got rid of by other means; volvulus of the sigmoid flexure; annular stricture of the sigmoid and imperforate anus. It may also be performed in cases of ulceration of the rectum, simple or specific, when all other treatment has failed. In recto-vesical fistula, and in excessive distension of the colon and atony of its walls, where, in spite of purgatives and enemas, fæces accumulate and symptoms of obstruction frequently appear, right inguinal colotomy is indicated. The bowel will, after a few weeks' rest, regain its tone and the artificial opening may be closed.

The modern development of Littré's operation is cœlio-colotomy. It may be performed on either side—on the left when it is desired to open the sigmoid flexure, on the right to open the cæcum or ascending colon. The operation may also be carried out through a median incision. Cœlio-colotomy, or as it is more generally called, inguinal colotomy, is coming steadily into favor, and it seems to be replacing, to a very large extent, the lumbar operation. It is the operation preferred by such excellent authorities as Verneuil, Ball, Allingham, Harrison Cripps, Greig Smith, and others.

As regards statistics of the two operations cœlio-colotomy gives a general mortality of about 10 per cent. and lumbar colotomy a somewhat higher mortality. Greig Smith in forty-eight cases of inguinal colotomy has had three deaths, two after complete obstruction, and one after ten days where the patient was very much exhausted previous to operation. Mere statistics cannot, however, give a proper or just estimate of the mortality, as many operations are performed when the patient is *in extremis*.

The advantages claimed for the inguinal operation are:

First. It is easier. Where the colon is distended the lumbar operation is an easy one, but where the bowel is flaccid and lies deeply in a fat patient it is one of the most difficult operations in surgery. In doing inguinal colotomy the soft parts are much thinner, and after opening the peritoneum the colon is much more accessible. In a stout patient the soft parts are easier to divide, and the resulting wound less deep and more readily dealt with than one in the loin; the bowel is more easily reached and with less disturbance of deep-lying soft parts. There is no risk of opening small intestine or of failing through abnormality of the colon.

Secondly. The peritoneum being opened, the site and extent of disease can be ascertained.

Thirdly. The shallower wound makes it much easier to draw out the intestine and make a satisfactory angle and spur, or to perform colectomy.