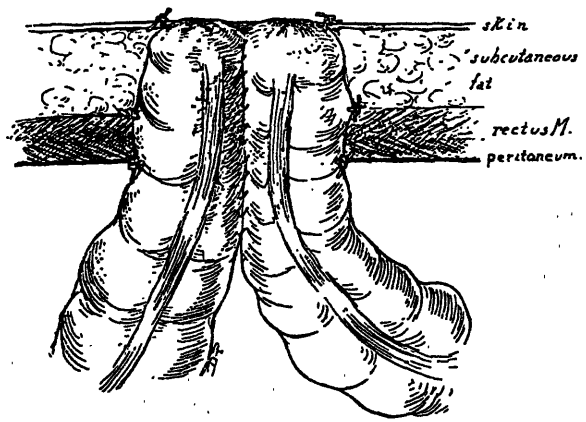
dominal incision, and some pieces of rubber tissue introduced making drainage to the surface, as a precautionary measure.

How shall we handle the intestine should there be much obstruction? In our experience, changes in the wall of the intestine caused by obstruction and leading to suture perforations some days after operation, has been the most common cause of death and it is almost an axiom in surgery never to resect an obstructed large intestine, even if the obstruction is moderate without employing protection against leakage, and when in doubt it is best to do a temporary enterostomy and resect later. In moderate chronic obstruction, we have found it advantageous to empty the distended colon by means of Monk's tube, resect and unite by the lateral method and finally fasten the site of the resection so as to leave it exposed in the wound after the Bloodgood method. If perforation then occurs it will be external. (See Fig. 2.)



Lateral anastomosis after the Bloodgood method.

A very good method is to bring the part of the intestine containing the obstructing tumor outside, and complete the operation as the first-stage of the Miculicz-Paul three-stage procedure. While we do not make use of this three-stage operation to the extent we did some years ago, in selected cases it gives excellent results. Until the tumor is thoroughly mobilized and the vessels divided, the technique is the same as in the usual method but instead of cutting the tumor away the two limbs of the intestine are attached to each other by sutures at a healthy point, and if it is more convenient, a separate lateral incision is made in the abdominal wall just long enough to enable the extrusion of the tumor. A few sutures on the inside attach the bowel to the peritoneum leaving the diseased sigmoid wholly exposed.