For the past 3 weeks he had been feeling out of sorts with what he calls a "bilious attack," suffering off and on with headache nausea, constipation and wind pains in the abdomen.

On Friday, Jan. 31st, he had a kind of fainting attack when in his cellar at home and for this he took salines and had a good movement of the bowels on Sunday. Monday the patient was not extra well but had no definite trouble. Patient had severe abdominal pain Tuesday morning, but went to work, but the pain became so severe that he had to come home at 2 p.m. During Tuesday and Wednesday, (Feb. 4 and 5), attacks of abdominal pain were very severe and required morphia. Salines oil and enemata were tried but had no effect on the bowels, and on Wednesday evening, the patient began vomiting, and by Thursday morning, the vomited matter was dark and smelt badly, and the patient came to Hospital at 2 p.m. (Feb. 6, 1906).

Personal History: The patient had always been healthy except for chronic constipation and flatulency. He had tapeworm 4 years ago. His habits have been regular and he uses no alcohol nor tobacco.

Family History: Good.

Present Condition: A thin muscular man of medium height; face very pale and of abdominal type showing great distress; lies in bed with knees drawn up and at times writhes in agonies of pain felt across the abdomen. T. 98; P. 72; R. 24.

Abdomen prominent especially upper zone, tympanitic and tender all over to palpation.

Rectum normal. Organs normal.

The abdomen was opened immediately, in the middle line below the umbilicus. The intestines were dark colored and the sigmoid flexure was found twisted upon itself with a double twist. It was delivered from the abdomen, the twist undone, and a rectal tube passed from the anus through which gas and feces escaped. The sigmoid was very long and very large, but no attempt was made to measure it.

The abdominal wound was closed and the patient made an excellent recovery and was discharged on the 20th of Feb. 1906.

I advised him, however, that on account of the great length of the sigmoid he would be exposed to the risk of subsequent volvulus, and that in my opinion, it would be wise before he left the Hospital to have the sigmoid flexure excised altogether. He would not consider this advice, however, and left as already said, at the end of two weeks. On the 21st of September, 1907, (19 months later), he was *readmitted*, complaining of severe abdominal pain, constipation and distension.

Since leaving the Hospital last year, the patient had been in good health save for occasional attacks of general abdominal pain, with cons-