found it satisfactory, if given in doses as required.

I sometimes use a brush or sponge for applying the solutions to the larynx and trachea, something after the plan of those recommended by Dr. Mackenzie. I used these brushes first in 1846, by making the handle in the same form from a whalebone, by bending the end of the bone, and piercing it with holes, then securely sewing through them, a very fine sponge or linen lint on and around the end for the brush, and trimming carefully before using.

My first treatment of diphtheria, was on Nov. 1, 1860, and I gave the treatment as directed by the medical journals of that day, and my patient died. I then adopted the same treatment I had used for croup in 1846, only being governed by the different stages of the case and the constitutions I had to treat. In the inflammatory or stage of high fever, I use ipecac, chlorate of potash, chloride of sodium, bicarb. of soda and gum acacia, and free bathing with strong saline baths. I use quinine, iron, and carb. ammonia in solution, also whisky, brandy or wine, and stimulants generally, taking good care of the stomach and bowels at the same time using creta præp. freely in case of diarrhoea, being very cautious as to the use of cathartics. I never give calomel or any medicine that will in any way weaken or prostrate, but always support and build up the entire system.

Out of 489 cases of diphtheria I treated from November 1, 1860, until February 15, 1861, as reported by me in the *Cincinnati Medical and Surgical News*, Vol. II, No. 4, page 104, only five died and 484 recovered. That same course I have since adopted and with the same results.

I will here quote an article from the May number of the *Medical World*, Vol. VIII, No. 5, page 181:

“Croup” is not confined to the air-passages alone. A form of croup attacks the urethra sometimes, and is indicated by the excretion of characteristic white membranous structures, mixed with more or less blood and pus. Croup of the bladder is more frequent in females, the membranous substance being reddish in color, and in much larger pieces.”

This statement is correct as to cases of diphtheria. The membrane may be found covering any part of the mucous membrane, mouth, nose, fauces, trachea, bronchia, stomach, bowels, kidney, urethra, rectum and vagina. I have at this time a small box of the membrane taken from the vagina. I also have had cases where wounds on any part of the body where the cuticle was removed were covered with this fungi. I call these cases diphtheria and not croup. All of which is respectfully submitted.

HOSPITAL BURNED.—The Mercy Hospital at Davenport, Ia., was partially burned on June 11. One of the Sisters perished in the flames.

OPERATIONS FOR THE RADICAL CURE OF HERNIA IN EARLY INFANCY AND CHILDHOOD.

Read in the Section of Surgery and Anatomy at the Forty-first Annual Meeting of the American Medical Association at Nashville, Tenn., May 20, 1890.

BY THOMAS H. MANLEY, A.M., M.D.,
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My object in submitting this article to the Section of Surgery is with a view, mostly, of presenting a few notes on a small number of cases in which, during the past four months, I performed operations for the cure of hernia, besides to offer a few comments on such cases as come within the scope of such operation.

I am particularly desirous of obtaining the views of several surgeons as to the desirability of doing a celotomy in early life, and their opinions as to the temporary or permanent character of such a cure as is wrought by modern surgical methods.

My cases are seven in number, all boys, the oldest seven years and the youngest three weeks; no history of heredity or injury in any of them. In every instance the protrusion was discovered shortly after birth. In none of them could a truss be worn with comfort, and in two no sort of contrivance would retain the hernia in its proper cavity. I had no deaths or dangerous complications after operation, and in all except one case the incision healed promptly and completely within fifteen days after the cutting was done.

Case 1.—P. B., aged 7 years, was first brought to me when 1 year old, with a large protrusion on the left side. From the mixed nature of the anatomical derangement and pathological condition I was unable to decide what the mass consisted of, as it in many respects was like a hydrocele of the cord, a scrotocele, or a new growth. I was not quite sure that it could be wholly reduced. On general principles, however, I recommended a truss. I saw nothing more of him again for four years. His father informed me that he secured a truss as I directed, but it gave the lad so much pain that it had to be laid aside, when he consulted others, who were undecided as to what the little fellow was suffering from. However, with nearly uniform accord they advised that a truss be worn. Another truss was applied, but in spite of it the hernia would slip down. However, as it was supposed it would prevent matters from getting worse, he was obliged to constantly wear it. I now advised an operation, but the father would not consent to it until two years later. I saw the boy again in December, 1889, when the protrusion had attained more than twice its former volume, and swung like an immense pouch down the inner side of his trousers, to such an extent that his mother could not devise any sort of garment which would effectually conceal this repulsive deformity; and

hence the boy had to endure the jeers and ridicule of his young associates. On careful examination the testis on the affected side was found reduced to more than half its size, and the protruded mass stubbornly resisted taxis. It was clearly evident now that the truss, by its constant pressure, had greatly reduced the nutrition of the generative gland, and, besides, had by its chafing, irritating pressure produced extensive adhesions.

I operated on him December 7 at the Harlem Hospital. On opening down over the enlargement it was at once seen to be a hernia of the congenital variety, there being no sac, the intestine and atrophied testis lying firmly bound together within the fascia propria. All the serous surfaces were found more or less adherent, and considerable peeling off and tearing had to be done before the gut could be liberated and returned and the testicle isolated. I now removed the testis, separating it from the spermatic cord high up. The tunica vaginalis was detached from its adjacent tissues, and it, with the funicular process of the peritoneum employed as a sac, was ligated off close to the abdominal aperture. The rent in the tissues was treated by the open method of McBurney.

He made a rapid and uneventful recovery. Except for a painful dermatitis excited by the bichloride gauze, there was nothing to mar his convalescence. He left the hospital in four weeks, and at the end of six weeks from the time of operation he took the upright position. Everything went well for two months, when it became evident that the hernia was threatening to return. A mass the size of a small marble was seen near the upper margin of the scar. A truss was immediately applied and worn since. Though there has been no recurrence of the rupture to any extent whatever since the truss was worn, I have, as a precautionary measure, advised that it be constantly retained while he is about in the day-time.

Case 2.—T. H. This baby was 10 weeks old when he came under my observation. The mother stated that for two weeks or more she had observed, when giving him his morning bath, that on the right side she would at one time see a large swelling in the region of the groin, and at another the testicle alone could be felt. Again, what puzzled her the most was that no trace of the testis, or anything whatever, was visible on another occasion. She brought the infant to me to have this state of things remedied. On examination no testis was found in the right pouch of the scrotum, but by searching for the outer ring the gland was felt just within and above the inguinal opening. Now, by making moderate traction under ether the testis could be brought down well into the scrotum, but it was evident that something else was coming close after it.

In opening up the parts, that small conical lamina of fibrous tissue designated the governor, or gubernaculum, was seen to be absent; but anatomically the arrangement was very similar to the first, except, instead of the testis being adherent to the intestine, the tubular structure of it, the epididymis, was firmly glued to a fringe of omentum. The latter was dissected away, when the testis was fixed in position by a fine suture penetrating the tunica albuginea and its opposing serous membrane. We then, commencing with the innermost layer of the coverings, closed them in *seriatim* from below upward, until the ring was reached. Here I turned in the divided omentum and sewed it into the pillars on either side with the kangaroo suture. With the exception of some trifling uneasiness for a few days, the operation was followed by no serious constitutional disturbance, and in ten days' time the wound was well solidified.

Case 3.—Dr. Ira B. Reed, of New York, requested me to operate for him on a baby three weeks old. The rupture was discovered three days after birth. It was on the right side. The testis was normal in every respect. The hernia came well down into the scrotum, and as no sort of bandage or truss arrangement could be worn, the doctor requested my advice and assistance. I recommended immediate operation. This hernia, though very large, was of the same identical anatomical structure as the other two, except that there were no adhesions.

I was content, in this instance, to open up the invaginated and enormously distended funicular process sufficiently at its base for inspection, and then closed the whole up to the ring—all the redundant tubular structure—with the cobbler's stitch. I saw that something must be done at the inguinal portal to close in and permanently obliterate it. In this situation I used small, strong silk, passing my suture first through the integument on the inner side, the connective and other tissues, then through the inner pillars of the ring, through the dilated fascia propria, over the spermatic cord to the opposite margin of the ring. Five of such sutures were employed and tied tightly, one end of the suture cut off and the other left in the wound. The portion of the cleft through the soft parts immediately over the ring were treated by fine packing from the bottom, as in the operation of McBurney.

This case has progressed satisfactorily. In three weeks' time the parts were solidly sealed, and now, more than three months since the wound closed, there has been no symptom of relapse.

Case 4.—M. O. T., 8 years old. Child sent to me by Dr. James Healy. The youngster had hernia noticeably when two weeks old, on right side. Large inguinal variety, and could not be retained with a truss without great discomfort.

With this case the hernia was a nearer approach to the adult type. Though not large, it had an independent sac. The testis was normal in every respect. The spermatic cord was most intimately bound down and thoroughly incorporated with the sac, requiring a most tedious and delicate dissection to isolate it. The sac contained intestine, which was pressed upward when it was ligated off and divided, that part presenting externally cut away, and the case treated essentially as the preceding.

Case 5.—W. R. This child was 4 years old, with no evidence of hernia till he was 2 years of age. Hernia in the left side. Owing to the long and severe pressure of a string truss the skin over the line of the inguinal ring was calloused and chafed, but no truss could be tolerated at all which would keep the parts up; and hence, rather than compel him to submit to the torture of a truss, the parents discarded them all and let him go about with his hernia swung in a home-made cotton bag. However, it was so rapidly attaining very broad proportions that he was sent to me for operation. The steps in the operative procedure varied but little from the others, except that I well refreshed the margins of the rings before I applied the silk sutures. Prior to the operation he suffered from nocturnal incontinence, but at once the rupture was cured the night-wettings immediately ceased. His recovery from the operation was rapid and complete, and now out of the hospital on his limbs again nearly two months, there is not the slightest evidence of relapse, and the mother tells me that whereas heretofore he was practically invalided through his deformity, now he no longer stands aside, but shares in all the games of boyhood.

Case 6.—E. M., an infant aged 8 months, operated on March 6. Mother said that when 4 months old she noticed, for the first time, that a testis was wanting, and brought him to a physician, who encouraged her to wait, as he said the missing organ would in time come down. She waited for a month, when she found a large swelling in the groin, which would vary in size and position, some days being well down, and on others higher up. She applied a truss, on the advice of a neighbor, but it worried the little fellow so much that it was removed altogether.

When we opened the flask-shaped enlargement no testis was found, but on going in the direction of the abdominal aperture a small testis adherent to the loose cellular tissue, just within the outer inguinal aperture, was found. After opening the fascia propria—for the intestinal protrusion had no visceral covering of peritoneum,—the gut was crowded inwards, and the prolapsed transversalis fascia, the sac, ligated off close to the free peritoneal border and divided. Under moderate traction and tearing the spermatic cord yielded sufficiently to allow me to bring the testicle well

down into the scrotum and secure it against the possibility of future retraction. The hernial wound was closed throughout, the parts brought together and sewed separately. The ring closed securely over the cord with strong aseptic silk.

Case 7.—H. B., operated on April 16, 1890. The baby was 3 years old. On admission to Harlem Hospital little of the surgical history of his case could be obtained, as he was an illegitimate offspring and was being brought up by an aunt. Of one fact there was no doubt, viz.: that the boy had a decided fulness along the line of the spermatic cord, which no truss would remove. There was some difference of opinion as to what the real pathological state was, one maintaining that it was a spermatocoele, and another that it was a hernia. The position of the testis was normal. The mass was conical in shape, with its base the reverse of ordinary ruptures. Its apex was at the epididymis, and its broadest part on a line with the ring. In straining or coughing it visibly expanded along its superior outline, and on taxis it was definitely ascertained that a portion of the abdominal contents passed through the canal. In dissecting immediately above the testicle and opening the tunica vaginalis a pure serous liquid escaped. By further inspection upward a small knuckle of intestine was felt and returned, which was probably prevented from descending further by its ligament. In this, as in the congenital varieties before noted, I closed in the distended spermatic sheath by the quilted suture of kangaroo tendon, except at the ring, where strength and moderate permanence were demanded.

This, as all the others, did well in every respect, and was dismissed from the hospital in three weeks, perfectly cured, with no trace of his former impediment remaining.

These seven cases comprise my experience in treating defects of this description in very early age by operative methods.

I am very well aware that the number is too small, and the time too short since operation, to draw any definite inferences or make practical deductions. However, the cases are not so few but they afford very many features of deep interest to the studious anatomist and progressive surgeon.

It is needless, in presenting a subject of this description before a body of well-trained surgeons, to consider the complex and varied anatomical arrangements found in each case, even if time permitted, though it is indispensable that this be thoroughly mastered before even the most rudimentary comprehension of the defect is possible.

The cases narrated are, I think, interesting when we remember that they were all in the male sex, and, with two exceptions, were associated with maldevelopment of the testis; when we see how

slight and transient the constitutional disturbances were after operation, and how rapid and complete was the healing of the incision.

It may be argued that measures less radical might have been tried before resorting to operative procedures; but with four, support was tried and found impracticable. Besides, it seems to me that when the surgeon can offer nothing but a truss to those unfortunates, it is a most humiliating confession of the limitation of the art which he practices. If the truss were properly constructed and applied and did its legitimate part, it would be a most welcome adjuvant; but the poor cannot afford expensive supports, and the cheaper article is worse than none at all.

With a man in possession of natural reason and judgment a truss may be worn with moderate comfort; but with the restive, growing child, unable to make known his wants, it may be an instrument of unbearable torture.

Herniæ will disappear, after a truss is worn a while, in young children. Yes; but according to the testimony of Astley Cooper, Malgaigne, Bryant, and others, it will almost invariably return when adult life is reached. In very many cases the truss is a prolific cause of varicocele of the cord and atrophy of the testis, by its pressure on the spermatic vessels, hence leading to impotence and diminished virility.

With those cases in which the generative organ lingers in its path downward, or has been drawn up more or less later, and by its incessant pressure, it excites inflammation of an adhesive kind, gluing the organ so rigidly to adjacent parts as, in the first place, to prevent a possibility of its descent towards its natural location, and, in the second, causing a sort of soldering together of testis, gut and sac in such a manner as to prevent a reduction of the rupture ever becoming possible, the patient being doomed to carry an enormous pendulous bag of his digestive apparatus between his legs for the remainder of his life.

The loss of blood is very badly borne by infants. With this operation, properly performed, there is none lost. With rigid antiseptics the peritoneum is safe from inflammation.

Every hernia, whether occurring early or late in life, is undoubtedly attributable to defective development at birth, and we all know that every species of malformation, whether of the osseous structure or the soft parts, is most successfully and easily dealt with at a very early age, no matter whether it be club-foot, cleft-lip, or anything else. With hernia it is a specially desirable period, as then the patient is in a constantly recumbent position for months, thereby giving the parts time to solidify, while the growth of the body, the rising of the trunk and the lateral expansion of the pelvis will tend to so alter the planes and curves of the inguinal region of the original vent that a later protrusion is scarcely a possibility.

The operation adds nothing to, nor does it take away. It is undertaken, not to restore what never existed, but to simply aid nature to perfect a process never completed.

It has been alleged that hernial operations entail the destruction of normal tissues. I deny it, unless we concede that every operation which involves the incision of the integument is destructive. Division and destruction of a part must not be confounded.

At a meeting, on April 8, of the Royal Society of Medicine and Surgery in London, Mr. A. E. Barker communicated the statistics of fifty consecutive operations for the radical cure of hernia without a death or a single complication unfavorable to the vitality of the testicle. The patients ranged from 3 months to 70 years old.

Parker, at the same meeting, stated that he had operated lately, as a rule, every time he discovered a hernia in infants, with most gratifying results. Mr. House reported twenty-five operations on patients under 12 years by divers methods, with cures in all except one, and no return of the rupture.

At the late congress of German surgeons, held in Berlin, April 12, 1890, Lauenstein, of Hamburg, presented the report of fourteen herniotomies performed in 1888, with but two relapses. McEwen was cited as having operated in eleven years, from 1879 to 1890, ninety-eight times, among whom were many children. He had no deaths, except one child, who was carried away by scarlet fever.

At the monthly meeting of the Société de Chirurgie in Paris, April 9, 1890, an animated discussion was held, at which Messrs. Richelot, Tuffier, Chappionniere, Marchand and Reclus separately and severally contributed reports of many cases on which they operated with success for ectopic testis, associated with hernia, in very young children. These quotations are from the proceedings of the medical societies of the three most progressive nations in the world, and the almost unanimous accord with which was received the reports of modern operations for the cure of hernia in early life by radical operation, is most gratifying and encouraging.

The tissues in early youth heal with marvellous rapidity, and hence the time occupied to seal the opening is only a matter of a few days. Certainly, if the little one inherit syphilis, scrofula, or other blood dyscrasie, the process of recuperation will be much retarded. It is not necessary that the baby be kept in hospital after operation. With ample fluffy dressings they will need changing only every few days; and though they will be quickly soaked with urine, I have found this to in no way interfere with rapid union.

In every case here detailed I found phymosis associated with the ventral protrusion. This adhesion of the glans with the prepuce in early life

I believe to be always physiological; but inasmuch as there has been some conflict of opinion with regard to this constituting a factor and as a contributory agency in producing hernia, I have in every child forcibly retracted the loose integuments and directed the parents to lubricate the glans and manipulate the parts until a liability to its relapse in the future is removed.

The real, enduring value of celotomy for radical cure must, to a certain extent, be estimated by the number of relapses, and whether, in such event, the protrusion may be more manageable by retentive apparatuses.

Among the avowed and uncompromising foes of every species of treatment which contemplates the incision into, or laceration of parts, it has been their charge that inasmuch as no operative procedure has yet been devised which will always ensure against relapses, none are justifiable. Superficially considered, this objection appears rational and logical, but on thoughtful examination and searching analysis its deception and its delusive character become only too apparent; for if its philosophy were sound and its premises impregnable, then, indeed, there would be little need of surgeons outside the domain of traumatism, as in every variety of pathological lesions it is a rule, with few exceptions, that they return almost invariably sooner or later, the surgeon's manual efforts being directed towards alleviating a local condition without in the slightest manner making an impression on the constitution or central organs. Must we condemn the surgical management of strictures, of calculous disease, of tumors, benign and malignant, of aneurisms, of neuralgias, of stenosis of the digestive tract, of the various bone lesions, and many other afflictions too numerous to mention, simply because we can make no guarantees against relapses?

Hernia will occasionally return, no matter what operation is performed; but there are very many that will not, and even if we can cure only a moderate proportion a very great gain has been made. Further, it must not be forgotten that operations devised for their cure by radical methods on an extensive scale are very modern, dating only from the general adoption of antiseptics.

Though many of the objections directed against operations undertaken for the cure of hernia carry with them much force, yet, when applied to infancy and early childhood they will scarcely hold. In the matured adult the parts have assumed a more permanent and durable position. The elongated mesenteric ligament has undergone marked changes in its histological elements. It has become greatly hypertrophied and indurated. The canal has lost its obliquity and become greatly expanded. The sac has acquired adhesions with very delicate and important structures; and like woman, with her thoracic brace—the corset—their use, by habit and by its evil effects on

her dorsal muscles, in time becomes a necessity, so with the truss; its wearer must feel a sense of insecurity after its removal, for a considerable period of time.

With the infant and child, on the contrary, its skeleton and structures are yet undergoing the evolution of development, and if faulty or defective, the time to remedy them safely, rapidly and permanently is while the parts are in their formative stages. This, I believe, has been demonstrated amply in other congenital lesions than in those seen in hernia.

In those cases in which a return of the mass is impossible and its steady increase a certainty; in those in which the funicular sheath of the spermatic cord is greatly distended, and the testis, with the intestine, are fused together, the only real, simple and sovereign remedy is operation.

A faulty descent of the testis—ectopic testis—is the foundation of all herniæ, I am confident. The testis, in its passage downward, forms attachments with the varied duplications of the peritoneum, which in time will surely lead to a weakness in the inguinal walls. As a consequence we seldom have a rupture without the testis or its adnexa sharing in the deformity, and the operation which removes the hernia contributes towards the full functional integrity of it.

I have not advised this operation in early life in those cases in which a truss can be comfortably worn. I am inclined to this custom for the present, until time will have tested the value of those operations which I have already performed. Many disappear under the truss in youth. Those cases treated in this manner which do not disappear, however, are sure to attain greater size with advancing years, liable at any moment to strangulation, soon acquiring such a volume that a truss is wholly useless, and leaving the patient an object of compassion and misery.

In conclusion it may be well to enumerate the varied stages of the radical operation, its technique, and the subsequent deportment of the patient after the parts are well united.

Inasmuch as but a very limited area of the soft parts is intruded upon, there is no shock following the operation. The fear always in mind with the elder surgeons, of the extension, upward, to the general peritoneum of inflammatory action, is efficiently eliminated by vigorous asepsis or antiseptics. I make an incision in the direction of the spermatic cord, beginning immediately over the central axis of the ring. I say ring, for there is no inguinal canal proper till the body has attained adult development. I now carefully divide the different tunics until the cord is reached, when, if I find an expanded, unclosed fascia propria, I press upward the gaping and descending viscera, gradually gathering in the loose margins of the spermatic fascia until the common line of the peritoneum is reached, when

I close in and approximate the divided serous surfaces with the buried suture of kangaroo tendon, as recommended by Dr. H. O. Marcy, of Boston. When I find very much separation of the pillars of the ring and considerable laxity about its aperture, I use silk; also in cases in which there is an independent sac composed of the fascia propria abdominalis, and where I need something which I can depend on for endurance and strength. Every sort of absorbable material is almost wholly useless when it is put on a strain, and especially in this situation. In dealing with the free ends of the suture after knotting I divide one and leave the other in the seam of the wound, for the purpose of temporary vent for drainage, and, besides, so that I may use it to withdraw the knot when the parts have solidly closed, when absorption and disintegration have liberated it, and I do not wish to take the chances of having a troublesome fistula to close later.

A troublesome experience has taught me to avoid the use of bichloride gauze on young children, as I have seen some of the most painful forms of dermatitis follow its use on their integuments; so that now we render our gauze simply aseptic by cleansing, with baking or boiling before using. I always insist that some sort of a compress be worn for at least six months after the operation, immediately over the cicatrix. For the remainder of the patient's life, after the upright attitude is assumed, I strenuously insist on the patient wearing a good, broad, strong belt which will pass around the girth below the crista iliæ, so as to shift the weight of the intestine swung by the mesentery from the spine to the pelvis.

Owing to the marked obliquity of the pelvis, the whole abdominal mass is thrown mainly on the lateral and anterior walls of the abdomen. Now, if this strain can be distributed by transferring it to the long base of the belly, a very substantial gain will have been made.

If, as with women, in whom we see so little hernia, the superincumbent weight of men's garments was borne more by the hips and less by the spine, the aponeurotic parts would not be so apt to give way. I have found, too, that hernia is altogether a much less frequent disease with the belt-wearing peasantry of certain nations in Europe, than among those who suspend everything from the shoulders. With many young children the mother will so adjust the child's waistbands that nothing further will be needed; but as he approaches adolescence and is required to commence active labor for a living, or to practice athletic exercises, then he must wear a substantial belt.

To finally epitomize my reasons for insisting upon the early operation for the radical cure of hernia, they are simply these: (a) No danger whatever attends the operation properly performed

on the healthy child. (b) As the infant remains in the recumbent posture till nearly a year old, ample time is permitted for thorough union before a strain is put on the parts. (c) At no period of life is time of so little value to the patient. (d) In those cases in which the mass can not be returned owing to adhesions, the operation, if for no other purpose than placing the parts in a condition by which a repulsive deformity may be forever obviated, is always imperative, and no delay should be tolerated. (e) No special operation can be recommended indiscriminately, as no two herniæ are precisely alike; and hence the technique must be in every case adapted to the condition found. (f) A belt of some kind should be always worn after operation during the remainder of life.

WHAT IS THE PRESENT MEDICO-LEGAL STATUS OF THE ABDOMINAL SURGEON?

Read by Invitation in the Section of Medical Jurisprudence, at the Forty-first Annual Meeting of the American Medical Association, at Nashville, Tenn., May, 1890.

BY WILLIAM WARREN POTTER, M.D.,

OF BUFFALO, N. Y.

CHAIRMAN SECTION OF OBSTETRICS AND DISEASES OF WOMEN, 1890.

The line of thought outlined in this paper, no matter how expressed, is intended to be suggestive rather than dogmatic—inquiring rather than assertive—as indicated by its title. The recent rapid advancement of the surgery of the abdomen has inevitably led to its separation from the general surgical field into a distinct specialty. It finds itself in a new environment, without traditions or statutes for its guidance, and hence with only a comparatively recent experience on which to found its legal or surgical status. For these and other reasons we may not speak in this place except suggestively or inquiringly.

That abdominal surgery now holds a place distinct and apart from other branches of the surgical art, need scarcely be argued here. That it must of necessity be considered a specialty appears reasonable, when we contemplate the nature of the organs dealt with, and the variety in the character of the operations upon these organs. The great point to be insisted upon is, that the lines that separate it from the other divisions of surgery are so well marked, that no matter how well a man may be equipped in these, unless he has had abdominal experience he has no right to enter its domain except under urgent necessity, where delay will lose life or endanger it less than the inexperience which proposes to operate. It is surprising that men without such experience, either practical or theoretical, will insist on attempting the work of reformed abdominal surgery, than which there can be nothing more delicately defined or exacting in all its details.