loops brought up into the abdomen, and the entire pelvis loosely packed with iodoform gauze.[1]

A gauze drain was also left at the site of the anastomosis. The patient stood the operation well. Her pulse did not rise above 100. The outlook, however, was not particularly flattering, considering the fact that there was a commencing peritonitis and also considerable œdema of the intestinal wall. Eight days after operation, on removing the last of the gauze, some fecal matter was found on the dressing. The fistula gradually closed, and the patient made an excellent recovery.

February 12, 1904. The patient has been at work for several months, performing general household duties without the slightest inconvenience. Her general condition is excellent. From her I learned that she had had typhoid (?) fever six years previously and was in bed for two weeks. For the last year she has had cramp-like pains throughout the abdomen two or three times a month, and recently the bowels have been more constipated than usual. She gives no history whatever of injury or bruising of the abdomen. For about a week before her admission to the hospital she had had intermittent abdominal pain. From the family history we were unable to get any data suggestive of hereditary tuberculosis.

Pathological Report. (Gynecological Pathological No. 6316.) The specimen consists of a small portion of the ileum, of the cæcum, and of about one-half of the ascending colon. The mucosa of the ileum is unaltered, that of the cæcum in most places is normal, but at a point directly opposite the ileocæcal valve is a perforation 5 mm. in diameter (Fig. 1). The walls of the perforation are rather smooth and the surrounding mucosa, over an area 1 cm. in diameter, is somewhat thickened. The ascending colon, about 5 cm. above the perforation, shows a marked constriction. At this point the lumen narrows down until it is not more than 2 mm. in diameter. Indeed, so small is it that a fine bird-shot would lodge and completely plug the canal at this point (Fig. 2). The intestinal wall at the point of constriction varies from 5 mm. to 8 mm. in thickness and is exceedingly firm in consistence. The constriction is 1 cm. in length and the ascending colon above this point is unaltered.

Histological Examination. The appendix, beyond showing a few adhesions on its outer surface, is normal. The cæcum in the vicinity of the perforation has entirely lost its glandular elements, the specimen consisting almost entirely of granulation tissue. The underlying muscle shows a varying amount of small round-celled infiltra-

[1] For several years, where the pelvis has been filled with free pus, I have made it a practice, after having wiped the pelvis and intestines off, to place the patient for a moment in the Trendelenburg posture. The pelvis has then been loosely but fully packed with gauze, the ends of which are brought out through the appendix incision. My object has been to prevent the intestinal loops from dropping down and becoming adherent or kinked in the pelvis. In my hands this procedure has yielded very gratifying results. The loops, although still liable to become adherent, are on a level and are not nearly so prone to become obstructed.