paralysis of the lower fibres of these muscles, with the result that either a ventral or a right inguinal hernia may develop.

As far as possible the division or injury of the deep epigastric vein is also to be avoided, especially when dealing with peritonitis or abscess, for septic thrombosis of this vessel may then follow and extend to the iliac veins, with disastrous results in the way of thrombosis or embolism.

The wound is made by a clean cut with a knife until the aponeurosis has been divided. Then the muscular fibres are displaced and held aside by smooth retractors. All bleeding is arrested with artery forceps and

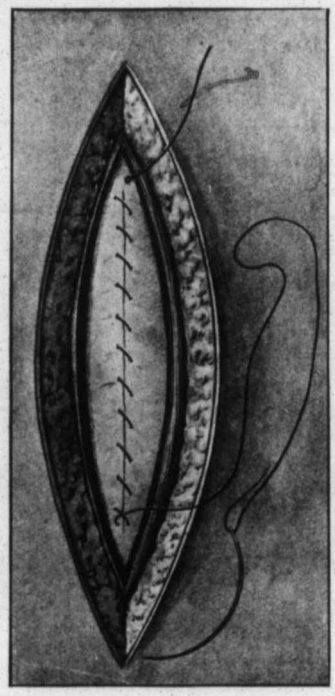

FIG. 4. The peritoneal suture of catgut has been commenced at the upper end of the wound.

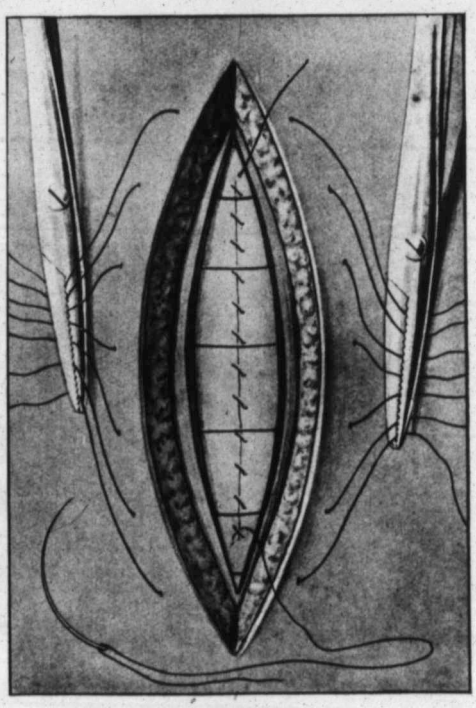

FIG. 5. Interrupted salmon-gut sutures have been inserted. Their ends are clamped while the catgut suture is continued up the anterior wall of the rectus sheath.

catgut ligatures. Then the transversalis fascia and peritoneum are picked up with toothed dissecting forceps and carefully divided either with blunt-pointed scissors or with a knife held sideways. First one and then two fingers are introduced to protect the bowel while the wound is enlarged with blunt-pointed scissors.

In many cases it is important to protect the edges of the wound from infection during the operation, and this can be done by accurately securing sterile pads round the edges with suitable forceps and self-retaining retractors directly the abdomen is opened.

Closing the Wound Accurately. This is of great importance in order to prevent ventral hernia. While both ends of the peritoneal incision are held well up by an assistant with long toothed artery forceps, medium-sized catgut threaded on a curved round needle is used as a