1. Hernia of the vermiform appendix is more frequent than is generally accepted.

2. It is impossible to diagnose with certainty a hernia of the vermiform appendix. When there are present the symptoms of an incarcerated hernia in the right inguinal or femoral regions, one should think of the possibility also of an incarcerated hernia of the appendix.

3. A hernia of the appendix may produce more or less severe complications inasmuch as the vermiform appendix is so frequently the seat of pathological processes.

4. This variety of hernia demands an early operative interference, because of the threatened complications which may arise from the appendix.

5. This operation, almost without exception, must consist in the resection of the vermiform appendix. The method of Mikulicz is the best employed for the closure of the stump. The appendix must not be returned unless absolutely normal.—*Archiv für klinische Chirurgie*, Band XLV, Heft 4.

III. Gangrene in Strangulated Hernia; Resection versus Anus Præternaturalis; Conclusions from 576 Cases. By H. P. ZEIDLER (St. Petersburg). This subject has been treated in an exhaustive manner by this thorough and uncommonly diligent writer. The paper embraces the histories of 289 cases in which primary resection was performed for strangulated hernia, and 287 cases in which the anus præternaturalis was made. In the first group 142 (49.13 per cent.) died, and in the second group 213 (74.22 per cent.); that is, an increase in the mortality of 25 per cent. The explanation of these numbers becomes clearer when the special cause of death is understood.

From the first series 20 cases, and from the second series 74 cases are excluded, because the definite cause of death was not stated.

	Resection.	Anus Præternaturalis.
Detailed cases	269	213
Fatal cases	122	139
	Per Cent.	Per Cent.
(a) From accidental causes	6.32	3.76
(b) From peritonitis and collapse which existed before the operation	19.33	24.88
(c) From secondary infection and peritonitis . .	15.95	20.66
(d) From other complications in connection with the operation. Narrowing of the lumen of the intestine. Exhaustion and in- anition	2.60	11.77
(e) In consequence of subsequent operations . .	1.11	4.22

SUMMARY.

(1) Independent of the operation <i>a b</i>	25.65	28.64
(2) Due to the operation <i>c d e</i>	19.66	36.65

Although the number which were hopeless from the first is 5.55 per cent. (24.88 against 19.33), greater in the second series, still the fact remains that through the choice of the anus præternaturalis, 17 per cent. of the cases died which might have been saved with more or less probability had the primary resection been performed.

Indeed, in the formation of the anus præternaturalis nearly all the dangers exist which are present in the primary resection, and, also, in addition, certain dangers and disadvantages which are absent from the latter. The only advantages of the anus præternaturalis are the shortness of the operation and the rapid and complete emptying of the intestine. These can be made of use temporarily, since Riedel has shown that the anus præternaturalis can be closed after a day or so by an early secondary resection, namely, in such cases where the primary resection is contra-indicated, either on account of the severe collapse, or on account of the impossibility of placing the sutures in entirely sound tissues, in those cases where the limits of the gangrene are not absolutely determined. The anus præternaturalis, as an exclusive treatment of gangrenous hernia, should be given up.

A contra-indication to primary resection is the presence of a diffuse peritonitis, especially when combined with collapse. If collapse is absent, the resection is not absolutely contra-indicated, but it should not be followed by a radical operation.

According to the histories of these above-mentioned cases, perforation of the intestine, infection of the sac, and phlegmon of the adjacent tissues have not proved to contra-indicate primary resection. The greatest danger and the most frequent cause of death is secondary gangrene of the sutured intestine. As one may resect a length of intestine, averaging up to 20 cm., without harm to the patient, so one should resect entirely in sound tissues. To aid this purpose the strangulated intestine may be drawn out as far as necessary after the abdominal wound is enlarged.

When the intestine is over-filled, it must be emptied before the sutures are passed.

If one is not sure about the limits of the gangrene, then the anus *præternaturalis* must be made. This may be followed by an early secondary resection.

The next most frequent cause of death after resection is the peritonitis, due to an infection from the sac. This danger can be lessened by careful disinfection of the sac before opening it; by closure of the abdominal opening during the manipulation of the strangulated intestine; by closure of the open ends of the intestine during the resection; by careful disinfection of the sutured intestine before its reposition; by tamponading the outer wound; by fixation of the sutured intestine and in surrounding the seat of the suture with tampons, etc. This last is of advantage in conducting away the *fæces* in case the sutures do not hold.

One must especially guard against any gangrene of the edges of the intestine. In a few cases the technique of the sutures may be responsible for this accident. Only in exceptional cases does a contraction of the intestine, at the seat of the sutures, lead to complete obstruction and death.

The temporary closure of the intestinal lumen during the opera-

tion may be accomplished by different methods, no one of which has any marked superiority above the others. That portion of the mesentery which belongs to the resected intestine should be cut away, and the corresponding edges must be carefully approximated and sutured.

The choice of the method of suture is not so essential, presupposing the principle of Lembert is understood.

The selection of the material for suture is not of special importance, but it is of the greatest importance that these sutures be passed in absolutely healthy tissues. After suturing, the intestine is to be replaced in all cases.

The radical operation can be completed only when there is no peritonitis and the sutures are in absolutely healthy tissues. If there be the least doubt, then the intestine should be fixed in the abdominal wound and protected by tampons. In all cases where the radical operation is not performed, the abdominal wound should be thus treated.

During the first few days after the operation the diet must be limited and opium given as is necessary.—*Centralblatt für Chirurgie*, January 21, 1893, p. 62.

JOHN B. WALKER (New York).

GENITO-URINARY ORGANS.

I. Thirty-two Cases of Operation for Tumors of the Urinary Bladder. By E. H. FENWICK, F.R.C.S. (London). Fenwick has operated thirty-two times with a definite object of removing tumors which had been diagnosed as being present. The first case proved a mistaken diagnosis, for the tumor was merely a small papillomatous-like tag coexisting with tuberculous disease. In another, a female case, he deemed it best to leave the tumor alone, but, probably with increased experience and better methods of removal, he states that he should not again hesitate to dissect a similar growth away. It proved to be a very dense epitheliomatous ulcer. On thirty occasions he removed tumors. The perineal operation was performed three times, because the growth was near the urethral ori-