colon, and extending down to near that sigmoid flexure. A positive diagnosis of ileo-cæcal invagination was made. The child was placed at once under the influence of chloroform, and while held in the inverted position air was inflated from a large rubber balloon. On carefully watching the effect of the inflation, it could be distinctly observed that the descending colon at first became very prominent, and after this the swelling was forced higher up and gradually became shorter, when suddenly the resistance was overcome, and air rushed through the ileo-cæcal opening into the lower coils of the small intestine. The child was now laid on its back and the abdomen was carefully examined, but no swelling could be found. The place previously dull on percussion, corresponding in location to the invagination, was now resonant, a positive proof that the invagination had been reduced. Within a few hours the child had a number of copious stools and made a speedy and permanent recovery.

Case 2.—An infant, six months old. The child had been perfectly well until six hours before it had been brought to me for examination and treatment. I found a colico-rectal invagination, the intussusceptum projecting from the anus at least six inches. It is evident that this extensive descent of the colon had taken place within six hours. The mucous membrane presented a swollen, œdematous and almost livid appearance. The tenesmus was constant and severe; the stools were frequent, but very scanty. The child was at once taken to the hospital, where it was chloroformed, and being held in inverted position the prolapsed portion was pushed upward beyond the anus, after which the invagination was readily reduced in a few minutes by rectal insufflation of air. The invagination did not return, and the child remained in perfect health.

Colostomy.—Two indications for the formation of an artificial anus might arise in the treatment of colic invagination: (1) In acute cases, when the general symptoms are so grave as to positively contra-indicate a laparotomy. (2) In irreducible chronic cases, when the lower portion of the colon is invaginated into the upper part of the rectum, where it is impossible to make a resection through the rectum or establish an intestinal anastomosis by lateral apposition. According to the location of the invagination, the operation is made either in the right or left inguinal region; in the former instance the opening being made in the cæcum, and in the latter in the descending colon. After exclusion of the obstruction from the fæcal circulation by this procedure, the patient may not only go on to recovery, but the obstruction is occasionally removed later spontaneously by disinvagination or sloughing and elimination of the intussusceptum. Dubois ("Enterotomie Pratiquee in Extremis,"—*Journal de Med. de Bruxelles*, December, 1878) reports a case of colic intussusception where the invaginated portion could be felt in the region of the sigmoid flexure through the abdominal wall. Colostomy was performed above the seat of obstruction, and the patient not only recovered, but four months later the permeability of the intestinal canal was restored spontaneously, although the artificial opening had not closed.

Enterostomy.—The formation of an external intestinal fistula or enterostomy should only be resorted to in irreducible iliac, ileo-colic, and ileo-cæcal invagination when the patient is in such a collapsed condition that more radical measures are inadmissible. As in the majority of cases, the primary seat of invagination is at or below the ileo-cæcal valve; the artificial opening should be made in the right iliac region. Should the invagination be located higher up in the intestinal canal, and an empty collapsed coil of intestine present itself in the incision, it should be pushed aside and search made for a distended loop. An enterostomy is justifiable even when the patient is in an almost pulseless condition as this operation is attended by little, if any, shock, as it could be done in a few minutes, and, if necessary, without an anæsthetic Emptying the bowel above the seat of obstruction will bring immediate relief by removing abdominal distension, and by favorably influencing the invaginated part by taking away the hydrostatic pressure above the obstruction, which in itself is a potent cause in maintaining vascular engorgement and inflammation. Langenbeck ("Verstellung eines Falles von Geheilter Enterotomie,"—*Verh. der Deutschen Gesellschrift fur Chirurgie*, 1878) saved the life of a patient suffering from invagination of the colon by enterostomy. The invagination had advanced so far