

13. Resection of more than six feet of the small intestine in dogs is uniformly fatal; the cause of death in such cases is always attributable to the immediate effects of the trauma.

14. Resection of more than four feet of the small intestine in dogs is incompatible with normal digestion, absorption, and nutrition, and often results in death from marasmus.

15. In cases of extensive intestinal resection the remaining portion of the intestinal tract undergoes compensatory hypertrophy, which microscopically is apparent by thickening of the intestinal coats and increased vascularization.

16. Physiological exclusion of an extensive portion of the intestinal tract does not impair digestion, absorption, and nutrition as seriously as the removal of a similar portion by resection.

17. Fecal accumulation does not take place in the excluded portion of the intestinal canal.

18. The excluded portion of the bowel undergoes progressive atrophy.

19. A modification of Jobert's invagination suture, by lining the intussusceptum with a thin, flexible rubber ring, and the substitution of catgut for silk sutures, is preferable to circular enterorrhaphy by the Czerny-Lembert suture.

20. The line of suturing, or neck of intussusceptions, should be covered by a flap or graft of omentum in all cases of circular resection as this procedure furnishes additional protection against perforation.

21. In circular enterorrhaphy the continuity of the peritoneal surface of the ends of the bowel to be united should be procured where the mesentry is detached by uniting the peritoneum with a fine catgut suture before the bowel is sutured, and the modification furnishes a better security against perforation on the mesenteric side.

22. In cases of complete division of an intestine, if it is deemed advisable not to resort to circular enterorrhaphy, one or both ends of the bowels should be closed by invagination to the depth of an inch, and three stitches of the continued suture embracing only the peritoneal and muscular coats.

23. The formation of a fistulous communication between the bowel, above and below the seat of obstruction, should take the place of resection and circular enterorrhaphy in all cases where it is impossible or impracticable to remove the cause of obstruction, or where, after excision, it would be

impossible to restore the continuity of the intestinal canal by suturing, or where the pathological conditions which gave rise to the obstruction do not constitute an intrinsic source of danger.

24. The formation of an artificial anus in the treatment of intestinal obstruction should be practiced only in cases where continuity of the intestinal canal cannot be restored by making an intestinal anastomosis.

25. Gastroenterostomy, jejuno-ileostomy and ileo-ileostomy should always be made by lateral apposition with partially or completely decalcified perforated bone plates.

26. In making an intestinal anastomosis for obstruction in the cæcum or colon, the communication above and below the seat of obstruction can be established by lateral apposition with perforated approximation of the ileum into the colon or rectum.

27. An ileo-colostomy, or ileo-rectostomy by approximation plates, or by lateral implantation, should be done in all cases of irreducible ileo-cæcal invagination, where the local signs do not indicate the existence of gangrene or impending perforation.

28. In all cases of impending gangrene or perforation, the invaginated portion should be excised, both ends of the bowel permanently closed, and the continuity of the intestinal canal restored by making an ileo-colostomy or ileo-rectostomy.

29. The restoration of the continuity of the intestinal canal by perforation approximation plates, or by lateral implantation, could be resorted to in all cases where circular enterorrhaphy is impossible on account of the difference in size of the lumina of the two ends of the bowel.

30. In cases of multiple gunshot wounds of the intestines involving the lateral or convex side of the bowel, the formation of intestinal anastomosis by perforated decalcified bone plates should be preferred to suturing, as this procedure is equally, if not more safe, and requires less time.

31. Definitive healing of the intestinal wound is initiated only after the formation of a net-work of new vessels in the product of tissue proliferation from the approximated serous surfaces.

32. Under favorable circumstances quite firm adhesions are found within the peritoneal surfaces in six to twelve hours which effectually resist the pressure from within outward.