joint amputation, I know of no operation which gives a better stump than this amputation through the knee; and I may remark, parenthetically, that I believe we should consult the prospects of recovery, and the future comfort of our patients, were we oftener to select amputation in this situation rather than in the upper third of the leg. [Two patients were exhibited showing this amputation].

In the leg, the incision may be drawn from before backwards and upwards, as in the thigh, special care being taken to slope the knife well upwards when dividing the sural muscles. Occasionally, on account of the tendency which the skin covering the inner surface of the tibia has to slough, I have taken the covering from the outside, retaining as much as possible of the muscular tissue attached to the fibula, and dividing the bones almost at the level of the incision on the inner aspect. The former method gives the better stump should no accident befal it, but the liability to sloughing is undoubted.

Although it is to amputation iu the lower limb that I look upon this operation as specially applicable, yet I have also had recourse to it in the upper. Here, probably, the covering is best taken from the posterior aspect; and, in one case of amputation through the elbow-joint, I obtained an exceptionally good result in this manner.

I have practised this operation now for over ten years, under the name "oblique circular" amputation, as a term best describing its main feature. I am bound to confess, however, what I have not long since discovered, that an operation in all essentials the same has for long been described by French writers, as invented by Soupart of Liege. Though I cannot, therefore, introduce it to you as a new operation, yet I can cordially recommend it as an old one. I should have been glad, had I been able, to bring before you a greater number of persons on whom I have practised it; but, although I have only succeeded in tracing three whom I could bring to this meeting, I can frankly state that their stumps are not better than those which may generally be obtained.—*Brit. Med. Journal.*

INTESTINAL OBSTRUCTION.

The innate disposition of human beings to argue, the almost invincible desire of men to differ from one another, was never more clearly demonstrated than in the discussion of the important question of "Intestinal Obstruction" at the recent meeting of the British Medical Association. From the *British Med. Journal*, October 6, 1883, we note that the discussion was opened by Mr. Rushton Parker, the essence of whose address was that in all cases of intestinal obstruction, we should avoid all active treatment, and content ourselves with merely watching the case carefully and noting any symptoms that may aid us to an accurate diagnosis, when our line of treatment becomes plain. The constitutional symptoms of intestinal obstruction are practically identical, no matter what the cause may be, and until some special sign calls our attention to the particular cause, Mr. Parker's expectant plan of treatment is clearly the rational one.

Suppose we have obstruction from invagination, or intussusception; we know that nature cures this condition by a process of gangrene of the incarcerated gut and union of the upper and lower segments of the unimplicated intestine; suppose now, before the union has become firm, or while the process of eating through of the invaginated gut is going on, we administer purgatives or enemas to remove the obstruction—will we not almost necessarily produce perforation, extravasation and death? Hence Mr. Parker's wise injunction: *When in doubt, use opium enough to control the pain, stimulants enough to keep up the strength, and avoid solid food;* if invagination be the trouble, this treatment will put the bowels in "splints," until nature restores the continuity of the canal; if it be not so, then no harm results from our treatment. But, on the other hand, if we can clearly make out the cause of obstruction, without excessive and likely to be injurious manipulation, and if it calls for surgical interference, as in strangulated hernia, adhesive bands binding down the gut, volvulus, carcinoma or some other tumor pressing on the bowel, Mr. Parker advised operation.

Several of the distinguished gentlemen present, catching only Mr. Parker's first part, or expectant plan of treatment, and either wilfully not hearing his wise regulations concerning the indications for operative interference, or actuated by a desire to hear themselves talk, roughly handled Mr. Parker. They assumed that he advised the "let-alone" treatment in all cases, and they censured him severely for it, indicating that operation was imperatively demanded in certain instances, and citing cases to sustain what they claimed, all of which Mr. Parker had already said. His views were probably a little more conservative than those held by some of his critics, for Mr. Lawson Tait held that it was wholly unnecessary and dangerous to wait for an accurate diagnosis, and he advocated early opening of the abdomen in the middle line, with the formation of an artificial anus in the first piece of distended intestine which presented. With all respect for this distinguished opinion we must think that the error of such precipitancy is evident; for should the obstruction prove a naturally curable one, as in many cases it would, we have not only subjected our patient to a dangerous operation, but we have afflicted him with a disgusting and inconvenient deformity. Again, by such a procedure, we are just as likely to open the gut