capable of success. The left side position gives a better passage to the fluid, owing to the turn of the bowel. Under the patient should be a well-warmed mackintosh, not reaching across to the far side of the bed, but doubled back to form a catch-water on the left side of the buttocks. Many a bed may thus be saved from accident.

Let the patient be taken into confidence, and have the simplicity of the proceeding explained to him. If the injection is a novelty to him, it will also be something in the nature of a shock. With some people it will remain so to the end, for to sensitive natures the mere necessity for dealing with the parts at all is a misery, almost a humiliation. To my mind an enema should not be given under cover. The fumbling entailed by the loss of the guiding eye is more harmful than the slight exposure on the other hand, and in addition serious mischief may be done in introducing the nozzle of the syringe. Keep your patient well covered, with just sufficient of the bedclothes turned back to show the buttock and anus. If you have him in proper position, there will be no difficulty in working your syringe with the basin on a chair by the bed. On no account should the bowl be placed on the bed, as recommended by a dearly-loved nursing-book in my possession. A very slight movement will upset a part at least of the fluid, to the damage of the bed and of one's own temper. Now warm the syringe, which should be a Higginson's, by passing the warm fluid several times through it until the warmth to the hand is comfortable—the temperature in the bowl being about blood heat—and expel the air, oil the nozzle, keeping the opposite end of the tube carefully in the fluid, tell the patient to open his mouth, and on no account to strain down, place the forefinger of the left hand at the anus, and with the right hand insert the nozzle into the rectum, the right buttock being slightly lifted by the back of the left hand to expose the anus. Pause a moment and ask your patient to breathe gently in and out with open mouth. It is wonderful how much this small precaution will facilitate the easy passage of the fluid. Halfway through the administration there will probably be felt a disposition to go to stool. It is almost invariably a false alarm, largely due to nervousness, and can be checked by momentarily desisting from pressure on the bulb, keeping it meanwhile at precisely the same point of tension, and resuming immediately. Gentle administration, even pressure, and an unceasing flow of the fluid into the bowel, should characterise a well-given enema. The end of the tube must not leave the water, but be kept fully covered. Should it rise above water level the nozzle must be taken from the rectum, the bulb re-filled, and the enema resumed. At the close of the enema the nozzle should be almost imperceptibly withdrawn, the finger being gently pressed against the anus. If the fluid is retained for a very few moments it is usually sufficient to ensure success.

A bed-pan should be ready to hand, and in the majority of cases, the patient should be placed on it immediately. The first flow from the bowel is often sudden, violent, and profuse. Care should be taken to have the bed-pan far enough forward, or the fæces are thrown over the rim and the bed is soiled.

But, when all due care has been exercised, it may happen that the fluid may flow out as fast as it is syringed in. In the case of old people, with relaxed sphincters this is unavoidable and the enema must take on the character of a rectal wash, smartly given, with a bed-pan under the patient. From two to three pints can be given in this way, the result being often surprisingly satisfactory. With this exception there are two main reasons for the immediate return of the enema, resistance on the part of the patient and mechanical obstruction. The first can usually be overcome by firmness and explanation, the second may be (*A*) natural, as in the case of pregnant women where the presenting part is already low down and presses on the bowel—(*B*) due to some malformation, a possibility for every nurse to bear in mind—(*C*) due to disease, such as a neoplasma in the rectum itself, or a growth higher up and pressing upon the rectum—(*D*) the more frequent cause, hard masses of fæces blocking the rectum. The latter cause is too often overlooked and the best and quickest remedy ignored, namely, the introduction of the oiled finger time after time removing the whole mass, when a most effective enema can be given.

I have dealt with the Higginson's syringe only. But for my own part I infinitely prefer as cleanlier, more effective, and less irritating to the patient the giving of enemata from a douche can on a stand, connected by a long tube to a glass nozzle. The steady flow, coming from a height, proves most effective, especially in midwifery cases.

Circumstances alter cases, and every nurse should be able to free herself from the rigid bonds of convention, and give her enema, if necessary, with the patient on the right side or on the back. The latter is important in cases of collapse where strong black coffee or alcohol is given, or of gastric ulcer with nutrient enemata. In either case the patient's strength

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