ever, not so well known that the sigmoid flexure, with a long or short mesocolon, as it may be, is in its most mobile part below the edge of the pelvis, only mounting above this line when distended into the upper pelvis, and that the descending colon, 6 to 12 cm. long, terminates in the iliac fossa, and is adherent to the iliac wall by the absence of peritoneum over one-fourth to one-eighth of its circumference. The colon on each side, while usually attached as described, may be more movable by reason of a mesocolon of variable length. Hernias, therefore, such as are spoken of in the present article as those of the slipped cæcum and sigmoid, really are hernias involving the ascending or descending colon.

This latter class of hernias—the subperitoneal, the sliding or slipped hernias of the ascending or descending colon—present difficulties of operative reduction which are not yet satisfactorily overcome, and in which my own endeavors, to be soon narrated, are but tentative, and yet need the corroboration of a larger personal experience and, more important, the confirmation of other surgeons.

Treigney, whom I have just quoted, presents sundry other cases of herniated large intestine which bear more closely on the point now in question. They are as follows:

	Inguinal.	Crural.	Total.
Hernias containing cæcum end of ileum, and ascending colon	8	1	9
Hernias containing sigmoid flexure	14	1	15
Hernias containing sigmoid flexure with small intestine	7	..	7
Hernias containing ascending or descending colon	5	..	5
Totals	34	2	36

Of twenty cases in which the ascending or descending colon, alone or accompanied by the cæcum or sigmoid flexure, was involved, a whole sac was found only in seven cases; in five it could not be determined, and in eight the hernia was *par glissement*. This will give some idea of the frequency of this complication. When it is present we have conditions that are prone to bring about such an amount of irreducibility that it demands a special surgical interference, or, if strangulation exists, which is possible, although rare, necessitates the surgeon to relieve only the constriction present and often to forego the intended radical cure of the hernia. The bowels in these instances, in which they have slidden into the hernial sac, are well seen in the diagrams, and are held in position by the connective tissue, which is generally