fectly true, as evidenced by the fact that the removal of the large bowel results in a marvellous improvement in the health and appearance of the individual and in the duration of life. But I would point out that the benefit which results from the removal of the large bowel does not show that the colon is the chief source from which toxins are absorbed in excess.

Indeed, in a considerable proportion of cases I believe the bulk of the absorption takes place from the small intestine.

Stasis of the small intestine with the associated infection of its contents by organisms to which it is unaccoustomed is not primary, but is secondary to a stasis in the large bowel.

In other words, if it were not for the presence of the large bowel the conditions producing stasis in the small intestine would not arise. If the caecum did not become overloaded the obstruction to the ileal effluent either by an acquired mesentery, an appendix hitching it up, or by simple stasis would not develop. Consequently the contents of the small intestine would not become infected by organisms, the duodenum would not be blocked by the drag of the small intestines obstructed at the end of the ileum, the mucous membrane of the duodenum would not inflame and ulcerate, the biliary and pancreatic ducts would not be infected and the obstructed outflow from the stomach, with all its associated sequelæ, would not occur.

Now I wish to show that the extraordinary improvement that results from short-circuiting and the disconnection or removal of the large bowel is due largely to the fact that the evacuation of the small intestine is facilitated by its introduction into the pelvic colon and that the infection of its contents by organisms which grow in the stagnating matter in the large intestine ceases abruptly. I do not wish to suggest that all absorption of toxins takes place from the stomach and small intestine, but I do maintain that the tract other than the colon plays a very important part and I believe by far the most important part in the process of absorption. It appears to me that the point of greatest difficulty in the passage of material along the gastro-intestinal tract is through the last few inches of the ileum. This is particularly the case when the caecum has been securely fixed by acquired adhesions in the iliac fossa. In such cases the delay of the effluent at the pelvic brim may be very great; indeed, in one of my cases which Dr. Jordan has examined with bismuth and the X-rays, the material remained in the terminal coil of the ileum for as long as eighty-five hours* without there being found at the operation any evidence of interference with the effluent by an acquired peritoneal band or by an appendix fixed in such a position behind the small bowel as to control the passage of material through it in certain positions. Now this form of simple