tonitis was produced with apparently thrombosis of the left iliac vein, and consequent dropsy of the left leg. Concomitantly with these there was absorption of the putrid materials contained in the sac, and the production of septicæmic symptoms, as indicated by the character of the breath and the temperature when she came into the hospital. This threatening state of matters was relieved greatly by the bursting of the sac into the bowel, and the subsequent free discharge of fœtid pus per anum. Into the grounds of diagnosis in this case it is hardly worth while to enter, as these are only too plain. We had evidence of an enlarged uterus which was empty, and along with that a very complete history of the occurrence of pregnancy with fœtal movements and milk secretion. As the fœtus had died, we had no scruples in using the uterine sound to confirm our belief that the uterus was empty. Though the diagnosis was easy, yet the sequel has proved that the case of Mrs. S. is extremely interesting. The centre of importance in the case is its treatment. It may be doubted whether I was warranted in attempting to remove the bones of the fœtus; and indeed, from my own experience of the alarming nature of the complications found, I would almost feel inclined, in another case to act upon the principle which was aptly put forward by Dr. Hart, when he came to see the patient the day after the operation, viz.: when there is any reason to fear communication between the sac and the intestinal canal, the moral of this case is to let well alone. Whilst I heartily said amen to Dr. Hart at that time, I am of opinion now that something has been added to our knowledge of what can be done by operation on the intestinal canal by the experience of this extraordinary case, and that though the general principle may be true, there is reason to expect not a few exceptions to it. No one present at the operation believed that the woman could live over twenty-four hours, yet to our surprise and delight she is now living and well, and nearly two months have elapsed since the operation. Besides what was I to do? The patient had been as above stated, nearly five months in hospital, and though she had improved very much, yet the slightest attempt at sitting up brought on attacks of pain that threatened to light up afresh all her peritoneal evils. I could not continue keeping the patient much longer in the house, and to send her out seemed consigning her to certain death. I accordingly reluctantly resolved to operate. From the amount of suffering which the history of this case shows that the patient went through, I should not, I assure you, lightly subject another patient to the same ordeal. But I rather think that if a patient similarly situated were to present herself again in my clinique, I would feel warranted in the light of the experience gained by this operation, to give her a chance for her life by operating. It will be noticed that the fœtal sac occupied the posterior and lateral aspects of the abdomen on the right, passing posteriorly behind the ascending colon, and anteriorly being closely connected with a loop of the small intestine, at least six inches long, which freely communicated with the sac, and, indeed, formed part of its wall, as we found it. This intestine was adherent to the abdominal wall; and it was on separating this adhesion by very gentle traction, believing it was the upper wall of the sac of the fœtus, so as to get at the bones which I felt through it, that to my horror and dismay I found myself in the cavity of the intestine. It is idle now to discuss the question whether with greater care it would have been possible to avoid this lesion of the bowel. I simply may say I do not think so, if the operation was to be carried out at all. Having found myself in the unlucky predicament of having to deal with an opening involving six inches or so of intestinal canal, the walls of which were ragged, thickened, softened and almost gangrenous, with, in addition to that, a considerable fæcal fistula of another loop of small intestine, I did my best for the patient by cutting out the unhealthy torn piece and bringing together the raw healthy surfaces as accurately as possible, whilst at the same time I rawed the edges of the small fistula and brought them thoroughly together. This left a gap in the mesentery, which had also to be sewed up. As no operation of this sort was expected, we had made no special preparations for it and were only provided with good catgut. I acted chiefly upon Sir Spencer Well's experience, who, finding he had made a considerable cut into the colon in one of his operations, states that he brought the opposing surfaces together with a continuous catgut suture. This I did to the very best of my ability, taking care to bring out the needle on the one side and enter it on the other exactly at the edge of the mucous membrane, so as to avoid including any portion of the latter in the grip of the suture.