from its natural cavity through an unnatural opening, or through a natural opening involuntarily distended. I daresay this seems rather hard to understand at first, but when once you have thoroughly grasped the idea of it, all the rest will seem comparatively easy. A hernia does not necessarily mean a protrusion of the *bowel*, though the term is usually restricted to that. It may take place with other viscera besides the bowel, but hernia of the bowel is the only one with which you, as Nurses, have to do, and of which it is necessary here to speak. You are now acquainted with the structure of the intestine, which lies in a cavity called the *abdomen*. The whole of the abdominal cavity is lined with a serous membrane *(peritoneum)*, which forms a shut sac, on the outside of which lies the viscera which it protects. The inside, or lining of the bag, is smooth and moist, so that the two (for the bag, you must remember, is an empty one) may easily slide one over the other. The outer side of the bag is that which is adjacent to the *parietes*, or walls, of the abdomen, with which it is loosely connected, and it is this outer side of the bag of peritoneum which forms the sac which the protruded bowel pushes before it when the hernia *descends*, as it is called. There is more than one variety of hernia of the bowel; but there are only some of which it is needful to speak. These are named first according to their position; and, secondly, according to the condition of the protruded viscera.

First there are Inguinal, Femoral, and Umbilical, and these are again classed into Reducible, Irreducible, and Strangulated.

I will very briefly describe the position of the first, and the nature of the second. *Inguinal* hernia is that which protrudes through one or both abdominal rings. *Femoral* hernia occurs in the neighbourhood of the femoral vein and the ligament called Gimbernat's and Poupart's ligament and the pubes. *Umbilical* hernia protrudes through the umbilical opening.

A *reducible* hernia, as the name indicates, is one capable of being replaced into its natural position, and by wearing a truss, or support, no great inconvenience is experienced.

A hernia may be irreducible in consequence of its size, or through adhesions of the thickened omentum, or folds of peritoneum. *Strangulated hernia* not only cannot be replaced, but also suffers *constriction*, which interferes with the passage of the contents of the bowel, and impedes the return of the venous blood, resulting in swelling and even gangrene. Protrusions in other parts receive different names.

Having now some knowledge of the anatomy of the part affected, and of what a hernia really is, the causes of the displacements naturally suggest themselves to your minds. These are weakness of the walls of the abdomen, straining of the muscles, which, when strained, or pulled out as a piece of elastic, on being relaxed, or let go, force the bowel through the walls of the abdomen, pushing with it the mucous membrane. The *exciting* cause is generally violent bodily exercise, lifting heavy weights, rowing, pulling, &c. The symptoms in each variety, of course, differ according to the nature of the hernia. In that termed *reducible*, a small compressible swelling appears at some part of the abdomen, which increases in size if the patient is in an upright position, decreasing or disappearing when recumbent. In an *irreducible* hernia, the soft compressible lump is always present in any position.

If the hernia is strangulated, however, in addition to the presence of the swelling, the symptoms are strongly marked. Vomiting is invariable, intense pain and tenderness; the patient lies with the knees drawn up, complains of tightness across the abdomen (umbilical pain), the countenance is pallid and distressed, and there is great restlessness.

The surgeon generally endeavours to reduce a hernia, even if strangulated, without having recourse to a Surgical operation, and for this purpose a hot bath is occasionally used, and what is called *taxis*, or reduction by means of the hand, is tried, but if this is unavailing, a very serious operation becomes necessary. Though a Nurse has seldom much to do with the dressing of a case of hernia, it is one which requires her incessant care. The object being to maintain perfect rest of the part affected, it is a very good thing to support the patient's knees with a couple of pillows placed under them. Light and unstimulating diet is given, and the patient must be saved the slightest possible exertion. A Nurse should refrain from giving even the simplest aperient without an order, and should watch carefully for sickness, pain in the abdomen, or bleeding.

You will often hear the different regions of the abdomen spoken of, and will find it useful to know that, chiefly for purposes of description, it is mapped out into nine divisions.

There are three horizontal zones, as they may be called, each of which is again divided partially into three divisions. The middle region of the upper zone is the *epigastric* region; on either side are the *hypochondria*. The middle region of the middle zone is the *umbilical* region; on each side are the *iliac* regions. The middle region of the lowest zone is the *hypogastric*, with the *inguinal* regions on each side.

The *peritoneum*, of which I have already spoken

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