BRITISH MEDICAL JOURNAL

SATURDAY 24 MAY 1980

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6226 BRITISH MEDICAL JOURNAL 1980 VOLUME 280 1239-1286
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 280 (6226) 1239-1286 (1980)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

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 textbooks[1] 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] Browse NL. *Symptoms and signs of surgical disease.* London: Arnold, 1978.

Awareness in general anaesthesia

SIR,—Tunstall[1] 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 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.

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