tives until the 14th of July, when he was seized with faintness, and became quite pale. This condition lasted all the afternoon, and the patient stated that he knew from his past experiences that he was about to have a hæmorrhage, and within a few hours a large quantity of dark clotted blood was passed per rectum. I now advised operation, to which he readily consented, and on the 19th of July I opened the abdomen in the middle line below the umbilicus and directly over the part at which the mass had been felt, although it had disappeared with the free evacution of the bowels and had not since been discoverable. Two loops of small intestine, each acutely bent upon itself, were found attached to a mass which overhung the brim of the pelvis. These were carefully separated, when it was found that they both communicated with a free cavity, bounded posteriorly by the mass above mentioned, and in which lay a long irregular mass of inspissated fæcal matter. The obstruction was at the upper of the two acutely bent portions of the ileum, and the bowel above this angle was three times as large as it was below it. Over a space of two inches in length, and involving one-third of the circumference of the bowel the wall of the gut was entirely absent. This portion was excised and the ends united by the Murphy button. At the lower attached loop the destruction of the bowel was less, being about one inch in length, and involving a narrow strip along the mesenteric border. These deficiencies in the wall of the bowel were apparently the result of a destructive ulcerative process. It was from this point that the hæmorrhages had occurred, and a small artery, which was ulcerated through, bled very freely. The vessel was ligatured and the opening in the bowel closed by a continuous Lembert suture running obliquely from the mesenteric border to near the free border of the bowel. This, of course, narrowed the lumen of the gut somewhat, and gave me some anxiety as to the possibility of the passage of the button, which, it will be noted, was on the proximal side of this suture. My only alternative, however, was another resection and end to end anastomosis,