below as *above* the obstruction, and in such an event we are truly "out of the frying-pan into the fire."

It may be much more brilliant surgery, but it seems more in accord with the dictates of common sence and prudence to postpone surgical interference, either until diagnosis is sure, or until nature has demonstrated that, unaided, she is incapable of correcting the trouble. Billroth has set the example of bold and almost reckless surgery; and in these days of competition and overcrowding, he has plenty of disciples, anxious to gain notoriety by similar boldness; but the teachings of our really great masters, of nature and of experience, clearly indicate that the resort of the knife should be truly a "*dernier ressort*," and that it is always best to give nature a fair show. It is easy enough to *cut*, but it is sometimes extremely difficult to *heal*, and it behooves us to think twice before we cut once. There are certain clearly defined cases of diseased condition, where the knife is the only corrective, and "intestinal obstruction" is not one of them. We will better fulfill our noble mission, if we patiently watch and wait, until nature tells us in unmistakeable terms that her opponent is too powerful for her great energies, and indicates clearly that she requires the assistance of the surgeon's knife, which we cheerfully admit in certain cases, such as tumors, constricting bands, and the like, she does.—*Med. and Surg. Reporter. Phila.*

CONGENITAL INGUINAL HERNIA, COMPLICATED WITH UNDESCENDED TESTICLE.

Dr. F. N. Otis related the following case in the New York Medical and Surgical Society (*N. Y. Med. Jour.*): Not long since, a farmer, about thirty-five years old had been sent to him by Dr. Fanning, of Stony Brook, Long Island, complaining of great difficulty in wearing a truss for inguinal hernia. The trouble was found to result from the presence of an undescended testicle. He stated that, from infancy, there had been a slight swelling in the inguinal region. But little was done for it until he was twelve years old, when a physician discovered that it was a hernia, and, reducing it easily, applied a truss. This caused a good deal of pain, and it was then found, on closer examination, that there was only one testicle in the scrotum. The other one was discovered just below the external ring, and was movable, but it was not situated low enough, and could not be pushed up high enough to allow of the use of a truss without pain. The hernia was of considerable size.

When the man consulted Dr. Otis, November, 13, 1883, he was considerably reduced and had an expression denoting habitual suffering. He said he had tried various kind of trusses, but they all produced intolerable pain if worn continuously for more than a few hours. The hernia always protruded to the size of a hen's egg on the slightest departure from the horizontal position but it was readily reduced, the ring being very large. The testicle was found lying on the aponeurosis of the external oblique muscle, between it and the superficial fascia, and movable, from an apparent point of attachment at the border of the external ring, nearly three inches downward—to just within the scrotum, and upward to a point opposite the anterior superior spine of the ilium. It was somewhat atrophied, being about an inch by three quarters of an inch in its diameters, and quite sensitive on pressure. The patient was very desirous of having it removed and the hernial opening closed at the same operation. He had been married several years, and his only child was three years old.

Dr. Otis believed that the testicle was of little use, and that it would be entirely proper and safe to remove it, as it apparently had no direct connection with the peritonæum. He was not so much inclined to operate on the hernia at the same time, however, and he asked that Dr. Markoe be called in consultation. Dr. Markoe agreed with him entirely. Rather more than three weeks ago he removed the testicle. It was pushed up as high as possible, and outward toward the border of the ilium. On cutting through the skin and the superficial fascia, the testicle protruded with its coverings. The cord was readliy drawn out to the extent of about two inches and a half, and was secured while excision was performed. The vessels, evidently considerably atrophied, were then tied. There was but little hæmorrhage. The wound was sponged with a solution of bichloride of mercury (1 to 1,000), and a carbolized-gauze compress and a spica bandage were applied. The patient had been subject to attacks of vomiting at times, and on such occasions he had been unable to retain the hernia within the abdomen by any means. He vomited a good deal after coming out from the effects of the ether, considerable pain was complained of, and, on removing the bandages, the hernia was found to have descended. It was easily reduced, the compress was replaced, and the patient did well.

PLASTER DRESSING FOR MOVEABLE FRACTURES.

I have read with much interest the concise and instructive article by Prof. Walker, of Detroit, on the use of plaster-of-paris as a dressing for surgical purposes. In a conversation with my friend, Prof. Dawson, of Cincinnati, last summer, he described to me a dressing for fractures occurring at or near the shoulder joint, in which the plaster on strips of muslin of variable lengths, was laid on and over the injured part, strip at a time, making a dressing