stout chromic catgut. I cannot understand how surgeons can consider it a complicated operation, and I am sure it is not extremely difficult to perform.

OBJECTIONS.

1. A new ring may not be formed by the suture closing the canal, and the tensity of the transversalis fascia is not completely restored.

2. An hypertrophied spermatic cord is not reduced in size.

3. The suture, closing the canal, passes over the spermatic cord, which, if tied too tightly, endangers the vitality of the testicle, and it cannot be as firmly secured as when the cord is transplanted.

III. McBURNEY'S OPERATION (*Medical Record*, New York, 1889, pp. 35 and 312) is a reproduction of the idea conceived and carried into practice by M. Theophile Anger in 1887 (*Bul. Soc. Chir.*, 1887, p. 664), and also by Schede, of Hamburg. The neck of the sac is ligatured as high up as possible, and the sac cut off. The edges of the skin are sewed to the deep fascia, the wound packed with gauze, and allowed to close by granulation tissue formation.

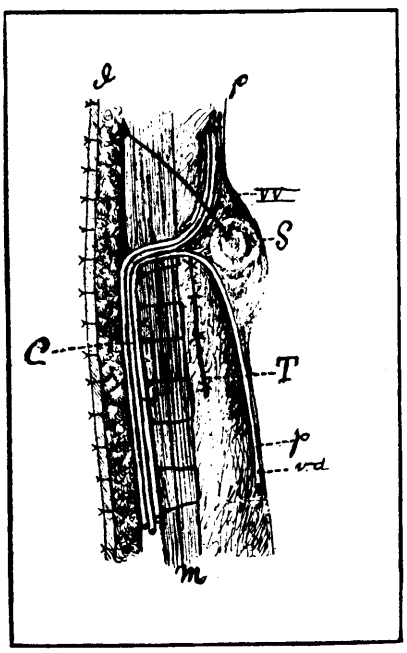

PLATE III.

C.—Cord in its new bed.
I.—Integument and subcutaneous tissues.
M.—Muscular wall sutured.
P.—Peritoneum.
VV.—Veins excised.
S.—Sac folded upon itself and showing the puckering suture.
T.—Transversalis fascia sutured.
VD.—Vas deferens.

OBJECTIONS.

1. The sac is sacrificed.

2. Scar tissue weakens, the older it gets. We are well aware of the changes that time works in all cicatricial tissues, rendering them thinner and softer. Lucas Championniere and M. M. Terrier (*Bul. Soc. Chir.*, 1887, p. 680) are decidedly of the opinion, as are many others, that scars resulting from granulation-tissue are not preferable to those obtained from healing by first intention, with which we agree.

3. The tensity of the transversalis fascia is not restored.

4. The pathological internal ring is not lessened in size.

5. The cord is not reduced when abnormally large.

6. Relapses are becoming more and more frequent.

IV. KOCHER'S OPERATION consists in dissecting out the sac, dragging it through a small incision in the aponeurosis of the external oblique, twisting it vigorously upon itself, strongly pulling it down, and laying it over the surface of the external oblique muscle in the inguinal canal, where it is firmly secured with sutures.

OBJECTIONS.

1. See objections 2, 3, 4, 5 and 6, to Czerny's operation, which stand equally good here.

2. It is not suitable to strangulated, incarcerated, irreducible or congenital hernia. The class of cases which Kocher selects for his operation is inferred from his own words, as follows: "The structures of the spermatic cord are now separated, in which by holding them toward the light, the border of a very thin hernial sac can be recognized." (*Annals of Surgery*, Vol. XVI., No. 6, p. 524.)

3. The results are not the most promising, and in this connection let me again quote from the same article, p. 505, as follows: "When we assume that about one-fifth of our patients are subjected to a second operation for recurrence," etc. Twenty per cent. of relapses does not speak very highly for an operation which does not in-