fluid and serum and sero-purulent liquid. The opening in the ileum was closed by a double row of Lembert sutures and the abdomen washed out with hot sterilised normal saline solution, Free drainage was provided by strips of iodoform gauze introduced in all directions between the coils of intestines and a large glass open ended drainage tube passed down to the bottom of the pelvis.

The progress of the case during the three weeks following the closure of the perforation was, on the whole, very satisfactory. The clinical aspect of the case was that of a severe typhoid. The course of the disease did not seem to be altered by the operation.

On the 24th day after operation a second perforation of the ileum occurred. The perforation could be seen through the abdominal incision. The almost complete absence of reparative power was very noticeable. When the stitches uniting the edges of the abdominal incision were removed, the incision gaped open to almost its full extent. This misfortune was good-fortune in this respect, that it enabled one to see the second perforation as soon as it occurred and to provide free exit for all matter running out from the bowel.

Four days later a third perforation occurred, together with a very considerable loss of blood. This last opening could also be seen. From this time the patient began to lose ground, and he died on the fortieth day after the operation for closure of the first perforation.

At the autopsy performed by Dr. Wyatt Johnston, the site of the first perforation was found. The closure was complete and there had evidently been no further leakage from that point. The fæcal matters escaping from the subsequent perforations had lighted up a septic peritonitis in the lower abdominal zone, and although the greatest care had been taken during life to keep the pelvic cavity clean, a certain amount of fæcal matter had found its way into Douglas pouch. There was found also a small abscess in the mesentery, Typhoid ulcerations were still present in the lower ileum and colon, showing the long continuance and severity of the original poison. Although this case must go on record as another failure in attempting to treat successfully by operation, a typhoid perforation, yet I think it may be fairly claimed that, had the second and third perforations not occurred, this patient would in all probability have recovered. When a patient makes satisfactory progress for four weeks after an operation for the closure of a typhoid perforation, the surgical treatment of the condition for which it was undertaken can hardly be called a failure. On the contrary, I feel more encouraged to try again. The statistics show that, including some cases where the diagnosis was doubtful there have been 30 operations for the