If it is necessary to relieve the obstruction immediately, the distal end of the gut caught with a clamp and the bowel divided half an inch beyond the skin and sterilized with the actual cautery at the mucous exposure. The proximal end is then caught temporarily in clamps an inch and a half beyond the skin incision. The entire tumor and attached intestine is cut away and a glass drainage tube with a flange or Paul's tube is passed into the proximal end of the bowel and tied tightly to hold in place. A rubber hose is attached to this drain carrying the intestinal contents into a convenient receptacle. If there are no immediate symptoms from the obstruction the tumor is not removed at once but is covered with a piece of rubber tissue and allowed to remain projecting externally until firm adhesions are formed. It is cut away on the second or third day leaving the proximal and distal ends of the intestine projecting from the wound like a double-barrelled shotgun. The final stage of the operation is then completed, on from the fourteenth to the eighteenth day, by passing a pair of strong clamps one blade down each intestinal lumen for three and a half to four inches, grasping the opposing walls of the intestine where they have been previously fixed by sutures. These clamps are left in position until they bite out the partition wall between, restoring the lumen. This usually takes place in from four to six days and the external opening gradually contracts and closes.

In acute obstruction with the patient in a serious condition, primary resection has an almost prohibitive mortality. After locating the tumor in these cases, a temporary colostomy is the wisest plan. Barker recommends a temporary ileostomy making a transverse incision in the ileum, introducing the tube and then fastening the ileum to the incision like a gastrostomy. In any event the enterostomy should be made at a point as remote as possible from the future operating incision.

Tumors of the distal end of the sigmoid are most difficult to remove. If possible an end-to-end anastomosis is made with the rectum, but as the rectal end is devoid of peritoneum, union is unreliable. It may, however, be aided by passing a three-fourths inch rubber tube with a lateral opening through the anus and rectum to a point three inches above the cut end and fastened in this position by a lateral catgut suture (Fig. 3). An assistant draws on the end of tube projecting from the anus until the cut ends meet. Interrupted catgut sutures unite end-to-end, the operator taking pains to accurately coapt the mucous membranes. The rectal tube is then again pulled upon until a one-half inch intussusception is produced, and a second seromuscular row of sutures is inserted. The tube is left in position for four to six days, coming away after the catgut has been absorbed (Fig. 4).

Occasionally a combined abdomino-perineal will be the best method,