head. I might have removed the contents of the tumor when I found that it was being absorbed so slowly, either by aspiration or excision, but I think the already greatly diminished deformity has justified my leaving the case severely alone.

This condition is said to occur once in 250 new-born infants. I have seen several, but never one before which had a firm bony covering form over it.

RESECTION OF THE BOWEL.

Dr. R. C. KIRKPATRICK read the following report, to which is appended the pathological report of Dr. W. H. JAMIESON, who exhibited the specimen.

J. C., aged 63, was admitted to the Montreal General Hospital on Sept. 18, 1896. He said that for three weeks he had not had a motion of the bowels, and that for a week before that he had been much constipated. Previous to this time (four weeks before the date of his admission) he had been well. He had been treated by all sorts of purgatives and injections before he came to the hospital.

The abdomen was evenly distended (37 inches in circumference at umbilicus), and tympanitic throughout. Liver dullness present (1½ inches on mammary line). No tenderness. Digital examination of the rectum revealed nothing abnormal. The case being urgent, the abdomen was opened in the middle line. The small intestines presented and were distended.

On drawing over the sigmoid flexure it was found to be distended until the lower part was reached, where a constriction was found. This was resected, and the ends of the bowel united by a double row of silk sutures. As soon as the rubber tubing (which had been tied round the bowel above and below the field of operation, to prevent the escape of fæces) was removed, the bowels commenced to act. A large rubber tube was inserted into the rectum, and a copious motion was passed, I should think a couple of quarts of fluid fæces. This line of union being apparently tight, the abdominal wound was closed. The patient died forty-nine hours after the operation, the highest temperature being 100° and the pulse 100. The abdomen remained soft and flaccid throughout. He had a slight bronchitis before the operation, and the ether made this worse, so that I was inclined to look on the pulmonary condition as the cause of death. However, the pathologist has another story to tell, namely, leakage from the line of the re-section, and septic peritonitis.

How should such cases be treated? Looking back on this case, I feel strongly that the best treatment would be a temporary inguinal colotomy. Then, when the enormous collection in the bowels had been got rid of, a resection could be done with much greater prospect of success. The bowel could be opened at once, or if the patient's condition would permit of it, after twenty-four or forty-eight hours, when there would be no danger of infecting the peritoneum by the discharges.

The strain put upon the line of union by the contents of the bowel is very apt to be too much for the sutures or whatever device is used to approximate the cut ends, especially as there is a chronic