ing closed. This procedure effected a radical cure of the hernia.

The wound in the parietal layer of peritoneum was closed by catgut sutures, introduced as in the Lembert suture. The abdominal incision was closed with silver sutures, which included all the tissues down to (but not touching) the peritoneum. For the prevention of ventral hernia after laparotomy, it is very important to include the fascia and aponeuroses of the muscles in the silver sutures. A Neuber's bone-drain was inserted. The abscess and sinus were packed with iodoformized gauze.

The operation lasted four hours. The patient rallied well, and was kept quiet with suppositories of opium She was kept on the back, and was not permitted to move body, legs, or arms for ten days. The diet was milk, beef-tea, and whiskey in small quantities.

October 23d, 6 A. M., fourteen hours after operation, temperature 99° F. Patient vomited at 4.30 A. M.

24th.—Pulse 120, temperature 99° to 100°.

25th.—Pulse 100, temperature 99·6°. Patient comfortable. Slept well.

26th.—The pulse and temperature were the same.

27th.—Pulse 80 to 100, temperature 98·4° to 99·6°.

28th.—Pulse 100, temperature 99° to 100°.

29th.—Pulse 100 to 106, temperature 99·2°.

On this the sixth day the silk threads came away under the continuous traction of the elastic ligatures attached to them. The wire sutures were also removed. Wound of incision united throughout. Bowels moved ; stool of normal consistence.

30th.—Pulse 94 to 100, temperature 99·2° to 100·2° F. Bowels moved again ; stool normal. Opium discontinued.

The subsequent history contains nothing of interest. The patient steadily gained her strength. On November 20th she sat up in bed, and on December 3d was walking about the ward. She is now fully restored and attending to her duties. There is no sign of obstruction or interference with the functions of the alimentary canal, and the hernia is at this date radically cured. The great emaciation of the patient at the time of the operation, and the fact that within half an inch of the opening into the abdomen there was a large abscess cavity, may be mentioned as the two conditions which rendered the prognosis grave.

The treatment of strangulated hernia with gangrene of the intestine may be considered under three methods :

1. Establishing a permanent fæcal fistula at the seat of gangrene.

2. Immediate exsection of the gangrenous portion of the gut, reunion at the ends by suture, and return of the loop.

3. Temporary fistula, followed, after an interval of some days, by laparotomy, excision, and suture.

To the first method may be consigned subjects so feeble that no operative procedure is justifiable.

As to whether exsection should be made at once or postponed after a free discharge through the fistula has been established, must be determined by the condition of the individual at the time of operation. If the patient is well nourished, and if the anæsthetic is well borne, it will be advisable to relieve the strangulation, and through the hernial opening draw out the gut until five or six inches of sound intestine above and below the gangrenous spot are in sight, remove the dead portion, and unite the ends at once. This is a much simpler operation than when an additional opening through the abdominal wall is required.

In most cases, however, it will be found that the condition of the patient is not favorable for immediate exsection. Shock is almost always severe, and not infrequently fatal, when the constriction has been so severe or lasted long enough to produce gangrene. In such cases the plan carried out in the case just detailed should be followed.

Finally, the subject of intestinal suture is one of such vast importance, that too much stress can not be laid upon the necessity for a thorough preparation for the operation. In the careful application of this procedure to penetrating wounds of the intestines, to exsection of gangrenous portions of the canal as the result of hernia, volvulus, intussusception, and in the removal of malignant neoplasms and strictures, many lives may be saved which, under the teaching of former years, were left to die without surgical interference. The difficulties of the operation are great, and the time required in exsection dangerously long, unless the surgeon has had sufficient practice to enable him to work rapidly and safely. I would advise those who are willing to undertake this procedure to