consequence of purgation the bacteria in the intestine are increased, and diminution only occurs when the bowel is thoroughly emptied; hence purgation immediately before operation, e.g., the day before, is a mistake. The purgative should be given two days in advance, on the evening before operation an enema is given and this may be followed by repeated small doses of magnesium salicylate gr. 5—q.—4 hrs. The value of this procedure has been shown in its lowering of the mortality in excision of the rectum for carcinoma, when, of course, the great danger is infection.

3. Mechanical obstruction to the outflow from the duodenum.

In some cases the duodenum participates in the dilatation, apparently owing to pressure of the superior mesenteric vessels on the third part of the duodenum, which they cross transversely.

It is in such cases that the prone posture may afford some relief.

In all cases of ileus after operation the use of the stomach tube should not be neglected, and if repeated lavage, the prone posture, and general treatment fail to bring about relief, Mayo Robson[1] suggests that the question of gastro-enterostomy should be considered, *provided* that the intestines do not participate in the paralysis.

Besides the prone posture, etc., it has been found that sitting the patients up in bed and allowing them to bend forward upon a test and giving plenty of fluids by mouth, i. e, water, will also greatly relieve when the condition seems due to mechanical obstruction of the duodenum.

Another explanation of this mechanical obstruction of the duodenum is that of Albrecht[2], who states that mechanical obstruction by the root of the mesentery, and the mesenteric vessels occurs, due to the sinking of the empty intestines into th empty plvis—thus causing some obstruction of the duodenum and consequent filling of the stomach. Enteroptosis is often observed to be present.

The opposite view is that the dilated stomach forces the intestines into the pelvis and thus completes the vicious circle.

The putting of the patient in the Trendelenburg posture is suggested to relieve the condition here.

Still another explanation of the mechanical obstruction is a shifting of the pylorus, as shown by Bismuth X-rays photographs, this shifting producing a kink, as suggested by Stiles[3].

4. Fear of operation, the anaesthetic, etc., have been suggested as possible causes, but no definite observations have been made.

5. Finally, it has been suggested that sluggishness of contraction of the intestinal walls was due to the too great exposure during operation, and that aeration of the intestines caused too great a loss of Co_2. Hence the suggestion of Yandel Henderson, to inject washed Co_2-gas