

report of a case which had occurred recently, where the patient was treated for several weeks for idiopathic peritonitis, and an operation done a few hours before death revealed double pyosalpinx and a ruptured ovarian abscess.

In six of the cases reported, an abdominal drainage-tube was used. The average time of convalescence in these cases was no longer than in the cases where a tube was not introduced; and the severity of the symptoms following the operation—the elevation of temperature, the rapidity of pulse, and the pain—were much less marked in the drainage-tube cases than in the others. The absence of pain in the drainage-tube cases was probably in part due to the fact that most of them were cases of pyosalpinx, where the tissues which were ligated and cut were so far degenerated that their sensibility was much diminished. He thought that the danger of abdominal hernia following the use of a drainage-tube had been exaggerated. In one of his cases there was now a small hernia, but it had occurred above the position of the tube and was probably due to some error in introducing the sutures. In some thirty drainage-tube cases which he had seen in the practice of Dr. Joseph Price, there had, as yet, been no hernia. It was probable that hernia was due more frequently to a long or a high incision and careless suturing than to a drainage-tube. The average length of time before the glass drainage-tube was removed in his cases had been about five days, the shortest two days and the longest eight days. In but one case had the discharge from the tube become purulent. The use of a cotton rope to act as a capillary drain added greatly to the value of the glass drainage-tube. It prevented any fluid from remaining in the bottom of the tube, and it removed the deposits of fibrin from the perforations in the glass.

One case was reported at length on account of the interesting phenomena attending the development and the subsidence of the peritonitis, and because it was treated throughout by sulphate of magnesium and rectal injections, and not by opium. And, indeed, he had not found it necessary to use opium in any of the cases reported.—*N. Y. Med. Jour.*

THE RADICAL CURE OF HERNIA.

The change which has taken place in modern surgery as a result of the introduction of antiseptic methods, is nowhere better seen than in the rapidly increasing frequency of operations for the radical cure of hernia and their great apparent success. At the annual meeting of the British Medical Association, held last year in Dublin, a series of interesting papers was read, which have only recently been published in full. (*Brit. Med. Jour.*)

The most important points to be noted are: (a) The treatment of the sac. (b) The treatment of the rings and edges of the canal. (c) The after-treatment as to the employment of pressure by truss or otherwise. Many details which cannot be considered as unimportant must be omitted from a brief summary, and should be studied in the original papers, which were remarkably concise and practical. Strict antiseptic methods were employed in every case.

Dr. Macewen carefully separates the sac from the entire inguinal canal and from the abdominal aspect of the internal ring; fastens a stitch in the fundus, throws the whole sac into a series of folds, transfixing them with the same stitch carried through one after the other up to the ring, threads the free end of the stitch in an eyed needle, and passes it through the abdominal wall an inch above the upper border of the internal ring, the skin at that point being pulled up so that it is not included. While traction is made on that thread, pulling the sac into the ring, so that its distal extremity is furthest backward and upward, the conjoined tendon is pierced by a ligature, so as to leave a loop inside; the lower end of that stitch is then carried through Poupart's ligament from within outward, the upper end through the transversalis, internal and external oblique muscles. Similar stitches may be introduced lower if necessary. The free end of the ligature through the sac is then fastened by passing it several times through the external oblique muscle, and the other stitches are tied, closing the internal ring. Chromicized catgut is used for these sutures, and to unite the skin. A decalcified bone drainage tube is laid in the lower angle of the wound. No truss is used. He states that the principle of the operation may be applied to femoral hernias, but gives no details.

Mr. Banks dissects out the sac, opens it, replaces bowel, ties and cuts away adherent omentum, pulls the sac well down, ligatures it as high in the canal as possible, and removes it. Finally, the pillars of the ring are brought together by two or three silver sutures, which are left in position. In femoral hernia the cleaning and removing of the sac constitute the whole operation. In ventral and umbilical hernia the sac is used as a plug to stop the aperture. He considers "freshening" the edges of the canal with the idea of securing union, to be "utter nonsense." He encourages his patients to wear light trusses afterward.

Mr. Ball isolates the sac completely, twists it on itself four or five times, and transfixes it with two sutures, passed first through one pillar of the ring, then through the sac, and then through the opposite pillar, after this the sac is excised, and the sutures tied over leaden plates. He objects to the subsequent use of a truss.

Mr. Stokes dissects the sac from the elements of