
Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity

How long do patients convalesce after inguinal herniorrhaphy? Current principles and practice

Having had a long-standing special interest in hernia surgery (1), I would like to add my comments to those already made on the article by Robertson *et al.* (*Annals*, January 1993, vol 75, p30) regarding rehabilitation after herniorrhaphy. The topic is of some socioeconomic importance as operations for inguinal hernia are among the commonest carried out all over the world.

In the USA over 1 million are performed annually, of which 10% are for recurrences. Views on timing of return to work and other normal activities are disparate as the article and comments reveal.

My own approach is to tell my patients that they can, with confidence, do whatever they want with immediate effect without jeopardising the success of the operation.

I have held this view and implemented this policy since I abandoned operations based on the Bassini principle of uniting the conjoint tendon to Poupart's ligament in 1968 and introduced primary prosthetic hernioplasty (2,3) using polypropylene mesh, since when I have carried out a personal series of some 700 of these hernia repairs without recurrence.

The essential difference between the Bassini operation and utilising a mesh prosthesis for the primary reconstruction of the inguinal canal for hernia, and which affects attitudes to post-operative rehabilitation and recovery, is that the former is carried out by coapting structures with distortion and under tension, as witnessed the tension-relieving manoeuvres that have been advocated as adjuncts to the Bassini repair such as the Tanner slide, whereas the latter is accomplished without distorting the normal anatomical lie of the structures comprising the inguinal canal with consequent absence of tension. The integrity of the repair in the prosthetic operation does not depend on a protracted healing process but is mechanically sound from the moment the mesh prosthesis is sutured into position and before the patient leaves the operating table. Patients are reassured to this effect.

It is this freedom from distortion and tension in the wounds that explains, in my opinion, the relative comfort of prosthetic hernioplasty patients postoperatively as several of my patients, who have had previous experience of a Bassini operation and who have thus been able to compare, have spontaneously observed.

Finally, patients of mine would not know what constituted the 'gentle sexual intercourse' [sic] allowed by Mr Gilmore (*Annals* 1993, vol 75, p216) in the second postoperative week. I say to all of them, quite simply, go for it, and they do!

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References

- 1 Tinckler LF. Pre-peritoneal prosthetic herniorrhaphy. *Br Med J* 1968; 4: 832.
- 2 Tinckler LF. Pre-peritoneal prosthetic herniorrhaphy. *Postgrad Med J* 1969; 45: 664-7.
- 3 Tinckler LF. *Pre-peritoneal Prosthetic Herniorrhaphy*. A Monograph in the series Advancing with Surgery. Ethicon Ltd., 1972.

Non-woven, disposable theatre gowns for 'high-risk' surgery

I would like to comment on the article by Jones *et al.* (*Annals*, May 1993, vol 75, p154). Risk to surgeons is of great concern in in areas of high HIV prevalence such as sub-Saharan Africa. Unfortunately, the disposable seamless gowns advocated by the authors are unlikely to be readily available in such areas and are likely to be prohibitively expensive.

Much of the risk can be removed by wearing a non-sterile apron under the surgeon's gown for all cases. This protects the trunk and legs. Obstetric gauntlets, which protect the forearm, can be worn for cases where the risk of contamination of the forearm is present.

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Comparative vascular audit using the POSSUM scoring system

I read the above article with interest (*Annals*, May 1993, vol 75, p175).

I would like to draw your attention, and the attention of readers of the *Annals*, to the fact that POSSUM is a computerised database which has been developed in Australia for the diagnosis of multiple malformations in children both with dysmorphic features and intellectual disabilities. The acronym is as follows:

P—Pictures
O—Of
S—Standard
S—Syndromes
U—Unknown
M—Malformations

This product is now being marketed worldwide to 44 countries and a number of systems are also in use in the United Kingdom. For those who are interested, additional details can be obtained by writing to Dr Agnes Bankier, Project Manager, POSSUM Program, The Murdoch Institute for Research into Birth Defects Limited, Royal Children's Hospital, Parkville, Victoria 3052, Australia.

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An improved method for oesophageal intubation

We found it difficult to understand why Bramhall *et al.* (*Annals*, May 1993, vol 75, p189) describe their modified technique for prosthetic intubation of oesophageal malignancy as 'an improvement', when it causes a perforation rate of over 20%, higher than any previously recorded in the literature. This is a high cost for the slight advantages of a possibly shorter procedure and avoiding the use of radiology, though the patients are still subjected to general anaesthetic rather than simple sedation. Even if mortality was not excessive, these perforations increase the hospital stay of these terminally ill patients, which is inadvisable on social and financial grounds.

Controlled introduction of a tube under radiological guidance using a device such as the Nottingham Introducer (1) gives