operation, it was believed that we could do for the patient equally well by providing for a large anastomosis and brought the proximal distal loops together making a three inch anastomotic opening by suturing between the proximal loop and the distal loop with a purse-string suture drawing up the end into a very small mass and closing up the bag lying between the anastomosis and the sigmoid so that by no possibility could the small intestine get in through and become strangulated. On the second day the patient's bowels moved normally, and so far as I could judge the treatment has been quite satisfactory. There is no distension, and the patient has improved so far as her indigestion symptoms are concerned by taking to food readily, and the general abdominal condition has been much improved. This is the only case I have met with of the so-called giant sigmoid.

GEO. E. ARMSTRONG, M.D.—Dr. Bell has brought before us a very interesting subject indeed, and one very timely, as it is occupying much attention at the present time. It would seem as if we were really dealing with two conditions, one which is congenital, and a second acquired condition. One remark in Dr. Klotz' report is of interest, namely, that where there is lots of room, where the lower end of the descending colon does not come too far down and is not too fixed, there is very little danger. The danger arises when the long fixed end of the descending colon and the upper fixed end of the rectum are near together. When these two points are close together and fixed, then volvulus may occur. In the second class, possibly more common in adults, it has seemed to me that the teachings and demonstrations of Mr. Lane in regard to the formations of bands are sound. Mr. Lane has published two papers, one in the *British Medical Journal,* and another in the Chicago *Journal of Surgery, Gynæcology and Obstetrics,* where he figures all the conditions—the formation of bands, the distension, and the fixed points. In the hepatic flexure, the colon is tied up under the liver, and in the splenic flexure, it seems to be tied up in the peritoneum extending to the diaphragm. It seems to me that this paper illustrates pretty well the ætiology of the condition as arising in some cases, at least in adults, from chronic colitis, causing bands which first hold the gut down or at most obstructing its movements. One of my cases was a young man, practically an imbecile, in which the condition was very extreme and had been going on practically all his life. The sigmoid here occupied the whole of the hollow of the diaphragm and the apex of the heart was visible and palpable in the second intercostal space. The volvulus had occurred in the usual way, and lay across the transverse colon. There was a large distended hepatic flexure, a large distended splenic flexure with this distended sigmoid