be introduced into the bowel. This treatment gave her temporary relief. For the past two months she had not noticed anything like a natural stool; little, round hardened masses would come away, leaving behind a burning, smarting pain extending up the bowel and radiating down the thighs, which would persist for an hour or so after going to stool. There was a discharge of bloody mucus, which had somewhat increased of late.

After due preparation, an examination was made under ether. The anus appeared quite healthy; there was no evidence of external hemorrhoids. On passing the finger into the bowel, the mucous membrane seemed to be quite healthy for an inch and a half above the verge of the anus; the finger then came upon a nodular surface, hard, resisting, and in ridges. The mucous surface felt raw and eroded. This was situated in the front wall, and could be felt distinctly through the vagina. The vaginal membrane appeared quite free, and did not seem to be implicated. With some little trouble the ulcerated mass was forced out through the anus and brought well into view; this aided materially the diagnosis. The finger could be passed well above the ulcerated mass, and the bowel felt quite healthy. There were two enlarged glands observed beneath the mucous membrane, but the finger could be passed well above, where the membrane felt quite soft and healthy. It was determined to recommend removal of the lower end of the bowel, and the operation was performed in the following manner on the 3rd of February, 1886:—The patient, being etherized, was placed on the table in the lithotomy position. The anus not being implicated, it was decided to save it. The incision was commenced immediately behind the fourchette, in the raphé, and carried backwards to the point of the coccyx. This incision bisected the anus, and on separating the flaps the extent of the disease outwards could be readily seen. The next incision divided the bowel on either side into the ischio rectal fossæ; this was carried well to the inside of the superficial sphincter, but wide of the diseased structure. This appeared to be of advantage, as no skin was sacrificed, and it aided materially the subsequent steps of the operation. The front wall of the rectum was now separated from the posterior vaginal wall its entire extent, until the serous fold was reached. This part of the operation was accomplished with the finger alone; the parts separated without much difficulty, but it had to be done with care, as the thin vaginal wall would readily tear. This, unfortunately, did occur, and had subsequently to be closed with catgut sutures. The posterior attachments were then separated, and the levator ani fibres