fist. She was vomiting a brownish, stinking fluid. The stomach was washed out before she was placed upon the table, and a large amount of foul fluid was siphoned off. On opening the sac, which contained considerable fluid, a large piece of omentum was adherent in the sac, and about four inches of the jejunum, which was very dark and threateningly dangerous. However, upon exposure, color began to return, so it was dropped into the peritoneal cavity and the wound closed according to Mayo. The woman did well. The bowels moved on the following day, and gas passed freely, and the temperature remained normal, but the pulse kept up above 100. On the third day, she looked sick, complaimed of pain in the left side and had some cough and temperature. On the following day it was evident she had a pneumonia of the lower left lung. She began to vomit a suspicious-looking fluid, making us fearful of peritonitis, and she died on the fifth day, apparently of heart failure due to toxemia or entero-sepsis, as she was not ill long enough to have died from the pneumonia. Post mortem, four hours after death, showed the wound nicely adherent and the bowels everywhere of good color, even the small piece which was strangulated had regained a normal hue and there were no evidences anywhere of peritonitis. The chest was not opened, as the family objected.

A number of the other cases had very large hernia, and had been irreducible for years. One—a Mrs. Mary E., referred to me by Dr. Whiting of Medina, N.Y., æt fifty-four; one child thirty-six years old—had the largest umbilical rupture I ever saw. She was a short, fat woman; five feet two inches in height, and weighed 210 lbs. The adhesions were very dense, and the sac was divided up into a great many compartments and the contents consisted of the small bowels, ascending colon with appendix, transverse colon with the omentum—a part of which was much hypertrophied—and a portion of the greater curvature of the stomach. However, upon pulling up the huge pendulous belly wall the abdominal cavity was ample, and with little difficulty the lower flap was which laps over, so as to bring together in apposition fascial surfaces I shall pass around a photograph which shows the patient two years after the operation.

Mayo in his writings has always favored pulling the upper flap over the lower and suturing it in this position, but I have found occasionally that it was easier to pull the lower flap over the upper, and in a personal communication from him to me, he writes that he didn't think it made much difference whether the upper flap was in front or behind the lower, so long as it was generously lapped over.

However, there is one point that I have always insisted on in my work, and that is to thoroughly peel back the peritoneum from the flap which laps over, so as to bring together in opposition fascial surfaces