we are to regard the liver as concerned in the diseased process, or not. But, though you may admit the importance of the distinction, you may be disposed to regard the discussion of the method of making it as a superfluous inquiry. This, however, is not the case. Many a time I have had patients sent to me as labouring under ascites who have not had a drop of fluid in the peritoneal cavity, but the increased girth of whose abdomens has been entirely due to œdema of the abdominal wall.

On what rules, then, may we fall back for the resolution of a case in which there is undoubtedly an increase of the girth of the abdomen? How shall we determine, in such a case, whether the effusion is external or internal to the abdominal cavity?

1. If the effusion is external—if the abdominal enlargement is due to œdema of the parietes—the following conditions will be found to be present.

a. On attempting to pinch up the skin of the abdomen, we shall find that we pinch up a thick firm "rool" of integument, firm and doughy, an inch or more in thickness; and we generally find that the lower down on the abdominal surface that we attempt thus to pinch up the skin the thicker is the rool of integument which we raise; because the lower is the abdominal surface the more developed is the œdema.

b. We find the umbilicus deep-set, and deep-set in proportion to the œdema. This is always the case; and the reason of it is this :—At the umbilicus the skin and the deep fascia are fastened to one another, and annot be separated; elswhere, from the intervention of a loose and extensible areolar tissue, the one can be freely raised from the other. Now, it is into this areolar tissue that the dropsical effusion takes place; and by this effusion, and in proportion to it, the deep and superficial fasciæ are separated from one another, and the skin raised. In proportion, therefore, to the effusion which raises the skin from the deeep fascia will be the depth of the pit at the point where it *cannot* be raised. This deep-set umbilicus is very characteristic, and I would especially recommend your attention to it.

c. Again, the parietes have a particular white opacity about them—an unnatural and uniform whiteness; and this, I think, is in part due to another appearance—an absence of any visible veins. The superficial veins lie in the subcutaneous areolar tissue; and this is so thickened and distended by the œdema, and the skin thereby so much raised, that the veins are no longer immediately beneath the surface.

d. Another characteristic of œdematous abdominal parietes is a peculiar quaggy vibration in them when they are tapped—a sort of jelly-like