of collapse and vomiting. Dr. Cuthbertson was sent for and saw her on Wednesday morning. I saw her with him on Thursday evening. She was then feeling much more comfortable, the vomiting having ceased. There was slight distention of the intestines with gas. She was evidently pregnant about the fifth month. It looked as if some rupture had occurred, either rupture of adhesions, rupture of extrauterine pregnancy that might be present with uterine pregnancy, or a rupture of the uterus at a point of previous ligation. The strangulation of intestine by a band was also taken into consideration. I advised immediate operation but the patient felt so much improved that she thought it unnecessary. The pulse was thready but not rapid. On Friday more marked improvement had taken place. On Saturday stercoraceous vomiting set in. I saw her again in consultation and found her cyanosed and blue, with cold hands and feet, suffering very much from shock. The chances of recovery after an operation were now very much diminished, but on the 15th of February, 1896, at the General Hospital, I opened the abdomen in the median line. The intestines were discolored in places. The colon was natural in color while the intestine above it was dark red and inflamed. On right side of the abdomen, about midway between the pubes and the ensiform cartilage, a coil of gangrenous intestine, about eighteen inches long, was found. This had slipped through under a band of adhesions. The adhesion was readily caught by two pair of artery forceps and cut through. The bowel was immediately freed. The abdomen was rapidly closed and patient almost died on the table. The stercoraceous vomiting ceased, but she remained restless. Next day, Sunday, she did well until towards evening, when, at midnight, without much pain, she aborted. The placenta was very adherent, and there was a good deal of hemorrhage. About six o'clock Monday morning she succumbed.

CASE 3.—Mrs. M., aged 28. I saw the patient in consultation with her physician, Dr. Harris. She had been operated on a year before for appendicitis. Two days previous to my visit she had been suddenly taken with pain in the abdomen, accompanied by persistent vomiting. The vomiting was at no time stercoraceous. The pulse fluctuated between 90 and 120; the temperature was not elevated and had not been elevated. She was dark under the eyes. No distention was to be made out. Dr. Harris had withheld purgatives, as he suspected obstruction. The patient complained of irregular severe pains or tormina. The stethoscope revealed increased peristaltic action of the intestines with gurgling, and we concluded that there was undoubtedly obstruction of the bowels present. Next morning, Jan. 21st, 1898, assisted by Dr. Harris, I opened the abdomen at the site of the old scar. The bowel was found firmly adherent to the parietal wall.