

series, removal of an infected suture did not result in loss of the graft or recurrence of the hernia.

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### DISCUSSION

DR. ASHBEL C. WILLIAMS (Jacksonville, Florida): I gave a paper many years ago before this organization at the time I was taken in. The subject was fascial transplants after the method of Dr. Edward Gallie. This was the last paper on the last day of the meeting. As I recall, Dr. Amos Koontz, Joe Hamilton and Calvin Klopp were the only ones considerate enough and loyal enough to stay and listen to it.

At that time I reported 54 inguinal hernias repaired with living fascia after the method of Dr. Gallie. I had talked with Dr. Gallie over the phone and had several letters from him prior to that time and ascertained that he still was completely sold on the method as he had originally presented it. This, I think, was in 1955.

Since that time I have had approximately 50 additional Gallie operations and to my knowledge there have been only three recurrences.

This operation has been done only on patients who had had hernia repairs previously or who had had huge hernias and were in very demanding physical lines of work where they were subjected to all types of stresses and strains.

At the time of the original paper I had followed some patients as long as 12 years postoperatively and quite a few of the original group have departed this earth because of age or other diseases, but only three, that I know of, have had recurrences of their hernia.

I have not been aware of all the erudite things that Erle Peacock has told us about what happens in the cellular compartments, etc., but I feel strongly that this fascial repair is the Cadillac of all hernia repairs.

After a brief experience with tantalum mesh in inguinal hernias, I gave this method up because the repairs were painful and if there was a recurrence the difficulty of correcting it was formidable.

On incisional abdominal hernias I use stainless steel or tantalum mesh and have been very impressed with the effectiveness and durability. I am sure, however, that fascia would do very well in these abdominal hernias, as it does in the groin. But the comfort in the groin of the fascia repair is not comparable with anything that I was able to accomplish with mesh. Some of the repairs encompass such a large area that I feel here that mesh would probably be preferable.

DR. ROBERT ZEPPA (Miami, Florida): When Dr. Peacock speaks, I

always learn something; but I remember calling him about a year ago about a problem with recurrent inguinal hernia. I had first occasion to see this gentleman for his third or fourth hernia repair and discovered that the first three had not been done to Cooper's ligament. So we did a Cooper's ligament repair, and six months later it was back.

That exhausted my therapeutic efficacy, so I called Erle, and he suggested putting in a large fascial autograft through the Cheatle Henry approach, which we did, which lasted six or eight months. On return to this inguinal area, no fascialata could be found, back to the peritoneum.

My question is this: Are there patients who have collagenolytic activity such that the application of fascialata, or other fascias, would be precluded because of their capability of dissolution, rather than the excitation of normal human collagen induced by such a graft? Thank you.

DR. ERLE E. PEACOCK, JR. (Closing discussion): Bob, you always get right to the point. That's one of the things we're studying: Can the graft get the disease, just like a transplanted kidney? Can it get glomerulonephritis and ruin the whole technical procedure?

This is premature for me to answer, though I promise you, within the next few years, enough data, I think, to help answer it. But I will say this now. We have two such patients such as yours. I think the groin situation is an entirely different matter, and collagenolytic activity in the groin is fierce. We have measured it, and it's fierce.

In the two patients in which we got recurrence from a massive graft, we were able to find that graft mechanically dislodged, rolled up, and it was due to the graft moving out of place. I couldn't find any evidence that the graft had actually gotten the disease, like the transversalis fascia did; and that's when we started to put it in like an aeroplane wing, from one lateral pelvic wall to the tip of the sacrum, to the symphysis pubis, across to the other wall, in a preperitoneal approach. But that's another subject.

With your permission, I'd just like to say that you asked just the question, and I promise that we will have some data that will satisfy you, both biochemically and mechanically; but now to say that I just really can't identify a patient who destroys a fascial graft that fast, and yours may be one that I wish was in my series, but we're bound to find one sooner or later like that if we keep looking and studying.