Cooper’s Ligament Herniorrhaphy (McVay)

Operative Technique for Direct or Large Indirect Inguinal Hernia

Incision and Exposure

Make a skin incision over the region of the external inguinal ring and continue laterally to a point about 2 cm medial to the anterior superior iliac spine. Open the external oblique aponeurosis with an incision along the line of its fibers from the external inguinal ring laterally for a distance of about 5–7 (see Fig. 76–2). Mobilize the spermatic cord. Excise the entire cremaster muscle from the area of the inguinal canal (see Fig. 76–3). Also remove any lipomas of the cord. Explore the cord carefully for the presence of the indirect sac. If a sac is present, dissect it from the cord. Open the sac, explore it, close the sac at its neck with a suture-ligature, amputate the sac, and permit the stump to retract into the abdominal cavity. Identify the external spermatic vessels at the point where they emerge from the transversalis fascia (see Fig. 76–7). Divide and ligate them at this point and remove about 4–5 cm of the vessels and ligate them again at the pubic tubercle (see Fig. 76–8).

In patients with an indirect inguinal hernia, identify the margins of the transversalis fascia around the internal inguinal ring. If the internal inguinal ring is only slightly enlarged, close the ring by means of several sutures between the healthy transversalis fascia along its cephalad margin and the anterior femoral sheath at its caudal margin. If the hernia has eroded more than 2 cm of posterior inguinal wall, a complete reconstruction will be necessary. In this case, incise the transversalis fascia with a scalpel beginning at a point just medial to the pubic tubercle (see Fig. 76–9). Carry the incision laterally with a scalpel or Metzenbaum scissors, taking care not to injure the underlying deep inferior epigastric vessels. The incision must be continued until the transversalis fascia has been incised all the way to the internal inguinal ring. Sweep the preperitoneal fat away from the under surface of the transversalis fascia. Free the deep inferior epigastric vessels so that they may be retracted posteriorly together with the preperitoneal fat. A few small branches may have to be divided and ligated.

If you follow McVay’s procedure, excise the iliopubic tract adjacent to Cooper’s ligament. Then apply two identifying hemostats to the cephalad cut edge of the transversalis fascia and elevate. This will expose the aponeurosis of the transversus muscle. Excise the fleshy portion of the internal oblique muscle overlying the fi-
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Fig. 77-1

Aponeurosis of transversus m.
(transversus arch)

Deep inf. epigastric a. and v. with stumps of excised external spermatic a. and v.

Fig. 77-2

External oblique aponeurosis
Rectus m.
Relaxing incision