surroundings properly protected and isolated from unsterile contact, the armamentarium, and hands and arms of participants sterilised, &c., a more leisurely examination was conducted before attempting taxis in the event of conditions requiring previous rectification, the boy having been submitted to chloroform narcosis. Investigation demonstrated prolapse of invaginated intestine in the vicinity of the umbilicus. The intussusception was both ascending and descending, the gut above and the gut below being received into and ensheathed by the distended mass which had the appearance previously mentioned. It was found that the umbilicus was intimately adherent to the gut throughout two-thirds of its extent and that the viscus had not escaped through the navel, but at the point indicated by the above-mentioned narrow red crescent, which was situate to the left of the omphalic cicatrix. There had at no time been a flow of fæces at this point, nor had the contents of the bowel ever discharged through the navel, but a moment's use of the probe disclosed a communication between the umbilicus and the intestinal canal. It is unnecessary to explain that the umbilico-intestinal fistula represented the vitelline duct, which connects the vitelline vesicle with the alimentary canal in the fœtus, and which is normally obliterated about the end of the second month of ante-natel life; in this child the process had failed to occur and the *ductus omphalo-entericus* remained an open canal. The diversion of the fæcal current from the canal may be explained by the apposition of the lateral aspects of the umbilical cicatrix, the geniculation of the adherent gut and the fact that the baby's life was singularly free from the perturbating influences which induce increased abdominal pressure. The avenue of escape for the prolapsed gut was afforded by the narrow crescent, which really marked a point of arrested development of the abdominal wall.

The exercise of patience and careful effort enabled us to liberate the intussusceptus from the grasp of the intussuscipiens at either end without serious damage to the entering, returning or receiving layer of gut, the soft adhesions at the point of contact between the superior and the inferior segment of invaginated intestine within the ensheathing bowel being easily disposed of. The reduced gut was eight inches in length, and after release from constriction and under the influence of hot sterilised normal-salt solution soon presented an appearance justifying our confidence in its continued vitality. The umbilicus was carefully dissected from the intestine and the already inaugurated procedure of omphalectomy completed. The abdominal cavity being still shut off by the proper disposition of hot moist aseptic gauze, the extra-peritoneal segment of intestine was again treated