without first submitting to tentative exposures. The tube should be as near the tumorous area as possible, the distance of the tubal wall from the skin never exceeding two inches. After there is a slight erythematous reaction within the immediate vicinity of the growth, the distance is increased at the next exposure, so that the rays gradually reach a larger area. When this wider field also becomes erythematous, the irradiation must be stopped for a few days until it shows signs of disappearing. If the skin is concerned, soft tubes must be employed, but deeper infiltration requires tubes of medium hardness. With our present means, powerful and long irradiation is a necessity, and this, unfortunately, entails the provocation of the dermatitis. Whenever a dermatitis has appeared in the author's experience, the size of the growth has diminished, edema and pain have decreased and the general condition of the patient has improved.—*N. Y. Med. Rec.*

THE RADICAL CURE OF INGUINAL HERNIA WITH LOCAL ANESTHESIA.

J. A. Bodine, New York, advocates the more general use of local anesthesia in the radical cure of inguinal hernia since the danger in herniotomy is represented very often alone by the danger of general narcosis. He briefly reports a series of forty-eight cases of radical operation without general anesthesia. In all the cases, muriate of cocaine was used as a local anesthetic, and in no instance was one-half of one grain of the drug exceeded. The anatomy involved in the operation makes herniotomy peculiarly well adapted to local anesthesia. The operative area is superficial, ligation of a bleeding point is scarcely ever demanded, intraperitoneal or visceral work, if needed, is of short duration, and of the most importance, the sensation of the entire field of work is presided over by three nerve trunks, which are superficially placed and easily found. These three are the hypogastric branch of the iliohypogastric, inguinal branch of the ilioinguinal, and the genital branch of the genito crural. The largest, most constant and easiest found is the iliohypogastric, which runs from the iliac crest inward, just beneath the aponeurosis of the external oblique muscle. If it is large, one or both of the other two may be absent, and a little time should be spent in their search. If the first nerve is found