sudden as in pneumonia, or, again, such falls follow copious hæmorrhages. In the latter case, however, the temperature rises again rapidly, while in perforation it remains low or rises very gradually. Perforation peritonitis lasts from three days to a week, during which time deceptive remissions may occur. The end is almost invariably fatal. In rare cases protective adhesions form, and recovery ensues. In the peritonitis due to the propagation of the infectious process through the ulcerated but not perforated intestine there is a lesion of the vermiform appendix, which may ulcerate and be perforated at the level of its abundant lymphoid tissue. The symptoms are the same as those of other typhoid perforations. "Paratyphoid peritonitis" is due to the remnant of a typhoid lesion of the appendix, and is characterized by a rise of temperature. Surgical treatment of this condition should be the same as in ordinary appendicitis. The problem of when to operate in a perforative peritonitis is a much more serious one, owing to the difficulty of determining that perforation has taken place, the necessity of speedy and opportune intervention, and the fact that there may be several coincident perforations. Operation, however, holds out some hope of success, and in spite of the ulceration suture may bring about healing.—*British Medical Journal.*

DIABETES AND CIRRHOSIS OF THE LIVER.—Pusinelli (*Berl. klin. Woch.*) records the case of a man, aged 48, who in 1887 had a slight attack of jaundice, and in the following year 1½ to 2 per cent. of sugar was present in the urine. The sugar subsequently disappeared, but was present again after 1892. In 1893 there was much ascites with œdema of the legs. Both the liver and spleen were enlarged. Ten litres of fluid were drawn off, and subsequently the tapping was twice repeated. The puncture then remained open, and after its spontaneous closure there was no further accumulation of fluid. No unevenness of the surface of the liver was ever made out. The amount of fluids taken by the mouth was at first greater than that eliminated; but eight weeks after the last tapping the order was reversed, and the ascites and œdema disappeared. The patient improved so much that he was able to resume his business; the jaundice also disappeared, and the liver became less in size. Later albuminuria supervened, and now and then œdema of the legs. The sugar disappeared from the urine while the ascites was present, coming back again as soon as the ascites was gone. This fact is difficult of explanation. As regards the treatment, perhaps the last tapping with a large trocar and the escape of fluid for several days afterwards may have been of importance, but this alone hardly accounted for the great improvement. Perhaps the large doses of cream of tartar taken produced this beneficial result. This remedy has been recommended by Sasaki in daily doses of 8 to 40 g.; if the patient's general condition is unsatisfactory, iron, quinine, etc., are given in addition. The author discusses the relation of the liver affection to the diabetes. The cirrhosis was certainly first in point of time, jaundice appearing a year before the glycosuria. As regards the form of the cirrhosis, syphilis, alcohol, and gall stones could with certainty be excluded. The course of the case differed in many respects both from Laennec's atrophic and Hanot's hypertrophic cirrhosis. Perhaps it is a special form of cirrhosis associated with diabetes; the liver and spleen are enlarged, there is periodical jaundice and considerable ascites, the course is prolonged with a tendency to recover, and there are no gastrointestinal symptoms. The author, among other conclusions, points out that attention should be given to the liver in diabetes and to