mission to the hospital. Delirious at times with a rapid and feeble pulse. She took nourishment fairly well and most of the discharges took place per anum, and for a time it was hoped she would recover. An eczematous eruption spread around the opening in the groin, and the patient gradually sank and died from exhaustion on the 26th of March. The autopsy showed omentum adherent to the femoral ring, as well as a perforated ileum about six feet from its termination, no spur could be seen and the fistula was the size of a thumb nail. There was a rather free passage towards the cæcum through which much of the discharges had passed.

CASE 16.—Mrs. P., aged 48. Was called on May 28, about 6 o'clock in the evening. The abdomen was greatly swollen, very tense and nothing had passed her rectum for 12 days, There was a swelling in the right groin in the region of the femoral canal. The patient was weak, pulse small and rapid. Two hours later she was admitted to the hospital, and under an anæsthetic, an incision made down to the stricture. Both bowel and omentum were adherent, the former gangrenous, and pus was present among the adhesions. The bowel was incised and an artificial anus made. Death took place in 30 hours.

Treatment of Gangrene.—These are the only two cases of gangrene of the intestine that have come under my notice, and as they afford an illustration of treatment by artificial anus, I have thought it my duty to draw particular attention to them. In looking up the literature of this subject I found the following taken from a valuable contribution by Runsohoff, of Cincinnati. Of 27 cases of hernia coming under his own observation, four were gangrenous, one being of the bowel and one of the omentum. Of 170 kelotomies for strangulation in Hagedorn's clinic, gangrene, real or suspected, was encountered but 25 times.

Of 486 cases collected from different sources, only 68, or about 14% were gangrenous. In the 170 cases of Hagedorn the omentum was dead in one only. This condition if so very rare that some surgeons doubt its existence altogether. In strangulated omental hernia the symptoms are said to be less severe, the pain, vomiting and constipation not so well marked. I have seen, however, as complete constipation in these cases as when the bowel occupied the sac. No doubt a number of omental hernias are irreducible and adhesions have formed long before the date of strangulation, the compressed portion of omentum receiving its blood supply from the wall of the sac beyond the point of constriction, and thus gangrene is averted. When this rare condition is met with the treatment consists in relieving the constriction, drawing down the mass, ligaturing, cutting off in sound tissue, and returning the stump to the abdomen. I am inclined strongly to the opinion that the cases in which gangrene is found are usually those that are reducible before strangulation, yet even here adhesions form around the seat of constriction, the septic products found in the sac are prevented from entering the abdominal cavity and the development of general peritonitis averted; but where this condition exists it is advisable in operating to use drainage and not close the wound. When gangrenous bowel exists, the question as to the proper course to pursue is a difficult one. Of late years, many recoveries have followed primary excision, with suture of the intestine. The old operation (formation of an artificial anus) is anything but attractive, and the per centage of deaths has been large. Much has been written upon the treatment of gangrenous hernia, and great difference of opinion manifested by surgeons. When the bowel is in what may be termed a doubtful condition it has been recommended by Paulsen to divide the stricture, and, after drawing down and covering the intestine with antiseptic dressings, await developments. I think, however, it is, as a rule, better to carry out the plan recommended by Treves, and replace it within the peritoneal cavity with a drainage tube under antiseptic precautions. When, after this treatment, the bowel gives way, experience has shown that the contents escape through the wound. Many experienced surgeons have met with cases in which the congestion of the bowel has been so extreme that they have doubted whether it were possible for repair to take place, yet its return led to complete reco very. As one meets with such a condition but rarely, it is difficult, or perhaps, impossible to say when the bowel is past the state of resolution. If the intestine, when exposed, be gangrenous, two courses are open to the surgeon, division of the stricture, followed by resection and suture, or formation of an artificial anus. Mr. Kendall Franks, of Dublin, has lately collected to-