been difficult. Not, indeed, from a paucity of topics demanding discussion, but from a feeling that any attempt on my part to offer *ex cathedra* opinions would be presumptuous. I may be pardoned, however, for briefly drawing your attention to the frequent occurrence of

INTESTINAL OBSTRUCTION FOLLOWING OPERATIONS IN WHICH THE PERITONEAL CAVITY IS OPENED.

Obstruction of the bowels causes between 1 and 2 per cent. of the deaths following ovariotomy and other operations involving opening of the peritoneal cavity. Sir Spencer Wells lost 11 out of his first series of 1,000 cases of ovariotomy from this cause (1.1 per cent.). Fritsch[1] places his mortality from ileus post-laparotomiam at 1.6 per cent. Klotz[2] has reported 31 cases of intestinal obstruction with 5 deaths due to this complication in a series of 421 abdominal sections and 148 vaginal extirpations of the uterus. I have been able to collect in the literature and from personal communications no fewer than 75 deaths from this cause. While this number seems large, it probably represents less than half of the deaths properly attributable to this accident, for there can be no doubt that not a few fatal cases of peritonitis and intractable vomiting after laparotomy are really cases of obstruction of the bowels.

Secondary or post-operative intestinal obstruction may be roughly divided into two classes of cases, one due to mechanical causes—adhesions, peritoneal bands, volvulus, accidental fixation by sutures, etc., and perhaps compression in exudation masses—and another due to paralysis of peristaltic movement of the intestines following sepsis or injury to the nerve supply of the muscular coat. The obstruction may be acute—*i.e.*, occur immediately after or within a few weeks subsequent to the operation—or it may develop gradually, and not become complete until months or years afterward.

The majority of cases in which the cause of the obstruction was ascertained by operation *intra vitam* or by necropsy have been found to be due to abnormal fixation of the intestines by adhesions, or to compression by peritoneal cords or bands inflammatory in origin. The statement is attributed to Olshausen that obstruction after ovariotomy is always due to adhesions between the bowel and the pedicle. A striking instance of this form is related by Sir Spencer Wells.[3] I have, however, observed a case in the practice of the late Prof. Erich, of Baltimore, where the small intestine was doubled upon itself and so firmly adherent that the gut was entirely impervious. Similar cases have been reported by Skutsch and G. M. Tuttle[4] after the removal of the uterine appendages. Adhesions of a knuckle of bowel to the abdominal incision or to other portions of the abdominal wall have frequently been found to be the cause of the