there is no danger of the suture slipping and the parts separating as the second turn is being made. A second Lembert suture should now be inserted on the other side of the mesenteric attachment, and an *intermediate* suture passed between these, through the substance of the mesentery and down into the strip of intestine which here is uncovered by peritoneum. Extra care must be taken to see that this part of each end of the cylinder is in perfect coaptation. The sutures are now inserted for the remainder of the apposing surfaces. The Lembert and intermediate sutures alternate through the entire circumference, and should be one-eighth of an inch apart. The mucous or Czerny sutures

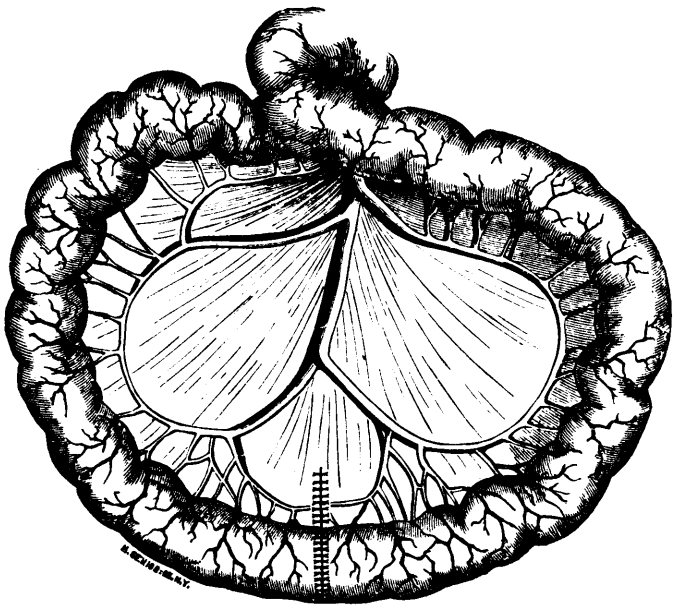

FIG. 6.—Showing the line of sutures in the mesentery and around the intestine.

should be from one-fourth to three-eighths of an inch apart. The relative proportion of these sutures is shown in Fig. 6. It is evident that while the Czerny suture is tied, leaving the knot within the cavity of the intestine for the first part of the operation, the last few threads must be tied leaving the knot imbedded between the mucous and muscular layers of the wall. In applying the sutures the plan followed was first a Czerny, then a Lembert about over this, next an intermediate, another Lembert, and after this a second Czerny suture, and so on. In other words, it was necessary to insert the mucous suture before the superficial sutures had quite reached that point.

All of these threads should be cut off close to the knot.

In this operation I had to leave the space between the sutures on the upper end of the gut a little wider than on the lower, for the diameter of the efferent tube was considerably smaller than that of the afferent portion. The intervening space was a flush one-eighth of an inch on one side and a scant one-eighth of an inch on the other. When the sutures were all in, the constricting tapes were removed. The gut immediately filled with gas. To the surprise of all present, the intestine below the line of suture instantly expanded to a size equal to that of the portion above the line of union. That the wound was tightly closed was demonstrated by forcing the contents of the intestine from opposite directions towards the sutures. No gas escaped.

The appearance after the tapes were removed is shown in Fig. 6. At intervals of about five minutes during the operation, a small quantity of warm Thiersch solution was poured over the exposed intestine. The warm Thiersch towels upon which it rested were changed every ten or fifteen minutes. No fluid was allowed to get into the abdominal cavity. Finally, the intestine was carefully washed with this solution, and returned into the cavity of the peritoneum.

It was now necessary to deal with the ring of intestine which occupied the femoral opening, and which led from the abscess into the abdominal cavity. Two strong silk threads were passed entirely through the opposing walls of this rim of intestine and tied so as to bring the edges well together. I then passed a silver probe from the hernial abscess cavity up through the femoral canal, and through the ring of adhering intestine between the two silk threads, until the end of the probe projected a half-inch into the cavity of the abdomen. The ends of both threads were tied to the probe, and this withdrawn, bringing the sutures out through the saphenous opening. By making strong and continuous traction on these, the mucous membrane was averted, the peritoneal surfaces brought in contact, and the femoral open-