

childhood or infancy, which was supposed to have been cured after wearing a truss; while, again, in others there was a history of the occasional appearance of a swelling which either was not present when they were passed for military service or was thought to be too trivial to require treatment. Though I operated on a large number of these cases, certainly several hundred, in many of which the hernia had only been present a few days or weeks, I never once found any bruising or other sign of traumatism. On the other hand, in a few the hernial sac was continuous with the tunica vaginalis, and in some others, a definite fibrous cord could be traced from the lower end of the sac along the spermatic cord to the upper part of the tunica vaginalis. The men were practically all strong and well-developed and otherwise healthy, and I strongly believe, in all these cases, that, though the hernia appeared to have been acquired, the sac was a congenital structure.

It will now be necessary to consider some points of the anatomy of the inguinal canal which explain how it is that this is not such a weak spot in the abdominal wall as at first appears to be the case. The inguinal canal is an oblique intermuscular space, about $1\frac{1}{2}$ inches in length, extending from the internal abdominal ring, which is situated about a finger's breadth above the centre of Poupart's ligament, to the external abdominal ring, situated just above the crest and spine of the pubis. The two rings are not opposite one another, so that the whole canal has a valvular arrangement. The canal is, of course, only a potential space, for it is normally entirely occupied by the spermatic cord. The vas and the other constituents of the cord, which, within the abdomen, are found in the extraperitoneal tissue, pierce, and gain a fascial sheath from, the transversalis fascia at the internal abdominal ring, which is situated immediately beneath the lower, free, arched border of the transversalis muscle. The internal oblique extends lower down than the transversalis, and, at first, is in front of the cord, thus forming part of the anterior or superficial wall of the canal. Its lower fibres, much more strongly arched than those of the transversalis, after crossing in front of the cord and supplying a covering of cremasteric fascia, turn downwards behind it to join the conjoined tendon