2. When the omental protrusion is of old standing; when its texture is thickened by adventitious deposit, or condensed by pressure; it should be left in the sac, in the hope that the inflammatory action which follows herniotomy will agglutinate it to the neck of the sac, and thus form a barrier against the re-descent of the hernia. Its return into the abdomen, if thus structurally changed, must expose the patient to the risk of peritoneal irritation. Its retention in the sac has never been followed within my experience, by any evil effects, and I have seen this treatment adopted in numerous cases. Suppuration of the sac has followed in several instances, but I have never observed any colic or dragging pains to indicate the impropriety of the practice. Considering that omentum, thus altered in structure, must, of necessity, have been long displaced from its natural relation to the abdominal viscera, I can scarcely suppose that serious inconvenience could result from its being allowed to remain in its new position. After the external wound has healed, the only precaution necessary is to apply a well fitting truss with a hollow pad instead of the ordinary convex one. Lawrence seems to think that leaving the omentum in the wound presents no particular advantages, but that it exposes the patient to the possibility of ill consequences from injury, inflammation, or disease. The experience of Hey, Chopart, and Desault, now strengthened by other surgeons, proves the success of the method, and shows that omentum thus left either recedes gradually into the cavity of the belly, or becomes atrophied. All chance of injury is obviated by the hollow truss.

3. If firm, organised, and general adhesions exist between the omentum and sac, the same law holds good. The abdominal viscera have, in such cases, become gradually accustomed to their changed relations, and would be liable to disturbance of function by a sudden and perhaps violent restoration to their normal position. I need scarcely advert to the slowness and care with which a dissection of omentum from the hernial sac must be effected, the danger of all protracted operations, and the especial risk of injury to which a prolongation of the largest serous membrane in the body is exposed by such a procedure, to enforce the importance of this rule.

4. When omentum is the seat of sphacelus, the dead portion should be separated by a clean incision, and every bleeding vessel secured by a ligature. In recent cases, where the return of omentum into the peritoneal cavity is determined upon, the ligatures should be cut short off, and great care must be taken to remove every portion of gangrenous tissue. If the omentum be thickened as well as devitalised, Macfarlane's plan of returning it into the abdomen should not be followed; the dead part should be removed, bleeding vessels tied, one end of each ligature being brought out through the wound, and the remainder of the mass should be pushed back so as to occupy the internal ring, and thus to form a natural pad, whereby the aperture may be closed. In no case should the cut extremity of the omentum be included in one strong ligature, a practice which has been pursued by some surgeons. The process by which ligatures are detached from living textures is apt, under such conditions, to run into spreading inflammation, and perhaps gangrene; the constriction of the omentum may keep up the symptoms of strangulation, and the least evil that can happen is a tolerably certain one, namely, suppuration and sloughing in the sac.

SOUTH DEVON & EAST CORNWALL HOSPITAL.

OPERATIONS FROM JANUARY 1ST TO JULY 1ST, 1856.

Communicated by W. J. SQUARE, Esq., Surgeon to the Hospital.

1. *Talipes Varus* of both feet in a child aged 1½ year. The tendo Achillis and tendon of the tibialis anticus were divided in each foot by Mr. Square on the 23rd of February. Discharged cured, April 1st.

2. Very extensive *Necrosis of the Tibia* in a boy aged

11 years. Removal of a large sequestrum by Mr. Square on 23rd February. Discharged on March 24th. A small wound still remains open, which discharges small particles of bone occasionally. This case, in its early stage, was complicated with synovitis of the knee-joint, softening of its lateral ligaments, and tendency to dislocation of the leg backwards.

3. A small *Lithic Acid Calculus*, lodged in the membranous portion of the urethra for a month, in a man aged 24 years. Removal by perineal section on the 25th day of January. Discharged cured on the 5th March.

4. *Varicose and Fatty Tumour* of the dorsum of the foot in a girl aged 19 years. Removal by Mr. Whipple on 5th of March. Discharged cured on May 7th.

5. *Talipes Varus*, consequent on fever. The tendo Achillis, tendon of the tibialis anticus, and plantar fascia, were divided by Mr. Whipple on the 1st of March. Cured May 14th.

6. *Large Malignant Tumour* of the buttock in a man aged 68 years. Removal by Mr. Square on the 16th of February. Cured April 16th. This man was seen a few days since. Apprehension exists of the return of the disease in the corresponding inguinal glands.

7. *Compound Comminuted Fracture of the Fore-arm*, with compound dislocation of the elbow, in a man aged 36 years. Primary amputation near the head of the humerus by Mr. Whipple on February 22nd. Cured March 24th.

8. *Dislocation of the Femur on the Dorsum Ilei*, of five weeks duration, in a man aged 54 years. Reduced by Mr. Fox by the use of pulleys, under the influence of chloroform, on March 20th. Great difficulty was experienced in retaining the head of the femur in the acetabulum, from which it slipped a week after its reduction. It was again reduced by the same method. The man was discharged cured on the 18th June, with the limb of equal length with the other, but still lame. It is believed that a fracture of the lip of the acetabulum complicated this case.

9. *Hydrocele of the Tunica Vaginalis* in a man aged 54 years. Injected with tincture of iodine by Mr. Square on the 16th April. Discharged cured on the 7th May.

10. *Hydrocele of the Tunica Vaginalis* in a man aged 26 years. He had been operated on by injection twice before admission into the hospital. April 26th the hydrocele was injected with tincture of iodine, by Mr. Whipple; the operation failed. The hydrocele was tapped again in the ordinary way; a piece of the end of a small gum catheter was passed through the canula, and allowed to remain in the tunica vaginalis five days, at the end of which period it was withdrawn. Serum constantly distilled through the catheter during this time. Considerable inflammatory action existed. Discharged cured on the 10th of June.

11. *Talipes Varus* of both feet in a boy aged 3 months. Tendo Achillis and tendon of the tibialis anticus divided in each foot by Mr. Square on April 17th. Discharged cured June 18th.

12. Very old and extensive *Ulceration of the Integuments of the Leg* in a man aged 52 years. Flap amputation below the knee by Mr. Whipple on the 3rd May. Still under care.

13. *Impermeable Stricture of the Urethra* consequent on injury, in a man aged 52 years. Division of the stricture, introduction and retention of silver catheter in the bladder by Mr. Square on June 16th. Still under treatment.

14. *Scrofulous Disease of Ankle-joint*, with bony anchylosis of tibia and astragalus. Abscesses in the lower end of the tibia. Circular amputation just below the calf by Mr. Square on April 1st. Discharged cured with a very good stump June 10th.

15. *Large Fungus of the Testes* in a man aged 30 years. Mr. Syme's operation performed by Mr. Square on the 16th of June. Remains under treatment.