

# Ilioinguinal approach

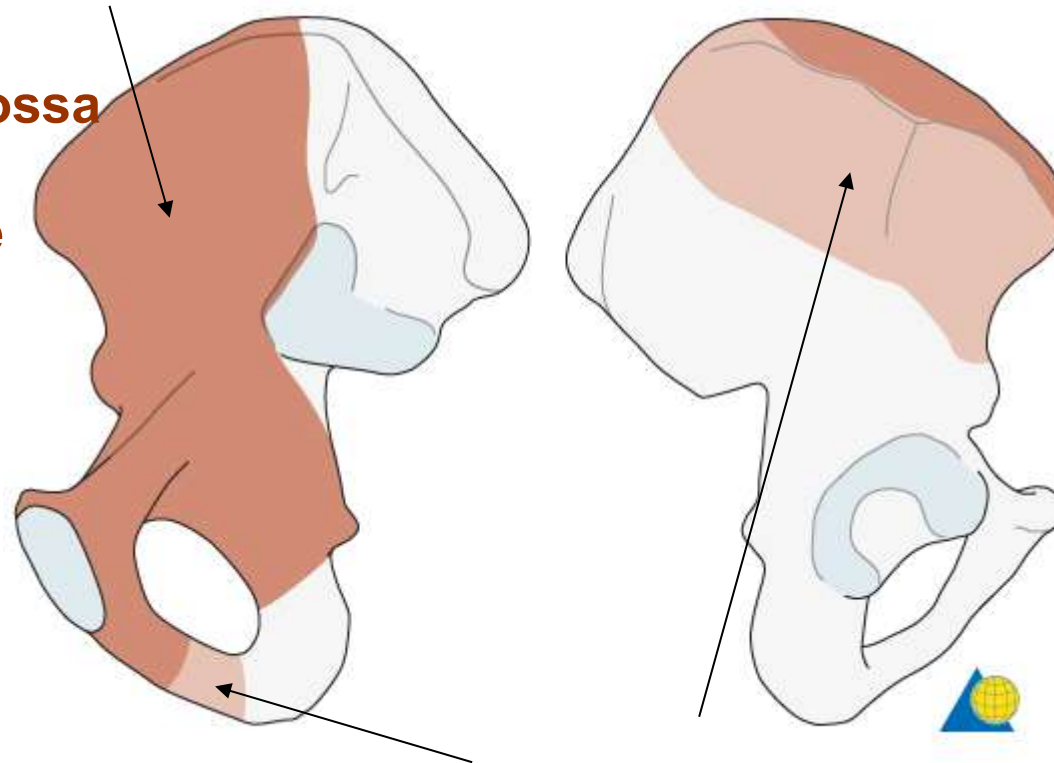
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# Ilioinguinal approach

Area which can be reached directly

Entire internal iliac fossa  
Pelvic brim  
Quadrilateral surface  
Symphysis pubis



Areas which can be reached  
by touch

# Indication

- Anterior column
- Anterior wall
- Transverse
- Anterior column + posterior hemitransverse
- Both column
- Superior pubic ramus and symphysis pubis (in pelvic fracture)

- Advantage
  - Excellent access to ant./ internal pelvis
  - Minimal heterotopic ossification
- Disadvantage / Danger
  - Extraarticular approach (unvisualized reduction)
  - Femoral nerve and vessel
  - Lateral femoral cutaneous nerve
  - Postoperative hernia

# Patient positioning

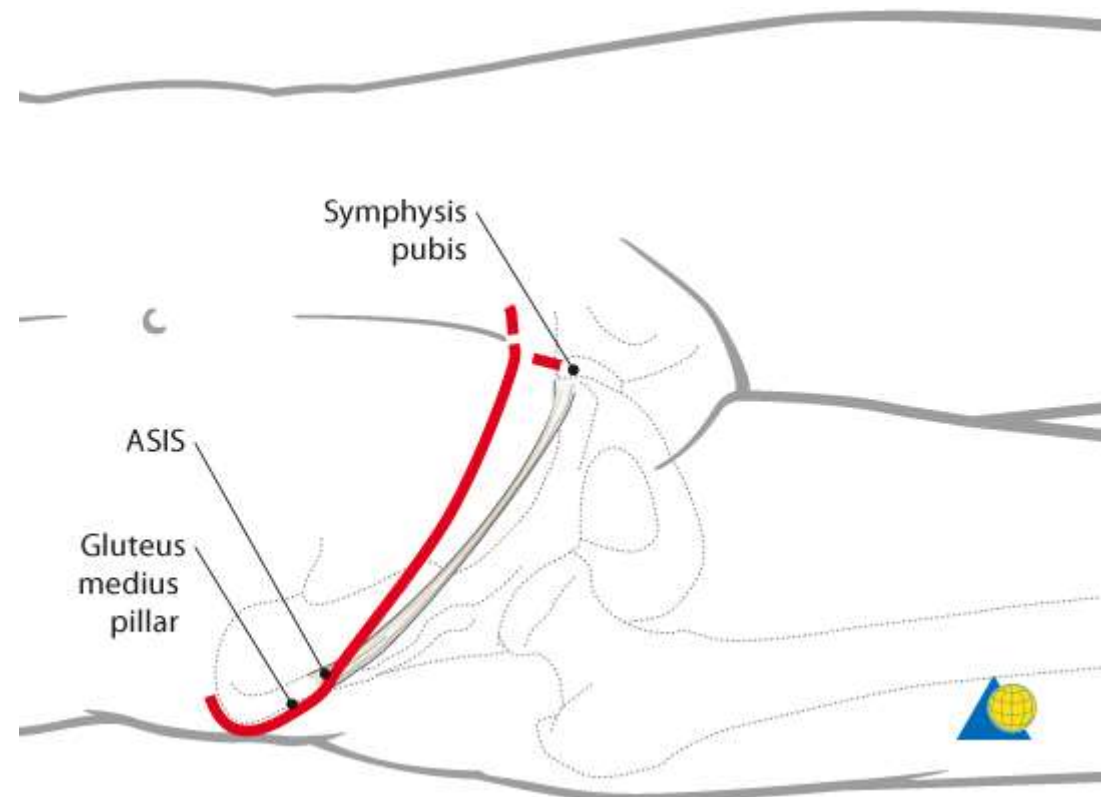
- supine



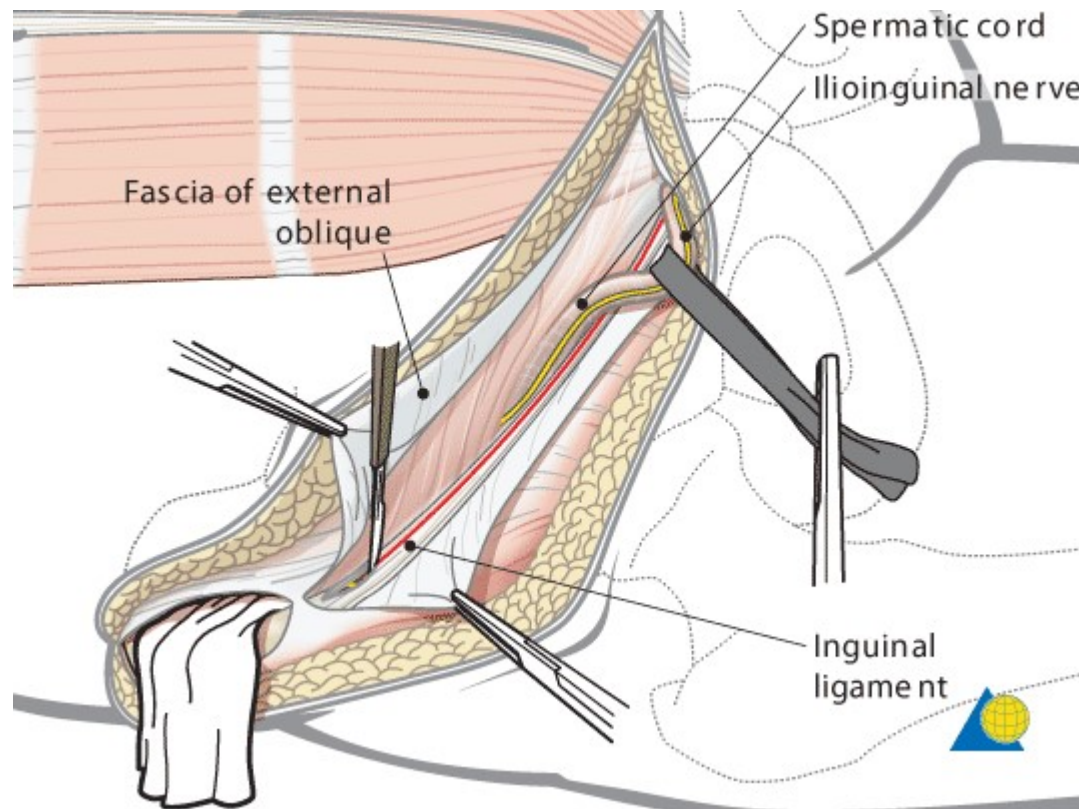
**Release the  
Iliopsoas M.  
tension by  
Hip flexion**

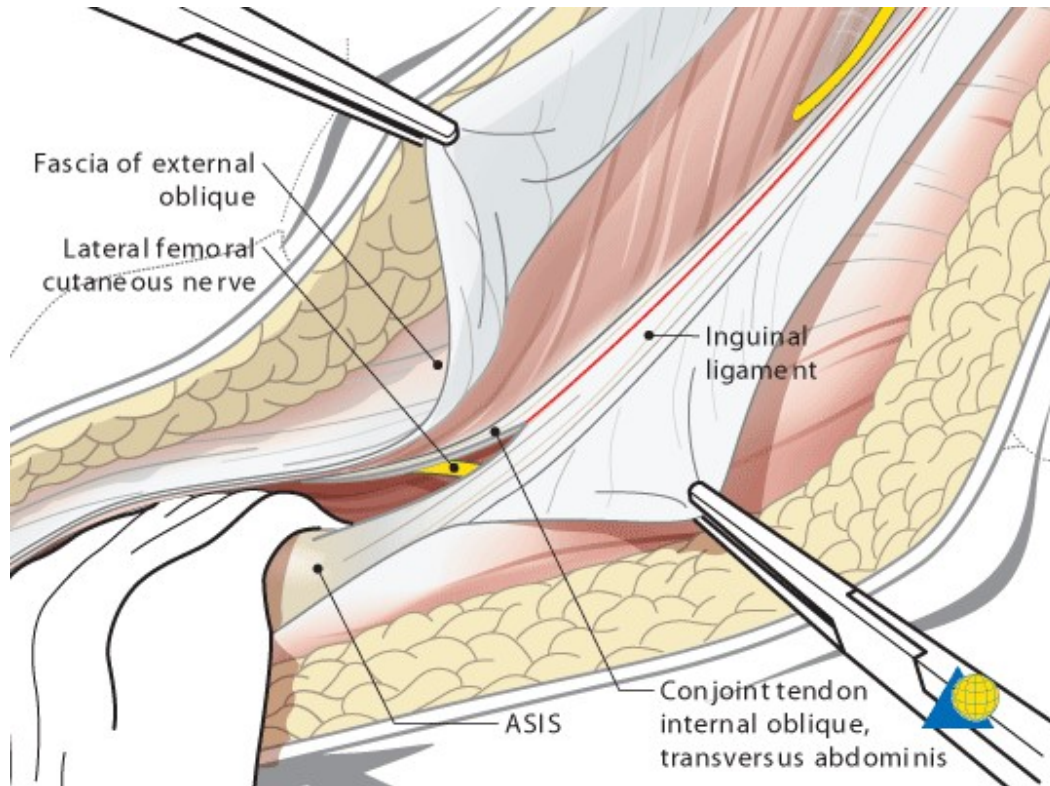
# Skin incision

- 3-4 cm cranial to symphysis pubis
- Curve to ASIS
- Parallel iliac creast
- Past most convex portion of ilium

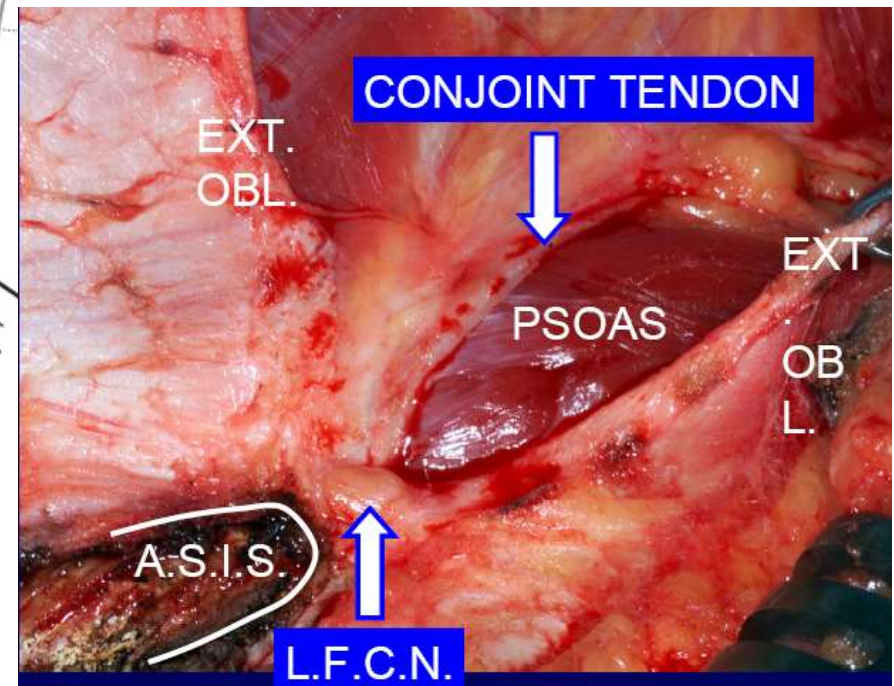


# Release the external oblique muscular attachment from the inguinal ligament





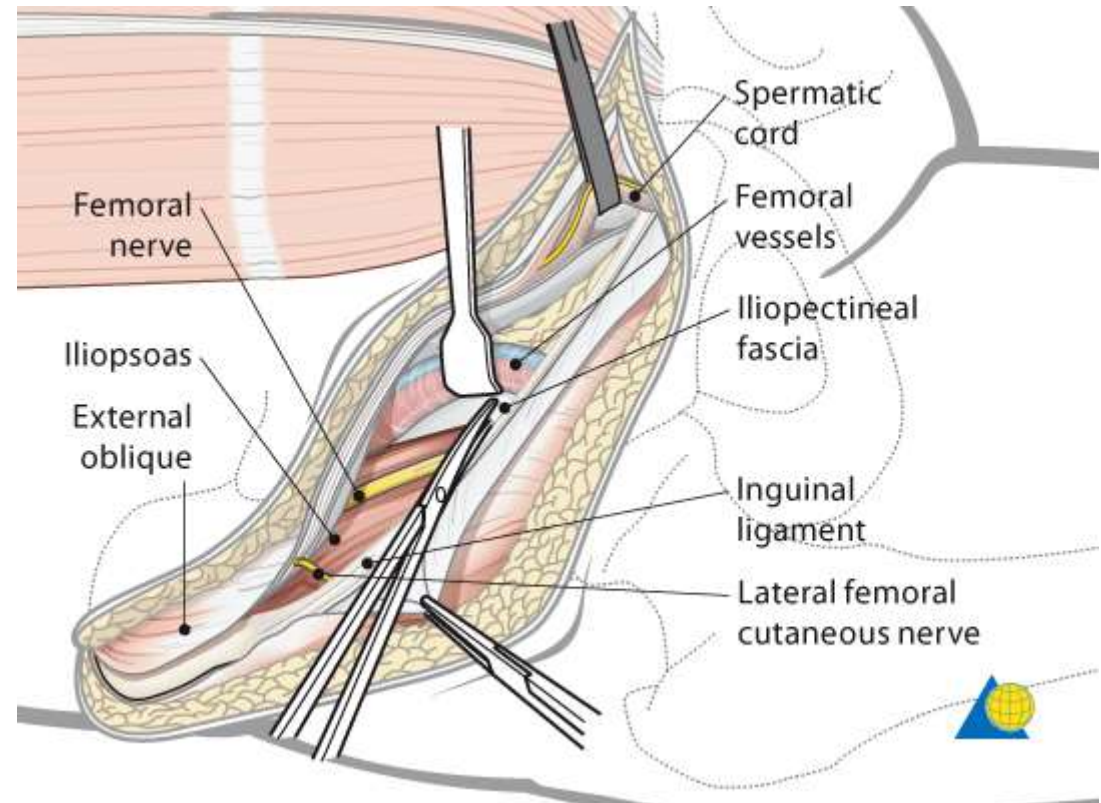
**Caution!**  
Lateral femoral cutaneous N.



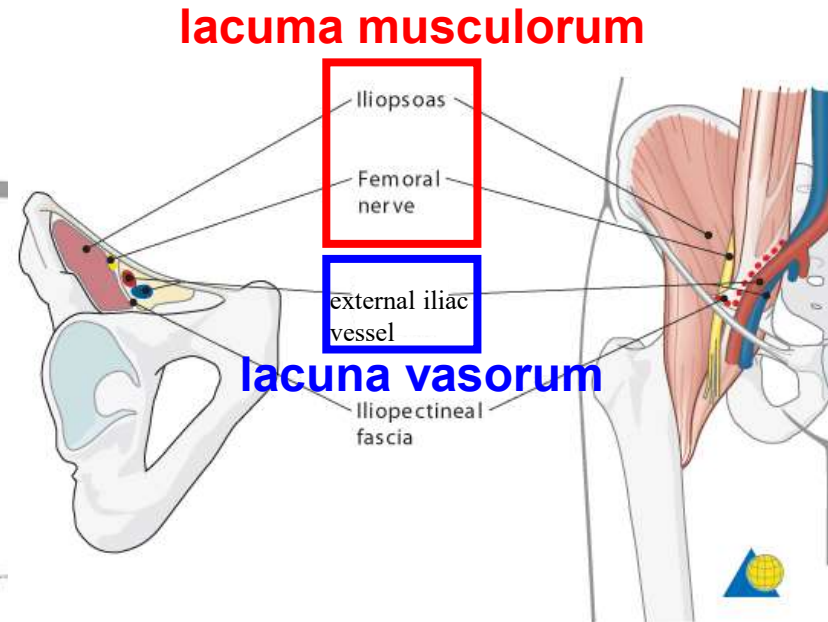
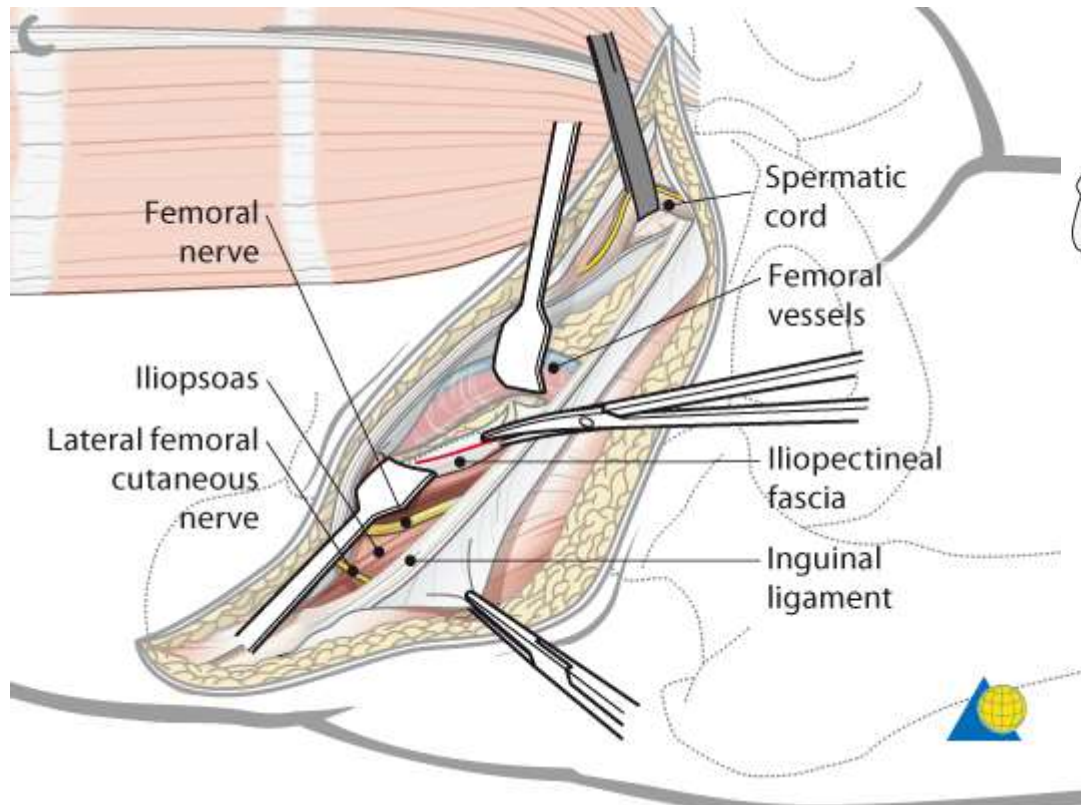


# iliopectineal fascia

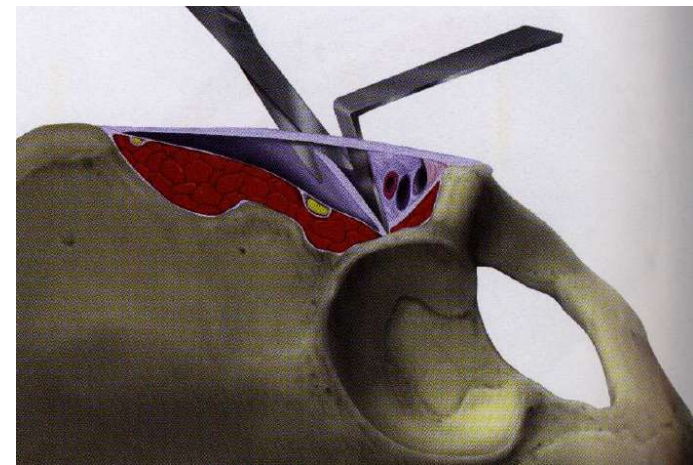
- The iliopectineal fascia is delineated by careful retraction of the femoral vessels medially and the femoral nerve and iliopsoas laterally. It is then divided distally, under direct visualization, down to the pubic root.



# Release the iliopectineal fascia



**This fascia separates the neural and vascular compartments and blocks access to the true pelvis from the internal iliac fossa.**



# 3 Windows



ASIS/Lateral Femoral Cutaneous Nerve

**Lateral window**

iliopsoas M./Femur N.

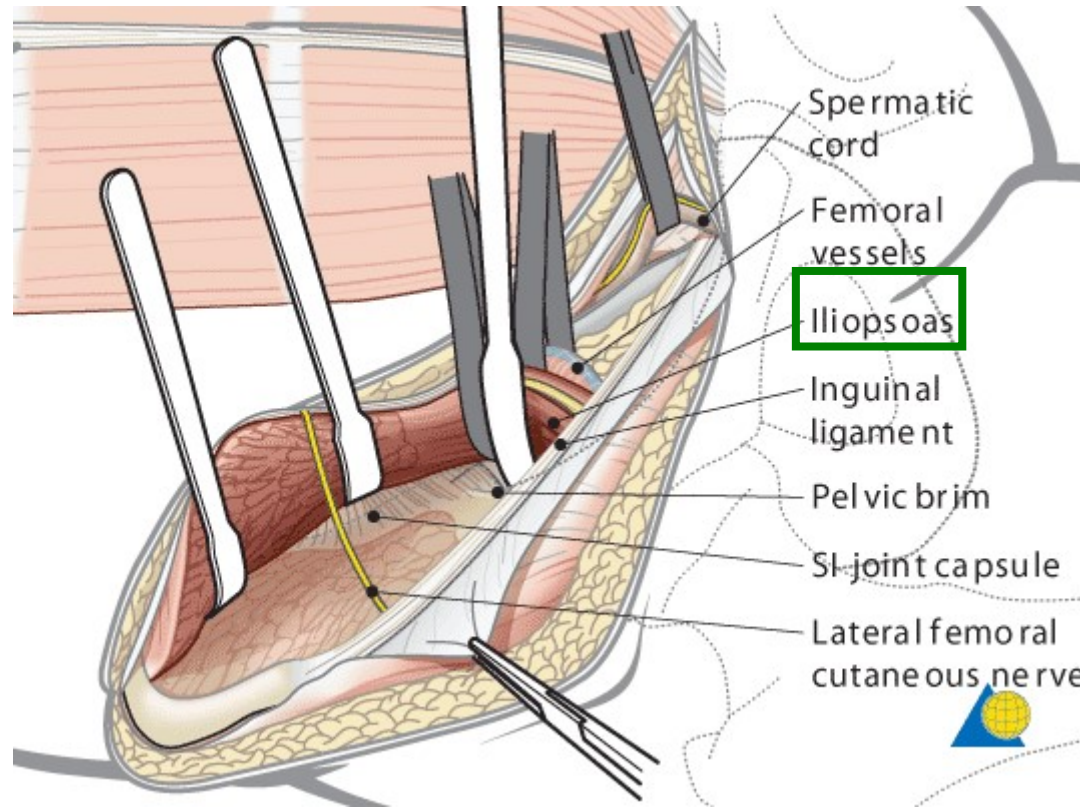
**Middle window**

External iliac Vessels

**Medial window**

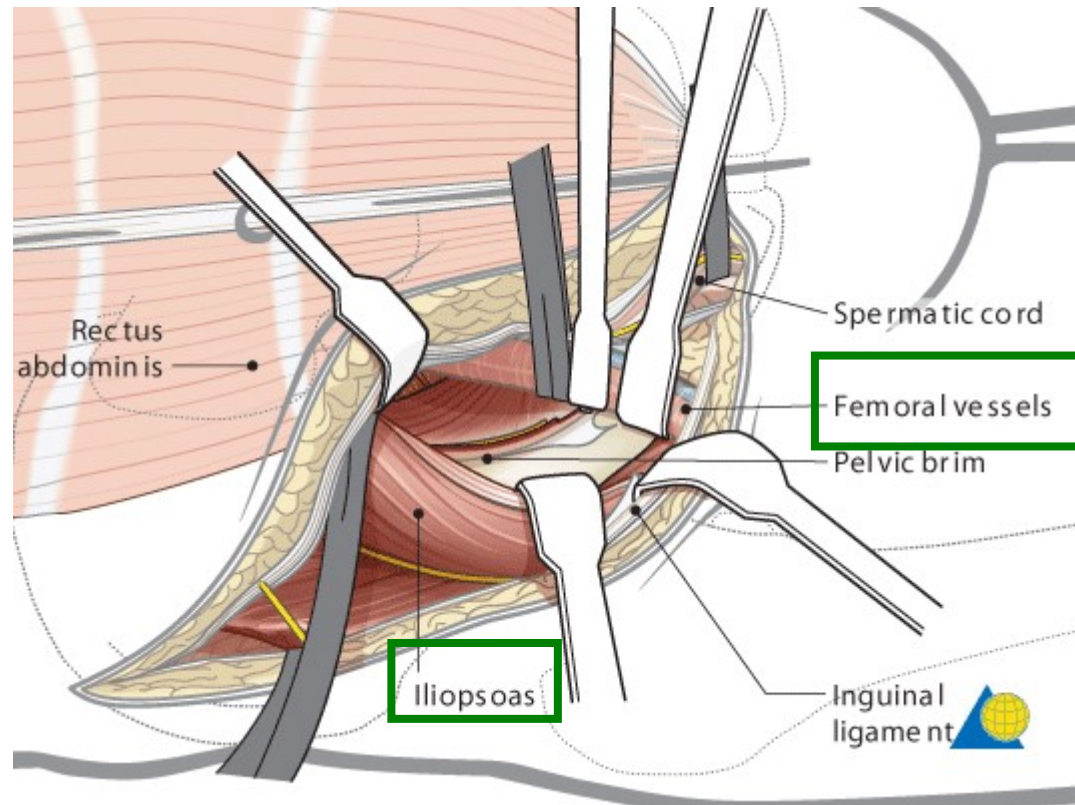
Spermatic cord/Round Lig./Ilioinguinal N./ Rectus abdominus M.

# First (lateral) window



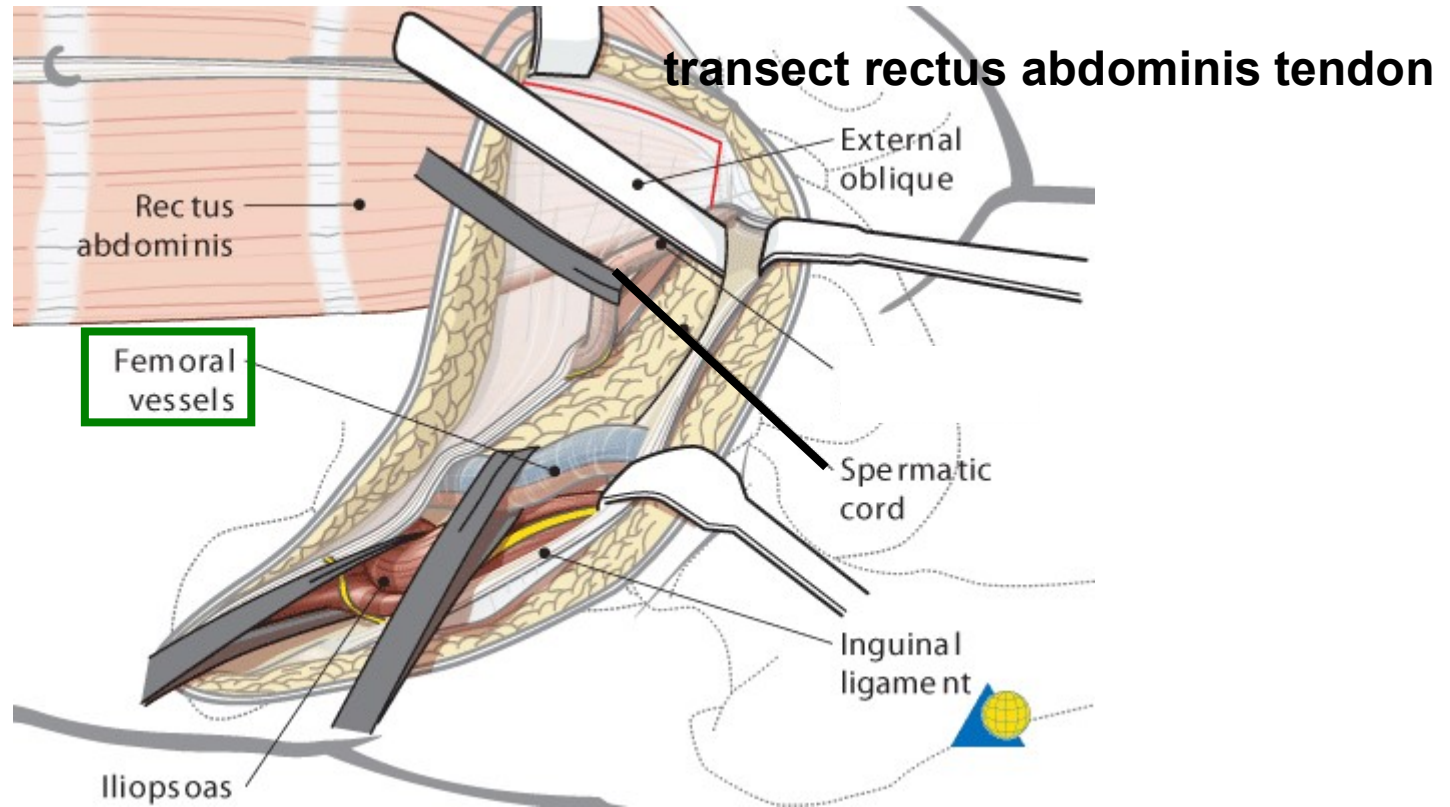
**Access to : internal iliac fossa and anterior SI joint**

# Second (middle) window



**Access to : pelvic brim and quadrilateral surface**

# Third (medial) window

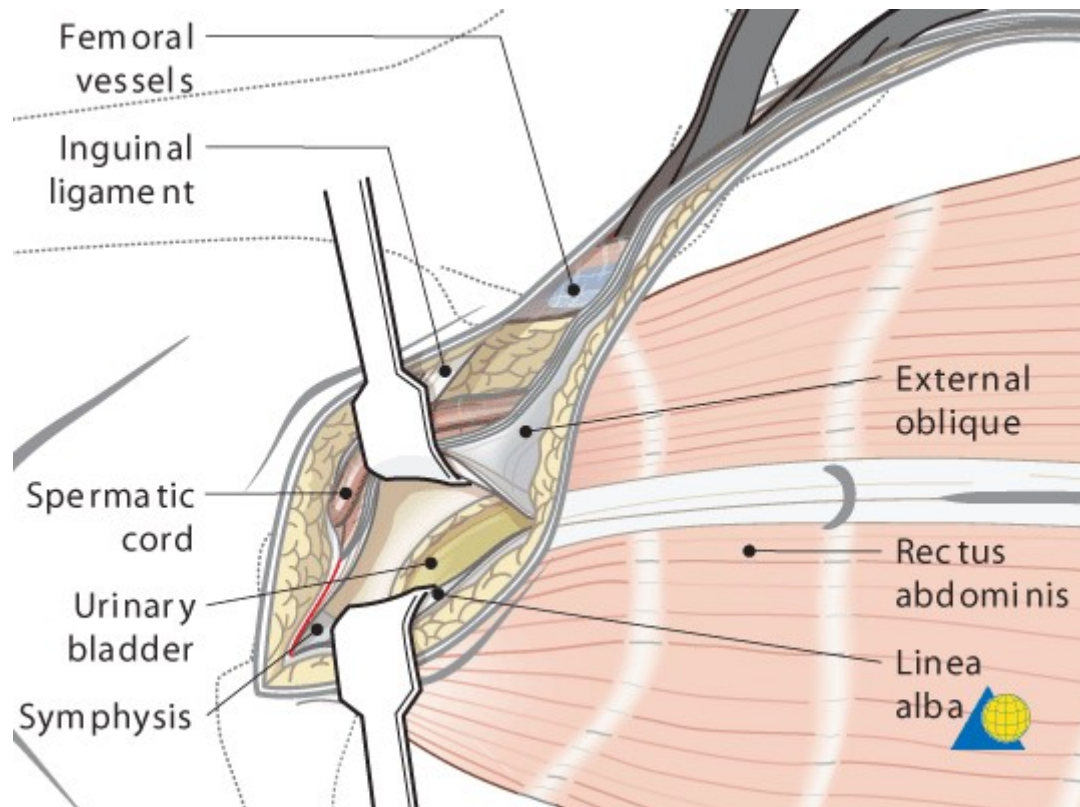


**Access to : superior pubic ramus and retropubic space of Retzius**

# Third window

- The third window can be developed in a number of different ways. The most limited of these leaves the ipsilateral rectus insertion attached and visualization is provided between the rectus and the spermatic cord (or round ligament).
- Alternatively, if the fracture pattern requires, the entire medial portion of the superior ramus and symphysis can be visualized by release of the ipsilateral rectus insertion.
- The same visualization can be achieved by leaving the rectus attached and splitting the rectus heads in the midline. With the rectus still attached, retraction is carried out posterior to the rectus with a Hohmann retractor placed along the superior ramus.

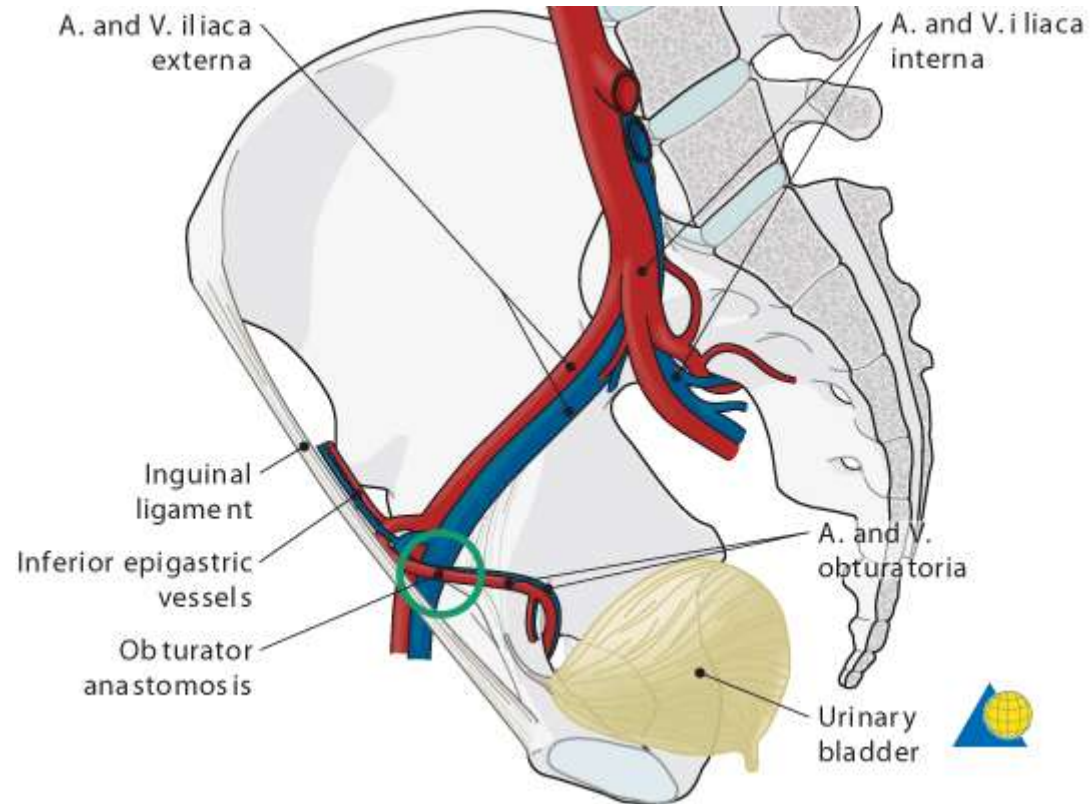




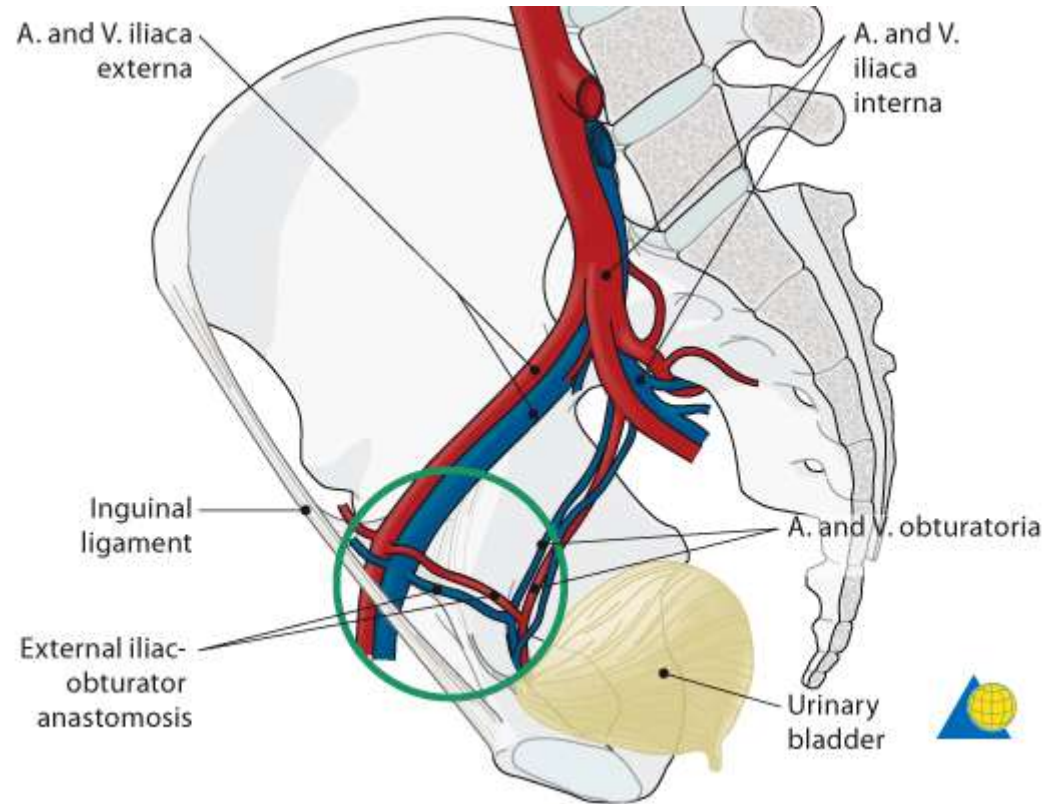
# **Retropubic vascular anastomoses**

- From the opposite side of the patient, one can more easily see any retropubic vascular communications between the obturator vessels and either the inferior epigastric (corona mortis) or external iliac vessels. Such retropubic anastomoses, present in 40% or more of patients, are at risk of being torn.

# Retropubic vascular anastomoses



# Retropubic vascular anastomoses



# Wound closure

