

knees. This was a hernial protrusion, containing readily reducible intestine and omentum. The mouth of the sac, measuring about 6 inches in diameter, was situated a little below the level of the antero-superior spines of the ilium. The coverings of the hernia consisted of attenuated skin and muscle, which, after reduction of the contents of the sac, formed large dependent folds. There were also two inguinal hernie—a large one on the left side, which necessitated the wearing of a truss, and a smaller one in the right groin, which came down only after reduction of the ventral hernia. The large central swelling had existed for about three years. It had first increased in size slowly; but after a time, in consequence of violent muscular exertion, suddenly enlarged, and subsequently continued to descend with greater rapidity. The patient could not tolerate the pressure of a truss on this hernia, which, as it increased in size, became more and more irksome. The frequently-renewed contact of urine and fecal matter caused a painful and obstinate excoriation of the skin on the lateral and posterior surfaces of the swelling, which, together with the weight of the hernia and its protrusion between the thighs, led the patient to seek urgently for surgical relief. After reduction of the contents of the hernia, a long incision, which exposed the interior of the sac, was carried through the abdominal wall from above, downwards, and inwards as far as the greater labium on the right side. The thick and strong peritoneal wall of the sac was then dissected away from the superjacent soft parts, during which stage of the operation the intestines were retained within the abdomen, and guarded by a large pad of antiseptic gauze. The dissection was carried as far as the mouth of the sac, and the portion of peritonium forming the neck then constricted by silver wire. After this the body of the sac was excised, and the free margins of the stump were brought together by catgut sutures. It was found impossible to bring together the thin fibrous and muscular margins of the opening in the abdominal wall. The surrounding structures, however, and the edges of the wound on the skin, were closely applied by numerous sutures. During the first three days after the operation the patient suffered much from frequent vomiting, with obstinate constipation, which excited a suspicion of intestinal obstruction. Those disquieting symptoms ceased after the administration of a copious enema; and the patient subsequently made a good and uninterrupted recovery. The wound healed by primary intention, and when the woman was last seen by the author, twelve months later, there was complete freedom from ventral hernia, and an absence of any protrusion, even on coughing, at the seat of the operation.—*Current Med. Lit.*

A SUBSTITUTE FOR DECALCIFIED BONE IN SENN'S DISCS.

Baracz (*Centralbl. fur Chir.*, No. 23, 1892) states that in experimenting with Senn's discs, the idea struck him that decalcified bone might be replaced by some other and more readily available material, which could be used by the practical surgeon without much preparation, and, consequently, with less trouble. After trials of numerous edible vegetables, such as potatoes, turnips, and carrots, from which sections of firm, flexible and moist discs can be obtained, the author found that the most suitable substance for his purpose was afforded by the Swedish turnip. Sections of this vegetable, it is stated, form a reliable material for use in gastro-enterostomy, and in establishing intestinal anastomosis, and one which can be more readily obtained and prepared than decalcified bone. That sections of fresh turnip present a trustworthy substitute for decalcified bone is shown by the results of the author's experiments on animals, and also by the success of an operation for gastro-enterostomy which he performed on the human subject early in May. The results of this operation, which was performed for the relief of carcinoma of the pylorus, had, up to the date of the publication of this paper, been very favorable.—*Current Med. Lit.*

IS THERE ANYTHING NEW UNDER THE SUN?

Was Cyrus acquainted with bacteriology? If not, how did he learn to boil his water? Herodotus, in his First Book, chapter 188, tells us that "Cyrus went up to battle, richly provided with goods and cattle from his own land, and he also took with him the water of Choaspus which flows by Susa. And the King had this water served at table, and no other, which was *boiled*; it was transported in silver vessels, borne on a four-wheeled carriage and drawn by mules." On his march Cyrus must have passed through many districts where little or no water could be obtained on his way to Capdus, and this would of course necessitate his carrying supplies on long marches. From the context we are informed that it was the custom to boil the river waters in Babylon before using them. Did instinct, experience or scientific knowledge prompt the Babylonians to sterilize drinking water 550 years before the birth of Christ? It is a pity the classics are now falling into such disfavor as a part of the medical student's training or some further light might be shed over the enzyme theory by the mature experience of our forefathers, though viewed by man as a *parva non bene selecta*.—*Medical Press.*