In cases requiring a resection for gangrenous bowel it has been found to be more satisfactory to open the abdomen through a separate paramedian incision rather than attempt resection from below, and the various methods whereby more room is obtained, such as division of the inguinal ligament, are not to be recommended. In the vast majority of cases resection is not required, and the operation can be most successfully completed from the low approach only.

Summary

A series of 120 cases of femoral hernia treated by the low operation have been carefully examined and the recurrence rate found to be 3.3%.

There was no recurrence in the 54 male cases. Heavy work, chronic cough, and the presence of strangulation did not especially predispose to recurrence. Of this series, six cases had previously been operated upon: one of these has since recurred; the other five have remained sound up to date.

Recurrence may take place at any time after operation—in the present investigation from three months to seventeen years—though it is much more likely to recur within the first year.

The clean dissection of the neck of the sac and its high transfixion are of prime importance, and only the sac itself must be included in the ligature. This clean dissection can be adequately performed from the low approach.

The low operation is suitable for almost every case, and gives most satisfactory results.

Even though the inguinal canal was not disturbed, 7% subsequently developed an inguinal hernia on the same side as the previous femoral repair.

Operation should be advised for nearly all cases of femoral hernia, as the results are so good and the low repair is so simple. Remarkably few patients are considered unfit for herniotomy, and the ever-present danger of strangulation is an indication for treating all cases by this surgical procedure.

The high incidence of a Richter hernia is to be noted.

Figures sometimes given stating that the low operation has a high recurrence rate would seem to be quite misleading.

The relationship of inguinal to femoral hernia has been found to differ in some respects from the accepted teaching, notably in the finding that femoral herniae are twice as common as inguinal in women, and that femoral herniae occur only one and a half times as often in women as in men.

In inguinal hernia the percentage of strangulations was only 2.6, whilst in femoral hernia the figure was as high as 25%. The presence of a femoral hernia is therefore potentially almost ten times as dangerous as an inguinal, and whilst a truss is sometimes advisable for the latter it is highly doubtful if it should ever be advised for the former.

I wish to thank Mr. H. Blacow Yates, senior surgeon, the Royal Hospital Unit, Sheffield, under whose care all these cases have been admitted, for his criticism and help in preparation of this paper.

The first of the series of regional courses in health education which the Central Council for Health Education is providing for various professional groups in university centres throughout the country was held in Birmingham on Sept. 13 and 14 for public health nurses, of whom 117 attended as the nominees of 12 local authorities in Hereford, Leicestershire, Shropshire, Stafford, Warwick, and Worcestershire. The course was held in the extra-mural department of Birmingham University, and the six lectures were given by Dr. R. G. Record, Lecturer in Social Medicine ("Personal and Environmental Factors Affecting Health"), Dr. Jean Mackintosh, Reader in Paediatrics and Child Health ("Physical Care of the Child—the Modern Outlook, and Problems of Childhood"), Mr. E. C. Cull, B.Sc., Lecturer in Education and Psychology ("Learning and Teaching") of the staff of Birmingham University, Miss M. Slack, S.R.N., S.C.M., Tutor to the Health Visitors' Training Course, City of Birmingham ("Psychological Needs of the Child"), and Dr. Norman Parfit, Deputy Medical Adviser, the Central Council for Health Education ("Health Education—the Nurse's Part"). Dr. H. P. Newsholme, medical officer of health for the City of Birmingham, took the chair at the opening lecture. A similar course for sanitary inspectors in this area will be held in Birmingham on Nov. 15 and 16.

REPAIR OF FEMORAL HERNIA BY A "POSTAGE STAMP" FASCIAL GRAFT

BY

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The closure of the femoral canal presents a problem which has not yet been solved by the adoption of a standard technique, although numerous methods have been described and have their adherents. As the proportion of femoral to inguinal herniae is about 1 to 15 it is not easy for any individual surgeon to collect a large series and allow an adequate time to elapse before assessing the final results.

The method here described was first performed by me in May, 1938, and has since been employed in 53 cases (51 patients). The principle of the operation is to cut a rectangular section of external oblique aponeurosis, leaving the attachment to Poupart's ligament intact, and then swing it down so that the free margin can be sutured to the periosteum of the pubic ramus. The femoral canal is thus closed by a trap-door of living fascia. The operation can be performed under a regional block with 1% procaine solution, but a spinal or general anaesthetic is preferable.

Technique

1. The incision extends from the midline, outwards for 4 in. (10 cm.), parallel to Poupart's ligament and 1 in. (2.5 cm.) above this structure. It is carried down to the external oblique aponeurosis.
2. Haemostasis is secured and "tetra" cloths are clipped into position.
3. Poupart's ligament is defined and a 3-in. (7.5-cm.) incision made through the external oblique aponeurosis a full inch above the upper border of the ligament.
4. In the male the cord is retracted. The fibres of the conjoint tendon are then divided transversely for 1 in. at the level of the femoral canal.
5. The neck of the sac is defined, the peritoneum opened, the sac dissected out and amputated at its neck.
6. The neck of the sac is closed with fine proofed silk and the original opening in the peritoneum closed.
7. The upper edge of the wound is retracted by a Czerny retractor deeply placed and the lower edge pulled down by two Spencer Wells forceps applied to the lower cut edge of the external oblique. The upper end of the femoral canal is then clearly defined; the coverings of the sac are ligated and usually left *in situ* so as to fill up the canal.
8. A flap, as illustrated, is cut from the lower edge of the external oblique after delineating the points of section with Spencer Wells forceps. It should be a little over 1 in. square according to the size of the femoral canal.
9. The femoral vein is retracted laterally with the forefinger. A very small fully curved steel needle on a holder is made to take a good bite of the periosteum of the pubis at the point where the internal border of the femoral vein lay before it was retracted. The fine proofed-silk sutures are then threaded twice through the free edge of the graft (as in inserting a pin). The double bite prevents the tissue tearing, and a knot is tied in the ligature at this point.
10. Two similar sutures are passed and fixed, one in the middle of the canal and graft and the other at the internal end.

11. When the proximal ends of the ligatures are pulled upon the flap rolls down like a blind to cover the femoral canal opening. The graft is fixed by tying the sutures and tested by the finger to see if a good fit has been obtained with the right degree of tension.

12. The cut edge of the conjoint tendon is then sutured to Poupart's ligament with interrupted silk sutures.

13. The external oblique is closed with interrupted silk sutures. A little ingenuity may be required to close the gap made by the removal of the graft, but it can usually be managed without undue tension or the performance of the relief incision parallel to and above the original cut in the external oblique.

14. The skin is closed with interrupted silkworm sutures.

Patients are taught to do special exercises both before and after operation, and the stitches are removed on the tenth day. They sit out of bed on the second day, walk about on the twelfth day, and go home on the seventeenth day. Light work is allowed four to six weeks after operation and heavy lifting only after a further three months.

The chief danger in the operation is of damage to the femoral vein when passing the first deep suture. The use of a small, strong, trocar-pointed $\frac{1}{2}$ -in. (1.25-cm.) needle is essential. The disadvantages in the operation are the small transverse incision in the conjoint tendon and the gap left in the external oblique, as both may tend to the formation of a direct inguinal hernia. It is important to close the opening in the posterior wall of the canal by carefully placed interrupted silk sutures to prevent a direct inguinal hernia.

Results

There were two recurrences of the femoral hernia, both in men, one of which was an emergency operation for strangulation in a man aged 63.

Four patients died—only one in hospital, a few days after an operation for strangulated hernia in a patient of 78. One patient died two years after operation, and her doctor states that there was no recurrence. The third died eight months after operation from a carcinoma of the lung, and when seen two months before death there was no recurrence. The fourth died at home suddenly, aged 67, cause unknown, a few days after discharge.

Table of Results

	Male	Female	Totals
Incidence:			
Right	12	25	37
Left	4	12	16
Strangulated:			
Right	8	7	15
Left	2	2	4
Bilateral	—	2	2
Recurrent:			
Femoral	1 (s.)	1	2
Direct	1	1	2
Died	2	2	4
(Age at death) ..	(67, 67)	(78, 84)	

Age:—Average over 50; oldest 84, youngest 24. Sex:—Males to females, 1:2. Side:—Right to left, 2:1. Strangulation:—2:5. Pain in scar:—3 (1 male, 2 females). Not traced:—1 female. Follow-up:—Longest 10 years, shortest, 1½ years; all cases were personally seen and/or have replied to questionnaires (February, 1948). Eight cases not included in this report have been operated on since January, 1947.

Summary

An operation for femoral hernia has been described in which the canal is closed by a "postage stamp" graft of living fascia.

Since 1938, 53 operations on 51 patients have been performed and have been followed up for 1½ to 10 years. Only one patient could not be traced.

There were two recurrences of the femoral hernia and two direct inguinal hernia.

Medical Memoranda

Herniorrhaphy Plus Appendicectomy

It is generally agreed that it is a wise procedure to perform incidental appendicectomy during any abdominal operation, provided that the condition of the patient is satisfactory and that no undue prolongation of the incision is called for.

Thus, following a cholecystectomy for gall-stones, it is usually an easy matter to withdraw the caecum and perform appendicectomy, provided that there are no adhesions in the ileocaecal region. Even so, it may be possible to separate frail adhesions digitally. Firmer adhesions commonly indicate previous appendicular inflammation, which increases the desirability of removing the appendix. In such cases extension of the incision is usually justifiable in order to gain access to the pathological organ.

The majority of gynaecologists scrutinize the appendix after a pelvic operation and, if the condition of the patient is satisfactory, perform appendicectomy. The recognized exception to this routine is the presence of raw surfaces or tissue planes such as may result from removal of a tubo-ovarian abscess or a total hysterectomy. In such cases most gynaecologists consider that the release of a few organisms might result in an inflammatory reaction which would not otherwise have occurred. (The introduction of a few millilitres of "mickraform" sulphathiazole suspension would possibly counteract this risk.)

There is one common surgical operation in which incidental appendicectomy can usually be performed without difficulty, but to the best of my knowledge few surgeons avail themselves of the opportunity. I refer to right inguinal herniorrhaphy. After opening the sac and dealing with the contents, unless the neck is unduly narrow, it is often a simple matter to withdraw the caecum and then to remove the appendix. The caecum normally lies just above the internal abdominal ring, and gentle traction with dissecting forceps the serrations of which are covered with rubber tubing usually coaxes the caecum into the sac. If the caecum does not present itself, or is immobilized by adhesions, the manoeuvre must be abandoned, but in more than half of the cases appendicectomy by this route presents no difficulty. Patients who undergo radical repair of a hernia are usually fit enough to withstand a short prolongation of the operation, and they are invariably surprised and delighted to learn subsequently that they have been relieved of an organ which possesses no virtue but only potentialities for mischief.

One very important point: when a patient has undergone incidental appendicectomy it is the duty of the surgeon, the assistant, and the sister in charge to inform him and a responsible relative that the appendix has been removed. Any surgeon of experience will recall patients with abdominal scars who are entirely vague about whether they possess an appendix or not. The complacency with which some patients offer their abdomens as a sacrifice to the surgeon's scalpel is a remarkable tribute of confidence, and they are quite content to wander forth again into the world in complete ignorance of the reason for or the results of surgical intervention.

R. J. McNEILL LOVE, M.S., F.R.C.S.

The Northern Ireland Minister of Health and Local Government, Mr. William Grant, speaking at the annual dinner of the Northern Ireland Branch of the Chartered Institute of Secretaries, said that the number of doctors in the health scheme was 730, while the number of persons on doctors' lists at July 5 was 996,051. This had since increased to approximately 1,250,000, representing 93% of the total population. New acceptance cards were still being received at a steady rate, and the response had been gratifying. The payment now being made to doctors out of the Practitioners' Fund (calculated at the rate of 17s. 6d. a year in respect of 95% of the total population) was £266,627. Payments to dispensing doctors for drug capitation fees totalled £12,481. These were the gross figures before deduction of superannuation contributions.