he began to complain of pain in the lower abdomen. Upon examination the abdomen was tense, tympanitic, with absence of liver dulness, and increase of pulse rate from 84 up to 120, together with the abdominal facies. Perforation of the damaged gut was diagnosed and I opened the abdomen through the former incision, wiped out a quantity of fæcal matter, and discovered a perforation the size of a split marrowfat pea in the small bowel where it had been damaged by pressure on the margin of the hernial opening. The opening was closed with two layers of continuous catgut sutures. The fæcal matter was washed out with some saline solution and four drainage tubes were inserted in different directions and the wound partly closed.

He was returned to bed in a greatly shocked condition and normal saline per rectum ordered. The pulse continued to fail and at midnight an interstitial saline was administered and these were continued every eight hours for the next thirty-two hours. On the 12th he was somewhat better and was put up in what is now called the Fowler position for better drainage. Bronchitis developed, and for the next few days he coughed up great quantities of muco-pus. On the 15th the large drainage tubes were removed and smaller ones inserted. It is unnecessary to relate the further progress of the case more than to mention that he was discharged from the hospital on February 23rd, and started for his home in Quebec.

The drawing made for me by Dr. W. E. Gallie represents the appearance of the sac looking at it from behind.

The second case was that of a boy aged 7, who, upon returning home from a party on the evening of January 4th, 1906, complained of abdominal pain, which was relieved by hot applications. The next evening he was seen by Dr. Harvie of Orillia, and though there was some indefinite abdominal pain there was no muscle rigidity, no increase in pulse or temperature and the bowels moved with an enema. The day following there was no increase of pain—more an uncomfortable sensation—but in the evening there was a sudden acceleration of pulse, from 88 to 140 in a few hours. The face took on the appearance so common in peritonitis and the abdomen became distended. When the patient was under the anæsthetic—after midnight of that day, really the early morning of January 7th—I was able to make out a large, sausage-shaped mass extending upward from the right iliac region toward the middle line, and I am free to confess that I thought we had a case of intussusception to deal with. Upon opening