forward rotation of the *right* ilium on the sacrum, with an apparent lengthening of the *right* leg. In that case again a lift under the short leg would be contraindicated. The correct treatment would be manipulative backward rotation of the right ilium, which will result in equal length of legs and levelling of the sacral top. To decide if a shorter (or longer) leg is due to a backward (or forward) rotation of the ilium the test described by Downing is invaluable. If my memory serves me right it is also mentioned in Menell's book on backache. It has been out of print for years and I do not possess a copy.—I am, etc.,

Bristol.

H. WOHLFELD.

Repair of Indirect Inguinal Hernia

SIR,—Mr. E. S. R. Hughes and Mr. J. T. Fathi (July 17, p. 135) record an interesting observation on the anatomy of the internal ring in cases of indirect inguinal hernia, and the refinement of technique which they introduce is worthy of attention. A sentence in their opening paragraph, however, invites comment. They state, "It is this weakness [at the internal ring] that may account for the high percentage of indirect herniae as well as their early reappearance after operation." This can only be taken to mean that a high proportion of "recurrence" after operations for indirect hernia occur at the internal ring. This appears to have been the case in those operated upon in the Services during the late war, a fact which has coloured much recent writing on the treatment of inguinal hernia.

In twenty years of civilian practice I have encountered my fair share of "recurrent" herniae, and almost without exception a direct hernia has been found in Hesselbach's triangle with no hernia at the internal ring. The discrepancy is possibly accounted for by the observation made in the Service cases that the sac had been left behind or incompletely removed at the first operation.

It is questionable whether a post-operative hernia in Hesselbach's triangle after radical cure of an indirect hernia should properly be called a "recurrence." Though the term is useful in that it reflects the patient's probable view of the matter and that it fastens the responsibility on the surgeon, it is misleading in that it obscures the pathology. The fact that the great majority of acquired inguinal herniae, whether post-operative or otherwise, are *direct* shows that in the absence of a patent processus vaginalis Hesselbach's triangle and not the internal ring is the weak point of the inguinal canal.

The moral surely is that to avoid post-operative hernia attention must be concentrated on reinforcing the medial part of the posterior wall of the canal, and that plastic procedures applied to the site of emergence of the spermatic cord at the internal ring are at most of only secondary importance.

If a relieving cut is made in the internal oblique aponeurosis well above its lower free border and extending well into the rectus sheath, a stitch firmly uniting its medial end to the periosteum of the pubic spine will hold the conjoined tendon down so that it lies practically in apposition with Poupart's ligament. These two structures can then be united by a row of stitches which do not need to be so tight as to cause either undue tension or strangulation of the contained tissue.

The effectiveness of this method in preventing post-operative hernia through Hesselbach's triangle—so called "recurrence"—is such that fascial grafts, darns with silk or nylon, filigrees, and the rest can be reserved for exceptional cases. Failures of the method are, I am sure, due to insufficient exposure of the pubic spine and consequent inadequate placing of the first and all-important stitch.—I am, etc.,

Edgware, Middlesex.

FRANK FORTY.

Penicillin in the Treatment of Neurosyphilis

SIR,—Will you allow me to add a postscript to your leading article on penicillin in the treatment of syphilis (July 17, p. 141), or rather to that paragraph of it which deals with neurosyphilis? Our American colleagues have a larger number of cases to treat than we have in this country, and it seems most likely that the question whether malarial therapy will still be necessary in G.P.I. and allied conditions will be settled by their experience, and their reports are now coming forward so rapidly that our few British accounts are superseded by the time they are published.

In a recent paper by Stokes¹ and his colleagues entitled "Three Years of Penicillin Alone in Neurosyphilis," observations on 321 cases are summarized. These authors continue to take the view (which I am unable to share) that the immediate

clinical improvement with penicillin in cases of paresis is not as great as that with malaria, but among their conclusions are the following:

"Malaria in paresis is superior to penicillin alone in the clinical improvement produced when compared with the first year or two of penicillin responses; but penicillin rapidly overtakes malaria in the second and equals it in the third year of observation. Taking the durability of penicillin effect . . . the comparative simplicity, short duration, and safety of penicillin therapy into account, it begins to look as if penicillin alone were the equal of malaria in paresis. . . . Spinal fluid results . . . are apparently superior with penicillin to those obtained with malaria."

"In tabo-paresis the fluid improvement with penicillin definitely surpasses that obtained with malaria, and the symptomatic improvement with penicillin is equal after the second year: in meningo-vascular neurosyphilis the results are markedly superior serologically and equal clinically. . . ."

Dathner² has recently summarized his observations on 151 patients treated with penicillin alone. Among these were 33 cases of general paresis and 19 cases of tabo-paresis, and they are considered chiefly in relation to the spinal fluid results. In two cases of general paresis the results were regarded as indefinite, but in all the others they were satisfactory in that the spinal fluid syndrome indicated an arrest of the disease process. Dathner is more clear than some other observers that all that can be expected from treatment is the extermination of the infection, and that symptomatic improvement thereafter depends on the recovery of the nervous tissue—a process which we have as yet little power to influence.—I am, etc.,

London, W.1.

J. PURDON MARTIN.

REFERENCES

- ¹ *Amer. J. Syph.*, 1948, **32**, 28.
- ² *Med. Clin. N. Amer.*, 1948, **32**, 707.

Prevention of Venereal Disease

SIR,—There will be no quarrel with the aim of the National Society for the Prevention of Venereal Disease, which, in Lord Horder's words (July 17, p. 171), is "to set the people free from V.D."; but there is no such general agreement as his letter implies, even among the experts, about the methods by which it is likely to be attained. Many would contest his assertion that in the protection of the fighting Services during the war "the enthusiasm of the officer-in-charge" (for preventive measures) was the decisive factor where such "protection" was achieved. Indeed, some medical officers having pressed prophylactic measures by every means at their disposal were driven to the conclusion that by so doing they had not diminished but increased the rate of infection in their units. "Enthusiasm" in this context is inseparable from the assumption that promiscuous sexual behaviour will be the general rule. That assumption, especially when openly avowed by the M.O., is bound to lower the resistance to such behaviour, among young soldiers in particular, and therefore leads to a higher exposure rate.

A good deal of wartime experience indicates that the amount of disease prevented by the "enthusiastic" advocacy of prophylaxis was balanced (some would say was outweighed) by the amount of infection among those who, without the prophylactic policy and its powerful suggestion, would not have incurred the risk of it. To retort that most Service men are promiscuous and that therefore all should be protected is precisely to beg the question; for even if the assertion be true it cannot be known how far the assumption by those in authority that the Service man's promiscuity is simply a fact to be reckoned with and, so to say, provided for is a major cause of the problem. No one should be too dogmatic upon this point. But Lord Horder and those who think with him should give due weight to the results in a number of units of quite different assumptions about the men's standards and conduct, and of the "combined operations" of C.O.s, M.O.s, and padres who tackled the problem in a more constructive and, I venture to affirm, a more enlightened way.

Lord Horder speaks of the "violent prejudice" which the society has to combat. It may be that all the prejudice is not on one side, and that those who insist that V.D. must be viewed as a medical problem and no more are leaving out of account factors which, however imponderable, are in the end decisive. V.D. is not just a medical or even a social problem; it is one