A distinct tumor could be felt on palpating the abdomen in the left lumbar region. It extended upwards into the left hypochondriac region and across to the upper part of the umbilical region. This tumor was sausage-shaped, but curved so as to form a segment of a circle with the concavity looking downwards and inwards towards the umbilicus. On digital examination of the rectum nothing abnormal was detected, but on removal of the finger it was found to be covered with a considerable quantity of bloody mucus; there was no fecal matter, however. The diagnosis of intussusception was made and operation was undertaken for relief. Chloroform was administered at 8 p.m. Under the anesthetic the tumor could be very distinctly marked out; it was shaped like an omega loop and was very hard. An incision was made in the middle line below the umbilicus, and was enlarged upwards through that structure in order to reach the tumor. An attempt was made to deliver the tumor mass upon the anterior abdominal wall, but there was considerable difficulty in accomplishing this, the tumor being fixed firmly by the ligamentum suspensorium lienis. It was found to be an intussusception about 10 inches long and 2½ inches in diameter. The intussusceptum proved to be the transverse colon which had become invaginated into the splenic flexure of the colon. The point of entry of the intussusceptum was far back in the left hypochondriac region, and was fixed there by the ligament already mentioned. It became necessary to enlarge the incision well up to the ensiform cartilage before we could deliver the whole mass on to the anterior abdominal wall. An attempt was now made by slight traction to pull out the intussusceptum, pulling upon the transverse colon above the tumor, but this was absolutely ineffective. I then asked Dr. Thistle, who assisted me, to continue this traction slightly whilst I manipulated the tumor mass. I found, contrary to all teaching on the subject, that pressure immediately over the apex of the intussusceptum was most effective. By pressure exerted by my right hand directly over the apex of the intussusceptum whilst firmly supporting the tumor with my left hand, the invaginated bowel was pressed out of the intussuscipiens. Some adhesions existed near the apex of the intussusceptum, but none existed elsewhere. There was, in fact, a remarkable absence of lymph or of peritoneal exudate. The following condition was now noted after reduction: Extensive ecchymosis was observed in the portion of the omentum which had followed the invaginated bowel into the intussuscipiens: The bowel above the tumor was quite collapsed; *there had been absolutely no distension.* A very much thickened piece of bowel formed the apex of the intussusceptum. The amount of thickening here was so remarkable