line of back, on the same level, located pus; an incision through thickened pleura and consolidated lung tissue entered the abscess track. Expectoration of liver abscess pus ceased in a few days; his recovery was uninterrupted, and he was convalescent in a month's time. A nearly dry sinus persisted for some time, but eventually healed, and he left hospital in the best of health.

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A METHOD OF FINDING AND SEPARATING OUT THE SAC OF AN INGUINAL HERNIA.

By Captain J. E. Churton.

Royal Army Medical Corps.

Having experienced difficulties in dissecting out the sac of an inguinal hernia, and having seen the same arise at the hands of others—probably owing to the somewhat ambiguous phraseology of the majority of books in dealing with this step of the operation—I am tempted to give a short account of a method which, to my mind, materially simplifies that which otherwise appears to be rather intricate.

(1) Exposure of the Inguinal Canal.—The inguinal canal is exposed by an incision through the skin, superficial structures, and the external oblique; the under surface of the lower portion of the latter is then freed to expose Poupart's ligament, and retracted in order to give a good view of the cord lying in the inguinal canal. (I have purposely omitted detail of this first step, as text-book descriptions of it are excellent.)

(2) Exposure of the Sac.—With a sharp scalpel divide, in the direction of and along the centre of the cord, the cremasteric fascia and muscle; then, holding aside this divided structure, the sac will become exposed to view, which, if empty, is easily identified by its being of a milky-white colour. If not empty—in the case of a reducible hernia—it is easily emptied and kept so by raising the patient up into the Trendelenburg posture. In the case of a bubonocele, that part of the internal oblique muscle which forms part of the front wall of the inguinal canal had better be retracted upwards and outwards, as in these cases the sac often does not reach beyond the lower border of this muscle.

(3) Separation of the Sac.—With dissecting forceps carefully pick up the upper wall of the sac, raise this, and at the same time, with some form of a blunt-pointed dissector (personally, I use the end of a pair of dissecting forceps with the blades held together), retract off from either side, in a perpendicular direction, the structures of the cord, until the lower edge of the sac is reached; now, with a finger passed completely round the detached portion of the sac, the remaining separation becomes a matter of simplicity.