ter[11], who examined 140 cases bacteriologically, found the pneumococcus in two cases only. In this variety of peritonitis it is advisable to delay operation until an abscess has formed, as fatal results have frequently followed operation in an early stage. The treatment then consists of incision and drainage.

The variations in the application of the term "diffuse septic peritonitis" have led to much confusion. The results of pathological investigations indicate that in acute infection of the peritoneum general diffusion of the exudation throughout the peritoneal cavity rarely occurs, and that in such cases, more especially those associated with perforative appendicitis, the internal organs, with their ligaments and mesenteric attachments, tend to prevent and delay extension.

In regard to peritoneal infections after perforative appendicitis, Kron[12] distinguishes diffuse pelvic peritonitis, diffuse unilateral peritonitis, unilocular peritonitis and multilocular peritonitis. Rauenbusch[13] distinguishes a supra-omental and infra-omental form, extension occurring from above downwards and from below upwards respectively. The most common form is that limited to the portion of the peritoneal cavity below the transverse colon.

Formerly, we were accustomed to hear of post-operative peritonitis, but this should never be allowed to occur. Scrupulous attention to technique, and above all, the covering of the hands of the operator by rubber gloves during operation, has added greatly to the safety of peritoneal operations. By substituting asepsis for antisepsis the defences of the serosa are preserved in their integrity. The perfection to which technique has now been brought prevents the entrance into the peritoneal cavity of germs from the digestive tract, the gall bladder, the tubes or the ovaries. This includes the carrying out of the greater part of the operation before the opening of the septic cavities, reduction to a minimum of the time during which they are open, and exact limitation of the field of operation.

It may be interesting here to mention that De Paoli and Callisti[14] claim that they have considerably improved their operative statistics by the injection of nuclein of soda thirty-six to forty-eight hours before the performance of laparotomy, and that in a series of more than two hundred laparotomies for various abdominal conditions they have had one death only from septic peritonitis. Arcangelo[15] reports thirty laparotomies in which he has employed the same method, without a single case of post-operative infection.

To prove that this is unnecessary, I may say that I can give a series of more than three hundred laparotomies done for various