that existed began to diminish, and in some cases eventually disappeared completely. These were evidently cases of functional or spastic pyloric stenosis, and the result was most satisfactory. In some of the cases lavage had been tried for a long time without benefit, and in one or two cases with increase of the symptoms. Twelve cases of gastric catarrh were treated by this method with uniformly good results whenever the patients bore the oil well. A certain number of patients, about 1 in 20, cannot take the oil in the doses required; that is, up to about 7½ to 9½ ounces per day. In one or two cases this method of treatment was tried as an absolutely last resort before operation, and it proved successful. Patients who had lost so much in weight as to appear almost cachectic began immediately to gain in weight, and within a couple of months gained from 15 to 30 pounds.—Cohnheim (*Med. News*, Aug. 18, 1900).

RECTAL ALIMENTATION.

For how long a period rectal alimentation should be administered depends upon the condition necessitating it. In ulcers and irritating affections of the stomach rectal alimentations will be administered alone without any additional nourishment through the mouth for a period varying from one to two weeks, when the natural mode of nutrition will be cautiously resumed. In cases in which there is an organic obstacle within the œsophagus or at the pylorus preventing the passage of food into the intestine, rectal feeding must be carried on as long as the impediment exists (in operative cases until a few days after the operation has been performed—in inoperable cases indefinitely). Here, whenever possible, besides the enemas, small quantities of liquid foods may be given also by way of the mouth.

Shortly after the operations on the œsophagus, stomach, and small intestines, rectal alimentation must be administered for a period varying from four days to a week or ten days.

Before administering the feeding enema, a cleansing injection, consisting of a quart of water and a teaspoonful of salt, should be given early in the morning, in order to thoroughly evacuate the bowel. One hour later the first rectal alimentation may be administered. The feeding enema is best injected by means of a fountain—or Davidson syringe, or a plain, hard-rubber piston-syringe and a soft-rubber rectal tube which is introduced into the anus five to seven inches. The injection should be administered slowly, without much force. After the withdrawal of the tube from the rectum the patient is told to lie quietly and to endeavor to retain the enema. The quantity of the feeding enema may be from 5