It is reliable, pragmatic, performed solely by surgeons, and obviates the need for ultrasound skills.

In 2 subsequent randomized controlled trials in patients undergoing laparoscopic cholecystectomy and total extraperitoneal repair of inguinal hernia, we demonstrated that laparoscopic-guided TAP block is superior to our previously used local anesthetic infiltration in terms of immediate postoperative pain scores, patient satisfaction, rescue opioid requirements, and postoperative nausea.[3,4] In analogy to the results of Hartford and colleagues,[1] the improvement in pain control and reduction in opioid requirements were more evident in patients undergoing hernia repair.[4] However, in our case, this could possibly relate to collection of data during the learning phase of the technique in the first trial.[3] We also used a standardized postoperative analgesic regimen of a combination of acetaminophen and nonsteroidal anti-inflammatory drugs, and an educational strategy in which patients were encouraged for early ambulation and to taper down the use of oral opioids to the minimum in hospital and at home. These interventions facilitated hospital discharge within 3 hours post surgery in patients undergoing total extraperitoneal hernia repair, and enabled us to discharge 80% of laparoscopic cholecystectomy patients within 24 hours of admission.[3,4] Similar results were obtained in a recent study by Warren and colleagues,[5] using an ultrasound-guided TAP block in patients undergoing open ventral hernia repair within an enhanced recovery after surgery program.

We believe that integration of the TAP block as an effective component of the STOP multimodal analgesia strategy in the study by Hartford and colleagues[1] and perhaps using the long-acting liposomal bupivacaine, would have yielded a significant difference in the postoperative pain scores, and would have further reduced the opioid requirements in the postoperative period. Therefore, we encourage the authors to do a similar study following incorporation of the TAP block into their practice.

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Surgical Repair of Occult Inguinal Hernia?

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We read the article, "Radiologic reporting and interpretation of occult inguinal hernia," by Miller and colleagues,[1] with great interest. There are several aspects of the article with which one might take issue.

First, the authors' premise that symptomatic hernias that cannot be palpated on examination are occult inguinal hernias is flawed. It is our belief that hernia and inguinodynia are distinct diseases. That being the case, a symptomatic hernia that cannot be palpated is not a symptomatic hernia, it is inguinodynia. The fact that a synchronous hernia may or may not be present is not necessarily relevant.

Second, the authors' definition of a hernia is overly broad. Their statement, "discovery of preperitoneal fat extending through the fascial defect would be considered a hernia; however, an isolated cord lipoma within the scrotum only and without visible extension from the preperitoneal fat would not be considered a hernia," is difficult to understand. By definition, a cord lipoma is an extrusion of preperitoneal fat that protrudes through the external ring lateral to the cord structures. If the fat is isolated to the scrotum only, it is not a cord lipoma. Per the authors' definition, all cord lipomas are hernias. In point of fact, although some cord lipomas may cause hernia-like symptoms, cord lipoma and inguinal hernia are separate and distinct entities.

Third, the authors' central point seems to be that they have trained a radiologist to interpret cross-sectional imaging in a nonstandard manner, and the radiologist now does so in a reproducible manner. They then explore the patient's groin, identify a hernia, and conclude that

the radiologist's interpretation of the CT study is the correct one. At best, this is a modal fallacy, confusing possibility with necessity. At worst, it is an argument of false authority and begs the question in that the authors' unique perspective on the diagnosis of inguinal hernia is used as a premise.

Finally, the authors provide correlation of their operative findings with their radiologist's imaging interpretations as results, but they provide no data on patient outcomes. One does not know whether the patient's symptoms were relieved and, if so, for how long. In a similar paper published by these same authors,[2] the writers blithely cite PJ Yong and colleagues,[3] stating, that "Although a hernia repair resolves the patient's presenting symptoms…" In point of fact, Yong and associates[3] conclude, "In select women with chronic pelvic pain, empiric laparoscopic inguinal exploration and mesh placement results in moderate improvement in outcome." Specifically, Yong and colleagues[3] note that there was pain improvement in 15 patients (35%); pain improvement, then return of the pain in 18 patients (42%); pain unchanged in 9 patients (21%), and worse pain in 1 patient (2%). Even if the patients experienced relief, it could not be surmised as to whether the same relief would be provided by a sham surgery as opposed to a repair of an anatomic inguinal hernia per se. In short, the cited outcomes do not support the rationale for surgery.

It is well known that surgical repair of palpable inguinal hernia with the intent of relieving chronic groin pain is often incompletely successful and may even lead to a worsening of symptoms. If one narrows the field to patients with small or occult inguinal hernias, then the utility of surgery is even less.[4] In this context, an argument in favor of expanding the pool of patients undergoing surgical repair of hernia to include so-called occult inguinal hernia seems misguided.

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Occult Inguinal Hernias Matter

In reply to Kaplan and colleagues

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We thank the authors for their letter, as radiologic interpretation of inguinal hernias is a topic of interest to surgeons, and this gives us an opportunity to address the important, yet debated, topic of occult inguinal hernias.

Let us clarify that symptomatic inguinal hernias are indeed a subset of inguinodynia diagnosis.[1] No evidence supports the "belief that hernia and inguinodynia are distinct diseases." In fact, an impetus for our manuscript was to help correct such beliefs shared by surgeons and radiologists.

It appears the authors have misread the purpose of our manuscript.[2] It was not to report our surgical outcomes. We previously showed that inguinal hernia repair for inguinodynia or chronic pelvic pain can be curative for 78% to 89% of patients on long-term follow-up.[3,4] We disagree that "the same relief would be provided by a sham surgery" because the patients we treat for occult inguinal hernias have suffered from their symptoms for 96 weeks, on average.

History is the most important factor to determine if occult inguinal hernia should be in the differential diagnosis of inguinodynia.[3] Physical examination is also important: point tenderness over the internal ring is a highly sensitive finding (96% to 100%) for occult inguinal hernia.[3,4] Not being able to see or palpate a bulging mass on examination does not rule out an occult inguinal hernia as the cause of groin pain. Radiologic studies are intended only as an adjunct to confirm the presence of inguinal hernias if there remains diagnostic uncertainty.[5] A failure in this sequence of events is what has brought many patients to our practice—cross-sectional imaging studies in hand.

In our retrospective study, the decision to operate on a patient with groin pain was not based on preoperative consultation with a radiologist, but rather, on our surgeon's own evaluation of history, physical examination, and available imaging. The impetus for this manuscript was the experience that the radiologic reports accompanying the imaging studies were often inaccurate and disparate from our surgeon's interpretation. If our surgeon were to rely solely on radiologic interpretation of imaging, then a large proportion of her patients would have been denied curative hernia surgery for their groin pain (note that even our expert radiologist was unable