improbable that the abdominal wall could be made strong enough to resist the pressure of the prolapsed intestines, therefore, in them obliteration of the hernial sac and suture of the abdominal wall should be followed by the wearing of a truss.

In conclusion I ought, perhaps, to refer to the operations of radical cure which may be performed after ketotomy. But so much has been written and said upon this subject that this may be done very briefly. First, however, it is not to be expected that any of these procedures can be undertaken without danger unless perfect aseptic precautions are used and attained, and too much stress cannot be laid upon the importance of sterilizing the sponges, ligatures, instruments, and materials used in the operation.

No operation for radical cure can be relied upon which does not achieve two things: first, absolute obliteration of the sac without leaving a depression at its opening into the peritoneum; and secondly, the repair of the abdominal wall. Macewen's operation fulfils these conditions, and, as he and others have shown, can be practised with safety.

However, I have found that as regards the treatment of the sac it has not always seemed wise to fold it into a pad, as Macewen recommends. In femoral herniæ the sac is sometimes in such a condition that it has been impracticable to convert it into a pad, and therefore I myself have usually dealt with it as follows. Its neck is transfixed and then encircled with a long and moderately thick silk ligature, and securely tied. Next the ends of the thread are passed separately, about an inch apart, through the abdominal wall, well above Poupart's ligament, so that when they are pulled upon the neck of the sac ascends the crural canal and is fixed by tying the ligature. Afterwards Hey's ligament and the pubic portion of the fascia lata are brought together by suitable sutures, and the wound closed after having been irrigated with perchloride.

The operation for the cure of inguinal hernia is more difficult to perform, and is now described in all the recent works on operative surgery. However, before undertaking its performance, it is highly desirable to take opportunities to practise its several steps. Macewen's operation, as regards its difficulties, seems comparable to staphyloraphy and requires a good knowledge of anatomy and considerable dexterity for its efficient execution.

OVARIOTOMY PERFORMED FOR THE THIRD TIME IN THE SAME PATIENT.

By GEORGE BUCHANAN, M.A., M.D., LL.D.,
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OVARIOTOMY has never been the monopoly of gynecologists in Glasgow. Indeed, the first successful case was performed by myself in 1864. Since that time it has been done by the operating surgeons in the hospitals as one of the ordinary operations of their service; and of late years with an amount of success equal to that of the gynecological operators in special hospitals or wards elsewhere. All the particulars with regard to preparation, operation, and after-treatment are so well known and practised that we look forward to an ovariectomy with less apprehension than to most of the major operations of surgery.

In consequence, there is little written about it at the present day unless when some specialist desires to compare his results per hundred or per thousand with those of some other operator, or when a case which has been seen by one gynecologist, or become known to him, appears among the cases of another, with, perhaps, a slight difference of phase from that which it appeared to possess when first seen, or the result has been somewhat different from what appears in the report.

As, however, the following case appears to me, if not unique, at least most unusual, I shall report it in a few lines.

Miss F., a patient of Dr. Robert Pollok, Pollokshields, is at present aged 42.

In December, 1877, with Dr. Pollok's assistance, I removed a large unilocular cyst. The pedicle was tied with a silk liga-

ture, and dropped into the cavity. Recovery was rapid. She continued to menstruate.

In October, 1882, I again operated, and removed a large multilocular ovarian tumour from the left side. Recovery was rapid; menstruation continued afterwards, but gradually became somewhat irregular.

About January, 1891, she again became aware that the lower part of the abdomen was becoming fuller, with occasional pains. An ovarian cyst was again diagnosed by Dr. Pollok.

On June 30th, I again operated, and removed a cyst about the size of an adult head—thick-walled, with limpid fluid contents—but with a number of cysts projecting into the interior from the walls, and also a few thin-walled cysts on the exterior, near the pedicle, which was long. There were no adhesions, and no difficulty was experienced in the manipulation. The third day after the operation menstruation came on; thereafter the progress to recovery was regular.

REMARKS.—I presume that the first cyst was parovarian, and that the pedicle being long and slender, the ligature was applied to it distal to the substance of the ovary. The second cyst was decidedly the ovary; either the one not formerly involved, or the other, from which the unilocular cyst had proceeded. The third cyst was multilocular, and therefore probably ovarian. The menstruation which occurred on the third day was imminent before the operation.

A METHOD OF PERFORMING INGUINAL COLO TOMY, WITH CASES.

By F. T. PAUL, F.R.C.S.,
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ONLY a few years ago lumbar colotomy was regarded as one of the most satisfactory of surgical operations. Its mortality was low, and the relief granted by it in some cases almost unequalled. Now the advocates of the inguinal operation give us a host of reasons intended to show how many may be the causes of failure in the lumbar operation. Strange that one practically meets with them so seldom. In my experience the only marked source of failure, in either right or left lumbar colotomy, has been the difficulty in completely cutting off the passage of *faeces per rectum* in some cases in which it was very important to do so. In the light of recent experience, I consider that when it is only necessary to open the bowel to relieve urgent distress the extraperitoneal operation is the more prompt, safe, and suitable; but that when it is desirable to divide the bowel, cutting off all communication with the part below, the inguinal operation is safer, easier, and better than Madelung's modification of lumbar colotomy.

The inguinal operation is undoubtedly easier to perform than the lumbar, but it has a source of danger from which the other is or ought to be free, and that is the danger of allowing faecal discharge to bathe a wound directly communicating with the peritoneal cavity. So serious is this that the pioneers—Messrs. Harrison Cripps, Jessett, and H. Allingham—all counsel delay in opening the bowel until adhesion has taken place between it and the wound. Each has his own special method of performing the operation, but the variation is directed in each case chiefly towards the ultimate opening of the bowel without risk of contaminating the peritoneum.

The object of the present communication is to point out how, by a very simple plan, this desirable result may apparently be safely accomplished without the usual delay.

CASE I.—In February, 1890, Dr. T. Eyton Jones, of Wrexham, sent me a case of extensive cancer of the rectum, occurring in a man, aged 46. His illness began in May, 1889, with diarrhoea, which continued off and on until he was operated on. In June he first noticed blood and slime in the motions. Sometimes they consisted of slime alone. He often suffered severely from pain over the lower part of the abdomen and back, which was usually relieved by the passage of motion. The constant loss of blood had rendered him very weak and anæmic. On admission he was well nourished, but very pallid. The rectum was painful and irritable. There was a copious discharge of mucus and a daily loss of blood. On in-