COMMENT



Comment to: a new groin hernia classification with clinical relevance

Giel G. Koning¹ · Kevin Buckley² · Erwin H. J. A. A. van Geffen³

Received: 14 April 2025 / Accepted: 21 April 2025

© The Author(s), under exclusive licence to Springer-Verlag France SAS, part of Springer Nature 2025

Keywords Giant · Inguinal · Hernia · Large · Inguinoscrotal · Classification

Dear Editor,

We read with interest the article 'A new groin hernia classification with clinical relevance by Yang G. and colleagues [1]. We congratulate the research group with their attempt to provide this classification system which incorporates essential clinical parameters, which allows the stratification of groin hernia into diferent stages [1]. Although the EHS classification [2, 3] is very functional and easy to remember, it may be of additional value to describe it in more detail. Further studies and validation should be performed to evaluate the usefulness and value of this proposed classification of Yang et al. in groin hernia management. In our opinion, some additional remarks could be mentioned describing this classification also in a more visual and practical way. Moreover, from a global point of view there is an unmet need for an universal classification tool that can be used world wide to describe any type of inguinal hernia by any health care worker. Our experience during several hernia missions in developing areas revealed the benefit of a supplemental anatomical tool in describing hernias adequately for internal and external communication, better pre-mission case load investigation and strategic management planning and theatre scheduling. We developed and modified this tool in a way that it fits our need for remote recruitment of hernia patients (also by paramedics) in a way that scarce mission time could be saved (Fig. 1).

- ² New York, USA
- ³ Department of Surgery, Jeroen Bosch Hospital, 's-Hertogenbosch, The Netherlands

In our experience very large inguinoscrotal hernias are difficult to grade using a standard classification. However, the proposed classification of Yang et al. (2024) in combination with Fig. 1 may contribute directly to this purpose and deserves a more global verification and validation. Colleague Yang stated that: "Apart from diferentiating which type of groin hernia it is, these classifications have limited ability to have any clinical impact on the management of the disease with such a broad diverse clinical presentation." We fully agree and hypothesized whether a more visual drawing in standing position may contribute additionally for selection of patients with very large inguial hernias. The items of Yang et al. such as reduction characteristics, hernia size, signs of strangulation, inguinoscrotal hernia with or without skin ulceration, recurrence, previous operations in combination with anatomical details/landmarks may indeed be a more complete way of hernia classification. Large inguinal hernias with scrotal component pose challenging problems to the patient in physical, social and mental ways, especially in underserved countries where patients have no access to medical care [4]. Both pre- and postoperatively, the zone classification (Fig. 1) [5] stayed central in our discussions, presentations and follow up. In our experience, all team members, but also the local hospital personnel developed the right feeling and rationale for using this tool rapidly [5].

Any additional tool to improve patient selection and hernia classification to deliver the best quality of care to patients is most welcome. The proposed classification of Yang is, to our opinion, a clear example.

Giel G. Koning giel.koning@euregio-klinik.de

Erwin H. J. A. A. van Geffen evgeffen@me.com

¹ Department of Surgery, Euregio Hospital, Nordhorn, Niedersachsen, Germany



Fig. 1 Length of hernia related to anatomical landmarks, from *Spina Iliaca Anterior Superior* (SIAS) to the knee-joint-line: Zone 1: located swelling external annulus, spontaneously visible / or Valsalva. Zone 2: hernial sac to upper third part of the thigh. Zone 3: hernial sac to middle third of thigh. Zone 4: hernial sac to distal third of thigh. Zone 5: hernial sac below the knee joint line. SIAS=*spina iliaca anterior superior*. Poupart ligament or inguinal ligament. Femur should be clinically interpreted as thigh



Declarations

Ethical approval We certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Patients gave full permission for using their anonymous data for this purpose.

Human and animal rights This article does not contain any studies with human participants or animals performed by any authors.

Informed consent For this type of study formal consent is not required.

Conflict of interest GK declares no conflict of interest. KB declares no conflict of interest. HvG declares no conflict of interest.

References

- 1. Yang G, Tung KLM, Tumtavitikul S et al (2024) A new groin hernia classification with clinical relevance. Hernia 28:1169–1179
- Muysoms FE, Miserez M, Berrevoet F et al (2009) Classification of primary and incisional abdominal wall hernias. Hernia 13:407–414
- 3. Miserez M, Alexandre JH, Campanelli G et al (2007) The European hernia society groin hernia classification: simple and easy to remember. Hernia 11(2):113–116
- 4. Weiser TG, Regenbogen SE, Thompson KD et al (2008) An Estimation of the global volume of surgery: a modeling strategy based on available data. Lancet 372(9633):139–144
- 5. Global Hernia Relief Foundation website (Video of mission 2024) http://www.GlobalHerniaRelief.com

Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.