most important, severe abdominal pain with nausea and vomiting; there is usually no distension or tenderness, and an absence of fever. When you have severe pain, vomiting and obstinate constipation without fever, without distension and without tenderness or rigidity, which usually comes later, you have a strong case for obstruction, and one should not wait for all the classical symptoms, such as tympanites and faecal vomiting before opening the abdomen. Several acute lesions, however, within the abdomen, such as perforation of a gastric or duodenal ulcer, rupture of a pyosalpynx, passage of a gall-stone, perforation of a vermiform appendix, acute pancreatitis, twisting of the pedicle of an ovarian cyst, etc., are ushered in with symptoms very much similar to those which follow the strangulation of a loop of intestine and often some hours must elapse before differentiating the cause of the sudden abdominal crisis.

The weight of authority, I believe, favors the view that symptoms of obstruction are rather the results of auto-intoxication than of a mechanical disturbance of the nervous structure in the intestine. Pain is always a pronounced and conspicuous symptom. It is usually violent and persistent when the obstruction is complete, generally more or less diffuse but often referred with greater intensity to the neighborhood of the umbilicus which corresponds to the site of the superior mesenteric and solar plexus. There is often slight periods of subsidence, the pain however, renewing itself again with greater intensity. At first the pain may be relieved by pressure.

Coincident with or quickly following the advent of pain, is nausea and vomiting; rarely it may precede the access of pain. The vomiting is copious and persistent, the vomited matter at first consisting of the contents of the stomach. Then it becomes bile-stained or thin brownish or pea-soup like, and finally, stercoraceous and filthy. Formerly the stercoraceous vomiting was thought to be due to auto-peristaltic movements, but recent experiments have demonstrated that it is produced by contraction of the abdominal muscles and diaphragm and of the mutual pressure that the distended coils of intestine exercise one on the other along the normal peristaltic movements of the bowel. The vomiting usually persists unless the case is relieved, until death.

Obstinate constipation due partly to reflex nerve action, but chiefly to the absolute obliteration of the lumen of the gut, usually appears as soon as the occlusion takes place. The contents of the rectum and sigmoid flexure may be lavaged with enemas, but one rarely sees a spontaneous evacuation of intestinal gases or faeces.

Meteorism is usually a later symptom of strangulation by bands or from hernia; it is most marked when the colon is the seat of the obstruction, and is especially pronounced in volvulus of the sigmoid flexure.