lowing within thirty minutes; slight hemorrhage. After eight hours of quietness, purgatives, massage and enemata were again tried but without the desired result. The area of dulness in right of abdomen increased, as also did the tympanites in other regions; temperature remained normal. The morning of the second day after delivery, the pulse was 115, feeble and irregular. Fecal vomiting set in. The patient became at times semi-comatose, the pain which at intervals had been intense over the dull area, disappeared. Hypodermics of strychnine were given and, as a forlorn hope, surgical measures were decided upon.

As the patient's condition forbade removal to the hospital, two trained nurses pressed the kitchen utensils and dining room table into service and at eight a.m. thirty-eight hours after delivery the patient was anaesthetized for operation.

Upon opening the abdomen to the right of the rectus muscle a dark fluctuating mass presented, resembling an inflamed and distended gall bladder. This proved to be an enormously distended loop of intestine, constricted by a small fibrous band. After severing this, the loop was withdrawn and examined as to its vitality. The bowel had lost its lustre, circulation was completely stagnated and the coagula extended apparently into the distended veins far up into the mesentery.

As the patient's condition was desperate, the anesthetist warning me that I had no margin of time, the necrosed section with half an inch of healthy tissue at either extremity was clamped, the mesentery ligated, the segment of bowel measuring fourteen inches was excised and the ends united with a Murphy button. The region of operation was hastily wiped with gauze and the abdomen closed without drainage, the patient wrapped in hot blankets and carried to her bed, temperature normal, pulse 115. It is needless to say that we expected nothing else but collapse. Enemata of brandy and saline solution were frequently administered with strychnine hypodermically. At 11.30 a.m., three hours after the operation, there was a slight motion from the bowels. In the afternoon the patient retained beef tea and in the evening there was a free motion and passing of flatus. The following morning temp. 98⅘, pulse 98. From this time forward convalescence was uninterrupted until the tenth day when temperature began to rise until on the eleventh day it reached 103. The button came away upon the ninth day.

In order to determine the cause of the secondary rise in temperature I examined the abdominal wound and reopened it sufficiently to explore the peritoneum but found everything normal. The lochia had also been normal, and the patient carefully managed to avoid all emotional disturbances. The only explanation that I could give was based upon the fact that the button passed one day before the rise in temperature occurred, and possibly in loosening from its position especially if the necrosis progressed more rapidly at one side of the bowel than at the other as one would expect that the part fartherest from the mesenteric attachment would be the first to give way and possibly with the other part still compressed between the segments of the button would exert a no little traction upon the recently formed adhesions as the button was pressed onwards by the bowel contents, and might have caused these recent ad-