come a large funnel-shaped cavity, so graphically described by Sir Astley Cooper years ago. The importance, therefore, of restoring the deep ring to as small a size as possible, without damaging the cord, and of obliterating the pathological funnel-shaped depression, is all-important. Macewen was the first to recognize that these two conditions (*a*) the anatomical infundibuliform process, (*b*) the acquired funnel-shaped depression, must be counteracted in order to prevent frequent relapses after operation for the cure of hernia, and this he aimed at doing by making use of the sac as a plug, at the peritoneal aspect of the internal abdominal ring.

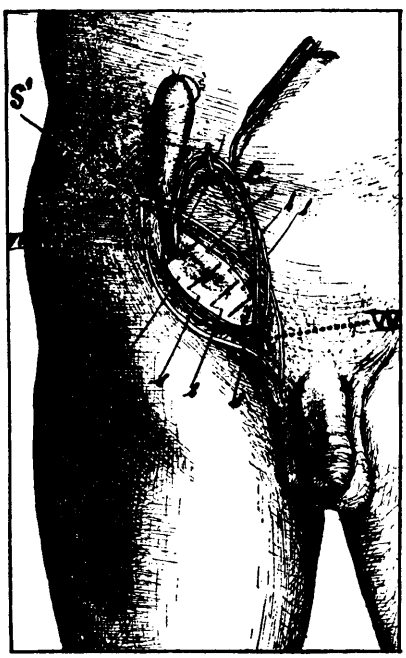

PLATE I.

S.—Sac.
S.—Suture in the sac.
C.—Cord.
W.—Veins excised.
T.—Transversalis fascia showing the deep ring enlarged.
SSSS.—Sutures in T. restoring the internal abdominal ring.

My experiences with Macewen's operation, in all those cases where there was a good-sized sac, and not too large an internal ring, nor an hypertrophied cord present, was all that could be desired. It is valuable to retain the sac, but when it is insignificantly small, and the transversalis fascia (at the deep ring) exceedingly relaxed and low down, it is not sufficient to fill the whole concavity at the seat of rupture. Let me say, however, that a small sac folded upon itself is better than no sac at all, and in support of using it as a tampon, let me here repeat what I have so often said before, that it is not much more liable to become absorbed than a severed tendo-Achilles, because, somewhat like it, its structure is comparatively a passive one, and fully matured white fibrous tissue. It has been my fortune to examine an anatomical preparation in the possession of Prof. Macewen, from a patient cured by his operation, who, without wearing a truss, had done heavy work for years, and then died of an aortic aneurism. The specimen showed the inguinal canal firmly closed, and at the abdominal aspect of the internal ring lay the sac folded upon itself into a dense cushion, which absolutely prevented any chance of a return of the hernia. Macewen stated that the rupture was one of long standing, and the sac very large and composed mainly of mature fibrous tissue. Should the rupture be recent and the sac principally composed of the elastic delicate peritoneum, then we could readily understand the correctness of Bassini's observation, that at an autopsy 95 days after an operation somewhat like Macewen's, not a trace of the tampon could be differentiated. I fancy, however, that the peritoneum must have been somewhat thickened at that situation, although the reparative plastic material had obscured it. That the tampon "must of necessity leave a hard painful swelling slow to disappear," as stated by Marcy, of Boston, has not been my observation in a single instance of a large number of cases.

3. The third condition, a pathological one necessary to counteract, is the overstretched condition of the transversalis fascia behind the spermatic cord, which is easily demonstrated by raising the cord from its bed. Bassini, Halsted, Marcy and others have recognized the importance of restoring the tensity of this strong fascia, and forming a new deep ring by suturing it from below upwards. Whereas Marcy does not, like Halsted and some others, cut through it, I prefer to follow somewhat in his footsteps, as being safer and more secure, particularly with my inversion stitches.

4. The spermatic cord is sometimes increased in bulk, by supernumerary and dilated veins. To Halsted is due the credit of counteracting this pathological condition, by removing all but one or two of the enlarged veins before making a new deep ring. A large cord, carrying a consid-