sections and some experiments on the cadaver which supported my claim regarding the congenitally deficient origin of the internal oblique muscle at Poupart's ligament. Accurate measurements made by me while operating verified the correctness of these findings.

The key to the radical cure of oblique inguinal hernia is suturing of the internal oblique muscle to the inner aspect of Poupart's ligament, as low down as possible, and without undue tension, after having ablated the sac and strengthened the internal ring with a few stitches above the root of the cord. Any operation that diverts the cord from its natural course will favor a return of the hernia, and endangers the integrity of the testis. In my operation I tie off the sac in order to obliterate a pathologic infundibuliform process and to make a new internal ring. The internal oblique muscle is sutured to Poupart's ligament at least two-thirds the way down, for the purpose of rectifying a congenital defect and to allow the muscle to protect the internal ring. The aponeurosis of the external oblique muscle is sutured in its normal position.

When the hernia is a direct one, or when the conjoined tendon is deficient or absent, it is necessary to split the sheath of the rectus muscle and sew the muscle over to Poupart's ligament, across the weak point. If, however, the entire inguinal area is deficient, thinned out or atrophied, I do not hesitate to transplant a portion of the sartorius muscle to this region.

The incision is made over Poupart's ligament, one and a half inches below the anterior superior spinous process of the ilium, extending inward and downward either in a curved or straight manner, circumventing the internal abdominal ring, and terminating over the conjoined tendon near the pubic bone. The vessels are exposed carefully and picked up with forceps before they are severed, thus preventing the staining of the tissues with blood. It is not necessary to cut the superficial circumflex iliac nor the superficial pudic vessels. With a pledget of gauze the skin flap is turned downward and outward over the thigh, bringing into view the aponeurosis of the external oblique muscle, the external abdominal ring, with its pillars and the intercolumnar fascia, the hernial sac, if it has descended through the external ring, the external surface of Poupart's ligament, the under-surface of the flap covered by the deep layer of superficial fascia, and the superficial vessels.

The next step in the operation is the severing of the external abdominal ring and the intercolumnar fascia. The longitudinal fibers of the aponeurosis of the external oblique muscle are separated directly over the inguinal canal, beyond the internal ring, over the surface of the internal abdominal