cavity should be performed in the shortest possible time consistent with good work. The scar resulting from an intestinal approximation should be one that would not contract. The doctor presented a specimen sent him in which approximation was made by means of the suture, and in another place in the gut where approximation had been made by means of the button. The approximations were in the same dog done on the same day. In the part sutured there was a contracted cicatrix; where the button had been inserted was very difficult to find, as the scar was almost invisible, and there was no contraction. Under the pressure of the button, the first tissue to be cut off and become approximated was the peritoneum; the next that gives way is the muscular coat, and this adheres to muscular coat. The connective tissue between the two becomes absorbed, leaving continuous muscle. The next coat to give way is the tunica propria, and then it approximates with similar tissue on the opposite side. The button was the first device, the speaker said, to accomplish the bringing edge to edge of corresponding tissues. The button had its drawbacks—defects, which he hoped would soon be overcome. Some had raised the objection that the button would cause obstruction. In 129 cases reported to him up to the present, there had not been one report of obstruction. In one pylorectomy he had heard of, the button had slipped into the stomach, but did not cause symptoms. He had not heard of its being stuck in the ileocæcal valve either. It had been retained in one case at the hepatic flexure of the colon. The only thing in the way of obstruction that was to be feared was the presence of adhesions in the gut below the point of approximation. He had learned of two cases where the button itself had become obstructed with fæces. It was difficult to see how this could be in the small intestine where the contents were fluid. Where the large intestine was approximated fluid diet should be administered. The doctor demonstrated to the association the proper way of inserting the button. One important point was in making the purse-string suture at the mesenteric attachment. By making one overstitch at this point, the peritoneal surfaces of the mesenteric peritoneum at this point were nicely approximated. As to results—in intestinal obstruction they must always be bad. The question to answer was how many were due to the technique of operation, and how many from other causes. In cutting of the intestine, it should be cut so that the greatest portion will be removed from the convex surface.

The doctor then presented a faulty button that a Toronto medical man had brought from New York. Dr. Murphy said that in the button presented the cup was too shallow in both the male and the female portions of it. That, however, was not the most dangerous element. The spring was placed in the female portion of the button, which was absolutely wrong,