potassium) and paracentesis fail to afford relief, or, in other words, in utterly hopeless cases, and (4) those in which there is no reasonable contraindication—the operation has a future. The cases are so hopeless, the technique so simple, the dangers so trivial, and the outlook so promising, that the prospects of this mode of treatment becoming an established one seem bright. That surgeons now have at their command a method of affording some relief in cases of intractable ascites, is evident.

The Application and Merits of Short-circuiting in Certain Diseases of the Intestines.—MAYLARD (*The Medical Chronicle*, April, 1901) states that the term "short-circuiting" is to be understood as the formation of a passage between one segment of the bowel above with another segment below, and thus the intervening portion of intestine is partially thrown out of action. There are two primary uses to which this method may be put—the one where it is desirable to divert the course of the intestinal contents past some obstructing influence, whether within or without the bowel; and the other where such diversion of fecal matter will admit of the closing of an artificial anus or fecal fistula. The author reports two cases of intestinal obstruction, both tubercular in origin, which made uninterrupted recoveries after this operation. This operation is indicated in cases of extensive malignant disease of the colon, and should prove a very valuable method of treatment. There are two methods by which short-circuiting may be executed—one by the lateral approximation and union of two loops of intestine and the establishment of a fistula bimucosa (entero-enterostomy, entero-colostomy, colo-colostomy), and the other by the division of a free segment of the gut, the closure of the distal end, and the lateral implantation of the proximal end into another free segment. The former method incompletely cuts off the passage of the intestinal contents through the partially occluded segment of gut, while the latter completely does so. Both methods have their own peculiar advantages, which are not immaterial in considering the particular method best suited for each individual case. Stitching should alone be employed in either method. In implanting the free end of the ileum into the colon it is as well to invaginate it for about half an inch. This is easily done by passing a traction stitch through the patent end of the ileum, and, after transfixing the colon at a couple of inches or so with the needle carrying the traction thread, pulling on the latter. While thus secured it is carefully stitched all around with a double circle of Lemberts. The traction thread is last withdrawn. The point requiring most attention is at the attachment of the mesentery to the invaginated end of the ileum.

In producing a fistula bimucosa the two portions of the gut involved in the union should be laterally approximated in such a way that the natural downward current of the feces is maintained. From two to three inches of the applied surfaces of the two segments of gut should be stitched first, this line of union forming the posterior boundary of the opening. Then the bowel wall of each segment is incised and the edges of the projecting mucous membrane of each orifice carefully united together, after which the posterior layer of stitches is continued on around the front until an external circle of Lemberts has been completed.