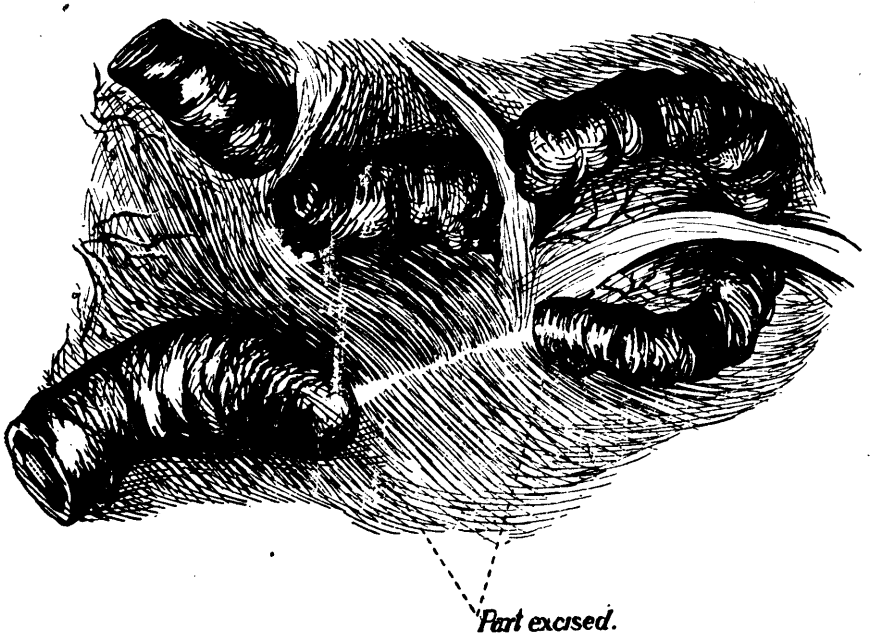
hesions to become slightly separated allowing leakage with localized peritonitis. The patient left her bed on the 20th of May and has since crossed the continent enjoying the best of health fully saturated with surgical experience.

I regret that in the unavoidable haste no opportunity was afforded to determine the exact nature of the constricting band, but from its appearance I concluded that it was probably a fibrous adhesion the result of the intense inflammatory action present with the previous appendicitis.

CASE 2.—Mrs. R. aged 56, family history good with the exception of one niece who succumbed to tuberculosis. For several years had suffered from flatulence with pain upon right side of the abdomen and occasional constipation. She also suffered from pharyngeal stricture which required occasional dilitation. Constipation becoming marked and the usual remedies failing, medical assistance was sought, I found an area of dulness below the liver with pain and tenderness upon pressure, no tympan-



itis and vomiting. Enemata, massage, purgatives and Faradism failed and as a last resort three drops of croton oil forced the issue and postponed only temporarily. the surgical measures which had been suggested. Patient regained strength rapidly and sat up. After eating a few ripe strawberries the obstruction returned with fecal vomiting and severe pain. The strength rapidly declined and pulse reached 115, when surgical measures were consented to and the patient removed to the hospital.

Operation, median section, general tubercular peritonitis in advanced tages was found, with effusion and universal adhesions, with great distension of intestine which required tapping in several places. It was also necessary