had vomited every day since November 29th, and upon admission the vomited material was brown, fæcal in appearance and odor. Enemas were given which brought away some fæcal matter, probably from the lower bowel.

Upon examination the patient was seen to be a rugged, well-nourished laborer. There was some distention of the abdomen and the presence of a marked peristaltic wave. There was some slight rigidity of the lower part of the right rectus. There was a tympanitic note over the entire abdomen, except in the region of the bladder, where there was an alteration in the note. The heart sounds were transmitted over the abdomen but were more marked in the upper half.

The facial appearance indicated some serious intra-abdominal condition, though the pulse was 70 and the temperature normal. Hiccoughing at times was distressing, but the pain was less severe.

On December 3rd the pain returned, became worse; the vomit was very brown in color, and though the temperature remained normal the pulse became accelerated. Immediate operation was decided upon.

The abdomen was opened in the middle line between the umbilicus and the os pubis. The small bowel in its upper two-thirds was distended, while near the ileo-cæcal end it was collapsed. Between these the bowel disappeared into an opening at about the level of the internal ring and between it and the median line. About eighteen inches of ribbon-like anæmic gut were drawn out of an intraperitoneal sac, and at once became better in appearance. That part of the bowel that impinged on the rounded edge of the sac looked damaged in its serous coat, but there was no solution of continuity. Upon dissecting out the sac it was found to consist of peritoneum and was tucked between the parietal peritoneum and the fascia transversalis. The margin of the opening was rounded and thick. When dissected out the sac was about three inches long, and the opening in the parietal peritoneum thus left was closed with cat gut sutures. The entrance into the sac would appear to have been originally a peritoneal pouch internal to the internal abdominal ring, and the hernia, instead of finding its way into the inguinal canal, pushed the peritoneal pouch out between the parietal peritoneum and the transversalis fascia.

After operation the vomiting ceased and the patient had two bowel movements the following morning. He continued to improve for five days, when on the evening of December 8th