

septic abdominal contents which may be liberated during the operation. To improve the view, and especially to ease the sewing of the deep layers of the wound, it is essential to make the incision in the skin longer than the one in the aponeurosis. The incision in the transversalis fascia and peritoneum is still smaller. Fortunately the length of the skin incision on the abdomen is immaterial, and in very stout people it is an advantage to make the skin incision unusually long so that the fatty layers may fall aside, thus giving a much better access to the deeper parts. As far as possible the muscular fibres of the abdominal wall are not cut across,

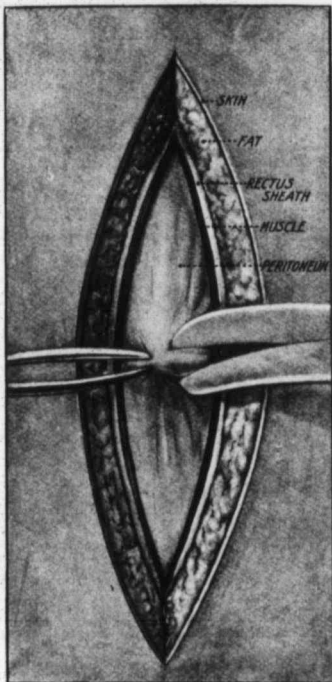


FIG. 2. Dividing the peritoneum, which is held up with toothed forceps.



FIG. 3. Enlarging the peritoneal wound, the fingers protecting the viscera.

but merely separated or drawn aside. This is a valuable safeguard against ventral hernia, especially in the lower part of the abdomen. In the upper part the division of muscular fibres is not so detrimental; for instance, the Kocher incision for gall-bladder surgery, although it divides the fibres of the rectus muscle, is very rarely followed by ventral hernia. Similarly the usual oblique incision in the loin for exposing the kidney is very rarely followed by hernia, and as it also gives a much better view most operators prefer it to any form of muscular separation. For the same reason no nerve fibres are to be unnecessarily cut across. A long vertical incision through the outer part of the rectus may lead to paralysis of this muscle by division of its nerves, and a troublesome form of ventral hernia follows. This is particularly liable to happen when the incision extends low down. Similarly injury to the nerves lying between the flat muscles during the ordinary operation for appendicitis may lead to