of Strasburg, on one occasion, removed six and a half feet successfully. The question arises, does the resection and suturing of the gut in gangrenous hernia present any advantages over attempting the formation of an artificial anus. Billroth, Dittel, Bergman and other German surgeons favor the latter course, but the writer in the *Medical News* thinks that those who resort to the operation of resection follow the proper course. If successful, the recovery is absolute; if it fails, and the patient survives with an artificial anus or fœcal fistula, his condition is not worse than if the operation had not been practised.

Dr. Porter reports a case (*Boston Med. & Surg. Journal*, May 15, 1884) where he excised a portion of intestine, including part of the ileo-cæcal valve, for the cure of a fœcal fistula. The patient had a right inguinal hernia at the age of eight years, and a similar condition at a later period developed on the left side. Three years previous to her admission to hospital, the hernia of the right side became strangulated, an operation was performed, a portion of intestine sloughed, and an artificial anus was formed in the right groin. Twelve days previous to entrance the hernia in left side became strangulated, and was relieved by operation. The resulting wound, which brought her to the hospital, was healed in two weeks, and then an operation for the closure of the fistula in right side was performed, which was unsuccessful. At the woman's earnest request, Dr. Porter operated for radical cure on Jan. 11, 1884. At that time the woman had two fæcal fistulæ, one above the other, in the right groin; these communicated. They were united by an incision which divided the lower margin of the abdominal ring and laid open the hernial sac; the incision was then prolonged, and exposed the whole sac, making a wound four inches long. The two fistulous openings in the intestine were an inch apart, and were connected by a cut made in a director. The opening in the bowel was then seen to be in the ileum and cæcum, just at their union. The finger could be easily passed into the large intestine, but not into the small, owing to cicatricial contraction involving the ileo-cæcal valve, the opening being only the size of a lead pencil. A dilator was used to enlarge the opening,