except in subjects with much adipose tissue, and such are not frequently affected with tubercular disease.

*The perineal route* receives the support of the best authorities, but various opinions are held as to the form of incision which most favors the exposure of the deeper parts by dissection.

Von Dittel places the patient in the ventral decubitus with thighs hanging over the end of the table, and makes an incision in the middle line from the coccyx to the central point of the perineum, sweeping around the anus and pressing the rectum to one side. (Fig. 2.)

Zuckerkandl's incision, Fig. 1, (*2*), is a semilunar one, commencing at one tuber ischii and reaching the other by a sweep across the perineum in front of the anus. I have employed this incision but found it somewhat disappointing as it confines the operations of the deep dissection to a narrow area bounded by very dense resisting walls.

The incision which seems to give the best satisfaction is that of Roux of Lausanne, Fig. 1, (*1*) who first in 1890 devised and carried out the rational and radical operation of removal of the testicle, vas deferens and vesicula seminalis at one sitting. The incision is about four inches long and a little more than an inch from the middle line on the left side. It passes from the front of the perineum backwards by the side of the anus and ends just behind the level of the coccyx. This incision I have found gives ready access to the vesicles and vasa of both sides; it involves less traumatism, affords good drainage, and presents a wound with good healing properties.

Roux divides his operation into two stages. The testicle with all infiltrated or diseased scrotal tissue is first removed. The vas deferens is isolated from the other elements of the cord, which are ligatured *en masse* and divided. Gentle traction is then made upon the vas, and it is freed by careful dissection of every film of fascia possible. When this is done it will be found possible to draw it from the inguinal canal with great ease. Retracting the skin upwards and outwards as far as possible, the vas is divided obliquely with scissors and its proximal end touched with pure carbolic acid, so as to avoid infecting the wound as it retracts. The scrotal wound is then stitched up, and the patient placed in the lithotomy position for the second stage. The incision above indicated is now made and the wound rapidly deepened. Some hemorrhoidal vessels are cut and may be clamped but do not require ligature. The transverse perineal muscle and artery are too far forward to be in danger, and the internal pudic could only be injured by gross error, but the proximity of the rectum must always be borne in mind, particularly in the deeper part