is a good landmark for our proceedings. If there is a portion of the bowel in a loop, or under a band, or in a pouch, we should draw on the lower or empty part, and this way experience has also shown to be the best way of disengaging an intussusception. If we have to deal with a small band we may break or cut it, but it is better to ligature a broad or large band at two places and divide it between the ligatures, as it is difficult and troublesome to secure any vessel which may bleed. If a foreign body is to be removed the portion of the bowel containing it should be drawn well out of the belly. After the substance has been extracted a false anus may be established by stitching the open gut to the superficial wound, or in favourable circumstances, the bowel may be united by suture. So much for laparatomy. It is, I repeat, an operation not to be undertaken with a light heart, or in any but the most desperate circumstances. There are other methods of operative relief which are much preferable, if they can be used. Of these, colotomy in the right or left loin would, of course, be chosen if we are so able to localise the obstruction as to be sure of opening the bowel above it.

In incurable obstruction seated in the rectum and sigmoid flexure—that is, low down, left lumbar colotomy (or Callisen's operation as it should be called), is the operation which beyond doubt would be employed ; but it is sometimes far from easy to be sure that by that operation we can get quite beyond the obstruction even in cases in which we seem to have clear evidence to support that conclusion. The descending colon has been often opened after very careful examination, and the obstruction found to extend above the point opened. That the bowel can be safely and comparatively easily reached in either loin is well established and attempts have been recently made to revive Littre's operation (in which the sigmoid flexure is opened in front through the peritonæum, that is, in the left groin); yet all the difficulties connected with getting beyond the disease are in that operation much enhanced by the near neighhourhood of the disease even when it is confined to the rectum. The necessity of opening the peritoneum in operating will make surgeons slow to substitute an operation which was in former years condemned for its unfavorable results, for one which possesses so many stronger claims to success. If the obstruction lies in the descending colon, left lumbar colotomy (Amussat's operation) is that which should be preferred. No one has yet proposed to re-introduce Fine's operation, in which the transverse colon (which is surrounded by peritoneum) is opened ; but in these days of obtrusive and restless innovation there is no saying what may yet arise. It is certain that in an immense proportion of cases of intestinal obstruction, the obstruction lies below the right loin. Bryant gives the proportion 15 to 1.

In the many cases in which the obstruction lies about the caput cæcum and the ilio-cæcal valve, Nélaton's operation (which is an extension and improvement of Pillore's) is beyond doubt the best surgical proceeding. Pillore opened the cæcum, but Nélaton demonstrated how by a very small incision in the right groin that region could be perfectly examined, and how with little risk life could be saved in irremediable cases by opening whatever coil of the bowel (necessarily the distended part, and so above the obstruction) protruded at the wound. The success of this operation has been great, and in the cases where I have myself had recourse to it, it has been most satisfactory in saving life. If the obstruction is such that it cannot be removed, or if the steps necessary for its removal (from the condition of the patient, involves too much risk, this is a most invaluable operation. No blood-vessel need be wounded. The bowel is not much handled or exposed, and an outlet is certainly secured for the imprisoned fæces. It is quite true that in most cases this is only palliative—that is, it does not remove the cause of obstruction in all cases, *but it saves life.* I hold it places the artificial anus at the most satisfactory place—a much better place than in the loin, as it is under the control of the patient, it can be dressed by himself without aid, and an apparatus can be best applied to restrain discharges. Finally, I hold that in the considerable residuum of cases in which we have done our best to determine the seat of obstruction, and have failed, that this right inguinal enterotomy is the right operation to perform.

In conclusion, I would say that, as a rule, if an operation for intestinal obstruction is to be performed, the sooner the better. In acute cases it is a question of hours, and in chronic cases delay beyond a week is inexcusable. Sometimes as in a recent case which I saw with Dr. Hugh Miller, our hand is held by the knowledge that similar attacks in the same patient have, after as long intervals, without interference passed off. But, as a rule, if internal remedies intelligently and perseveringly administered have failed to bring relief, then no good but only evil can come of delay. The using of purgatives should be by the rectum alone ; and nourishment, too, as is well known, can be largely administered by the bowel, and it is well that full advantage should be taken of this knowledge. Exhaustion, peritonitis, and perforation are imminent, and the mere hopelessness of the patient will so oppose success that the operation can only lead to disaster. The length of time the obstruction has existed is not so good a criterion in determining whether we should operate, as the violence of the symptoms and, above all, the persistence of the vomiting, which does so much to exhaust the patient. Vomiting, pain, distension, are perhaps the most threatening conditions, and if they continue, are the strongest arguments for operation. If the