Intussusception, which represents the next form of acute obstruction is one very commonly met with, about one-third of all the cases being made up of this variety. Nearly one half of those reported were of the ileo-cæcal kind, next in frequency was the enteric, then the colic, and lastly the ileo-colic. More than 50 per cent. of all cases occur during the first ten years of life, and about 25 per cent. in infants under a year. In this respect intussusception differs remarkably from the two preceding forms of acute obstruction. The most common exciting cause noticed has been diarrhœa; but, according to Treves, only about 10 per cent. were preceded by this disease. In all three cases of my own, diarrhœa preceded for a day or more the establishment of marked symptoms of obstruction. One of the most striking as well as frequent concomitants of intussusception is the *passage of bloody discharges*. About 80 per cent. of the acute cases presented this symptom, and about 50 per cent. of the chronic ones. In a very large proportion there was also a marked degree of *tenesmus* present, especially in the more acute cases. A third distinguishing feature of intussusception is the presence of a more or less distinct tumor, which may be felt in about half the cases, and is apt to grow harder and more defined during a paroxysm of pain. It varies in size from that of an egg to that of the forearm, and as a rule is more or less fixed. Its length may be as much as 5 or 6 inches or more. In nearly one-third the cases the lower end of the tumor projected from the anus, or could be felt by the finger in the rectum. The *Chronic* forms of intussusception are more difficult to diagnose than the acute, and the symptoms may be protracted for months. Diarrhœa very commonly alternates with constipation in these cases, and there are intervals when the patient seems to be in fair health, although more or less emaciation necessarily accompanies the malady in its progress. Spontaneous relief may take place in any case of intussusception either by reduction of the bowel, with or without the assistance of opiates, or by sloughing of the invaginated portion and union of its ends. A partial recovery occurred also in one case reported, when a fæcal fistula formed about the seat of obstruction.

We come now to a consideration of the 4th class of acute obstruction, namely, that caused by the presence of a foreign body. More frequently, however, the symptoms produced by such pursue a more or less chronic oourse, although the final result as in chronic intussusception may be brought about suddenly. These substances are of course found to be of various composition and character, and are introdnced into the alimentary canal by swallowing some hard or indigestible material, which, either singly or by accumulation, brings about obstruction. Among the largest of these masses may be mentioned those composed of cocoa-nut fibre or hair In one instance one of the former weighed 4 lbs.; and I myself saw Mr. Knowlesly Thornton remove a mass of hair and thread from the stomach of an hysterical yonng woman, which measured 9½ inches in lengih, and was 2½ and 4½ inches in diameter at either end.

In Mr. T's case, however, little or no obstruction to the passage of food was caused, and the patient was fairly well nourished. Allied to this class of cases are those in which one or more gallstones or intestinal calculi are the cause of symptoms of obstruction, which are generally subacute or chronic in character. A tumor can of course be often detected in all these varieties of the 4th class of obstruction.

Turning now to the consideration of the 2nd great division of our subject we shall find *stricture* of the intestine the best representative of the causes giving rise to chronic obstruction. In almost all instances of such there will be got a history of previous attacks, somewhat similar to that which has led to complete obstruction. The rule is for these attacks to become more and more frequent as well as severe up to the end of the case. Among the anatomical lesions found are simple contraction due to the healing of former ulcers, stricture from former herniæ and old injuries, and finally that resulting from epithelioma and other growths in the intestinal wall. Cases of *stricture* generally occur between the ages of 20 and 60 years. Closely allied to stricture are those cases in which the gut is closed by the pressure of tumors, abscesses etc., from without. In most of these the obstruction is situated in the rectum or sigmoid flexure, for the reason that the swellings producing it are most frequently met with in the pelvic region. They differ from cases of stricture in being much more frequently acute in symptoms.

Fæcal accumulations, when giving rise to in