In October he was transferred to the Royal Military Infirmary, Dublin, where he came under my care. On admission a solid mass could be felt filling up the whole right iliac fossa and extending across the middle line. Injections of Coley's fluid, commencing with \( \frac{1}{3} \) \( ml \) doses given subcutaneously, were at once given; the maximum dose which could be tolerated was \( 2 \) \( ml \). After the first week the injections were given into the tumour. In all he had seventy-seven injections, and ultimately the tumour disappeared. It was found necessary to give the injections for about ten days, followed by a week's interval. I had an opportunity of seeing this man some nine months afterwards at Aldershot. He was then in excellent health and doing full duty.

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THE RADICAL CURE OF SACCULAR INGUINAL HERNIA.

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The fact that the operations described for the radical cure of this form of hernia are very many and of great ingenuity and variety, and that they all possess the common factor of some form of sac obliteration, rather tends to suggest that this part of the operation is the essential thing and that the method of completing it is comparatively unimportant.

Now Bassini's operation, or some slight modification of it, is still largely done in the Service, and the object of this short paper is an attempt to show that the muscle-suturing part of this procedure is unnecessary and harmful, and that it involves a longer operation and a longer convalescence.

When we consider the conditions under which hernia is prevented from occurring in the ordinary way during increased intra-abdominal pressure we have a mental picture of a fixed diaphragm, contraction of the abdominal muscle, straightening of the curved lower border of the transversalis and internal oblique, close approximation of these to Poupart's ligament, and automatic closure of a possible exit which, owing to position and structure, is the weakest part of the abdominal wall. The above action is helped by flat pressure from the external oblique aponeurosis.

We are thus forced to the conclusion that the integrity and free action of the lower fibres of the transversalis and internal oblique are essential in the prevention of hernia from the normal abdomen, and when a sac has been tied and reduced and normal conditions thus obtained, common sense suggests that the less this important bundle of muscle fibres is interfered with, and the sooner it is freely working again, the better.

Why then anchor it down to a nearly rigid structure? Why alter the natural function of the part? Is not Nature's method good enough?

Moreover the muscle cannot stay permanently where it is sutured unless
it becomes paralysed and useless. It must either resume its function by breaking away from its sutures or do what all muscle does when its action is in abeyance—become weak and wasted.

I have often heard men say, "See what a gap you find between the internal oblique and Poupart's ligament when operating." The explanation, of course, is that the patient is recumbent and the abdominal muscles are completely relaxed by an anaesthetic. If a normal person lies down and draws up his knees and rests them so, he can easily insert his fingers under the internal oblique, but if he contracts his abdominal muscles forcibly, a very complete closure of the inguinal canal can be demonstrated.

Unless there is an abnormal musculature, which is uncommon, the "gap" is of no importance because a hernia does not recur if the sac be tied high up and reduced.

So far, common sense and non-interference with a natural function seem to be in favour of the argument against Bassini's operation, but there are many other reasons for a mere ligation of the sac—the quicker and simpler operation, and the uniformly satisfactory results (as long as asepsis is maintained), combined with a very much shorter convalescence.

The long period during which a man is unfit for duty after Bassini's operation is in all probability due to the time required by the sutured and injured muscle to shake itself free from its shackles and recover its vitality and function, but if Nature's method of preventing a hernia is left intact it is difficult to see any reason for a prolonged after-treatment.

For five years I have performed a single ligation of the sac high up and reduction of the stump within the abdomen to cure an inguinal hernia, and have had no cases of recurrence as far as I know.

I now get the patient up ten days after operation and discharge him from hospital eleven days later, and he is fit for duty at the end of a month's complete treatment. I think that even this period might be reduced with advantage.

There is, of course, no claim for any novelty in this contribution as the simple procedure of sac ligation is coming more and more into favour with surgeons at the present day, and the fact that they find it uniformly satisfactory shows that Bassini's method and its modifications involve an unnecessary disturbance of anatomical structures and an unnecessarily long convalescence; in fact, it is out of date.

To conclude: The best operation for the radical cure of a saccular hernia is the quickest and most simple one. What a relief it will be to the student when the various and more or less complicated methods at present described are deleted from the textbooks.