accumulation is the chief feature, are capable of being favorably influenced by laparotomy, provided there is no serious tubercular lesion elsewhere in the body (lung, pleura). The *modus operandi* is, in all probability, the same as in tuberculous ascites; the operation itself is, however, very much more difficult, and at the time less satisfactory, for the interference is literally a mere inspection of the parts exposed by the wound. Infinite care must be taken not to injure the bladder or intestine. When one fails to open the peritoneal cavity in the middle line below the umbilicus, a second, or even a third, incision should be made; for unless the peritoneum is cut into, no improvement can reasonably be anticipated. In view of the fact that adhesions are always more pronounced below the umbilicus, the second incision, when required, should be made above this level, for by so doing the peritoneal cavity will be opened into with greater certainty. A drainage tube must on no account be employed. The formation of a fæcal fistula is not an infrequent complication, but so long as it opens on the skin surface it is not of serious import; it is quite otherwise when the fistula discharges in the midst of the matted coils of intestine. It has been abundantly shown that perforation of the wall of the bowel is not the result of ulceration of the mucous membrane (which is quite exceptionally present in cases of tubercular peritonitis), but the result of the breaking down of a tubercular nodule on the peritoneal or external surface of the bowel: *i.e.* from without inwards.—Alexis Thompson, M.D., F.R.C.S. Ed., in *Pract.*

INTESTINAL OBSTRUCTION.

In an editorial in the October number of the *Archives of Pediatrics*, the writer remarks that intestinal obstruction is a comparatively common affection during childhood and infancy. It may be due, he says, to congenital malformation, and if such malformation is extreme, the infant does not long survive, but soon dies with all symptoms of obstruction of the bowels. In rare instances obstruction results from constriction by adhesions, the impaction of foreign bodies, fæcal impaction, or diverticula. Volvulus is comparatively rare in children. When it occurs, its most common site is the sigmoid flexure. Pain in such cases is violent, and the constipation is obstinate, there being no passage either of fæces, of mucus, of blood, or of flatus. Vomiting occurs late, and is rarely urgent. An operation is extremely unsatisfactory, as the volvulus, even when successfully straightened, is prone to recur.

Of the various conditions to which intestinal obstruction may be due, intussusception is by far the commonest among children. In infancy, intestinal obstruction and intussusception are almost synonymous terms. In more than half of all the cases the lesion begins at the cæcum, the ileo-cæcal variety being the most frequent. The cæcum is first inverted, and afterward the colon. The ileo cæcal valve is pushed before the ileum and is found at the apex of the intussusception. In rare cases the ileum slips through the valve, forming the ileo-colic variety. In all forms of intussusception, except the ileo-colic, the apex remains constant, while the neck changes its position, the intussusception growing at the expense of the sheath. The tumor, therefore, advances. In the most common form, the ileo-cæcal, although the lesion begins on the right side, when it has become sufficiently extensive to be detected by palpation the tumor is felt on the left side. The mass with the ileo-cæcal valve at its apex may commonly be felt at the rectum, and not infrequently it protrudes.

The symptoms, says the writer, frequently obscure at the outset, usually become distinctive as the lesion progresses. Violent pain, at first spasmodic; vomiting, frequently persistent; obstinate constipation, with a discharge of mucus and blood from the rectum; tenesmus, which, with the discharge of mucus and blood, may lead the unwary into a diagnosis of dysentery; and the presence of a tumor, are the points upon which a diagnosis is to be rested.

In another editorial the writer deals with the treatment of intussusception, which, being a mechanical condition, he says, must be relieved by mechanical means. Drugs, except opium, are either useless or dangerous. A cathartic should not be used under any consideration when there is even a suspicion of this condition. If one has been administered before the diagnosis has been made, its action should be checked as far as possible by the free use of opium. Opium in small doses, by relieving pain, may, in the first stages, prove of the greatest service. The chief objection to its use is the danger that it may mask the symptoms and lead to the false belief that the patient is improving. Attempts at reduction should first be made by means of injections. Time should not be wasted upon various methods of inflation and taxis. Injections of warm water by means of a fountain syringe are so far superior to all other methods that when they have been thoroughly tested and failed an operation should be resorted to. Thorough testing does not mean spasmodic efforts with a bulb syringe. This is a dangerous instrument, for a man may easily apply a pressure of ninety pounds to the square inch—a force sufficient to rupture the intestine. Here, as in many other conditions, spasmodic pressure may utterly fail, while continuous, steady, and properly regulated pressure will succeed. Such pressure can not be obtained with a bulb syringe, a bellows, a siphon of Vichy water, or the genera-