are acute and those which are chronic. Of the acute obstructions I shall have little to say in this connection—the most of them, when operated on in an early stage, can be relieved by simpler operative methods. The intussusceptions may be drawn apart, the volvulus untwisted, the binding cord cut, and the hernias reduced.

The question of anastomosis comes in for consideration only when the gut has become gangrenous. In such cases the surgeon has a choice of a variety of procedures, none of which is very promising. He may immediately cut off the mortified coil and make either an end to end or lateral junction of the severed ends. This operation on the nearly moribund patient is only occasionally successful. It is difficult to determine the extent of bowel which must be sacrificed, and the surgeon is obliged either to excise a long piece of the gut or to operate on a tissue that is inflamed, soft and uncertain. Sutures are apt to cut through such tissues and permit an extravasation of feces. Many surgeons prefer to fasten the diseased coil in the abdominal wound and leave it to nature in hope that the patient may recover sufficiently to permit a secondary operation for the resulting false anus.

I venture to suggest a combination of these methods, which I have tried in one fatal case, and which seems to me to offer the best hope for the patient. In my procedure the surgeon draws the gangrenous coil out of the abdomen far enough to permit him to unite the two limbs of the bowel at a point where they seem healthy, by means of a rubber ligature. This requires very little time and causes no shock. All of that part which is liable to slough is then fastened outside of the abdomen, and the wound closed around it. The immediate result is a false anus through which the intestine may relieve itself of its contents, and when we consider the character of those contents we may hardly doubt that it is better that they should be discharged by the shortest and quickest route. At the end of two or three days a new channel has been cut by the rubber ligature and the false anus becomes unnecessary. It may then in time close spontaneously, or be closed by the simple operation of inverting and suturing the ends. In this way we may escape both the great danger of an immediate excision with an end to end anastomosis, and the severe secondary operation for the cure of an active false anus. The closure of the fistula when a free communication exists between the two segments of bowel above it would hardly require the opening of the abdominal cavity. Most physicians recognize the necessity of surgical procedures in cases of acute obstruction, although they are often too slow in arriving at a positive