cases were treated by operation. Younger children and infants particularly premature babies were operated at earliest date available. 92% of the cases are treated by Fergusson procedure as 46 children were >1year of age and 8% treated with Mitchell banks procedure for 4 children were <1year of age under appropriate anesthesia. For all cases high ligation of sac was done. There was no operative or post operative morbidity or morality related to congenital hernia surgery in this series. In those 2 cases which were operated as emergency, the hernial sac was opened to evaluate for incarceration or sliding structures. All incarcerated hernia treated by elective surgery after reduction. Rowe et al[30] recommended elective surgery after reduction, since it has a lower rate of complication compared to emergency surgery (1.7 Vs 22.1%). In the present study there were no case of strangulation and gonadal infarction. The less number of complications in this series could be attributed to larger number of elective cases and fewer emergencies that too operated in time.

Controversy exists for routine C/L exploration in presence of a clinical inguinal hernia. Various modalities to detect C/L hernias have been described, like USG and laparoscopy, but its efficacy and necessity are debatable. Recent 'Inguinal Hernia' guidelines of the Association of Surgeon of the Netherlands[32] there is no indication for routine C/L exploration. In this study only the side with an obvious hernia was operated. Carneiro PM et al[33] concluded in his study that the risk of occurrence of contralateral inguinal hernia following unilateral inguinal herniotomy is not significantly excessive when compared by age or sex. Despite the significant risk of developing a C/L hernia in children with left-sided hernia, the authors do not recommend routine right-sided exploration as the frequency is not high.

6.3 Post Operative Analgesia

Postoperative analgesics were provided on a routine basis and were consist of either acetaminophen suppositories (10mg/kg every 4 hours for 24 hours, then as needed) or diclofenac suppositories in children more than 1 year or caudal block. For 45 cases intraoperative rectal suppositories was put at the end of surgery and observed that 90% of cases were comfortable and were not required additional analgesia. For 5 cases caudal block given, it was observed that post operatively patient were comfortable without additional analgesia up to 6 hours after surgery. Use of suppositories have adequate pain control and can be used routinely.

6.4 Duration of Hospital Stay

Most operations are performed on an outpatient basis and sent on day of surgery. 3 cases had inadequate pain control and 2 cases had emesis and were kept under observation in the recovery room. 2 cases that were discharged on the day of surgery had emesis and came next day in coma with pin point pupil due to hypoglycemia. Patient recovered after infusion of 25% Dextrose. Average duration of stay was 1.2 days. Hernias in children were operated as Day care procedure but in our study 2 cases had hypoglycemia on next day after discharge. Generally preterm babies that are below 60 weeks (CGA) are kept under observation.

7. Complication

In the post operative period of 50 children, there were 2 cases of wound infection and 2 cases had hypoglycemia. No other complications were noted. All of them responded to conservative treatment. Carneiro P.M.R.[68] had six years retrospective review of 397 herniotomy in 380 children up to the age of 10 years and encountered 16 minor post operative complication. Lawrence R. Moss and Edwin I. Hatch[70] in a study of 384 patients who underwent inguinal hernia repair during a 5 years period found 9 minor post operative complications.

8. Recurrence

During the period of 1 & ½ years study and follow up period of 12 weeks to 52 weeks, 3(6%) cases had recurrence. Recurrent inguinal hernias are relatively uncommon. Reports from most children's document an incidence of 1% to 2%. The recurrence may be associated with comorbid conditions including increased abdominal pressure, prematurity, malnutrition, and anemia and connective tissue disorders. Other causes of recurrence include a missed sac and injury to the floor of the inguinal canal resulting in a direct hernia. Recurrence is also seen more frequently after an initial operation for incarcerated hernia. The repair of a child's hernia is not a parlor piece, but a master's work and should be preformed or supervised by a skilled surgeon.

9. Conclusion

Inguinal hernia and hydrocele in children remain one of the most common congenital anomaly observed by surgeons. The threat to loss of testis, ovary or a portion of bowel due to incarceration or strangulation remains. Prompt diagnosis and early treatment of the inguinal hernia continues to be the mainstay if these complications are to be avoided. The childhood inguinal hernias are generally more predominant on the right side and this has been attributed to the delay in descent of the right testis. Regarding the sex prevalence, males are more commonly affected. Congenital anomalies like undescended testis and hypospadias can be associated with inguinal hernia and hydrocele. In the case of undescended testis, orchiopexy should be done at the time of hernia repair. Parents are usually the first person to notice the swelling or bulge. USG is a good alternative tool for diagnosing CPPV.

An inguinal hernia will not resolve spontaneously and should be repaired as soon as possible after the diagnosis because of the risk of incarceration or strangulation. In general, infants and children require general anesthesia for the operative repair of inguinal hernia and hydrocele. Post operative complications are usually rare following elective operation whereas minor complications do occur after emergency operation. There was no disabling or prolonged morbidity related to the common operative procedure. Recurrence is usually rare if operated by experienced surgeons but it can occur. Inguinal herniotomy in children is a safe and effective operation done as Day care procedure but risk of

hypoglycemic shock has to be kept in mind which can be a grave consequence of Day care surgery.

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