fell easily into position. The patient made an uninterrupted recovery, the wound healing by first intention. The limbs remain in normal position. She has free movement in every direction and a good strong limb, and there is half an inch of shortening, although from the tilting of the pelvis it seems greater.

Resection of the Intestines.—Dr. SHEPHERD exhibited two cases in which he had resected the bowel.

Case I.—This case was shown to the Society soon after operation three years ago, and she was now again brought before the Society in order to show in what a good condition she was. The resection was for stenosis following strangulated hernia, for which operation had been performed. At the time of operation the gut had looked suspicious, but was returned; more sloughing occurred, and this was followed by the stenosis for which resection was performed. Several inches of the bowel had been removed, and the cut ends sutured end to end by an inner row of interrupted silk sutures passing through muscular and mucous coats and an outer row of Lembert's sutures through the serous coat. The patient recovered well, and when shown appeared in good health. Her age is 56.

Case II.—This was a case of resection of nine inches of small bowel in a woman aged 40. The bowel had been strangulated for five days, and was found gangrenous at the operation for the relief of the strangulation. As the patient's condition was fairly good, immediate resection was performed. The cut ends of the bowel were sutured by two rows of continuous sutures, the inner row passing through the mucous membrane and muscular coat, and the outer, a continuous Lembert, through the serous coat. The hernia was an inguinal one, and after suturing the bowel a radical cure was performed by excising the sac and obliterating the inguinal canal. The patient got well without a bad symptom, and the bowels moved naturally on the fifth day. She went out in four weeks perfectly well. It was now six weeks since the operation. Dr. Shepherd remarked that it was now his custom to use the continuous suture, and that he used no plates or other apparatus. The suturing of the bowel did not take very long, some twenty minutes. It was his experience that the divided mesentery gave most trouble on account of the hæmorrhage and its liability to tear. He was strongly of opinion that immediate resection was the best treatment in all cases of gangrenous hernia where the condition of the patient was good; in other cases it would be the better treatment to open the bowel and form an artificial anus, which could be closed by a subsequent operation.

A Case of Pylorectomy.—Dr. ARMSTRONG exhibited a woman from whom he had recently excised the pylorus. She came to the Montreal General Hospital on the 10th of May, 1894, complaining of a tumor situated in the right hypogastrium just below the seventh, eighth and ninth ribs, associated with pain and nausea after eating. Wishing to gain some accurate knowledge of her gastric condition, Dr. Armstrong sent her to the medical wards under the care of Dr. Lafleur, who made the necessary investigations.

Dr. LAFLEUR had first seen the patient in the out-door department, and under the impression that it was a case of malignant growth of the pyloric extremity of the stomach and of a kind suitable for operation, he sent her upstairs to Dr. Armstrong, who confirmed this view, but returned her to the medical department for further information as to the functions of her stomach. Her history was as follows: In December, 1893, she began first to feel out of sorts, without, however, any definite stomach symptoms. In January, 1894, there was pain in the epigastrium after eating. February, 1894, the pain persisted, but was regularly relieved by an attack of vomiting coming on after two hours after eating. She grew slowly weaker, and by the end of the month had to take to bed. These conditions persisted during the following March and April, accompanied by a steadily progressive loss of flesh She lost 37 pounds from the beginning of her illness until the date of her appearance at the out-door department of the hospital. She was a dark woman, much emaciated, but with her muscles still in fairly good condition. Examination of the respiratory, circulatory and urinary systems proved negative. The digestive symptoms were poor appetite, bad taste in the mouth, constipation, pain in the stomach and vomiting after meals. Physical signs as detected under examination in the ward were enlargement of the stomach ascertained by means of the peristaltic waves observed to traverse from left to right. The boundaries were above, extending on a line with the ninth costal cartilages on both sides, and below, reaching as far as the umbilicus, typical hour-glass contractions of the stomach were at times noticed. There was a hard tumor about the size of a hen's egg, movable in every direction except downwards, and varying greatly in its situation. No contractions could be observed in this tumor, and percussion gave a dull note. It was continuous with the funnel-shaped outline of the stomach. No nodules were observed. On May 19th a test breakfast, consisting of a small piece of bread and a cup of tea without milk or sugar, was given, and withdrawn one hour afterwards. The examination of its contents revealed a complete absence of free hydrochloric acid, the gastric juice seemed effective, but lacked the presence of the acid. The want of this latter constituent seemed to be the chief abnormal feature. A few days later a second meal was administered,