abdomen and fastened there so as to form a prominence on the internal aspect of the peritoneal cavity, which in the most efficient manner possible plugs the femoral canal from within outward with the most desirable material.

Macewen completed the operation by stitching the falciform process to Gimbernat's ligament, thus restoring the valve-like condition of these parts in their natural relationship.

Dr. Cushing closed the femoral ring with a quilted suture, fastening the pubic portion of the fascia lata, covering the pectinous muscle, to Poupart's ligament, before closing the saphenous opening after Macewen's method. This, to my mind, counteracts all the pathological conditions presented in the vast majority of femoral herniæ, and a radical cure is effected.

I close the canal with three inversion sutures (Plate V, Fig. 1), seizing hold of the pubic fascia close to the bone, and then grasping the ligament of Poupart from above downward, which, when tied, recede the falciform process behind them into the canal on a level with the deep crural arch. In this position, the external structures are closed upon the boss within. When the sac is small and slender, and Poupart's ligament cannot be brought down sufficiently close to the pectineal fascia to effectually obliterate the femoral canal, there need be no hesitation in raising a periosteal flap from the pubic bone, sewing it with quilt sutures to the deep crural arch (Plate V, Fig. 2), and then fasten the falciform process beneath it, as already described. I have raised the periosteal covering only in one case, but it admirably suited it, and a most satisfactory result was obtained.

Dr. W. Watson Cheyne (*Lancet*, London, 1892, p. 1039) described a new method for operating for femoral hernia. The sac was ligatured and cut off, and a flap from the pectinous muscle (taking its whole thickness) was raised and sutured into the femoral canal as an external tampon. It is hard to see the philosophy of cutting off a sac which can be readily, safely and efficiently utilized as a plug, being already fibrous tissue, and raising a mass of muscular tissue which in time becomes converted into fibrous material. Should the sac be too small, and the canal large, no doubt Cheyne's flap would be a great help to prevent relapses.

Dr. Josef Fabricius (*Centralblatt für Chirurgie*, Feb. 10, 1894) recommends to ligate the sac and cut it off; freely expose the crural canal by division of the superficial layer of deep fascia and removal of loose cellular tissue; the internal attachment of Poupart's ligament is divided, thus relaxing it, and it is then stitched to the pectineal fascia, the origin of the pectineal muscle, and to the periosteum of the horizontal ramus of the pubes. The first stitch is applied next to the femoral vessels, which have been held by a blunt hook toward the ileo-pectineal eminence, and this stitch prevents them from returning to their normal position. The author also recommends to stitch the superficial layer of deep fascia to the pectineal fascia along the femoral vein. The objections to this operation are (1) the removal of the sac; (2) the division of Poupart's ligament, and (3) the permanent displacement of the vessels (if such is possible), which would have a tendency to produce a varicocele of the femoral vein.

Bassini (*Arch. für Klin. Chir.*, Bd. 47) has given his method of operating on femoral hernia. It consists in removing the sac and then using two rows of sutures, one fastening Poupart's ligament to the pectineal fascia to close the femoral canal, and the other securing the falciform ligament to the pectineal fascia.

Let me recapitulate the steps of the operative procedure I recommend for the radical cure of femoral hernia.

I. The skin incision is made parallel to Poupart's ligament, and half an inch above it. This allows one to reach the neck of the hernia with ease and accuracy; the scar will be out of reach of the pressure or friction of the thigh, and it allows of an examination of the inguinal canal and rings, which is important.

II. The sac is dissected from the surrounding structures and opened, unless by feeling you are certain that it is empty. As a rule it is better to open the sac, and should omentum be found, it is tied with interlocking ligatures and cut away. The raw stump left should be covered with peritoneum before returning it into the abdomen.

III. The sac is now folded upon itself and fastened within the opening of the crural canal (Macewen). The whole sac is better than the stump of one, or no sac at all. It should not be ligatured round its neck and then retained, as is the practice of some surgeons, because its nutri-