As the wound was sutured in layers, two nodules were observed on the peritoneum covering the transverse colon, but it was found impossible to remove them.

Report of Section sent to Pathological Laboratory.—"Section shows the presence of a sclerosing carcinoma simplex of high malignancy."

March 9th.—Progress of Patient.—On return from the operating theatre, the patient was placed in a previously prepared and well warmed bed in the supine position with head turned to one side to prevent choking from an accumulation of mucus in the throat. The foot of the bed was raised on nine inch blocks, and a continuous drip rectal saline commenced immediately. The temperature, pulse and respirations of the patient were recorded hourly. The patient's condition was considered satisfactory, Morphia gr. $\frac{1}{4}$ and Atropine gr. $\frac{1}{100}$ were given hypodermically and the patient had a comfortable night, and retained the rectal saline throughout the night and complained of no abdominal discomfort.

On the second morning the blocks were removed from the foot of the bed, and the patient placed in Fowler's position

Technique of placing patient in Fowler's position.

The patient is propped upright in a sitting posture with the aid of pillows, and the knees flexed over a bolster, securely fastened to the head of the bed to prevent the patient slipping. The bolster should be placed in a jaconet cover and afterwards wrapped in a drawsheet, the ends of which should be tightly tucked in under the mattress. The patient should sit on an air-ring to prevent soreness of the buttocks. The patient should be kept in this position as long as the surgeon wishes. It is the best position for a patient after an abdominal operation, as it allows drainage of surplus fluid to the pelvis, where absorption is not so rapid.

The Patient was placed on a Special Diet.

First day.—Sterile water 1 oz. given hourly.

Second day.—Milk and water, 3 oz. given two hourly.

Third day.—Milk and water, 4 oz. given two hourly.

Fourth day.—Milk and water, 6 oz. given 3 hourly.

Fifth day.—Milk and water, 6 oz. given three hourly and custard and jelly for lunch.

Sixth day.—Milk and water, 6 oz. given three hourly and Typhoid bread and butter, pounded fish, and egg custard and jelly for lunch.

Seventh day.—As for sixth day with the addition of thin bread and butter.

Eighth to 14th days.—As for the seventh day, with the addition of a poached egg.

After the 14th day normal diet is given in small quantities.

Antiphlogistine was applied to the patient's chest every evening. The patient's mouth was cleansed with glycerine and carbolic mouthwash after every feed. All pressure points were treated four hourly, day and night. The patient's progress was uneventful and satisfactory until April 14th.

April 14th.—Temperature rose suddenly to 102 Fahr., pulse 110 and respirations 24.

April 15th.—Temperature high all day.

April 16th.—Temperature fluctuating between 100-102° Fahr., pulse 110, respirations 24. Wound probed and a large collection of pus found. Hot boracic fomentations applied to the area every three hours.

April 17th.—Wound open for one inch at the centre of the incision. Large amount of pus found. Hot boracic fomentations applied to the area every two hours. Temperature 99° Fahr., pulse 100 and respirations 20 at 2 p.m.

Patient given sterile water feeds only by mouth and continuous rectal saline with the addition of glucose commenced mid-day.

April 21st.—Wound gaping widely showing rectus muscle. Hot boracic fomentations applied to the area every four hours. Discharge of pus from wound considerably less. Continuous rectal saline discontinued and diet recommenced as from the third day of the post-operative gastric diet. Temperature 100.4, pulse 106 and respirations 24 at 2.p.m.

April 23rd.—Patient developed rather a bad cough, and expectorated large quantities of offensive brown and green sputum. Condition of abdominal wound much improved. No discharge. Abdominal wound resutured under local anæsthetic. Temperature 100.6, pulse 120 and respirations 36 at 2 p.m. Patient complained of insufficient sleep, and was therefore given morphia gr $\frac{1}{6}$ by hypodermic injection at 10 p.m. and had a fairly comfortable night, although his cough was very troublesome in the early hours of the morning.

April 24th.—Patient seen by Medical Registrar, who performed an exploration of chest, and aspirated 900 c.c. of purulent yellow fluid. A specimen was sent to the Pathological Laboratory for investigation, The patient appeared much relieved. Morphia gr. $\frac{1}{6}$ was given by hypodermic injection at 10 p.m., and the patient passed a comfortable night.

April 25th.—Report received from Pathological Laboratory *re* fluid withdrawn from chest.

CYSTOLOGY.

Polymorphonuclear 96 per cent.
Lymphocytes 4 per cent.

BACTERIOLOGY.

Cultures.—Streptococcus non-hæmolytic B. Coli.

Abdominal wound progressing favourably. Hot boracic fomentations discontinued and flavine dressings applied. Patient's cough getting more troublesome, and more sputum expectorated. Temperature 100.8, pulse 120 and respirations 36.

April 26th.—Patient had a very restless night. Cough extremely troublesome and breathing very distressed. Chest examined by House Surgeon. Respiratory movements very limited on the left side. Dullness to percussion and "breath sounds" absent here. Chest X-rayed in ward by portable X-ray apparatus, and following report made: "Effusion in left pleural cavity with basal collapse. Some encystment seems to have occurred." Chest aspirated and 300 c.c. of offensive, moderately thick yellow fluid withdrawn. Morphia gr. $\frac{1}{6}$ given by hypodermic injection at 10 p.m. and patient had a fairly comfortable night.

April 27th.—Condition much improved, although cough still very troublesome, and temperature still high. Abdominal wound progressing very favourably. Patient appeared to have developed an inclination towards drugs, and does not attempt to sleep without them. Morphia gr. $\frac{1}{4}$ given by hypodermic injection at 12 midnight, after which patient slept fairly well.

April 28th.—Condition unchanged. Chest X-rayed again in the ward, and the following report made: "Left hydropneumothorax with adhesions." Temperature 99.8°, pulse 120, respirations 28 at 2 p.m.

April 29th.—Condition unchanged. Chest X-rayed again in the ward, and the following report made: "Hydro or Pyo-pneumothorax with upper lobe collapse. I assume Diaphragm is normal in position, outlined by the gas in the stomach and colon. I can find no evidence of sub-diaphragmatic infection." Morphia gr. $\frac{1}{6}$ given by hypodermic injection at 10.30 p.m. Patient had a good night.

May 1st.—Chest aspirated again and 700 c.c. of offensive greenish yellow, fairly thick fluid withdrawn. It was observed that pus and air escaped from the site of aspiration.

May 3rd.—Patient complained of much pain at the site of the last aspiration. The area was swollen and inflamed. Temperature now 100.6, pulse 128, and respirations 34,

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