement:** Laparo-endoscopic techniques have less chronic pain and faster recovery than the Lichtenstein repair (level of evidence – Strong)
- **Statement:** The direct operative costs for laparo-endoscopic inguinal hernia repair are higher. The difference decreases when the total community costs are considered and the surgeon has sufficient experience (level of evidence – Strong)
- **Statement:** The learning curve for laparo-endoscopic techniques (especially TEP) is longer than for Lichtenstein. There are rare but severe complications mainly described early in the learning curve. It is imperative that laparo-endoscopic techniques be learned in a properly supervised manner in order to minimize complications (level of evidence – Strong)
- **Recommendation:** **For patients (all sexes) with primary unilateral inguinal hernia, a laparo-endoscopic technique is recommended because of a lower postoperative pain incidence and a reduction in chronic pain incidence, provided that a surgeon with specific expertise and sufficient resources is available. However, there are patient and hernia characteristics that warrant Lichtenstein as first choice** (level of evidence - **Strong**; level of recommendation - **Strong**)

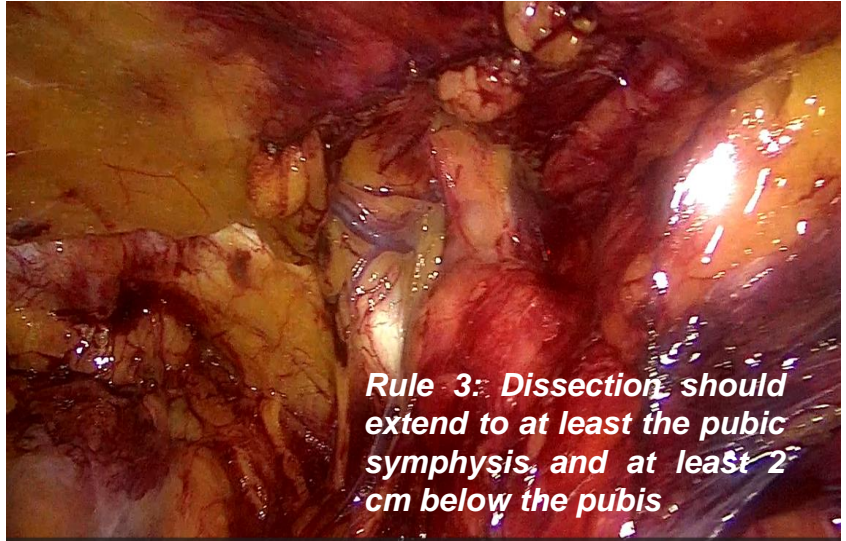
Ten golden rules for a safe MIS inguinal hernia repair – our experience



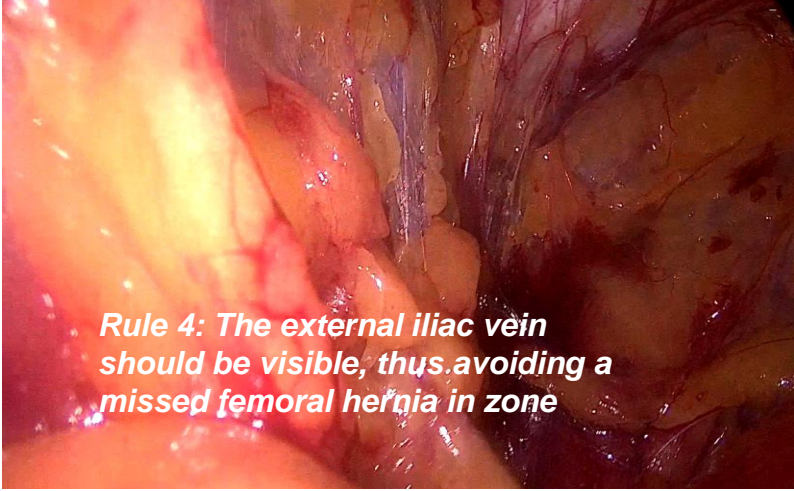
Rule 1: In TAPP, incision of the peritoneum should be at least 4 cm above the deep inguinal ring



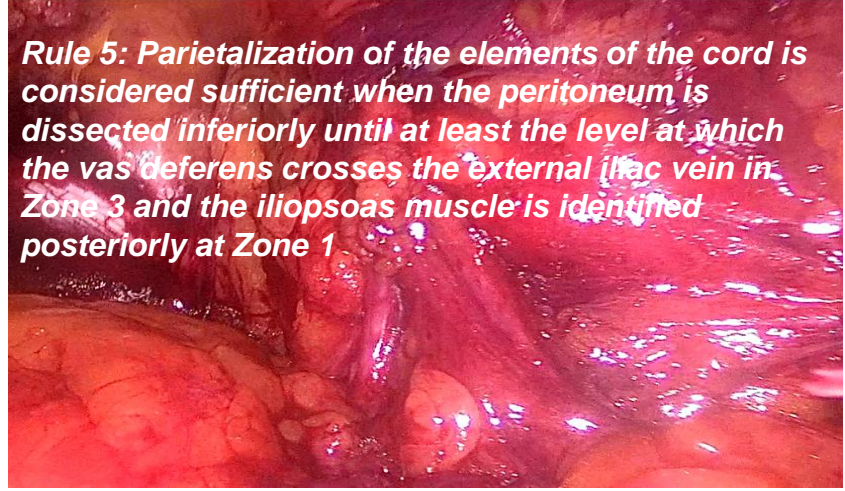
Rule 2: Dissection should follow the peritoneal plane



Rule 3: Dissection should extend to at least the pubic symphysis, and at least 2 cm below the pubis.



Rule 4: The external iliac vein should be visible, thus avoiding a missed femoral hernia in zone

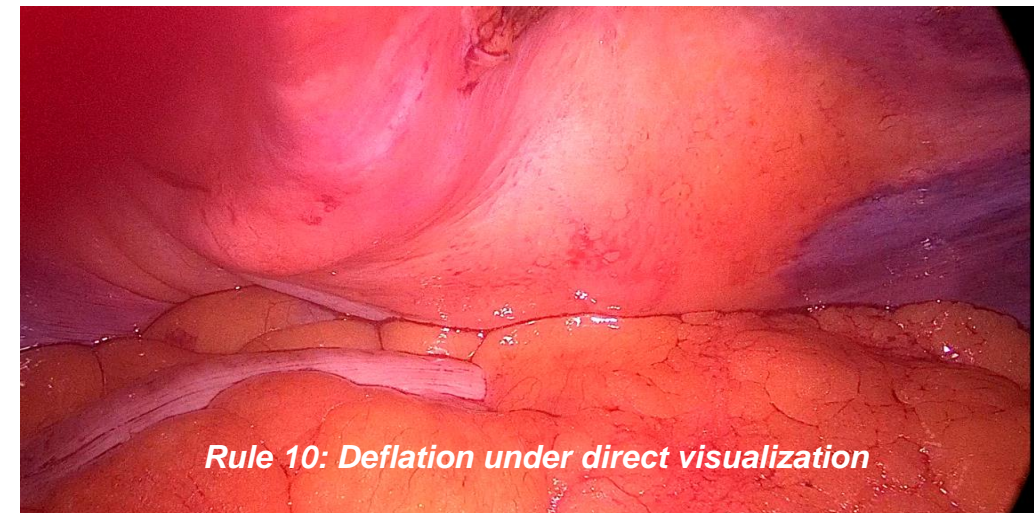
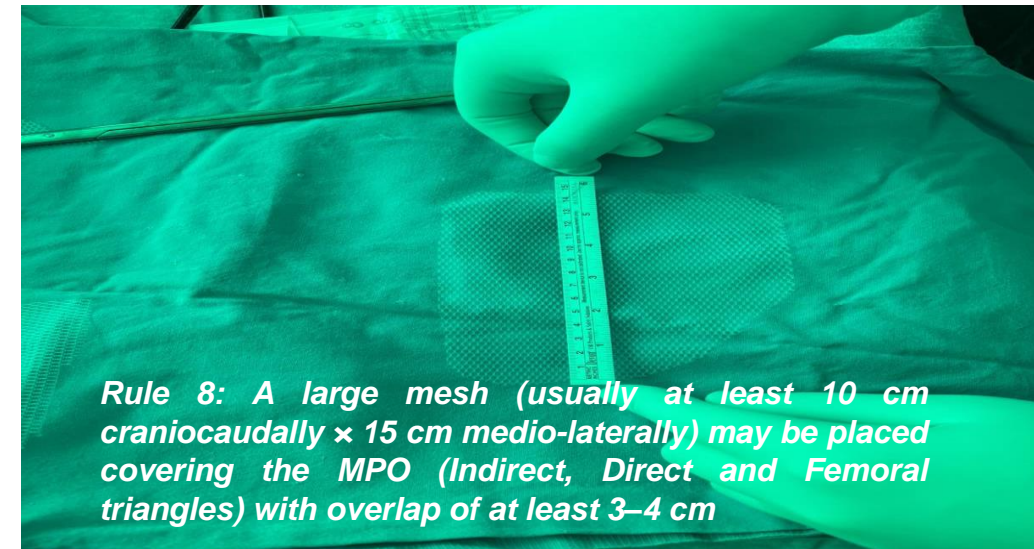
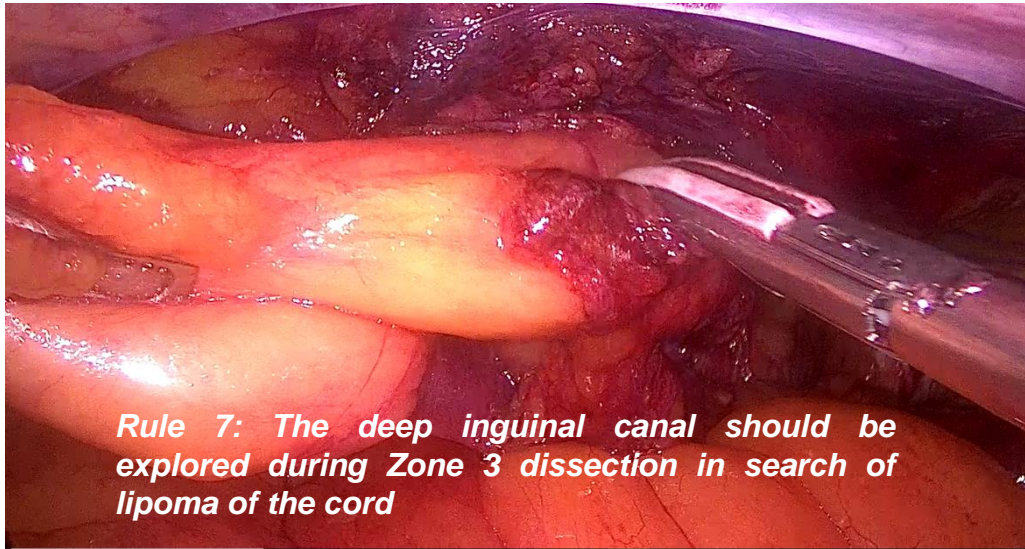


Rule 5: Parietalization of the elements of the cord is considered sufficient when the peritoneum is dissected inferiorly until at least the level at which the vas deferens crosses the external iliac vein in Zone 3 and the iliopsoas muscle is identified posteriorly at Zone 1

Rule 6: In large or inguino-scrotal hernias, it is recommended to transect and abandon the distal hernia sac within the scrotum:

(At our hospital, we do not use a laparoscopic approach for inguino-scrotal hernias)

Ten golden rules for a safe MIS inguinal hernia repair – our experience



Materials, methods, results and conclusion - Our experience

- We retrospectively analyzed a single surgeon's experience in Clinical hospital Shtip, with elective inguinal hernia repair from 2016 to 2024 using medical documentation.
- Out of 309 elective inguinal hernia repairs performed by a single surgeon in the same number of patients over the nine-year period, 222 (72.08%) were open according to Lichtenstein, and 86 (27.92%) were laparoscopic performed by Transabdominal preperitoneal approach (TAPP). The laparoscopic approach was used for relatively younger patients with an average age of 48.76 vs 57.18 years, and mostly for bilateral inguinal hernia in 72 (83.72%) patients.
- There was 1 case of recurrence in TAPP group and none in Lichtenstein group.
- **After completing the long-term learning curve, careful follow-up of modern recommendations is of basic importance for a safe laparoscopic inguinal hernia repair.**

