the nerve disorder? He thought there was.

Dr. Lapthorn Smith wished to ask three questions:

1st. Was he a smoker?

2nd. Was he a drinker?

3rd. Had codeine or codeia been tried? In one case he had known codeine to be very effective in diminishing the quantity of urine. He thought this a case of disease going on about the base of the brain, which was at the same time pressing on the floor of the fourth ventricle and on the origins of the spinal nerves going to the affected side.

Dr. Gardner said he had had one case in which 150 ounces a day had been passed for several weeks following ovariotomy. The patient had a large appetite and great thirst. He asked if there were any recognized causes for polyuria.

Dr. Hingston found such cases very frequent after operations.

Dr. Stewart replied that the man was a non-smoker and temperate. Morphine had been tried, but not codeine. He could give no explanation to Dr. Gardner's question.

Dr. Hingston showed several stones which he had removed by lithotomy from a man with an enormous prostate. The peculiarity of the case was that he had the greatest difficulty in finding the stones. It was only after making several examinations, and with a sharply curved sound, that he had succeeded in detecting them. Another peculiarity was that not a drop of urine passed by the wound, and he was able to retain urine in the bladder very well.

Dr. Shepherd asked whether he had suffered from retention up to the operation?

Dr. Lapthorn Smith said that he had experienced the same difficulty in finding the stones in several cases of greatly enlarged prostate; he thought the inflammation was the formation of a pouch below the level of the urethra, as proved by the large amount of residual urine in these cases.

Dr. McDonnell read the history of a case of appendicitis, which began twelve months ago by a sharp pain in the right iliac region, which lasted some time. Five months ago had a second attack, which left patient in bed three weeks. After being up for three weeks another attack came on, lasting till June. Nine days before admission was taken with severe pain and vomiting, followed four days later by a severe rigor. Before entering hospital was treated with opium. On entering the hospital there were all the symptoms of peritonitis, pulse being 120, small and hard, and breathing being very rapid. Temperature 100.8. Opium was administered, but the patient continued to grow worse; in fact the prognosis was so bad, and the symptoms pointing to appendicitis, laparotomy was thought to be warranted, and it was handed over to the surgical side.

Dr. Shepherd then read the following report: On 14th Sept., assisted by Dr. Bell, he operated. On cutting through the abdominal wall two abscesses containing pus were evacuated. There was a gangrenous ulcer of the appendix, which latter had to be tied very close to its union with the cæcum, it was so much diseased. By the end of a week there was no fever, but a fœcal fistula formed. It was packed with iodoform gauze. Although a small sinus still remained, the patient was well and at work. This case illustrated the importance of early operation. In several other cases he had operated on they had all died because the operation had been resorted too late. In some cases such violent peritonitis is set up by the rupture of the abscess that no operation can avail.

Dr. Bell said that he strongly advocated early operation; the trouble was in the peritoneal cavity, and we could not afford to trifle with it. Lateral incision was much better than median incision. He had had two successful cases.

Dr. Hingston regretted to say that he had had one case in which he did not operate, and the patient died. In future he would operate.

Dr. Gardner said that when there is an abscess to be evacuated, and a drainage tube is used, there is no necessity for covering the stump with peritoneum. If, on the contrary, the abdomen is closed without any tube, then it is better to cover the stump.

Dr. Springle had seen two cases in the dissecting room.

In conclusion, Dr. McDonnell urged all practitioners to be on the lookout for these cases, so as to recognize them early and to operate; and Dr Shepherd said that he had lost six cases because they were operated on too late.