

VAUGHAN (G.T.) Compliments of the writer.

A NEW OPERATION FOR THE RADICAL  
CURE OF INGUINAL HERNIA.

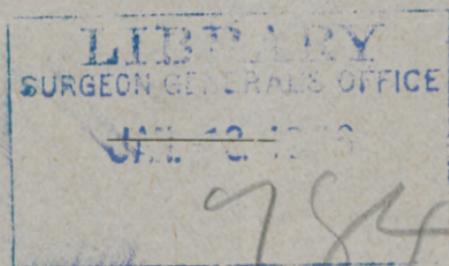
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## A NEW OPERATION FOR THE RADICAL CURE OF INGUINAL HERNIA.

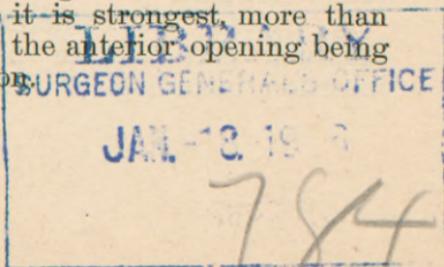
BY GEORGE TULLY VAUGHAN, M.D.

Of the various operations for the radical cure of inguinal hernia, I believe it is generally agreed that those of Bassini and Halsted respectively are the best; as to the choice between these two methods there is some difference of opinion.

Unquestionably the method of Bassini comes nearer to restoring the tissues to their original condition and relations before they were stretched and distorted by the protruding viscus than any other operation now before the profession, and the number of relapses following this operation when carefully done is probably less than from any other.

Halsted's method has the appearance of strengthening a naturally weak place in the abdominal wall by increasing its thickness beneath the cord by the addition of the aponeurosis of the external oblique and some fibers of the internal oblique and transversalis muscles, but he brings the cord straight through the entire thickness of the abdominal wall (except the skin and fascia) at a point slightly higher and more external than the normal position, dividing partially the external, internal, and transversalis muscles in order to do so.

In the operation proposed the normal inguinal canal is obliterated, the cord is placed deep, next the peritoneum and passes through the abdominal wall both obliquely and where it is strongest, more than half the circumference of the anterior opening being formed by bone and tendon.



Another advantage is that the two ends of the inguinal canal are placed nearer on the same level, so that a viscus engaging in the posterior end would not have the same tendency, not being aided by gravity, to descend through the canal, as it does when the anterior opening is lower than the posterior.

Two objections would naturally be suggested to this operation; 1, that division of the muscles forming the conjoined tendon weakens the abdominal wall, and 2, that the new position of the cord may produce constriction and harm the testicle. To the first objection it may be said that with aseptic care and accurate approximation the muscle unites through the medium of muscular tissue not connective tissue. (See Senn, Principles of Surgery 1896, p. 46, and others) and is probably as strong as ever.

So far as I have heard, Halsted has had no trouble from dividing the muscular fibers above the internal ring and relapses from Halsted's operation, judging from my own experience, are owing to the cord being brought straight through the abdominal wall instead of obliquely, and, that this opening is surrounded by yielding muscle unsupported by bone or tendon. In reply to the latter objection I can only say that there has been no interference with the integrity of the testicle in any of my cases. The objection to bringing the cord out over the symphysis pubis in a more exposed position is of no importance.

The operation is performed as follows:

1. Make an incision over the inguinal canal from the internal abdominal ring to the center of the symphysis pubis through the skin and fascia; then split the fibers of the aponeurosis of the external oblique, exposing the cord and hernial sac.

2. Separate the sac from the cord, ligate or sew across well within the internal ring and cut off the redundant part.

3. Divide the conjoined tendon through its muscular part four or five centimeters above its insertion including the internal pillar of the ring,

down to the peritoneum, avoiding the deep epigastric artery.

Separate by blunt dissection the conjoined tendon from the rectus and pyramidalis muscles down to the pubic bone and place the cord in this position between the conjoined tendon and rectus. The cord still passes through an oblique canal at its anterior portion, as the conjoined tendon overlaps the rectus and pyramidalis for two and a half centimeters or more, being inserted in front of these muscles. Unite the divided ends of the conjoined tendon and of the internal pillar with mattress sutures, and accurately approximate them with continuous or interrupted sutures.

4. Close the old inguinal canal with interrupted sutures, uniting Poupart's ligament to the conjoined tendon, and in the outer part including the transversalis fascia over the cord. I usually pass two or three of these sutures through the conjoined tendon to include the edge of the rectus.

5. Unite the superficial structures with a continuous suture and the skin with a subcuticular suture.

Kangaroo tendon is the best suture material to be used throughout the operation. The cord is thus placed next the peritoneum and brought obliquely through the abdominal wall at the strongest point. This operation is more difficult and requires rather more time in its performance than that of Bassini. I have performed it only five times but so far as known the results are all that could be desired. One patient was seen five months after the operation. He had been at work and was then in good condition. The others have not been heard from though they were requested to write to me in case of relapse.







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