oblique muscle, Delicate transverse fibers are encountered and severed. The two flaps of the aponeurosis of the external oblique muscle are retracted to each side, so as to expose the contents of the inguinal canal. These structures are now inspected carefully in order to determine whether the operation is to be typic or atypic. When the structures are well defined, and not too much weakened by pressure atrophy, a typic operation can be done.

The sac of the hernia is now opened, preferably at its neck, and is then dissected from the cord and the internal ring from above downward, its contents are inspected, and dealt with properly. If the sac is of congenital origin, it is split in two, the distal half to form a tunic for the testis, and the proximal half being ligated high up or sometimes sutured or an internal pursestring suture thrown around it.

When the omentum is found within the sac and is adherent to it, it is withdrawn, tied *en masse*. cut off, the stump is covered with its own peritoneum, or is rolled beneath and within a fold of omentum and there held by a stitch or two of fine chromic catgut. I have in a number of instances employed Downes' electro-thermic hemostat clamp for the removal of omentum, and I believe it is safer than the ligature. When the omentum is redundant or hypertrophied, its amputation decreases intra-abdominal pressure and lessens the tendency to a return of the hernia. If the omentum is not adherent, it is usually not necessary to remove any portion of it.

When the sac is opened, I have often found it to be advantageous to place the patient in the Trendelenburg position in order to prevent the protrusion of and injury to the intestines and omentum. This position also aids in the closure of the peritoneum, whether by ligature or by suture. The transplantation of the stump of the sac high up underneath the deep muscles, or twisting and suturing it at the internal ring, is a procedure which has nothing special to recommend it. It must be remembered that when a new internal ring is made the stump of the sac is buried beneath the transversalis fascia, which must protrude it into the peritoneal cavity, and at its site a convexity is obtained.

The cord is not disturbed. Raising it out of its bed is without any anatomic reason to recommend it, any physiologic act to suggest it, any etiologic factor in hernia, congenital or acquired, to indicate it, or any result to justify its continuance. Let the cord alone, especially the vas deferens; nor should the veins of the cord be disturbed. If a varicocele complicates the hernia, it is to be dealt with in the usual way, but without ablating the veins in the canal, for that endangers the testicle.