rhage. In my case no attempt was made to enucleate the cyst. It was simply incised and drained, and this treatment in a large number of similar cases has proved very successful. In 1897 Mr. Alban Doran stated that he had collected seventy cases treated in this way, and that of this number sixty-five had recovered.

Many retroperitoneal cysts with deep and central connections have been successfully removed, but I do not think there are many cases in which this operation can be undertaken without considerable danger to life. In any case, however, where very little enucleation is required, and a well-defined pedicle is present, which can be transfixed with a needle, leaving only a small cut surface after the separation of the tumour, the operation may be undertaken with a good prospect of success. Sir Spencer Wells recorded a case, diagnosed as an ovarian tumour, which was operated on by Bozeman. Twenty pints of fluid were drawn off, the pedicle tied, and the cyst cut away. But there are other cases in which the serious connections of the tumour prevented the completion of the operation. The difficulty of extirpation arises from the deep and almost inaccessible position of the base of the growth, and the important nervous and vascular structures with which it is connected. Portions of the pancreas have sometimes been excised with the cyst and the splenic artery ligatured. These operations are occasionally followed by very troublesome fistulae.

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STRANGULATED FEMORAL HERNIA : SUCCESSFUL PRIMARY RESECTION OF THE DAMAGED GUT.

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Up to the present time it may be considered a still debatable point as to the best course to pursue when the state of the bowel indicates that its recovery is beyond hope. In many cases our course is decided by the condition of the patient; there is no alternative to leaving the diseased gut *in situ* and allowing an artificial anus to form, this lesion to be repaired later by some method of secondary operation. If the patient's condition is good, a primary operation may be done with a very good prospect of success, and certainly a great saving of time. As to how the resected bowel should be joined, whether by mechanical aids or by simple suturing, this depends on the opinion of the surgeon. Mr. Jonathan Hutchinson junior's statistical paper on the subject in vol. xxxii *Transactions of the Clinical Society* shows a marked superiority of suturing, 46 per cent. of recoveries against 7 per cent. for those where Murphy's button was used, which 46 per cent. might have been improved by the inclusion of another successful case of my own.¹ These figures, however, point forcibly to the conclusion already held by most surgeons that simple suturing, if expeditiously carried out, is more certain of accurate apposition, and has the great advantage of removing all anxiety as to the ultimate fate of the button.

From the technique employed in the following case three points may be drawn attention to: (1) The accurate apposition of the mesenteric border of the cut ends was attained by the stitch similarly used by Maunsell in his method of resection. (2) The adoption of a continuous Lembert's suture whereby the sutured edges are more evenly supported and much time is saved. This method I adopted in my other case. (3) The resection *in situ*, instead of making an abdominal incision, withdrawing the damaged gut and running the risk of fouling the peritoneal cavity. Should any difficulty be met with in replacing the bowel, the opening can be enlarged and then resutured without causing any weakening in the lower part of the abdominal wall.

S. S., 45, married, was admitted into St. Thomas's Hospital under my care on June 6th, 1899, with a strangulated femoral hernia.

History.

The hernia, which was on the right side, was first noticed some seven weeks before, coming on after a severe attack of vomiting (cause). She was fitted with a truss, and suffered no further inconvenience until June 4th, when she was suddenly taken ill in church with pain and vomiting. The hernia was found to be irreducible. The constant vomiting with severe abdominal pain continued for forty-eight hours, when she sought admission into the hospital.

Condition on Admission.

She was found to have a small tense right femoral hernia without any impulse, and with some oedema of skin over it. Her pulse was 84, respirations 20, and temperature 99°. The vomit was bilious, and no flatus could be passed. There was some hiccough.

Operation.

Immediate operation was advised and proceeded with. After opening the hernial sac in the usual manner and setting free some turbid fluid, it was found that only a small knuckle of gut occupied the sac. This gut was very black, thickened, and covered with lymph in patches, and after relieving the constriction and drawing down the gut, it was seen that the upper end was ulcerated through down to the serous layer, and the lower point of constriction was also thinned. From the state of the intermediate gut and the age and condition of the patient being favourable, it was determined to do immediate resection rather than allow an artificial anus to be formed.

The resection was able to be done *in situ*. Makins's clamps were applied above and below the lines of constriction, and three inches of bowel were removed with scissors, with the corresponding portion of mesentery. All bleeding points were ligatured with fine silk and the cut mesenteric edges united. A fixation stitch, as in Maunsell's method, was then passed between the mesenteric edges of the cut ends of the bowel, and they were brought close together with the serous layers apposed and the mucous edges inverted. A continuous catgut stitch then brought the mucous edges together without any constriction, and a continuous Lembert's suture of fine silkworm gut was then passed through the sero-muscular coat. With slight enlargement of the wound upwards into Poupart's ligament the gut was easily replaced in the abdomen, after sponging it with normal saline solution. The sac was separated, ligatured, and removed. The pectineal fascia was dissected up, and stitched over the femoral opening to Poupart's ligament, which was itself resutured up where it had been divided. After suturing the wound with horsehair it was dressed with cyanide gauze. The whole operation took about forty-five minutes, and the patient's condition was most satisfactory, her pulse maintaining its former rate of 84 per minute.

After-History.

On the evening of the operation she was given a simple enema, and then one of a pint of normal saline solution. Temperature 99.4°. Put on rectal feeding.

June 7th. Condition very comfortable. Temperature 98.8°; pulse 80. Allowed a teaspoonful of warm water by mouth every hour. In the evening temperature 100.2°, respirations 24, pulse 84.

June 8th. Flatus passed during the night. Temperature 99°, pulse 60. Given teaspoonfuls of egg albumen and brandy.

June 9th. Temperature 99°. Milk and water ordered; given simple enema.

June 10th. Temperature normal, and continued so; calvesfoot jelly.

June 11th. Raw meat juice given.

June 12th. Very comfortable. Taking now beef-tea Oj, milk Ojss, and eggs.

June 13th. Wound dressed, stitches removed, one small stitch now suppurating.

June 15th. Bowels opened naturally; given milk puddings.

June 18th. Fancy diet; wound quite healed.

June 21st. Allowed to get up.

June 27th. Left the hospital quite well.

REFERENCE.

¹ *Lancet*, 1897, vol. i, p. 1614.

SOME REMARKS ON THE RADICAL CURE OF HERNIA; BASED ON 190 CASES OF OPERA- TION FOR THE CURE OF OBLIQUE INGUINAL HERNIA.*

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I HAVE chosen this as the subject of my address for two reasons—first, because it is one of which I have had a fair amount of experience, and secondly, because there is perhaps no other operation in surgery about which so much difference of opinion exists, and none about which more has been said or written during recent times. Early in 1899 I read before the Nottingham Medico-Chirurgical Society a paper detailing 117 cases of operation for radical cure, and since then I have operated on 73 cases, bringing the total number of operations

* An abstract of the Presidential Address to the Midland Branch of the British Medical Association.