

## Ambulatory eTEP Repair for Inguinal Hernia: A Safe and Effective Outpatient Approach with Low Recurrence Rates.

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### Aim

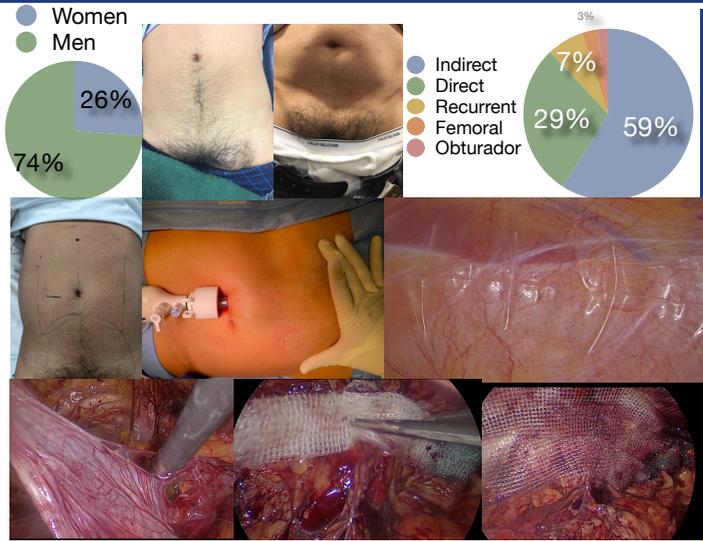
To assess the effectiveness and safety of eTEP as an ambulatory surgical procedure for inguinal hernia repair.

Inguinal hernia is a common condition globally, with the Lichtenstein technique as the gold standard. Although laparoscopic methods like eTEP offer benefits such as less

invasiveness and quicker recovery, their adoption remains low, with only 20% in the U.S. and 5% in Mexico using them. This study evaluates the feasibility of using eTEP as an outpatient procedure to enhance patient outcomes and healthcare efficiency.

### Material & Methods

Retrospective, observational, and descriptive study reviewed 450 patients treated with eTEP from January 2015 to December 2024 by the same surgery group. Patients underwent general anesthesia, a balloon dissector to create the preperitoneal space, critical view of the inguinal space was done and ProGrip® mesh was used in all of them. Postoperative care involved early ambulation, pain management, and discharge once the patient met recovery criteria.



### Results

Of the 450 patients, 96% were discharged the same day. Minor complications, such as seromas and scrotal hematomas, were noted in a small number of cases. A patient (.22%) presented intestinal obstruction due to an unnoticed opening of the peritoneum, he underwent reoperation 36 hours later, an exploratory laparoscopy was performed, the peritoneum was closed, and he was discharged with adequate progress. The recurrence rate has been minimal (.88%), highlighting the procedure's success. The average follow up 18 months, the four patients who experienced recurrence did so within the first six months, which we attribute to a technical defect: they had direct hernias, and 15x10 cm meshes were used.



### Conclusions

eTEP is a viable outpatient technique for inguinal hernia repair, demonstrating low complication rates and promising long-term outcomes, making it a valuable alternative to traditional methods. After reviewing our statistics, we adjusted our decision to always close direct defects larger than 3 cm and place 16x12 cm mesh in direct hernias, regardless of whether the defect was closed or not.

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