PROCEDURE
The patient was taken to the operating room and after being identified was placed under general anesthesia with endotracheal intubation. His anterior abdominal wall and bilateral groin were clipped, cleaned, prepped, and draped in usual fashion. Using a 1-cm paramedial incision to the left of the umbilicus, this was sharply dissected down to reveal the anterior rectus sheath. This was sharply opened and a muscle-splitting incision was used to reveal the posterior sheath. The potential space between the rectus muscle and the posterior sheath was then developed. A 10-mm port with a self-containing balloon was entered through this potential space and pneumoextraperitoneum was achieved to 14 mmHg. A 10-mm angled scope was then placed through this port site and under direct vision, two 5-mm ports were placed in the midline at 5 and 7 cm above the pubic symphysis. The right inguinal hernia was initially repaired. The patient was placed in Trendelenburg and rotated to the left. The right conjoint tendon was seen. The right inferior epigastric vessels as well as the inguinal canal contents were seen and preserved. Anterior medial to the inguinal canal contents was a thin-walled hernia sac which was easily dissected off. The resultant moderate hernial defect was identified. A ProGrip mesh was brought in the field and this was used to repair the hernial defect. It was anchored medially and superomedially to the conjoint tendon and anterior abdominal wall laterally and superolaterally to the anterior abdominal wall using the Securestrap.

The patient was then rotated to the right and left inguinal hernia was then repaired. The left conjoint tendon was seen. The left inferior epigastric vessels as well as the inguinal canal contents were seen and preserved. Anterior medial to the inguinal contents was a thin-walled hernia sac that was easily dissected and walled off. A small hernial defect was noted that had a lipoma within it that was also removed. A ProGrip mesh was brought in the field and this was used to repair the hernial defect. It was anchored medially and superomedially to the conjoint tendon and anterior abdominal wall, laterally and superolaterally to the anterior abdominal wall using the Securestrap. When this was completed, an On-Q pain pump was placed in the area and both areas were bolused with approximately 7.5 mL of 0.5% plain Marcaine.

When the above was completed, hemostasis was checked and found to be correct. All the ports were removed as was the 10-mm angled scope and pneumoextraperitoneum was released. The anterior rectus sheath was re-approximated using 0 Vicryl in a UR6 needle in a figure-of-eight type suture. All the skin incisions were then closed using 4-0 Monocryl subcuticular continuous sutures. All the closed incisions were then injected with a total of 15 mL 0.5% plain Marcaine and then dressed with Mastisol, 2 x 2, and OpSite. The On-Q pain pump was also dressed with Mastisol, 2 x 2, and OpSite. The patient was then reversed from general anesthesia, extubated, tolerated the procedure well, and taken to postanesthesia care unit in a satisfactory condition.