testinal obstruction, may generally be easily diagnosed from the history, coupled with the presence of a tumor, which can be more or less easily indented by firm and steady pressure of the finger.

Chronic intussusception and obstruction from foreign bodies having been already referred to, we will now turn our attention to the important subjects of *diagnosis and treatment.*

In reference to *diagnosis,* we will first enumerate the prominent features of most cases of acute obstruction. The symptoms are generally extremely *abrupt* in their onset, and may be briefly named as follows: 1st, severe pain in the abdomen, followed rapidly by frequent and persistent vomiting; 2nd, often after a few hours, there supervenes more or less meteorism, which however may be localized, and occasionally even, when the seat of obstruction is high up, may be entirely absent; 3rd, we have as a rule from the first absolute constipation, not even flatus passing per anum; 4th, after a shorter or longer period, depending upon the acuteness of the symptoms, there will appear a collapse; which is often attended by either intestinal or fæcal vomiting.

The diseases with which acute obstruction is most likely to be confounded are perhaps acute peritonitis due either to perforation or other causes, cholera and dysentery. Acute peritonitis is the more apt to be mistaken for acute internal strangulation, for the reason that quite frequently cases of the latter disease have the former developed during their progress. If, however, one is called early in the case, he will find several points of difference, which will pretty certainly fix the diagnosis. In peritonitis the temperature is generally considerably raised, while in acute obstruction it is as a rule subnormal, becoming perhaps elevated some days afterwards from the supervention of inflammation. Tenderness is a marked symptom in peritonitis, while there is an almost or entirely complete absence of it in the other disease. This gives rise to a striking difference in the attitude and behaviour of the patient. In peritonitis, he of course usually assumes the dorsal decubitus with knees drawn up, and is unwilling to move or be moved. In cases of acute obstruction, however, he writhes about in bed, assuming all sorts of positions, or gets up and walks about the room like one suffering from an ordinary attack of colic, while he is even also relieved sometimes by pressure as in that affection. Again we have a diagnostic symptom of much importance, namely, the existence of rigidity of the abdominal muscles, giving rise to a *board-like* feel; in cases of peritonitis, which contrasts strongly with the flaccid and soft abdominal walls in obstruction. Also, vomiting is a much more prominent symptom in strangulation, and becomes after a few days either intestinal or distinctly stercoraceous. It is exceedingly rare for it to attain such a character in peritonitis, and then generally only at the close of a fatal case. Furthermore, constipation is almost invariably absolute after obstruction has become established; except perhaps in cases of intussusception, which however, on account of the bloody discharges that are generally present, are not likely to be confounded with peritonitis. It is only the ultra acute cases of intestinal obstruction which would be mistaken for an attack of cholera, such as strangulation near the stomach or acute cases of intussusception in very young children. The prevalence of the epidemic at the time may aid us in deciding between them, while cramps and a severe diarrhœa accompanied with rice water discharges would generally serve to make us sure of the diagnosis. From dysentery we may generally readily diagnose obstructions by the absence of febrile disturbance, and by the greater severity of the pain and vomiting. From my own experience in three cases, where I had I think good grounds for believing that I was dealing with intussusception, I would be inclined to lay considerable stress upon a difference between the discharges of dysentery and those of intussusception, to which no one as far as I am aware has called any special attention. I was myself particularly struck by the *bright-pink* colour of the serous dejections in in these cases, which seemed to me to contrast very remarkably with the dark dirty hue of those of dysentery. In my cases also I saw very little if any mucus, though the absence of this may have been due to the fact that the rectum was not involved, no tumor being felt by the finger per anum. Furthermore, any blood seen was of the same bright red colour, and thus differed materially from the dark clots generally observed in cases of dysentery.

Although the diseases above referred to are perhaps the chief of those which may be mistaken