ation chiefly recommended at the present day in case of adults. Bryant prefers the oblique incision.

I commenced the operation by making a transverse incision in the left lumbar region, three inches in length about midway between the ilium and last rib; the centre of the incision corresponding to a point half an inch behind the mid-point between the anterior and posterior superior spines of the ilium, according to the rules laid down by Allingham in his work on diseases of the rectum. The fascia and muscles were carefully divided on a director, layer by layer, keeping the bottom of the wound the same length as the incision through the skin. When the incision was made through the lumbar and transversalis fascia, the adipose tissue was unravelled, exposing the colon, which bulged up into the opening, and was easily recognised by its greenish color, distended appearance, &c. The bowel was then caught up from behind by a tenaculum, and pulled forwards and outwards to the surface of the wound, keeping clear of the peritoneum. A curved needle armed with a strong silk thread was then passed through the edge of the wound into the bowel, diagonally across, and out at the opposite side, then another at right angles to the first. The bowel was then opened between the two sutures, the loops drawn out, cut and tied, thus making four sutures, and securing the bowel to the edge of the wound. The balance of the edge of the bowel was then fastened to the edge of the wound by silver wire sutures. The anterior and posterior parts of the wound were drawn together by deep wire sutures, and the operation completed. Works on surgery recommend that the posterior part of the wound be not drawn together by sutures, but left to heal by granulation. I think that it would have been better if I had not closed the posterior part of this wound, as the sutures gave way, and the wound had to heal by granulation. During the operation not more than an ounce of blood was lost; no vessels were cut requiring a ligature. There was only slight hemorrhage from the deep lumbar muscles which was easily controlled by a styptic application, doing no more harm than causing a slight delay in the operation. Shortly after the operation was completed, the bowels commenced moving, and discharged enormous quantities of soft fæces through the artificial anus for several days.

It is not necessary to give a history of the patient's condition from day to day. I think that it will embrace all that is required in this case, by stating that the next morning after the operation, the temperature and pulse were normal, tongue moist; and from that time the patient never showed an unfavorable symptom from the effects of the operation. The upper edge of the bowel adhered to the edge of the wound by first intention; but the sutures in the lower side cut through, and allowed the edge of the bowel to drop down into the wound. This gave me considerable anxiety for several days, in case some foreign matter might work its way into the peritoneum, but the constant pressure of fæces kept the edge of the bowel pressed out against the wound, which soon formed adhesions, and gave no trouble whatever. In looking over the statistics of these operations, I do no find that the edge of the bowel is very apt to drop away from the wound in case the sutures should give way. Parts of the wound that did not heal by first intention, healed very nicely by granulation, and the patient was soon able to be up, and around. On the seventh and eighth days after the operation, his bowels moved per natural anus; then after that they would only move per natural anus every third or fourth day until the patient was up and around on the streets, when he put a leaden plug into the artificial anus. He had then a natural operation every day; but it caused him so much pain through the pelvis, that he took out the plug, and allowed the bowels to evacuate themselves through the artificial anus. I think that in all probability when the bowels became obstructed, the pressure and distention from above may either have caused the stricture to become inflamed and swollen so as to occlude the narrow opening altogether; or the bowels loaded with fæces may have pressed down on the stricture in such a manner as to prevent anything from passing through. After the operation the pressure was taken away from above so as to relieve the stricture, and allow the stools to pass through. This case may have been similar to a case mentioned by Hilton in his twelfth lecture on rest and pain. He says "that upon making a *post mortem* it was found that there was no cancer. There had been contraction of the intestine where the sigmoid flexure of the colon joins the rectum. This had produced an obstruction, and, consequently a distention of the colon.