that he has already removed all cause of obstruction, and it has probably frequently happened that patients have died because the possibility of such a complication was not thought of. The long interval between the relapses which some of the cases showed was possibly due to a temporary subsidence of the œdema present at the primary point of obstruction, caused by the rest and treatment of the secondary lesion. The occurrence of five cases in fifty-two operations performed by the author for intestinal obstruction shows that the condition is not so rare as might be supposed.

The diagnosis is materially assisted by considering the patient's statements as to where he first experienced pain and what the locality was in which the obstruction seemed to him to be situated. More certain is the observation in the early stages of peristaltic movements in the distended colon and the subsequent change in the location of the symptoms. The change is generally one from a condition in which therapeutic measures might be considered to one in which only immediate operative interference can be considered.

The symptom at the time of operation which will lead to the detection of such a condition, when it is suspected, is the contrast between the two portions of the colon. Above it is hypertrophied from the continued action required in overcoming the chronic condition prior to the complete obstruction, while below in the descending colon the intestinal wall is of normal thickness.

The Operation of Gastro-enterostomy Conjoined with Entero-anastomosis.—In discussing the present status of this operation, WEIR (*Medical Record*, April 16, 1898) summarizes his views on the subject in the following conclusions:

1. That gastro-enterostomy, as usually performed, is yet an unsatisfactory operation.
2. That its principal relivable danger is from bile or stomach retention due to operative defects, either primary or secondary—*e. g.*, spurs, kinks, twisted or distorted openings, and possibly stomach atony.
3. That a posterior stomach opening favors gravity action by the evacuation of the organ, particularly if it is atonied, and diminishes the risk of pressure or of pulling on the attached intestine.
4. That the operation is best conducted by means of the Murphy-button.
5. That a gastro-enterostomy, associated with an entero-anastomosis in the afferent and efferent portions of the jejunum, probably gives the best assurance against obstruction. Experience in this method, while so far gratifying, should, however, be enlarged to ascertain if the increased risk of the additional button overtops the danger of the bile and pancreatic obstruction.

A Simple Method for Controlling Hemorrhage During Disarticulation at the Hip.—THOMAS (*Lancet*, April 23, 1898) details a simple method for controlling hemorrhage from the femoral artery which he used with satisfaction in an amputation at the hip.

The common femoral artery and vein were temporarily compressed immediately below Poupart's ligament. At this point the artery is quite super-