Inguinodynia is the recommended generic term for chronic groin complications occurring after Lichtenstein mesh inguinal hernia repair more than 3 months after surgery. It is one of the most important complications occurring after inguinal hernia repair and it occurs with greater frequency than previously thought. Majority of chronic pain has been attributed to ilioinguinal nerve entrapment. Routine excision of the ilioinguinal nerve is an attempt to decrease the incidence of chronic groin pain caused by nerve entrapment, inflammation and fibrotic reactions around the nerve.

AIMS AND OBJECTIVES: The purpose of the current study is to evaluate the effect of routine ilioinguinal nerve excision compared to nerve preservation on chronic groin pain, paraesthesia and also on the quality of life when performing Lichtenstein tension free inguinal hernia repair.

Method: A total of 100 patients admitted for inguinal hernia had surgical repair of hernia over the study period from August 2016 to August 2018. Ilioinguinal nerve was identified and preserved in 50 patients (group A), and elective division of the ilioinguinal nerve was done in 50 patients (group B). The primary outcome was the incidence of chronic groin pain at the end of 1 month, 3 months and 6 months following the procedure. Secondary outcomes included incidence of postoperative sensory loss or sensory change at the groin region and quality of life measurement assessed by modified SF-36 questionnaire at the end of 6 months.

Results: About 93 out of 100 patients completed the study protocol fully. The incidence of post-operative groin pain at rest in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showing was 8% versus 6% at 1 month, 8.33% versus 2.05% at 3 months, and 8.52% versus 2.18% at 6 months. The incidence of post-operative groin pain during Normal Daily Activities in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showed 10% versus 8% at 1 month, 8.33% versus 2.05% at 3 months, and 8.52% versus 2.18% at 6 months. The incidence of post-operative groin pain after Moderate Activities in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showing was 14% versus 12% at 1 month, 8.33% versus 2.05% at 3 months, and 8.52% versus 2.18% at 6 months. The incidence of post-operative groin pain after Vigorous Activity in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showing was 21% versus 17% at 1 month, 27.09% versus 2.05% at 3 months, and 21.28% versus 2.18% at 6 months. The incidence of Post Operative Hypoaesthesia in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showing was 30% versus 18% at 1 month, 27.09% versus 2.05% at 3 months, and 21.28% versus 2.18% at 6 months. The incidence of Post Operative Hyperesthesia in this study compared ilioinguinal nerve preservation versus routine excision of ilioinguinal nerve showing was 10% versus 20% at 1 month, and 4.2% versus 18.4% at 3 months, 4.3% versus 13.05% at 6 months. The incidence of post-operative Hyperesthesia compared ilioinguinal nerve preservation versus nerve excision showed 26% versus 20% at 1 month, 4.17% versus 8.2% at 3 months and 4.26 versus 0% at 6 months.

Conclusion: The prophylactic excision of the ilioinguinal nerve during Lichtenstein mesh hernia repair decreases the incidence of chronic groin pain after surgery. Furthermore the procedure is not significantly associated with additional morbidities in terms of local cutaneous neurosensory disturbances. So when performing Lichtenstein inguinal hernia repair, routine ilioinguinal neurectomy is a reasonable option.
A proposed mechanism for the development of post-operative chronic groin pain is inflammation and fibrosis induced by the mesh, which is in close proximity to the ilioinguinal nerve. The purpose of this study was to evaluate the effect of routine ilioinguinal nerve excision compared to nerve preservation on chronic groin pain and other sensory symptoms when performing Lichtenstein inguinal hernia repair.

AIMS AND OBJECTIVES
1. To compare and correlate the therapeutic effectiveness of routine ilioinguinal neurectomy versus nerve preservation with respect to:
   a. Post operative groin pain during rest and various activities.
   b. Post operative paraesthesia.
   c. Post operative patient satisfaction and wellbeing.
2. To arrive at a consensus concerning management of the ilioinguinal nerve during hernia repair and try to provide uniform terminology to be used in this context.

MATERIALS AND METHODS
This is a prospective comparative study conducted in the Department of Surgery, M.K.C.G. Medical College Hospital over a period of 24 months from August 2016 to August 2018. In this study, the clinical material consists of patients admitted with uncomplicated inguinal hernia (both males and females), 50 cases with ilioinguinal nerve preservation (Group A), and 50 cases with elective division of the nerve (Group B).

INCLUSION CRITERIA
1. All patients between the age of 18 and 80 years.
2. All patients with unilateral inguinal hernias either direct inguinal hernia or indirect inguinal hernias.
3. All patients who is fit to undergo elective surgery with good performance status.
4. All patients with uncomplicated unilateral hernias.
5. All patients were planned for elective hernia repair.

EXCLUSION CRITERIA:
1. Patients with bilateral inguinal hernias
2. All patients aged below 18 years and above 80 years.
3. All patients with complicated inguinal hernias like obstructed or strangulated inguinal hernias requiring emergency management.
4. Those with recurrent hernias.
5. Those with h/o peripheral neuropathy.
6. Those with impaired cognitive function.
7. Patients with poor performance status.

OBSERVATION AND RESULTS
A total of 100 patients were eligible for the study during the 24 months study period. These patients were randomized with 50 patients each in neurectomy and nerve preservation group.

Seven patients were not followed up regularly after discharge out of which 4 patients belonged to neurectomy group and 3 patients belonged to nerve preservation group, and therefore, only one month data were available for them. These patients were not considered in the results of the study. Rest of the patients were followed for a period of 6 months.

Table 1: Mean Age and Standard Deviation

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurectomy</td>
<td>50</td>
<td>51.56</td>
<td>15.15</td>
<td>18.00</td>
<td>80.00</td>
</tr>
</tbody>
</table>

In our study, the minimum age of the patient presenting with inguinal hernia was 18 yrs in the neurectomy group and 18 yrs in the nerve preservation group, while the oldest being 80 yrs in the neurectomy group and 72 yrs in the nerve preservation group.

Table 2: Sex Incidence

<table>
<thead>
<tr>
<th>Sex</th>
<th>Neurectomy</th>
<th>Nerve preservation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48 (96.0)</td>
<td>49 (98.0)</td>
</tr>
<tr>
<td>Female</td>
<td>2 (4.0)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

P=0.557
In our study, 2 female patients were present in Neurectomy group and 1 female patient was present in Nerve preservation group.

Table 3: Diagnosis - Type of Inguinal Hernia

<table>
<thead>
<tr>
<th>Inguinal hernia</th>
<th>Neurectomy</th>
<th>Nerve preservation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Direct</td>
<td>10 (20.0)</td>
<td>13 (26.0)</td>
</tr>
<tr>
<td>Left Direct</td>
<td>09 (18.0)</td>
<td>05 (10.0)</td>
</tr>
<tr>
<td>Right Indirect</td>
<td>20 (40.0)</td>
<td>22 (44.0)</td>
</tr>
<tr>
<td>Left Indirect</td>
<td>11 (22.0)</td>
<td>10 (20.0)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

P=0.642
In our study, the incidence of right indirect hernia was the highest, being 40% in neurectomy group and 44% in nerve preservation group. The least was of left direct hernia.

Table 4: Pre-operative Pain

<table>
<thead>
<tr>
<th>Pre-operative Pain</th>
<th>Neurectomy</th>
<th>Nerve preservation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>22 (44.0)</td>
<td>27 (54.0)</td>
</tr>
<tr>
<td>Present</td>
<td>28 (56.0)</td>
<td>23 (46.0)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

P=0.317
Pre-operative pain was present in 56.0% of the patients in the neurectomy group and 46.0% of the patients in the nerve preservation group.

Table 5: Pre-operative Paraesthesia

<table>
<thead>
<tr>
<th>Pre-operative Paraesthesia</th>
<th>Neurectomy</th>
<th>Nerve preservation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>42 (84.0)</td>
<td>47 (94.0)</td>
</tr>
<tr>
<td>Present</td>
<td>08 (16.0)</td>
<td>03 (6.0)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

P = 0.110
Pre-operative paraesthesia was present in 16.0% patients in the neurectomy group and in 6.0% patients in the nerve preservation group.

Table 6: Pain at Rest

<table>
<thead>
<tr>
<th>Pain at Rest</th>
<th>Follow up n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 month</td>
</tr>
<tr>
<td>Neurectomy</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>47(94.0)</td>
</tr>
<tr>
<td>Present</td>
<td>03(6.0)</td>
</tr>
<tr>
<td>Total</td>
<td>50(100)</td>
</tr>
</tbody>
</table>

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In the present study, a validated questionnaire was used to evaluate the presence or absence of pain in the groin, at rest, pain during normal daily activities, pain after vigorous activities and pain experienced on walking. The questionnaire was updated at every follow up, which was at 1, 3 and 6 months.

DISCUSSION
Post operative complications
1. Post operative pain:
Direct comparison of pain between our study and other studies is not possible because of the different available methods used to determine the severity of pain like the Visual Analogue Scale (VAS), Verbal Rating Scale (VRS), 10 point Likert scale, Mc Gill pain questionnaire etc.

In the present study, a validated questionnaire was used to evaluate the presence or absence of pain in the groin, at rest, pain experienced during normal daily activities, pain after moderate activities, pain after vigorous activities and pain experienced on walking. The questionnaire was updated at every follow up, which was at 1, 3 and 6 months.

Pain at rest:
In the neurectomy study group, pain at rest was present in 6% patients at 1 month which reduced to only 2.18% at 6 months, whereas in the nerve preservation groups, it was present in 8% patients at 1 month which reduced to 4.3% at 6 months post operatively. In the study by Picchio et al, pain occurred in 5% and 6% of the studied patients in the neurectomy and nerve preservation groups, respectively, at 1 month. This subsided to 3% (neurectomy study group) and 2% (nerve preservation group) of patients at 1 year.
Incidence of chronic groin pain at rest was similar between the neurctomy and nerve preservation groups (P = 0.595) which complimint the findings of Mui et al7 (P = 0.056) and Picchio et al6 (P = 0.56).

Pain experienced during normal daily activities:
In our study, at the end of 1 month, pain was present in 8% of patients in the neurctomy study group and 10% of patients in the nerve preservation study group. After 6 months, incidence of pain reduced to 2.18% in the first group and 8.52% in the second group. Mui et al7 found a high incidence of pain at the end of the first month, in both the groups (66% v/s 74.5%). However the incidence of pain drastically reduced by 6 months (0% v/s 2%).

The results are consistent with those of Mui et al7 (P = 0.24) and were found to be insignificant between both the study groups (P=0.519).

Pain experienced during moderate activities:
In our study, at the end of 1 month pain was present in 12% of patients of Neurectomy group and 14% of patients in Nerve preservation group where as this pain incidence reduced to 2.18% in neurctomy group and to 8.52% of patients in nerve preservation group.

Pain after vigorous activity and on walking:
Significant differences were found in the incidence of pain after vigorous activity, between the neurctomy group and the nerve preservation group (10.87% v/s 51.07%, P=0.0096), as well as in the incidence of pain on walking (2.18% v/s 21.28%, P=0.0485) with a noticeable decrease in the incidence of pain in the neurctomy group over the 6 month follow up period.

These findings are consistent with those of Dittrick et al8 (3% v/s52%; P=0.003) and Malekpour et al9 (6% v/s 21%; P=0.033), however, Picchio et al6 reported an almost equal incidence of pain after one year (18% v/s 21%).

Ravichandran et al10, in a pilot study in the year 2000, compared incidence of pain after preservation or division of the ilioinguinal nerve in hernia repair and found that the differences in both the groups were insignificant. These results were limited by a small sample size which therefore fails to confer an adequate and strong statistical power.

2. Postoperative paraesthesia:
In our study, at the end of the first month of follow up, incidence of hypoesthesia was higher in the neurctomy group (20% v/s 10%) as compared to hyperesthesia which was higher in the nerve preservation group (20% v/s 26%).

At 6 months of follow up, overall incidence of paraesthesia decreased but hypoesthesia persisted in 13.05% patients of the neurctomy group as opposed to 4.3% patients of the nerve preservation group.

These results are comparable with those of Mui et al7 (26% v/s 18.4%) and G.W.Dittrick et al8 (13% v/s 5%).

This finding is complimented by the study of Abdullah et al11, wherein the preservation or division of the intercostobrachial nerve in patients undergoing axillary node dissection (for invasive breast cancer), did not change the incidence of post operative numbness. The explanation being that when sensory nerves are excised, there are usually abrupt patterns of numbness followed by a gradual recovery, based on the formation of collateral nerves.

3. Quality of life:
In our study, there was no significant difference in the health related quality of life between the two study groups. These compliment the findings of Mui et al7. However in a historical cohort survey by Poobalan et al12, patients with chronic pain after hernia repair reported significantly worse scores on three dimensions of the SF- 36: social functioning (P<0.046), mental health (P<0.018) and bodily pain (P<0.001). This difference between patients in our study, suffering from chronic pain, and those of Poobalan et al12 can be explained by the lower mean IQ of our patients, the lower socio economic status of our patients, which makes them more resistant to the emotional and functional aspects of chronic pain and the relative indifference to chronic pain owing to their daily lifestyle and habits.

CONCLUSION
The results of this comparative study demonstrate that prophylactic excision of ilioinguinal nerve during Lichtenstein inguinal hernia repair decreases the incidence of exceptional chronic groin pain after surgery. Furthermore, as the procedure is not associated with additional morbilities in terms of routine cutaneous neurosensory disturbances or deterioration in quality of life. Ilioinguinal neurectomy should be considered as a routine surgical step during open mesh hernia repair.

REFERENCES