this had become very intense. The temperature had been gradually coming down for a week not more than 100° in the evening and dropping to 98⅘° towards morning. The pulse was 108, respirations 20. At noon November 10th the pain was very severe, the pulse suddenly rose to 140, although the general appearance of the patient did not suggest anything very serious.

Operation was advised, believing there had been a perforation, but permission was not obtained until well on in the afternoon.

F. R. ENGLAND, M.D.—When I saw the patient she was very ill indeed, the pulse was small and rapid and could hardly be counted at the wrist. All the usual symptoms of peritonitis were present, pain, tenderness, and rigidity. The abdomen was opened by a median incision. A small amount of purulent fluid escaped on opening the peritoneal cavity. On passing the hand towards the right iliac region the finger tips passed through a large perforation in the cæcum directly into the bowel causing a large amount of fæcal matter to be poured out into the peritoneal cavity. Very extensive ulceration of the cæcum was found. The mucous membrane around the perforation was loosened and dissected away from the muscular coats, the whole cæcum seemed softened and the seat of extensive ulceration. The perforation was sutured after trimming the margins of the ulcer as well as several other points of ulceration in the neighbourhood where perforation threatened. The ilium was inspected and appeared to be in good condition. The patient's condition being desperate the peritoneal cavity was cleansed and the abdomen rapidly closed.

A. G. NICHOLLS, M.D.—The specimen speaks for itself. In making an examination of the body I found the usual signs of severe typhoid, with a certain amount of bronchitis and cloudy swelling of the glandular organs. The chief interest was in connection with the intestines. A small quantity of thin fæcal matter was found in the right flank about the cæcum and also in the true pelvis; a small quantity of gas bubbled up through the fæcal matter. I removed the intestines carefully *en masse*. The usual site of the chief typhoidal ulceration is, of course, in the ileum. In this case, all I could detect in this situation was some depression of the Peyer's patches, but no sign of recent inflammation or ulceration at any point. I concluded from this that at some time or other there had been typhoidal inflammation, but that the patches had healed up, and I feel inclined to think that this had occurred weeks or even months before, because had not this been the case, one would have thought that some at least of the lower Peyer's patches would have manifested traces of acute inflammation. Practically the whole mucous