Medical Memoranda

The Filigree Operation for Hernia

For a considerable time the filigree operation for hernia has fallen into disrepute in this country, but during the last two or three years one or two British surgeons have become increasingly interested in this method of treatment, and several, though not making use of the actual lattices of silver wire known as filigrees, have nevertheless used sutures of silver or other unabsorbable material in order to repair the damaged inguinal canal.

During the past two years I have had the opportunity of watching the operation performed regularly at the Seamen's Hospital, Greenwich, and have been impressed by the apparent solidity of the repaired canal at the time of operation and also by the first-class results seen in the follow-up clinics there. In spite of this I have been reluctant to adopt the method wholeheartedly because of the great prejudice against it. I decided to discover exactly why the method had been condemned, and, by a combination of both clinical and experimental means, to investigate fully all criticisms directed against it. This would seem to be the only way to determine whether or not such objections really are valid or whether, in point of fact, the dangers and difficulties of this operation have been exaggerated, thus deterring surgeons from making use of what seemed to me to be a method which has a very definite place in the curative treatment of hernia.

After much discussion with my surgical colleagues I have come to the conclusion that the objections to the filigree operation put forward by competent and experienced men may be listed as follows:

1. The operation causes marked immediate post-operative pain, and this persists longer than is usual for cases operated on by other methods.
2. The filigrees move about in their beds when the patient moves his legs or trunk during convalescence.
3. The filigree is capable of movement in the tissues at a later period.
4. A rigid structure such as a silver filigree is apt to cause delayed post-operative pain and limitation of movement in the area in which it is implanted.
5. Secondary haemorrhage may occur from ulceration of blood vessels in the neighbourhood of the metal.
6. Faecal fistulae may be produced owing to the silver coming into contact with the bowel.
7. There is a great liability for the wound to become infected.
8. If the wound becomes infected the surgeon is faced with an exceptionally difficult problem, as the metal cannot come away in small fragments, as can silk, but must be removed *in toto*.
9. It is a bad surgical principle to implant foreign bodies in the tissues.
10. If there is a recurrence of the hernia following this operation its cure is rendered doubtful and very difficult owing to the presence of the previously inserted filigrees.
11. Finally, it has been stated that since hernia is the operation of choice for teaching surgery to beginners, a highly skilled technique such as the implantation of filigrees would render the cure of hernia too difficult a procedure to allow surgeons to use it as a teaching ground for their juniors.

This list of objections could easily be divided into two groups—the one capable of solution by careful clinical study of patients before, during, and after the operation, and the second by animal experimentation in the laboratory.

In the first group may be included the question of post-operative pain, secondary haemorrhage from ulceration of blood vessels in the neighbourhood (in all those cases that I have seen operated on the filigree has been placed in direct contact with the deep epigastric vessels), rigidity of filigrees causing limitation of movement following operation, and the special liability to wound infection. Whether or not the filigrees move in the body at later periods can easily be discovered by a

careful study of stereoscopic skiagrams taken shortly after the operation and again at an interval of weeks, months, or years. During the past few months I have collected many skiagrams which should yield useful information on this point.

In the second group experimental methods would seem to be necessary to determine how readily faecal fistulae are produced should the metal come into contact with the bowel, and might also be expected to shed light on the question of secondary haemorrhage from vessels in the neighbourhood if such lattices were implanted in direct contact with blood vessels and bowel in the experimental animal. The question of limitation of movement after the use of silver lattices could also be solved in this way.

I hope to be able to investigate the dangers of operating for recurrent herniae in a field already containing filigrees by reproducing a similar set of conditions in some small animal, such as a rabbit, and also the difficulties liable to be encountered if removal of filigrees from the tissues should become necessary at a later date.

Though it is true that the use of filigrees can be criticized on the ground that foreign material is being introduced into the tissues, it seems to me strange that this objection carries but little weight when applied to the use of other unabsorbable materials, such as silk, thread, etc., at present employed in so many operative procedures. Therefore it would appear useful to investigate further the relative tissue reactions provoked by introducing such substances as silk, thread, silver, tantalum, etc., into the tissues of the experimental animal. These investigations are at present being undertaken, a number of experimental operations having already been performed. I propose, as soon as the investigation is completed, to give a full account of this work, together with the conclusions reached.

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Primary Lymphogranuloma Inguinale in the Female

In countries where lymphogranuloma inguinale is prevalent the primary lesion is rarely seen in females. The following case in which the lesion developed in a contact under surveillance in this country is therefore of interest.

The husband, a Service man, came for examination one month after exposure to infection in Bombay. Three weeks after intercourse he had noticed stiffness in the right groin when walking, and a painful swelling had appeared there. On examination there was a slight mucoid urethral discharge, and on the right side of the coronal sulcus was a herpetiform vesicle. The right inguinal glands were enlarged, matted together, and fixed to underlying structures and to skin which was otherwise normal. Clinically the case was typical of lymphogranuloma inguinale. The Frei test was negative at this stage, but inclusion bodies were demonstrated in scrapings from the wall of the urethra. Tests for the other venereal diseases were negative.

The wife also was examined on the same day. She had no symptoms and no clinical signs. Five weeks later she returned complaining of swelling in both groins. There were then three small herpetiform vesicles on the lower third of the inner aspect of the right labium minus. A similar lesion was present on the anterior lip of the cervix. Both right and left inguinal glands were enlarged and painful. As in her husband's case, tests for the other venereal diseases were negative, but the Frei test was positive at the end of 72 hours. The genital lesions had also increased in size, though no apparent change in the glands was noted. By the end of ten days the primary lesions had healed spontaneously and the inguinal glands had become smaller. Thereafter she attended for examination every fortnight, and nearly four months after the date of the original diagnosis ulceration with oedema and infiltration of the anterior rectal wall had occurred. Inclusion bodies were demonstrated in scrapings from the rectal ulcers.

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