It is well to remember that dark spots on the intestine may be due to small blood clots between its coats, or there may be clotted blood within the interior of the bowel, although the latter is believed to occur rarely, except in children. It has been an experience frequently repeated with the speaker, in infants who had suffered temporary strangulation, who, after reduction by manipulation, have passed blood with the next two or three stools.

Inflammation of bowel and sac will usually be found associated with exudation of lymph and with considerable fluid within the interior of the sac. Great care is necessary in separating these adhesions that the bowel is not lacerated, and at times it will be found advisable to cut out a portion of the sac and return with the gut, after due precautions about thorough cleansing, and the use of the hot water to aid in restoring the bowel to its normal condition.

Here, again, must be repeated the caution about drawing the bowel down to a healthy portion and seeing that all adhesions are broken up before it is returned to the abdomen. Ulceration and perforation are also more liable to occur at the point of stricture than in the body of the loop.

The loop is usually found distended with gas, or fluid, or both, and this brings up the question of tapping, in order to secure easier reduction. I can hardly think that any surgeon of experience would, at the present day, do otherwise than advise against this procedure, even with the finest hypodermic needle. It has been found that making a puncture point in an already partially paralyzed intestine is quite a different thing from treating a healthy bowel in a like manner, and that it is inviting a breaking down of tissue at this point after the bowel is returned to its natural cavity. For the same reasons I look upon all forms of aspiration in attempted reduction of strangulated bowel with the greatest disfavor.

Tension upon the loop will be relieved when the stricture at its neck and surrounding adhesions are frely divided.

Laceration and perforation.—These two words have reference to two quite different accidents. Laceration may, and frequently does, occur as the result of violent taxis, or in separating adhesions during the operation in otherwise fairly healthy bowels; while perforation in this sense implies a solution of continuity by a destructive process, and that this degeneration of tissue extends beyond the point visible to the eye. To lose sight of this latter fact is almost certain to result in disaster to the patient. In either case, we usually have to deal with a septic condition, due to extravasation of the contents of the bowel, as well as a more or less localized peritonitis, and it is advisable to wash out all foreign matter as carefully as possible with a weak bichloride solution, followed by boiled water. If the opening into the bowel is of large size, it is well to close the bowel on either side by means of temporary clamps. Clamps designed for the purpose are not a necessity. A piece of iodoform gauze, or a flat rubber band surrounding the bowel and held by forceps, will answer every purpose. These precautions having been attended to, release the bowel at its point of constriction, both that its damage here may be estimated, and that normal circulation may be as quickly re-established as possible. Every care must be taken to prevent entrance of septic matter into the peritoneal cavity and surrounding tissues.

In closing rents in the intestinal canal, as in doing any work upon the viscera, there are a few points always to be borne in mind. 1st. That in bringing surfaces together where their union is intended, it must always be serous membrane. 2nd. It matters less what form of stitch this is accomplished by than that they are brought accurately together, with their surfaces in perfect apposition. 3rd. Moderate scraping of the surfaces to be brought together to secure their earlier and more perfect agglutination (a point made prominent by Dr. Dawbarn). 4th. The absolute cleanliness of the part after work is done upon it before returning to abdominal cavity.

Senn (*Journal Am Med. Ass'n, Aug. 12, '93*) has called attention to the advisability of having the line of sutures run transversely to the long axis of the bowel, when possible, so as not to encroach so much upon its lumen. Linear lacerations must be closed, however, according to the direction in which they run, and this can usually be done with no serious impairment of the size of the tube. In most of this work, the Lembert suture, either interrupted or continuous (Dupuytren) will be found best; applied with a small round needle, and the material preferably of silk.

Perforation from degenerative process is so closely allied to gangrene that the greatest caution