took place during the administration of the ether and before the operation had been commenced.

Case III.—Mrs. C., æt. twenty-eight. Dr. B. first saw her June 23, 1885, in the sixth month of her fourth pregnancy, and naturally of a very strong constitution. She was complaining of severe abdominal pain with diarrhœa, which she attributed to getting her feet wet a day or two previously. Pulse was rapid, but her temperature was normal. An anodyne was prescribed, and she was not seen again for forty-eight hours, when she had a rapid pulse (108) and a temperature of 99.8° F.; she complained of pain and tenderness in the abdomen, and was confined to her bed. Next morning she was much worse. She had an anxious expression of countenance, considerable lividity of face and lips, with a temperature of 102.5°, and pulse of 120; tenderness was marked in the right iliac region and extended across the median line; there was slight abdominal distention. That evening she was comfortable. At 2 P.M. labor pains came on and the child was born before Dr. Blackader could reach the patient. There had not been much hemorrhage, but the mother was very pale, her lips were livid and her pulse feeble; the placenta was retained. After waiting a short time the placenta was delivered by passing the hand into the uterus; there was no hemorrhage. Vomiting set in shortly, and she died the same evening at 6 o'clock. No post-mortem examination was allowed.

Case IV.—Mrs. B., æt. twenty-four, consulted Dr. B. about the end of October, 1887, for frequent and painful micturition. She had been married in August. The symptoms did not yield to remedies, and a vaginal examination was made and the uterus was found anteverted and decidedly enlarged. Absolute rest in bed was insisted on. By the end of December she was up and about and apparently as well as ever. She was not seen again until the middle of February. She then complained of pain in the right iliac fossa and back; there was also a good deal of nausea, a thickly furred tongue and constipation. Pulse and temperature normal; no tenderness on pressure was detected. Salines were administered (March 2d) with partial success. A fortnight later the pain became suddenly much aggravated, apparently after eating heartily; there were much tenderness over the cæcum and slight distention of abdomen. Temperature 102°, pulse 100. Slight nausea but no vomiting. The patient was anxious, restless. On the evening of the 5th Dr. Brune was called in and agreed that there was a local peritonitis. A few days later the symptoms became so serious that the question of abdominal section was discussed. There were considerable distention and great tenderness of the abdomen, especially in the right iliac region, and vomiting was frequent. Pulse weak, and 120–130; temperature 101°. Morphia was given hypodermatically and the symptoms gradually subsided. On the 12th the right parotid gland became inflamed, and then the left gland was likewise affected but both subsided without suppuration. On the 14th of May the patient was safely delivered of a healthy child, labor was in every respect normal and convalescence was uninterrupted. Since her confinement there have been two slight attacks of abdominal tenderness in the right side, with slight pyrexia—but now the patient is quite well.

Dr. Blackader said that there was no reason why peritonitis should not occur during gestation, while there are reasons why it might even be more frequent at that time. A very small number of cases are recorded in medical literature, and he thought it must be of rare occurrence. No reference is made of peritonitis during gestation in any of the works on obstetrics, and very few cases are reported in medical journals. Dr. Blackader could find only four. Dr. Gow reports a case in the *Edinburgh Medical Journal* for January 1888, which was given by the reader of the paper in full. The patient died, and no cause for