Any lymph or thickening on the bowel in the neighborhood of the fistula was dissected off. It was then found that the calibre of the gut was only slightly narrowed, and this was apparently caused by the suture introduced longitudinally at the beginning of the operation to close the opening in the bowel. This suture was therefore cut and removed, and the opening into the bowel re-sutured transversely (instead of longtitudinally) as is recommended in the operation of pyloroplasty, and first practiced by Heineke, of Erlangen. A second continuous Lembert suture was introduced, and for further security against leakage a piece of omentum was brought like a cuff around the bowel and sutured on either side to the mesentery.

Lastly, the old cicatricial tissue in the abdominal wall was cut away and the wound closed.

February 20.—Temperature 98, pulse 100. Patient passed a fair night and suffered very little pain. Flatus passed per rectum.

February 21.—Patient feeling well, and asking for food. Pulse and temperature normal.

February 23.—Patient feeling well and hungry. No distention. Flatus passing. Six tablet triturates Hydrarg. Subchlor. gr. 1-10 were ordered, one to be taken every hour, to be followed by a saline.

February 24.—Patient feeling perfectly well. Has had two large natural stools. From this time on his recovery was rapid and complete, his bowels moving twice daily without medicine. The stitches were removed on March 4, (thirteen days after the operation). The abdominal wound healed by primary union. Two days later the patient was up and about the ward and in excellent health.

On March 13 the patient complained of feeling poorly. He suffered from a sore throat and vomited a number of times. Temperature 102½°F., pulse 120. The following day a characteristic scarlatina-form rash made its appearance, and he was sent to the Civic Hospital, where he is now convalescing.