the sac. Opening this there was a small amount of fluid found, and the appearance of the strangulated gut, a portion of small intestine, was reassuring. The orthodox method of enlarging the constriction was followed, and it was somewhat difficult to get even the hernia knife into the ring, so tightly was the gut constricted. On freeing the bowel and gently pulling it out to examine the part pressed on in the ring, its contents began to flow into the wound. This was found to come from a rent about one-half inch long in the outer side of the bowel, surrounding which was a zone of gangrenous gut. The remainder of the bowel was apparently fairly healthy. One of three courses was now imperative; 1st, either resect a portion of bowel, using a Murphy button to approximate the divided ends; or, 2nd, stitch the bowel to the wound in groin; or, 3rd, suture the perforation. The latter course was chosen, using silk ligatures with continuous Lembert sutures. To make this secure it was necessary to go well away from the affected portion and turn the latter in. This completed the hernia was returned. It did not seem prudent to attempt special treatment of the ring, as in the event of a failure to repair the perforation the leakage into the abdominal cavity would certainly prove disastrous. A large drainage tube was therefore inserted, the wound closed to its lower angle with silk worm gut, and a dressing of gauze and absorbent cotton, with sheet wadding, (the two latter having been previously baked to insure asepsis) applied and held by a spica bandage. The patient came out of the anesthesia well and there was no subsequent vomiting. Morphia was given to insure quiet. The highest temperature was recorded next day 101°⅘, which quickly fell and thereafter ranged from 99° to 100°⅘. The pulse dropped to 104 within two hours after operation. On changing the dressings in three days there was no pus but a slight discharge on the gauze quite dark in colour. The drainage was not removed until the 5th day, when the discharge was found to be from the sloughing sac. This was easily removed by dressing forceps, and the stitches taken out of the lower part of the wound. Iodoform gauze now replaced the drainage, and on the 7th day the bowels were moved by an enema.

Subsequently the progress was rapid, and only as a safeguard could the patient be induced to remain in bed, which she finally left in three weeks after operation. Since then her bowels have acted in a satisfactory manner. There is no sign of a return of the hernia, and a pad is worn, which will be changed for a truss as soon as the cicatrix permits of pressure.