which could be separated by percussion from the spleen. It was quite freely movable. Small doses of bichloride of mercury were administered, and in a few days the temperature fell to 100°, and remained at this point, and the other meningeal symptoms disappeared. There was no colic indicating tubercular peritonitis. The child became now even more anæmic than before, and the abdominal swelling increased in size. It seemed hardly possible that the mass could be a psoas abscess pointing in such an unusual position. After some time the mass became larger, and moved towards the posterior surface of the abdomen. In consultation with Dr. W. T. Bull, it was decided to be inadvisable to operate. The child died six days ago, and for a few days before death there was slight jaundice. The *post mortem* examination showed that the abdominal tumor was formed by a tubercular mass which united the intestines into one large mass. There were no small miliary tubercles scattered over the peritoneum. One little band pressed upon the gall bladder, and so accounted for the jaundice. The kidneys were firmly bound down with adhesions, and the left one was very large and waxy, and its pelvis was much dilated. There was a large quantity of fluid in both plural cavities, and cheesy nodules at the apices of the lungs. The heart was enormously thickened; the brain was not examined.

The chairman thought the symptoms described were more like those of an acute non-tubercular meningitis, as in the initial stage of the tubercular variety a high temperature was usual, and the pulse was ordinarily slow or intermittent. Then, again, the subsidence of the symptoms was not in accordance with such a diagnosis.

Dr. Kelly called attention to the fact that in the early and late stages of tubercular meningitis the pulse was rapid, while in the intermediate stage it was slow.

Dr. Ridlon said that he inferred from the remark of the chairman that he shared in the general feeling in the profession that if a child survived it was proof that the meningitis was not tubercular, and *vice versa*. He desired to dissent from this opinion. Eight or nine years ago he had treated a boy who had suffered from a form of meningitis which several eminent consultants considered to be tubercular; and they had an opportunity of seeing the patient a good many times. The patient was still alive, but he did not believe this proved that the diagnosis was incorrect.

The chairman said that he had never seen one undoubted case of tubercular meningitis recover, although he believed there were a few such cases on record.

Dr. H. W. Berg was not aware that there was any symptom, either subjective or objective, which would enable one to make a diagnosis between simple and tubercular meningitis. He thought that where there was a high temperature at the beginning of a meningitis, it was due to a series of eclamptic seizures, which, by paralyzing the heat centre of the body, allowed of a sudden rise of temperature.

Dr. Townsend had had an opportunity of seeing a considerable number of cases of tubercular meningitis, almost all of which had been proved by autopsy to be tubercular, and he could not recall any case where there was an extremely high temperature at the beginning.

Dr. R. H. Sayre said that he had looked upon the meningitis as tubercular because of the very general tubercular infection. The child looked as if it would die within a few days after the onset of these meningeal symptoms, and he was much surprised when the acute symptoms subsided so rapidly. The high temperature might have been due to the abdominal lesions. The extent of the abdominal lesions was remarkable, as they were younger than the disease in the spine.

CLINICAL SOCIETY OF MARYLAND.

WM. T. WATSON, M.D., *Secretary.*

Baltimore, December 4th, 1891. The 258th regular meeting was called to order by the president, Dr. Robert Johnson.

Dr. Thomas Opie read a paper on

THIRTY-TWO UNSELECTED ABDOMINAL SECTIONS.

These cases were operated upon by Dr. Opie at the Baltimore City Hospital in the twelve months ending October 31st, 1891. The conditions for which the operations were performed were as follows: Ovarian tumors, 6; chronic ovaritis, 7; fibroid tumors, 4; pyosalpinx, 5; retroflections, with adhesions and dysmenorrhœa, 3; exploratory incisions, 3; extra-uterine pregnancy, 1; cyst of broad ligament, 1; cystic degeneration of ovary, 1. The number of deaths was four; as follows: Oophorectomy for double pyosalpinx, 1; shock from ovariotomy, 1; oophorectomy for acute mania, 1; abdominal hysterectomy for fibro-cystic tumor, 1.

Stitch abscesses occurred nine times, most frequently in cases where the drainage tube had been used. Early opening of the abdominal dressings favor their occurrence. When the dressings remained intact for seven days, there seemed to be greatest immunity from the stitch abscess. Dr. Welsh says that the staphylococcus epidermis albus is the most common cause of stitch abscesses in wounds treated aseptically and antiseptically.

Drainage was used in but three cases. In one case it retarded convalescence: in another it seemingly did no good, and a small superficial abscess at the entrance of the tube followed its withdrawal. In the third case an abscess also occurred at the site of entrance. A plentiful supply of fine properly-prepared elephant-ear sponges will do away with the necessity for flushings in most cases, and remove the need for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac, in positions below the pedicle, in taking up blood or secretions, in staunching hemorrhages, in separating adhesions, in protecting the intestines while closing the abdomen.

Drainage is doing more harm than good, and ought to be abandoned by the abdominal surgeon. The oft-repeated removal of dressings of the patulous drainage tube must of necessity be a very great danger; surely it favors decomposition and invites germs. After an anæsthetic, restlessness and jactitations are not wholly restrainable, and it is easy to see how physical injury may accrue to the patient during this time from these smooth but not at all innocent glass tubes. When the laboratory physician says that bruised tissue is a paragon