When the obstruction is due to a slight or localized peritonitis it may be relieved by saline cathartics, enemata, and drugs which stimulate peristalsis. Saline cathartics may also be of value in the post-operative paralytic obstruction so often associated with diffuse peritonitis. Strychnine, atropine and physostigmine excite the intestinal fibres and stimulate peristalsis, but physostigmine is the most effectual of these drugs. Salicylate of physostigmine should be injected in doses of grs. 1/50 every two hours for three doses, and then every four hours. Other drugs which have been recommended are oil of ricini and calomel.

I have occasionally found benefit from the use of hot fomentations, with a little sprinkling of turpentine in cases of great abdominal distension. It is quite possible that the resulting hyperemia may influence the circulation in the intestinal coils, and thus favor peristalsis.

If, however, at the time of operation the coils of intestine are seen to be distended and thinned it is useless and dangerous to employ medical measures. Cecostomy or appendicostomy may be of service, but in severe and advanced cases enterostomy should be performed. In exceptionally severe cases it may be necessary to make multiple fistulæ. Volterrani has recently published eight cases, six of which were cured by enterostomy.

My results in enterostomy have not been so fortunate, and I do not think it advisable to establish intestinal fistulæ, excepting as a last resource, in view of the unpleasant nature of the complication, and the fact that fistulæ of the small intestine and cecum have a deleterious influence upon nutrition. In apparently hopeless cases, I have made multiple punctures of the intestines by means of a fine cannula, the openings afterwards being closed. In two cases at least this procedure has saved the life of the patients, and in the other cases it has at least added very considerably to their comfort.

I should like especially to emphasize the importance of careful observation in regard to the symptoms of mechanical obstruction, which, as previously mentioned, usually appear at the end of a week or ten days, and to urge immediate operation. If, at the end of a few days or a week, the patient suffers from nausea and vomiting, and if a purgative or enema is not effective, it is in my opinion very wrong to delay more than a few hours before resorting to surgical measures. If much time is wasted in this way the patient will become so weak that even though the operation is performed later and the obstruction relieved, recovery will not follow.

Since I have kept a close watch for mechanical obstruction, and have made it a rule to operate at once, I have not lost a single