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Comments on: Three stitch hernioplasty

The Editor,

I have read an interesting paper by Dr. Patchayappan *et al.* "Three stitch hernioplasty: A novel technique for beginners,"[1] so I would like to extend my thanks to the authors for the interesting idea. Besides the favorable opinion, I would like to express some comments on this article.

First comment: Table 4 and Table 5 are completely the same. I think the inclusion of the same table twice is a mechanical error, but it would be better to avoid such errors.

Second comment: In Table 7, the type of hernia of the remaining 4% of patients is not mentioned. I think either there is also a mechanical error or they perhaps had combined inguinal hernias. Anyway, it would be better not to forget about these four patients.

Third comment: The authors mentioned in the materials and methods that pain assessment was carried out by visual analog scale with a score of <1 as mild, between 1 and 5 as moderate, and more than 5 as severe pain. At the same time, they presented visual analog scale in Table 6 with a score of <1 being no pain, up to six points being moderate pain. This can also be a mechanical error, of course. However, I believe such discrepancies should be avoided.

Fourth comment: In the results, the authors mentioned the operative time to be 95 ± 32 min while later in the discussion it was stated that the average time of the entire operation was similar to that of Stoppa repair and laparoscopic approach and appeared to be 1 h. Perhaps for large operations such as Whipple procedure 95 min and 1 h are not of vital importance as these time intervals make a fifth part of the entire operation. In case of hernioplasty, it is crucial to know exactly the mean time to understand whether three stitch techniques allow to reduce operative time.

Fifth comment: In the materials and methods, the authors mentioned that postoperatively the patients were treated with antibiotics and analgesics. However, they did not notice the cases when antibiotics are used. For example, incarcerated hernia could be an indication for antibiotic therapy. I think it would be better to separate this group because maybe demonstrated complications were mostly encountered in this group.

Sixth comment is regarding the three stitch technique itself. Without any doubt, the aim of stitches is fixation, not hemostasis, aerostasis, or hermetic closure. From this viewpoint, regardless the number and the type of stitches, the hernia mesh should be adequately and safely fixed to avoid such complications as mesh migration or recurrence of hernia.[2] The question is how adequate the fixation in given three points is. Another point is what to do with mesh tails. The authors did not notice whether they fixed the tails and if yes, how they fixed them. I think crossed and fixed (probably stitched to the inguinal ligament) tails thus forming deep inguinal ring is an important point in open inguinal hernioplasty. If the authors fix them, probably the technique is four stitch rather than three stitch technique.

Overall, the work by Dr. Patchayappan *et al.* is an interesting idea requiring further research for what I would like to express my gratitude to the authors.

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Conflicts of interest

There are no conflicts of interest.

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