

along the edge of the overlapping structures. To complete the operation, the cord is laid on the external surface of the external oblique muscle, and the skin sutured over it with a continuous buried suture (Halsted), or in the ordinary manner.

I have only operated after this method for about a year, and sufficient time has not elapsed to speak of results; but the combination operation (as I call it) should commend itself, in that it is based on anatomical and pathological facts, and upon the results of other operations. It utilizes the sac for a purpose; tightens up the transversalis fascia, and makes a new ring for good reasons; it reduces the size of the spermatic cord when it is redundant; it makes the best use of the aponeuroses to thicken and strengthen the abdominal parietes; and it is suitable to every degree and form of oblique inguinal hernia, from bubonocoele to a complete scrotal, even incarcerated or strangulated.

Should the hernia be congenital, the enlarged tunica vaginalis testis is divided into two parts obliquely from below upward to a point where separation of the serous membrane from the cord is most easily effected, and each half closed by itself—the one forms a neat tunic for the testicle, and the other half a sac to be used as a tampon (Plate IV). The operation is now proceeded with as already described.

Plate III. schematically represents a longitudinal section of the completed operation.

THE RADICAL CURE OF FEMORAL HERNIA.

The radical cure of femoral hernia has not engrossed the attention of surgeons to the same extent as have operations for the inguinal variety. This may be partly because the material is not so abundant, and owing to the belief of the operation being more difficult to perform. Even our most recent text-book, "An American Text-Book of Surgery," takes no notice of the radical cure of femoral hernia.

The crural rupture is much more liable to become strangulated than is the inguinal. It is not uncommon to find it

"strangulated at the time of its first descent," which fact alone calls for more consideration of this affliction.

Sir Astley Cooper dissected out the sac and closed the femoral ring by sutures. Mitchell Banks places a ligature around the neck of the sac and then cuts it away, but no attempt is made to close the canal. Ball and Heuston twisted the sac, ligated its neck and cut it away, and closed the femoral canal with sutures. Barker removes the sac after ligating the neck. The stump of the sac is pushed under the femoral arch and the canal closed with sutures which grasp the pubic portion of the fascia lata and Poupart's ligament. Marcy cuts the sac off below a ligature, and closes the canal by sutures of kangaroo tendon. McBurney used the open method: the sac ligated, cut away, and the wound packed with iodoform gauze. Macewen, of Glasgow, used his unique method, which has not yet been surpassed, especially with the slight modifications recommended by Cushing, of Boston, and others who have followed in his footsteps. The sac is saved, folded upon itself with a puckering suture pushed within the

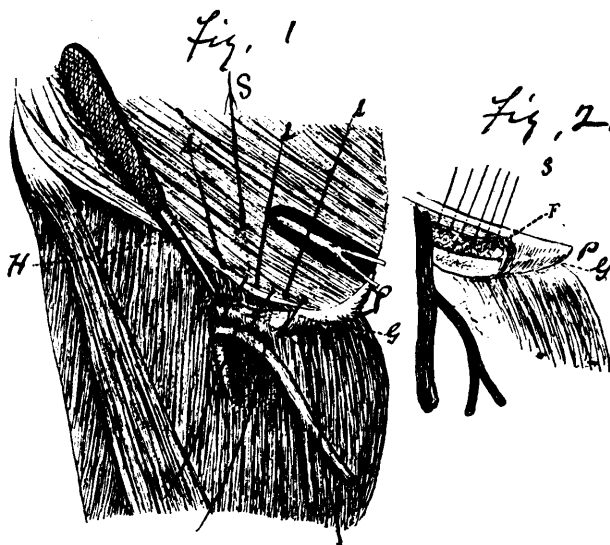


PLATE V.

FIG. 1.

H.—Blunt Hook raising the falciform ligament.
S.—Suture holding the puckered sac in situ.
SSS.—Sutures inserted into the pectineal fascia and Poupart's ligament.
P.—Pubic bone.
G.—Gimbernot's ligament.

FIG. 2.

F.—Periosteal flap.
S.—Sutures uniting F with Poupart's ligament.