8. If repeated attacks of dangerous obstruction have occurred, with long intervals of perfect health, it may be suspected that the patient is the subject of a congenital diverticulum, or has bands of adhesion, or that some part of the intestine is pouched and liable to twist.

9. If in the early part of a case the abdomen becomes distended and hard, it is almost certain that there is peritonitis.

10. If the intestines continue to roll about visibly, it is almost certain that there is no peritonitis. This symptom occurs chiefly in emaciated subjects, with obstruction in the colon of long duration.

11. The tendency to vomit will usually be related with three conditions and proportionate to them. These are (1) the nearness of the impediment to the stomach, (2) the tightness of the constriction, and (3) the persistence or otherwise by which food and medicine have been given by the mouth.

12. In cases of obstruction in the colon or rectum sickness is often wholly absent.

13. Violent retching and bile-vomiting are often more troublesome in cases of gallstones or renal calculus simulating obstruction than in true conditions of the latter.

14. Fecal vomiting can occur only when the obstruction is moderately low down. If it happen early in the case, it is a most serious symptom, as implying tightness of constriction.

15. The introduction of the hand into the rectum, as recommended by Simon, of Heidelberg, may often furnish useful information.

TREATMENT.—1. In all early stages, and in all acute cases, abstain entirely from giving either food or medicine by the mouth.

2. Use anæsthetics promptly. Put the patient under the full influence of ether; examine the abdomen and rectum carefully before tympanites has concealed the conditions; administer large enemata in the inverted position of body; and, if advisable, practise abdominal taxis. If you do not succeed at first, do it repeatedly.

3. Copious enemata, aided perhaps by the long tube, are advisable in almost all cases, and in most should be frequently repeated.

4. Fluid injections may be sometimes replaced by insufflation of air in cases of invagination, since air finds its way upward better, and is more easily retained. It is, however, somewhat dangerous, and has perhaps no advantage over injections with the trunk inverted.

5. Insufflation is to be avoided in all cases of suspected stricture, since the air may be forced above the stricture, and there retained.

6. Saline laxatives are admissible in certain cases where impaction of fæces is suspected, and in cases of stricture where fluidity of fæces is advisable.

7. Opium, or morphia, must be used in proportion to the pain which the patient suffers. It should be administered by the rectum or hypodermically, and should be combined with belladonna. If there be not much pain or shock, it is better avoided, since it increases constipation and may mask the symptoms.

8. A full dose of opium administered hypodermically will put a patient in a favorable condition for bearing a prolonged examination under ether, and attempts at abdominal taxis.

9. In cases of uncertain diagnosis it is better to trust to the chance of spontaneous cure or relief by repeated abdominal taxis, than to resort to exploratory operation, or in desperate cases iliac enterotomy should be done. Operation for the formation of an artificial anus in the right or left loin may be performed whenever the diagnosis of incurable obstructive disease in the lower bowel is made.

10. The operation for the formation of an artificial anus through the anterior part of the abdominal wall and into the small intestine should be resorted to only in certain cases of insuperable obstruction, in which the seat of disease is believed to be above the cæcum.

11. In all cases in which the precise seat of disease is doubtful, but the large intestine is suspected, the right loin should be preferred. If the colon here be found to be empty, the peritoneum may be cautiously opened, and a coil of distended small intestine brought into the wound.

12. My last suggestion as to the treatment is one which, speaking as I do in a medical section, I feel some delicacy in making. It is, however, I believe, a very important one; and it is this, that cases of mechanical obstruction are really surgical and not medical cases. They require manipulative measures both for diagnosis and for treatment, and they require them early. It is difficult to explain why it has come about that, as a rule, a physician is called in first, and nothing but drug-treatment usually adopted in the early periods; and it is, I am convinced, much to be regretted. The surgeon is but too often asked to see the case only in the last stage, when it is thought that perhaps an operation may be desirable. At this period the abdomen is distended, and an accurate diagnosis impracticable; but, what is worse, the stage at which abdominal taxis is most hopeful has passed. My remarks do not of course apply when the medical attendant possesses the knowledge and exercises the functions of both branches.—*Louisville Med. News.*

ADMINISTRATION OF CHLOROFORM.—T. Hughes, M.D., in London Lancet of November 2nd, says: if I were about to be placed under the influence of chloroform, I would say, "Never mind my pulse, never mind my heart; leave my pupil to itself. Keep your eye on my breathing; and if it becomes embarrassed to a grave extent, take an artery forceps and pull my tongue well out." It was the observance of this simple yet all-important rule that