or the removal of its coats. On no account must an attempt be made to pull out the intussusceptum. The greatest difficulty may be encountered at the apex when from swelling the intussusceptum is wedged and locked into its sheath. In some cases it will be impossible to effect this reduction and we have a tumor irreducible and either gangrenous or non-gangrenous.

In the irreducible but non-gangrenous it is permissible to unite the bowel above the obstruction to that below. This has been called the short-circuiting operation. When the bowel is gangrenous, however, it must be removed and one of three procedures presents. According to Moynihan

(*a*) The whole mass may be excised and an end-to-end or lateral anastomosis done;

(*b*) Jessett's operation—the removal of the invaginated portion through an incision in its sheath;

(*c*) Resection and formation of an artificial anus may be performed.

In (*a*) the end-to-end operation is done unless there is much disparity in the lumen of the bowels involved—in this event the lateral operation is chosen.

Jessett's operation: An incision is made in the sheath close to its junction to the intussusceptum at the neck. The invaginated portion is pulled through the wound or excised if possible without drawing out the imprisoned portion. A running stitch holds the edges of the excised intussuscepted and returning portion together. The incision in the sheath is closed. As an additional security the sheath may be stitched to the intussusceptum as it enters.

Resection, with the formation of an artificial anus, is unsuited to the conditions of childhood, and should therefore be practised only when other measures are for some reason utterly impossible.

In intussusceptions involving the colon where there is undue mobility of the meso-colon, it is well to unite the cœcum to the peritoneum of the right iliac fossa. In many of these cases the mobility is owing to the lack of secondary fusion of colon to posterior abdominal wall.

In the enteric type the mesentery may be folded on itself. A catgut thread is applied to the mesentery proximal to the obstruction and a continuous Lembert suture is run through the peritoneal covering of the mesentery to a point distal to the tumor. These sutures are not in a straight line, but opposite the obstruction include a wider area of the mesentery between the attachment and the intestine. As these sutures pass only through the peritoneum they do not obstruct the circulation of the mesentery. The effect of these sutures is to shorten the mesentery, more particularly opposite the tumor, and tapering off to the exit and entrance of the sutures.