abdomen is soft, unresistant to the touch, and there is no tenderness. Fluctuation is sometimes elicited in the flanks, but seems to vary greatly and is probably associated with fluid in the intestines. Percussion yields a tympanitic note throughout, except for a modified dulness on each side low down.

The hepatic and splenic dulness are normal. On auscultation there are borborygmi heard, but otherwise no abnormality. The rectum showed no signs of disease nor stricture. The urine is normal. In the chest there is no evidence of disease, beyond that induced by the pressure upon the diaphragm from below. An operation was performed by Dr. Bell on January 16th, and the abdominal cavity opened in the median line, giving exit to a small quantity of serous fluid. The distended bowel was found to consist of sigmoid flexure, whose diameter was 9—10 cm. There was elsewhere no signs of collapse of the bowel or stricture, nor could any obstruction be detected. The rectum was examined again, but found perfectly free, and the abdomen was therefore closed and nothing further done.

The patient recovered well, and the bowels moved by means of enemata and the distension was markedly diminished, though the girth was never less than 55 cm. The condition, however, otherwise remained in *statu quo*, so a second operation was performed on January 30th, and an incision made in the left inguinal region. Bougies were introduced per rectum to empty the large bowel, but failed to move some impacted fæces. Accordingly large trochars were employed and the bowel punctured in the abdominal cavity, and semi-solid fæces were then pushed out of the dilated sigmoid flexure, and the wound thereafter sutured in the usual manner.

For five days the patient did well, but on the sixth day symptoms of perforative peritonitis developed and death ensued.

The *autopsy* was performed 17 hours after death and the following notes from the report are abstracted concerning the conditions of the abdominal cavity :

The operation wounds are both almost entirely healed On opening the abdominal cavity fetid gas escapes, and about 400 cc. of creamy, greyish fluid having a fæcal odour is removed. It is for the most part free, but in portions is sacculated off by the recent plastic adhesions in the peritoneum. There is a very recent general peritonitis ; the omentum for the most part covers the small intestines and is adherent to the lower end of the sigmoid flexure. The visible intestines are covered with a plastic exudate, and the coils are loosely adherent to each other. The lower half of the abdomen is occupied by the enormously distended and hypertrophied sigmoid flexure, which