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Distinguishing direct and indirect inguinal hernias

SIR,—The facts contained in the article by Mr D N L Ralphs and colleagues (12 April, p 1039) analysing the ability of surgeons to differentiate direct from indirect inguinal hernias were interesting, but not surprising. The conclusion that we should not teach medical students to try to identify these two forms of hernia, however, is not acceptable.

When a surgeon examines a hernia he has two objectives: to make the diagnosis and plan the management. The second cannot be achieved without the first. The diagnosis of an abdominal hernia depends upon five cardinal signs: the presence of a swelling, with an expansile cough impulse, which will reduce through a palpable defect. The student is taught to attempt to elicit all these physical signs because he will then have the best chance of making the correct diagnosis. Often the only physical sign is a swelling, but if the other signs are present and he can succeed in defining the site of the defect in the inguinal region then he is justified in making a guess as to whether it is medial or lateral to the epigastric artery—whether the hernia is direct or indirect.

Everyone who teaches medical students tells them that the variety of inguinal hernia—direct or indirect—makes no difference to the

management, but everyone who teaches undergraduates should continually emphasise that every patient must be examined completely and thoroughly. One way of stimulating students to examine the inguinal region thoroughly is to ask them to define the variety of an inguinal hernia. When they fail to examine the inguinal region properly they often misdiagnose as inguinal hernias lesions such as low incisional hernia, undescended testis, hydrocele of the cord, Spigelian hernia, and, worst of all, femoral hernia.

As the author of one of the textbooks¹ indirectly criticised by Mr Ralphs for its conservative and orthodox approach to clinical examination, I make no apologies for demanding from my students the clinical discipline of defining the variety of an inguinal hernia. Indeed, I would re-emphasise that it is an important exercise for the medical student. If you do not take a careful history and examine your patients fully and thoroughly you have no basis for management.

N L BROWSE

Department of Surgery,
St Thomas's Hospital Medical School,
London SE1

¹ Browne NL. *Symptoms and signs of surgical disease*. London: Arnold, 1978.

the operation. It will require a large clinical trial, however, to establish this,² and although the technique may provide a welcome reduction in the incidence of factual recall it is unlikely to guarantee complete protection since, rarely, some patients are conscious and yet unable to respond.³ Secondly, amnesic wakefulness has been uncovered in an anaesthetic technique used satisfactorily for many years with only infrequent complaints of awareness. Consequently one might choose to ignore the distress signals from the patient's hand, but by extension this would condone surgery in the fully conscious patient who was rendered amnesic.

I believe amnesic wakefulness is unacceptable, and for some months I have used the isolated-forearm technique to indicate the need for supplements. An ordinary sphygmomanometer cuff is adequate and inflation for 15 minutes is sufficient.³

M E WILSON

Royal United Hospital,
Bath BA1 3NG

¹ Tunstall ME. The reduction of amnesic wakefulness during caesarean section. *Anaesthesia* 1979;34: 316-9.

² Cormack RS. Awareness during endotracheal intubation. *Br J Anaesth* 1977;49:1175.

³ Russell IF. Awareness in general anaesthesia. *Br Med J* 1980;280:1056.

Awareness in general anaesthesia

SIR,—Tunstall¹ has drawn attention to the state of amnesic wakefulness in obstetric anaesthesia when, for the sake of the fetus, no analgesics are given, and anaesthesia is maintained with 50% (or less) nitrous oxide until delivery. Amnesic wakefulness is not peculiar to this light anaesthesia since, using the isolated-forearm technique, I have observed it during anaesthesia for other procedures. Forty patients were premedicated with lorazepam or an analgesic (for example, papaveretum and hyoscine). Before induction with thiopentone the majority were given analgesic supplements, and then all were paralysed and ventilated with 66% nitrous oxide. Fourteen patients squeezed and relaxed the hand on command, and when told to squeeze if uncomfortable or in pain six of these indicated that they were not in distress and one indicated appreciation of pain. Twenty-

five patients contorted the hand into a claw during intubation or incision, and although this activity may be reflex it is quite possible that it was a gesture of anguish. These responses could be abolished by giving larger amounts of analgesics or other agents. Among the apparently distressed patients, intubation sometimes caused an alarming rise in blood pressure and pulse rate. The incision produced only minor cardiovascular changes, and without evidence from the isolated arm nothing appeared amiss. A day or so after the operation none of the patients questioned remembered any event or dream occurring during the anaesthesia.

The discovery of amnesic wakefulness raises some important issues. Firstly, the isolated-forearm technique may be used to indicate the need for anaesthetic supplements in the hope that they will prevent memories of

Prophylaxis of surgical wound sepsis

SIR,—This problem of surgical wound sepsis still seems to be with us even after many years of trying to reduce the numbers of bacteria in the air of operating theatres, and despite great improvement in the sterilisation of instruments and drapes and the use of new and very effective antibiotics. Contamination of wounds should certainly have been reduced, except perhaps in special cases where an obstructed or unprepared colon has to be opened. One is sometimes surprised and distressed to find what should be a clean abdominal wound discharging pus some days after the operation or when the skin stitches are removed. The edges of a well-sutured rectus sheath seem to separate so easily in the presence of infection, resulting in incisional hernia or the breakdown of an inguinal hernia repair.

Your leading article (19 April, p 1063) did not mention the importance of a haematoma or a collection of blood and serum in the deep

region of the wound as being a common source of wound infection. By the time frank pus is discharging the evidence of the haematoma has disappeared. If wounds are carefully looked at daily, evidence of haematoma can be seen early and aspiration or evacuation on removing a skin stitch or two often prevents the development of infection. Antibiotics are effective where there is a blood flow through the tissues but do not reach the centre of a blood clot.

Meticulous haemostasis may be tedious and time consuming but is surely very important in the prophylaxis of surgical wound sepsis.

E E O'MALLEY

London W1N 1AH

Rectal biopsy in the diagnosis of lymphoma

SIR,—I was interested to read the short report by Dr J M Rhodes and others (12 April, p 1043) advocating the early diagnosis of alpha-chain disease by rectal biopsy. The recognition of abnormal lymphoid cells in the rectum does not appear to be confined to patients with pure alpha-chain disease. In a series of 80 patients who presented with non-Hodgkin's lymphoma there was an overall incidence of 24% of cases where probable nodules of tumour were detected in the lamina propria. In a preliminary analysis of the data it was found that by no means all patients were those with advanced disease and in only four of the 18 positive cases was there overt gut disease as a presenting feature. The tissue was processed for immunoperoxidase study rather than immunofluorescence, and in the majority of cases it did not show monoclonal staining. However, the amount and pattern of infiltration was convincing on a morphological basis; and it appears to be a genuine phenomenon that the rectal mucosa may show tumour infiltration in non-Hodgkin's lymphoma, particularly of low-grade malignancy.

ROBERT LEONARD
Oxford Lymphoma Group

Department of Medicine,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

Kidney biopsy

SIR,—We do not disagree with many of the worthy comments (12 April, p 1054) made by your correspondents on our article on kidney biopsy (23 February, p 547). We were not asked to review the subject in depth and we simply described one method which in practice works.

Dr M C Bateson's dogmatic advice—to follow the procedure recommended by the manufacturers—is, however, puzzling. The technique we described is one of the two alternatives given in the instruction leaflet, which does not refer specifically to the kidney but which says that it may be the preferred one for breast biopsy. Presumably he is referring to the method the leaflet advocates for "usual biopsy procedures," in which, after the needle has been inserted with the obturator retracted so that the specimen notch is within the tissue, the cannula is retracted and advanced with the obturator held fixed. This might be relevant to liver biopsy but is not applicable to the kidney. The difference is that the surface of the kidney has to be located by the biopsy needle and if his suggestion is

followed the specimen obtained will probably be perinephric fat. The Menghini needle is unsuitable for the kidney because the weight of its attached saline-containing syringe must increase the risk of laceration of the kidney. We do not have enough information to comment about the relative economics and safety of disposable versus reusable needles but, on the page following Dr Bateson's letter, Dr C E Blogg (p 1055) writes strongly in favour of disposable ones for the different but comparable technique of lumbar puncture. In any case we did say that the reusable Vim-Silverman needle was equally suitable.

Advising the measurement of bleeding time as a screening test, Dr R G Hughes refers to a paper published in 1940, which was many years before percutaneous kidney biopsy was introduced. We have never used the test for this purpose ourselves, and in several hundred biopsies carried out or supervised by one of us (PS) only one patient had a bleed large enough to require blood transfusion, and none has required surgical intervention.

While we fully agree with Dr J R T Gabriel's implication that considerable practice (under supervision) is necessary before one becomes proficient, we are less certain than he is about the need to do "at least two biopsies each month" to maintain competence. In this respect renal biopsy is not all that different from riding a bicycle.

PAUL SHARPSTONE
RICHARD MCGONIGLE

Royal Sussex County Hospital,
Brighton BN2 5BE

Organ donation and the GP record card

SIR,—The recent request by ophthalmologists for more people to donate their corneas, allied to the ongoing discussion about the lack of enough kidneys for the transplant surgeons has highlighted for me an important omission in the present GP record card, and one which does not figure largely in discussions about how the card might be improved. Would it not be a good idea if there were a small but prominent marked space on the front of the card where it could be indicated if the patient has made any organ bequests? Quick action after death is needed, and I wonder how many organs are lost for transplantation because the existence of a bequest is not realised soon enough even by the doctor in attendance. The relevant legal documents are doubtless tucked away somewhere inside the folder; but they may well be overlooked, particularly if the death occurs suddenly or if it is not the patient's own doctor who is called. This situation would be unlikely to occur if there were an appropriate indicator on the outside of the record card. Furthermore, knowledge by the public that such a space is standard on every record card might encourage people to bequeath organs who at present do not do so simply because the matter goes by default.

TOM GLYN JONES
Witney, Oxon OX8 7HQ

Development surveillance at 8 months

SIR,—In Dr H B Valman's article on developmental surveillance at 8 months (12 April, p 1049) the section devoted to examination of vision contains information which I consider to be misleading.

A description of the cover test for the detection of squint is given. It is stated that one eye is covered with a card which is gradually moved away sideways and that if the eye which is being uncovered moves there is a squint. If this is meant to imply that a manifest squint is necessarily present it is incorrect. For even in the absence of a manifest squint an eye may deviate when it is covered and will move to take up fixation when the cover is removed. Such behaviour indicates the presence of a latent squint (heterophoria) and is common and not necessarily of significance. If the presence of a manifest squint is being sought the child is made to fixate an object and each eye is covered in turn. It is to the eye which is not being covered that attention should be given. If this eye has to move to take up fixation when the other is covered then it must have been squinting before. If neither eye moves when the other is covered a manifest squint is almost certainly not present. One may then go on to examine the movements of the eye which is being uncovered to determine if a latent squint is present.

The article then goes on to say that if a squint is seen or suspected any time after 6 months the infant should be seen by an ophthalmologist. This gives the impression, possibly unintended, that a squint seen before this age may safely be ignored. It is true that during the period when the binocular reflexes are being established a squint may sometimes be seen. Such a squint is usually short lasting and the eyes will rapidly become straight again. A permanent squint should never be ignored whatever the age of the infant. It should not be forgotten that a squint is sometimes the result of poor vision due to organic disease in an eye or affecting the visual pathway. A squint may also result from damage to one of the oculomotor nerves by active disease. Such conditions, although uncommon, must be excluded at the earliest opportunity. Delay in diagnosis may even prove to be fatal—for example, if a retinoblastoma is present.

I must therefore urge that any infant with a squint, however young, be referred immediately to an ophthalmologist for examination, including inspection of the fundi after mydriasis.

ROY HARFITT

District Eye Unit,
Sutton Hospital,
Sutton, Surrey SM2 5NF

* * * The impression that a squint seen before the age of 6 months may safely be ignored was unfortunately given because the article dealing with development surveillance at 6 weeks was in the journal of 5 April, which has not appeared owing to the printing strike. This article will, however, be published later.
—ED, *BMJ*.

SIR,—Whereas one has much enjoyed the series by Dr H B Valman on paediatric problems, I fear that his method of hearing testing at 8 months cannot go undiscussed (12 April, p 1051).

The method he describes is in essence the Dr Mary Sheridan technique, and although this can give useful information I feel that methods of testing have moved on since then. To test infants' hearing reliably the baby must be sitting firmly. It is necessary to know the approximate level of intensity of sound used; to pass free-field hearing as normal one expects