toneum, and, when the bowel is distended, this surface is much larger. With a large curved needle, you then pass a stout silk thread through the skin to one side of the ink-mark, across the bowel, and again through the skin at a corresponding point on the other side of the mark, repeating the proceeding at the other end of the incision. Thus the colon is held to the margins of the wound before being opened. A transverse incision is now made into the bowel between the threads, and, the finger being introduced, the two loops can be drawn out, and, on dividing them, you have four threads to fix the bowel to the wound only requiring to be tied. The rest of the incision on each side of the bowel is then closed by ordinary sutures, and the operation is completed. The complications are very small. The greatest difficulty is in reaching the bowel when it is empty, but, with a little experience, this becomes quite easy.

Last week, with Mr. Erichsen, I saw an interesting case of total obstruction in a gentleman who had been treated homœopathically for three weeks. The small intestine was distended to three times its normal size, and there was a clear history of obstruction of the large bowel. We decided on colotomy, and I performed it as usual in the left loin. After I had finished the operation, on putting my finger into the lower opening in the bowel, I found a mass of disease, evidently cancerous, at the upper part of the sigmoid flexure; for I may say that it is not really the sigmoid flexure that is opened in colotomy, but the junction of the transverse with the descending colon; since, on putting your finger into the upper opening, you find that it goes horizontally in front of the kidney. This patient survived the operation seven months.

These being the principal points concerning the operation, you will watch the one on Wednesday with greater interest.—*British Medical Journal.*