latter method appears to give more postoperative pain, but the ultimate results are equally as good as where the bowel is severed.

There should be no mortality following this operation if the surgeon be careful to leave no conditions favoring internal hernia or obstruction. The Trendelenburg position should be used at least before the abdomen is closed, so as to make sure that the small intestines are in their place, and not in the pelvis, which should always be packed with the large bowel. The omentum should be placed over the anastomosis. No drainage is necessary if the peritoneal toilet has been satisfactory.

As to retroperistalsis, I have not yet had any cause for anxiety. Occasionally I make a lateral oblique implantation, leaving about an inch of the ileum projecting into the sigmoid in the direction of the intestinal current. This, if it survives, would act as a valve to prevent, or at least hinder to some extent the passage of fecal matter backwards. I would also suggest a partial unilateral enfolding (intussusception) of the bowel, so fixed that an increase of the enfolding could not occur. Quverain suggests that the lumen of the colon above the auastomosis be reduced by plication.

Previous to removal of the colon, or part of it, ileosigmoidostomy should receive consideration. Even in malignant cases, the drainage and removal of intestinal fermentation would decrease the intense toxaemia so frequently present, and would also improve nutrition, thus adding materially to the success of the radical operation. Another point not to be forgotten is the fact that in the secondary operation the surgeon has to deal with a functionless organ with a lessened blood supply, and with one-half the operation previously performed—the anastomosis—the patient has the double advantage of less shock and one-half the anesthetic, both factors of utmost importance in debilitated subjects. In this we are following a most valuable surgical precept, that wherever possible, to divide all complicated operations in which there is risk to life into proceedings of lesser risk.

The diarrhœa which follows these cases lasts but a few days, the sigmoid rapidly adapts itself to the new conditions, and no rectal incontinence has followed.

When, after careful elimination of other causes, when regulation of diet, massage, lavage and medical treatment have failed, when obstructions, kinks, adhesions, gall-stones and mischievous appendices have been given their desserts, and still constipation, with its hideous train, persist, we are justified in undertaking the simple, yet most promising, ileosigmoidostomy.