side of the bowel. The wall of the intestine felt as though it was thickened and somewhat contracted. I then carefully introduced a rectal tube up alongside of my finger, guiding the end into the apparently contracted bowel, but this manipulation caused him so much pain that I discontinued further explorations for the present, and prescribed a pill containing podophyllin, gr. 1, ext. colocynth comp., grs. iv., ext. hyoscyamus, grs. ij., to be taken that night, and to report himself next morning. This was the only purgative that was prescribed during my treatment of the case.

I did not hear from him until the next night, when I received a call to see him at a friend's house near the north end of Virginia City. I found him suffering very much from distention of the bowels, colic and vomiting. The pill had not operated; he had passed no gas from his bowels, although belching up considerable quantities from his stomach. I ordered an injection of warm water, but was unable to inject any more than than would fill the rectum, which gave him no relief. I then gave him a hypodermic injection of morphia sulph., gr. ¼, atropia sulph., gr. $\frac{1}{100}$; prescribed one grain of opium to be taken every two or three hours if in pain; and ordered hot fomentations to be applied over the abdomen. Saw him next morning, found him no better; abdomen more distended, still vomiting, pain somewhat relieved by the opium. Tried injections of warm water again, with the addition of asafœtida, but obtained no relief, not being able to inject any more at a time than would fill the rectum. During the afternoon I called Dr. Hall, of Gold Hill, in consultation. The doctor recommended ext. belladonna in addition to the opium. During the next five or six days we invited Drs. Conn, Aiken, and J. Manson, of Virginia City, to see the case with us at different times, and everything that was likely to benefit the patient was diligently tried, but without relief; the patient getting worse all the time. It was quite evident the obstruction was in the region of the sigmoid flexure. We could never succeed in introducing the rectal tube further than the left ileo-sacral symphysis; nor inject more liquid at a time than would fill the rectum.

On the seventh day of our treatment, we chloroformed the patient, and Dr. Aiken tried to introduce his hand into the rectum to explore the sigmoid flexure more thoroughly, but was unable to do so. We then introduced a trocar and canula into the large intestine in the region of the cæcum, and let escape a large quantity of gas, which greatly relieved the distention, and enabled us to arrive at a more correct diagnosis of the case. We could feel a hard ridge about two inches long along the sigmoid flexure, and there seemed little doubt but that the cause of the obstruction was a stricture of the bowel in that region, and the only alternative was an artificial anus. To this the patient reluctantly consented, after telling him that the false opening might be closed up at some future time, if he survived the operation, and the natural passage ever got well so as to justify the artificial one being closed. There were no bad effects from introducing the trocar into the cæcum. The bowels were again greatly distended, tongue dry and cracked, with a brown coating over it; temperature not higher than 102½; pulse 120, and the patient's strength failing fast. It was very evident that we would soon lose our patient if nothing more was done, so we decided to operate at once. Drs. Conn, Weber, Bronson, and J. Manson, of Virginia City, were present by invitation. After the patient was thoroughly chloroformed, Dr. Bronson, who has a small hand, succeeded in introducing it into the rectum, but could not introduce it high enough to make any further discoveries. I was ably assisted in the operation by Drs. Hall and Conn, Dr. J. Manson attending to the chloroform. In Bryant's "Practice of Surgery," page 367, he says, "that in irremediable stricture, or mechanical obstruction of the rectum from any cause, Callisen's operation of opening the colon in the left loin should always be followed; and when the seat of obstruction is higher than the rectum, and it is a point of doubt whether it be in the sigmoid flexure or transverse colon, Amussat's operation in the right loin should be performed." In this case the stricture or obstruction was in the lower end of the sigmoid flexure, so that there was little or no danger of not getting above the obstruction by operating in the left loin.

There are three methods of operation, that of Callisen, by longitudinal incision, Bawden's, by oblique incision, and Amussat's, by transverse incision. These different methods of operation are fully described in nearly all recent works on practical surgery, so that it is unnecessary to repeat them here. I chose Amussat's, it being the oper-