

oblique about three-eighths of an inch from its edge, so as to secure a good hold. It is then passed through the periosteum at the point of origin of the pectineus muscle, emerging about one-half an inch from the point of the entrance upon the upper margin of the bone.

This suturing is the most important step of the operation, and upon the care with which it is done depends the entire success of the procedure. If the periosteum and bony attachment of the pectineus are caught well up by the needle, a good hold will be secured upon the structures, and firm and solid attachment of Poupert's ligament in its new position effected. All the sutures are first laid, and after cleansing the parts each is separately and securely tied. As we proceed with the sutures toward the median line we must avoid injury to the deep epigastric artery and vein. Five or six sutures are usually required. (Fig. 6.)

This portion of the technic accomplishes for the femoral canal what suturing of the pillars does for the inguinal canal in the operation for the radical cure of inguinal hernia. To suture the margins of the crural ring to each other, or to Poupert's or Gimbernat's ligament, as in the older operations for the radical cure of femoral hernia, would be analogous to suturing the margins of the external ring in inguinal hernia after ligating the neck of the sac and leaving the latter in the inguinal canal, without attempting to obliterate the canal itself. This, as you can readily see, would be a serious error, and likely to lead to a recurrence.

In order that the closure may be sufficiently solid, it is advisable, although not always necessary, to re-attach the superficial layer of the fascia by means of sutures to the aponeurosis of the external oblique. (Fig. 7.)

The remainder of the wound is now closed. If the superficial fascial structures reflected from the abdominal wall to those of the thigh present themselves with well-marked edges, these may be sutured separately with a continuous catgut sut-

ure. Usually, however, these may be disregarded and the skin-wound closed at once. This may be done by any method which the operator may fancy. To employ drainage is an acknowledgment on the part of the operator that the demands of asepsis have not been fulfilled.

In closing the wound I have derived great satisfaction from the use of the subcuticular suture employed after the Franks-Marcy method. This is applied by catching the skin upon its under surface and about three-sixteenths of an inch from the edge, with a curved needle armed either with silk or linen thread. I employ the latter on account of its smooth surface, which facilitates removal. The direction taken by the needle is parallel with, and at right angles to the skin edge. Care should be exercised not to pass the needle through the entire thickness of the skin, as this would defeat one of the principal objects of this method of applying a suture, namely, the avoidance of the risk of infecting the suture line—an infection likely to follow in cases in which bacteria, impossible of destruction by the ordinary methods of disinfection, exist in the outer layer of the skin.

The stitch is passed back and forth across the gap from one edge of the skin to the other, the loops being drawn taut every two or three turns of the suture, until the wound is closed. Sterilized gauze dressings are applied, and the whole secured in position by a spica bandage. In children, in whom restlessness may disturb the dressings, a plaster-of-Paris spica may be supplied for additional security.

The patient should be kept in the recumbent position for at least fourteen days, at the end of which time some freedom of movement may be permitted in the upright position. The subcuticular suture is removed at the end of ten days by simply drawing on one of the free ends. A spica, with an underlying supporting pad of gauze, may be worn for two or three weeks longer. A truss should not be worn.