gether a table of 222 cases of gangrenous hernia in which resection of the bowel had been performed, the mortality amounting to 48 per cent., while in a rather larger number, where the surgeon had made an artificial anus, the deaths amounted to 80 per cent. (*Med. Rec.*, Nov. 11th, 1893, p. 621). Zudler, of St. Petersburg, gives a paper of 289 cases in which primary resection was performed, and 287 in which an artificial anus was made. The first group showed a mortality of 49.13 per cent., and the second, 74.22 per cent. As to which method is the better, resection and suture of the bowel or the formation of an artificial anus, the decision must depend upon the local condition of the hernia and the ability of the patient to withstand a prolonged operation under an anæsthetic. In some cases of gangrene, more particularly of the femoral variety only a very small knuckle of intestine is involved, and this, after the formation of an artificial anus, closes frequently without any operation whatever, the gut being simply incised and the wound treated as an abscess, when a small fæcal fistula results and the contents of the bowel take their natural course with trifling danger of death from inattention. Banks strongly recommends that the stricture be not divided in these cases as the abdominal cavity is opened and exposed to infection from the putrid sac. In one of the cases presented, although no operation was ever attempted, nature performed all this for the patient, the small aperture discharging, and most of the intestinal contents passing her anus, and had the patient been admitted to the hospital earlier, or been younger in years, and had better care, I feel quite confident she would have recovered.

In other cases where there is a considerable section of the bowel in the sac where the strangulation has existed for several days, or been unusually acute, the portion at the line of constriction may be completely dead from direct pressure. The bowel beyond, may be gangrenous throughout or only in part; the centre of the coil, directly opposite the mesenteric attachment, is the portion that usually suffers. If the strangulation has been of long duration adhesions will be found inside the constriction, rendering the withdrawal of the bowel extremely difficult, after the stricture has been divided from inflammation and subsequent matting together of the hernial coverings. The intestine above becomes filled with a brownish fluid under going fermentation, and the gut enormously distended with gases, causing paralysis to some extent, and rendering the intestine incapable of recovery, even after the stricture has been relieved. The portion of intestine below the constriction is, on the contrary, decidedly pale and contains as a rule, only mucus. When delay has brought the hernia into this most deplorable condition the general symptoms are those of collapse, the muscular system relaxed, the urinary secretions diminished, the skin cold and moist, the heart feeble and the end not far off. When patients reach this state of exhaustion death is most likely to ensue, whatever line of treatment is adopted, for after three or four days of strangulation the chance of recovery is small. In cases so extreme an artificial anus should be made, having the advantages of a short operation and small amount of technical skill necessary for its performance; the sac should be freely opened up, well washed out with an antiseptic solution, the bowel freely incised, left in position and well-drained, after dusting the parts with iodoform. The weight of authority is in favor of not dividing the stricture for fear of infecting the peritoneal cavity. The experience in case 17 shows that this is not necessary. If one is sure about the limits of the gangrene, if the patient young and in a fairly good condition, and free from peritonitis, resection and suture of the bowel may be undertaken with a fair hope of success. When the operation is decided upon, the question arises whether it is to be effected at the site of the hernia, or through a median abdominal incision. In inguinal hernia the wound can be enlarged and will afford ample space but in the femoral variety the crural ring is so small, that it may be necessary to either divide Ponpart's ligament, or incise the abdomen in the median line. The mesentery is divided a short distance from the intestine and in a parallel line, the gut being controlled by the fingers of an assistant. The continuous Lembert suture is probably the best to employ, using fine silk both for the mesentery and bowel. The excision must be made wide of the gangrene so that the stitches shall lie in healthy tissue and great care taken to avoid infection of the peritoneum from the sac. One great objection to this operation is the time