given frequently. I prescribed tinct. opii, m xv . every three hours until I saw the patient again. Late in the evening I paid another visit. I was then informed that he had had a large passage from the bowels. On examining the evacuation it was not hard to discover that the greater part of it consisted of intestine. Having washed it I was astonished to find the specimen of which I send a photograph.

The patient was now suffering much less pain. He had taken half a pint of milk during the five hours which had elapsed, and had only vomited once.

On May 2nd there was slight improvement. He could take milk in small quantities without ill effects. The temperature was 103° , the pulse 120, and the respirations 45. He was not in so much pain. There was a slimy discharge from the bowels, and small masses of faeces were passed. From this date the patient made steady progress. The slimy discharge, which had been constant, ceased on May 10th. He sat up for an hour on May 14th, and came downstairs a week later. Diarrhoea still continued, the bowels being moved sometimes six times in twenty-four hours.

It is now twelve months since the attack. The boy looks strong and healthy. He has not had any pain in the abdomen for ten months. His bowels have been slightly relaxed ever since the attack.

The portion of bowel, as will be seen from the photograph, consists of ileum with Meckel's diverticulum. The total length was $11\frac{1}{2}$ inches. The upper portion was invaginated into the lower, the entire length of the diverticulum appearing through the lower orifice.

CASE OF INTUSSUSCEPTION WITH SLOUGHING OF INTESTINE; RECOVERY.

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THE following case presents some features of interest, especially in the very rare circumstances of the passage of a sphacelus of bowel.

J. W. G., aged 17 years, on the morning of June 23rd, 1893,

began to suffer from severe abdominal pain and vomiting, which continued through the day, and under treatment (by belladonna and morphine) passed away during the following night. The next morning he felt so much better that he got up and seemed quite comfortable when I called. He began, however, to be worse later in the day, and vomited several times. In the evening I found some general tympanitic swelling of the abdomen, but as far as the finger could reach in the rectum there was nothing abnormal to be felt, and externally I could detect no tumour. From this time all nourishment swallowed was rejected, and the tympanites rapidly increased to the fullest extent, and for eight or nine days this condition continued. The patient refused food altogether, and only took ice, and vomited occasionally dark brown or greenish matter, which, however, had not a distinctly faecal odour. Several enemata of soap and water—as much as could be retained—were given by means of the long tube, which could be passed about half its length. This was repeated once a day at the boy's desire, as he said he felt much relieved by it. Some fluid faecal matter usually came away with the enema. In addition to this, nutrient enemata, every six hours, of beaten egg or Brand's essence dissolved in water were given and retained.

On July 1st, the faecal matter passed was mixed with blood. There was extreme tympanites, and in the general swelling the ascending and transverse portions of the colon stood out very clearly defined and resonant. There was very little tenderness, but at a point corresponding to the junction of the transverse and descending colon there was some dullness on percussion, and pressure was resented.

About July 5th the bowels began to act spontaneously, bringing away solid faeces, and the tympanites gradually lessened. All motions passed were examined, and on July 10th, seventeen days from the onset, a piece of intestine came away. I found this to be 13 inches long, and my first impression was that it was small intestine, its size (flattened breadth being about an inch) and general appearance decidedly giving that impression, though the physical signs pointed to obstruction beyond the transverse colon. The presence of an unmistakable appendix epiploica, however, showed it to be large intestine. Of intact bowel, with some mesentery attached, there was 7 inches, while the rest of the length consisted of a ribbon of only one half the circle of the gut, evidently the remains of one broken up fold of the volvulus.

On July 16th the patient began suddenly to have abdominal pain and vomiting; the temperature was 102° , and there was much tenderness to the left of the umbilicus. Tympanites increased, but soon subsided, and all inflammatory symptoms disappeared by July 21st. On August 6th he had frequent dysenteric stools, mucus flowing away involuntarily. On examination by the rectum the finger came in contact, just inside the anus, with a large tumefied mass, round and tense, in the centre of which the finger could be passed through a small hole into the lumen of the bowel. Round the mass was a *cul-de-sac*, the extremity of which could apparently be reached by the finger with an effort. On August 9th he passed much pus, with mucus, but was improving generally.

From this time he made good recovery. The mass in the rectum gradually disappeared, and soft folds of membrane only remained. For some time he required aperients. He has since had one severe attack of colic, with tympanitic distension, which quickly passed away. His bowels now act regularly, and he is in good health.

Among the noteworthy features of this case it may be mentioned that apparently there was never absolute occlusion, as some faecal matter could always be washed away, and the vomited matters never gave a distinctly stercoraceous odour. It is also remarkable that, considering so much of the bowel was involved, the transverse colon should be apparently intact, as was seen during extreme tympanitic distension, and at the same time nothing could be felt by the rectum. The attack of local peritonitis on July 16th was no doubt due to some defect in complete coaptation, and would be reparative in its effect. To account for the structural condition felt in the rectum later, it would seem that there had been a secondary descent of the bowel, with severe inflammation of the coats.