work, but was at one time the foremost pathologist on this continent. To Dr. Clarke has been given a large part of the credit for promulgating the opium treatment of peritonitis. It was said of him that if he has done nothing more than to put forward his views on this subject he would be entitled to the lasting gratitude of mankind. The dose of opium that he administered was not fixed, but depended upon the needs of each individual case, all the time bearing in mind the important fact that cases of acute peritonitis will, as a rule, bear very massive doses of this drug.

Among the most frequent causes of peritonitis is some break in the chain of continuity from the stomach to the rectum and in such cases purgatives can only do harm by causing the pouring out of more of the contents of the digestive tract into the peritoneal cavity.

After abdominal surgery had made some considerable progress it was found that numbers of patients died from post-operative peritonitis and a crusade was instituted against the use of opium in the treatment of this disease. Many surgeons were satisfied in their own minds that free evacuation of the bowels after operation within the abdomen produced rapid convalescence. From this standpoint it was argued that purgation and not obstipation was the proper treatment for peritonitis. We know now that many of these patients who were thus rapidly relieved were not suffering from true peritonitis, but from a certain amount of peritoneal irritation and congestion and they would have made an easy convalescence without the use of any drugs.

Two great advances were made, the one largely through the work of Howard Kelly, of Baltimore, and the other through the work of Prof. Mikulicz, of Breslau. In the first instance drainage of the peritoneal cavity was done away with and this source of post-operative contamination from without was removed from the surgical arena. In the second instance Prof. Mikulicz taught us how to isolate irremovable infective areas by the protective agency of intraperitoneal gauze packing.

Those of us who have been doing abdominal surgery for years now see less not only of peritonitis but of the peritoneal irritation above mentioned than we saw in times past, owing to the two changes in treatment above mentioned, and also to the fact that our aseptic technique is now more thoroughly carried out.

All abdominal operators have unfortunately seen patients in whom purgatives have been administered for the relief of post-operative peritonitis, become more and more distended with tympanitis and succumb finally to the disease without having a single free evacuation of the bowels. On the other hand, abdominal operators have seen such patients die after they have