being such as to necessitate so formidable a procedure as resection of the bowel, an operation attended with much mortality even when performed in non-gangrenous cases. Mr. Arthur Barker in 1888 collected 73 cases of intussusception which had been treated by abdominal section; 13 only of these cases recovered; in 34 the bowel was simply released and no further operative measures undertaken, yet only 12 recovered. In 133 cases recorded by Mr. F. Treves, there was a mortality of 72 per cent.; when reduction was easy, in 30 per cent.; and when difficult, in 91 per cent. The reasons for this great mortality are (1) the tender age of the patient, and (2) the late performance of the operation. Operations on infants, in whom the affection is most commonly seen, are rarely successful, the patient usually dying of shock caused by the necessarily prolonged manipulation of the bowel which is needed to reduce the invagination. Now, what should first be done when we are confronted with a case of intussusception? Should other means than operation be first employed? Certainly, it would be well first to arrest the peristaltic action of the bowels by the administration of opium, or even to give emetics. We should then try to force back the invaginated bowel (which can nearly always be felt through the anus) by means of air, hydrogen gas, or water injected per rectum, whilst the patient is under the influence of an anæsthetic. Probably air or gas is safer than water, being lighter and less liable to cause injury to the bowel. This method has been fairly successful, especially in children under one year. Should it fail, then immediate resort should be had to abdominal section. This should be in the median line, and, when the tumor is come down upon, by careful manipulation we should try to pull out the invaginated bowel, not using too much force. Even if there be no adhesions great difficulty is often experienced in reducing the intussusception, owing chiefly to the resistance offered by the ileo-cæcal valve and the cæcum. This is seen in one of the cases narrated below. When the invagination has been reduced, the bowel should be carefully examined for gangrenous spots and rents. The gangrenous areas should be excised and the rents sewed up. If we find the bowel gangrenous throughout, resection is our only resource Resection is rarely successful, owing to its tediousness and the shock caused by the operation on an already enfeebled individual. Senn advises lateral anastomosis in cases where the bowel is not gangrenous but cannot be reduced, or where the continuity of the bowel cannot be restored by circular suturing because of the difference in size of the two ends of the resected bowel, or owing to inflammatory softening. The plan adopted by myself in Case 2 seems to me to be preferable to lateral anastomosis in cases of irreducible and non-gangrenous intestine. Should the bowel, however, prove gangrenous, Barker's operation may be proceeded with through the same incision. Some recommend that an artificial anus be established. The results of this procedure have been, however, almost uniformly unsuccessful. Mr. Arthur Barker* recommends an ingenious procedure, the feasibility of which is very attractive, and I have been waiting, ever since reading his paper, for a suitable case in which to put this method into practice. It is briefly as follows: "At the point at which the intussuscipiens receives the intussusceptum the two portions of the bowel are at once united by continuous circular sutures of fine silk, taking up the serous and muscular coats of each and carrying the sutures on to the mesentery. A longitudinal incision is then made for about two inches through all the coats of the intussuscipiens in its free margin. This gives access to the sausage-like intussusceptum. The latter is then drawn through this incision and cut across at its upper end, or if too long to be drawn out is first cut across *in situ*. A few stout ligatures are, however, passed through all the walls of the stump as the mass is gradually cut off, and are tied tightly so as to keep the serous surfaces in contact and control all bleeding vessels. The stump is now cleansed, dried, and dusted over with iodoform, and allowed to drop back through the incision into the intussuscipiens, and the longitudinal incision in the latter is closed by a continuous suture from end to end." Mr. Barker has operated in two cases, but both ended fatally, owing to the fact that the operation was undertaken too late. It appears to me that this operation has much to recommend it, being more rapid and safer than resection, and in-

* *The Lancet*, Jan. 9th, 1892.