required some assistance. She immediately felt sharp pain in the right lower quadrant of of the abdomen, and had to be helped to bed. At the time of the doctor's visit her pulse was 120, and temperature 101 F. Her abdomen was slightly distended, and very tender, especially in the right iliac region. The uterus was quite movable, but drawn to the right, while in the right fornix, above and behind, could be felt an indistinct tender mass. Believing the case to be one of salpingitis, with commencing peritonitis, small doses of morphia were given, and hot boracic vaginal douches ordered.

There was no improvement on the 15th, and I saw her for the first time on the 16th, when the picture was that of a moderately sharp attack of pelvic peritonitis—abdomen distended, very tender, but not markedly rigid. An indistinct tender mass occupied the right fornix. There had been no movement of the bowels since the onset of the attack—calomel and rectal enemata both proving ineffectual. Ice bags were applied to the abdomen and the hot douches continued. During the next three days the distension increased, absolute constipation continued, the temperature dropped to normal, the pulse became more rapid, the patient more restless, and continuous hiccough with occasional vomiting supervened. In short, the picture of abdominal inflammation had given place to one of acute obstruction. An interesting feature at this time was the entire absence of visible paristaltic movements—a symptom I place great reliance on in the diagnosis of mechanical obstruction of the bowels, nor could any be elicited by flicking the abdominal wall. A very occasional gurgling could be detected by the ear placed over the abdomen. The pelvic mass was larger but extremely hard to map out, owing to the distension. An aspirating needle was introduced into this without result.

Feeling that the patient was dying from obstruction of the bowels of the paralytic type, possibly due to a peritonitis, I advised laparotomy. This was hurriedly done without removing the patient from her bed. Through a short incision in the right rectus below the umbilicus, a coil of distended small intestine was withdrawn, incised, and a tube introduced. There was no free abdominal fluid, though the peritoneum was intensely injected. Owing to the extremely bad condition of the patient I made no further exploration. For twenty-four hours her condition was critical, but gas and fluid feces were finally passed from the artificial anus, assistance being given by turpentine stupes, and gentle abdominal massage.

The distension gradually subsided, some bowel contents being