her calomel grs. x, tr. belladonna, m. x, every two hours with nothing else by mouth, except sufficient water to get the dose down, stimulants and nutrient enemata being administered by rectum. She took eight doses before any effect; having vomited first dose, she had seventy grs. of calomel, and seventy minims of tr. belladonna in her stomach before bowels moved. After this they moved pretty freely for a time, but she made an excellent recovery; she continued to be troubled with flatulence, however. I have not seen her since she left hospital, but had a letter from her last winter stating that she had been quite well since, except a small lump in line of wound which, from description, I have no doubt is a ventral hernia.

Whether the neglect to wear an abdominal supporter in all cases for several months after operation, is of much importance as a cause, is a question of dispute. Most operators think it important. Wylie, however, thinks if proper union of wound is obtained, it is not necessary to wear an abdominal supporter after.

The symptoms from which ventral hernia cases suffer, are principally disturbances of digestive and nervous systems. Both strangulation and rupture may occur. Eddebohls, in a paper referred to, mentions five cases where death followed operation for relief of strangulated ventral hernia, and two other cases where recovery followed such operation. He also mentions three cases of rupture, so that the possibility of strangulation, though not great, should not be lost sight of.

In the treatment of cases, I think that if the hernia can be replaced, and kept in place by an easily-fitting truss, this, the palliative treatment, may be adopted. Where it cannot be kept in place in this way, or where the patient, from any cause, prefers operation to a truss, it should be operated on for radical cure.

With regard to method of operating in my case, I do not claim anything original with myself in the operation. When with Mr. Tait, last year, I saw him operate in this way, except that he united skin with continuous silk suture instead of silk-worm gut. In every other particular the steps in operation were the same. So far as I know, this method of flap-splitting for ventral hernia, and bringing flaps together with buried silk-worm gut sutures, and closing the wound without drainage, is original with Tait.

I think the results are more satisfactory, recurrence being almost an impossibility after an operation done in this way than from any other method. Whether the sac should be opened or an extra-peritoneal operation performed as advocated by Eddebohls, will depend on whether the sac can be easily separated from its coverings or not. In the majority of cases I think it cannot. If the skin cicatrix is not spread out much, it need not be dissected out. After opening sac it is not necessary to break up all adhesions of contents, but just enough to get mass back into cavity. If the operation is performed aseptically, and precautions taken that nothing is left in wound to interfere with primary union, there will be no necessity for drainage, and the buried sutures will never cause any trouble.

Mr. Tait has operated for the radical cure of ventral hernia many times with no deaths, and without a single instance of recurrence of the hernia. In nearly every case he opens the sac. He never uses drainage of any kind, and considers the operation for the radical cure of ventral hernia an operation attended with scarcely any risk.

OCULAR PARALYSES FROM BASAL LESIONS—REPORTS OF CASES.*

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CASE I.—J. A., æt. 56, builder, referred by Dr. Clarke, Jan., 1892, suffering from convergent strabismus. He presented the following history, for which I am indebted to Dr. Clarke:

"On the 20th of Feb., 1891, when coming out of an office door, he slipped on an icy step, falling ten to twelve feet, and alighting on the back of his head. When picked up was in full possession of all his faculties, but bleeding from the right ear and the nose. The bleeding was very profuse, a trustworthy bystander thought he must have bled a gallon. Bleeding continued in smaller quantity for three or four days, then gave place to a watery discharge, not copious, which lasted only a day or two. Headache and vomiting set in a few hours later,

*Read at the Ont. Medical Association, June, 1892.