phasizes the danger of such a method and the liability of rupture of the bowel where ulcers have existed.

All operative measures have hitherto been unsuccessful and the various incisions and punctures produced relief for but a short time and death resulted either from shock or peritonitis. But the rationale of an operation performed upon the enlarged intestine itself, may well be questioned inasmuch as the paralysed condition of the muscle wall would render the evacuation of the bowels still difficult, and it is evidently for this reason that Rolleston has made what seems an admirable suggestion viz :—To open the lower end of the small bowel where there will be no obstruction to the out-flow of fæces and by this means to relieve the distention and accompanying symptoms.

Where any kink has formed or where there is contraction of the meso-colon one might expect by relieving these conditions to obtain a good result only in those cases where the dilatation had not become excessive, otherwise it would seem that the diseased condition induced by the stretching and hypertrophy would be irremediable.

Where indeed very much hypertrophy and distention have occurred and the symptoms are in no way relieved, it may truly be said that the large intestine where affected is to all intents and purposes a foreign body and it may therefore be reasonably considered whether total extirpation of the affected portion is not commendable and whether an operation for intestinal anastomosis could not easily be performed between the two healthy ends remaining. This could be attempted either between the unaffected colon and the rectum, or if the whole upper colon be involved an anastomosis could be accomplished between the lower end of the ileum and the remaining portion of the healthy rectum. In this way fæces would have a ready escape and the sphincter action of the rectum and anus would remain intact. This could be done either by means of an end to end anastomosis, or, as my friend Dr. A. E. Garrow has suggested, better still by a lateral anastomosis which would thus obviate the liability to intussusception and prolapse.

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