shown will prove that nothing less than excision could have been successful.

Notwithstanding attention to feeding, to frequent washings of the bowel both above and below the opening, and to the free use of antiseptics on the surrounding cutaneous surface, it was impossible to get the skin into a satisfactory condition. It was made as clean as possible beforehand, but was a source of great anxiety throughout the after history of the case.

I operated on July 4th, 1892, before several members of the hospital staff, and was ably assisted by Drs. Porter, McInnis and Metcalf, members of the house-staff. My incision was made in the left linea semilunaris, and was about two inches long. After opening the peritoneum, I carefully separated the adherent bowel from its attachments, using fingers only for this purpose. I then brought the involved intestine outside the abdominal wall, and the balance of the work was done extraperitoneally. On examining the bowel I found the opening was fully two inches long, and that just below the opening a ring of constriction had already formed to such an extent that I could not pass the tip of my little finger through the contracted portion. In the specimen shown, the glass tube would not pass through the lower portion until its end had been drawn out to a cone-shaped terminus. On account of the occurrence of this annular contraction, and the certainty that complete stricture would soon follow, excision of the intestine was the only course open to me.

As I had no proper forceps for occluding the bowel above and below the field of operation, I used tapes passed through the mesentery and tied firmly around the intestine. I then, with scissors, made two transverse incisions across the bowel, between three and four inches apart, and removed the intervening portion with a triangle of the mesentery. For use in suturing, I had prepared fine cambric needles threaded with the finest Chinese twist silk. The silk should be cut in lengths of about two feet, and tied with a single knot at the eye of the needle, with one end cut to within two inches. Invert each cut end of the bowel and close it with a double row of continuous silk suture. Then draw the ends past one another to the extent of six inches, if possible, and apply two parallel rows of continuous suture to unite the bowels near the mesenteric line. Make the suture line one inch longer than the length of intended opening, and leave the needles threaded at the end of each row. Open the bowel on each side with scissors, placing the incision about one-quarter of an inch from the double row of sutures already inserted, and making it three or four inches long. To check hæmorrhage from the incised wounds, a quick, continuous, overhand suture is run along the cut edges, including all the coats on both sides, and continued around each free edge. The needles on the double line of suture previously placed along the mesenteric border are now picked up, and the sutures continued around the upper or free side of the incisions until they reach their point of origin. The lateral openings in the bowel, besides the sutures placed along the edges to check hæmorrhage, are completely surrounded by a double row of continuous sutures, a pretty sure guarantee against fæcal extravasation. In order to prevent invagination of either blind, pouch-like end, it is wise to pass a stitch near each end to unite it with the adjacent bowel surface. For cleansing the parts nothing but pure boiled water is required. After thorough douching, the bowel is dropped back into the abdomen, the omentum drawn down over it, and the external incision closed by two lines of silk sutures. No drainage and no flushing of the peritoneal sac is necessary. The artificial opening through the abdominal wall was thoroughly curetted, swabbed out with chloride of zinc solution, packed with iodoform gauze, and then left to fill in with granulations. The operation performed and, indeed, almost the words used in describing it are copied from a pamphlet published by Dr. Robert Abbe, of New York, on "Intestinal Anastomosis and Suturing."

The operation, from the time of commencing chloroform to her return to bed, occupied nearly two hours. When the patient reached her ward about 4 p.m., she was in capital condition. The first twelve hours she had no food or drink, the next twelve hours she had cracked ice only, and then began to get half-ounce doses of milk or beef tea every hour. There was slight vomiting and hiccoughing the first night, but after that the patient expressed herself as being free from pain and very comfortable. The bowels were kept locked up by opium for forty-eight hours, and then she received