endowed with powers of active locomotion, and so soon as any localized injury and inflammation manifested itself, forthwith some portion of its border, more especially of its right border, formed a feeler, made its way to the affected area, and within a little time became adherent over it, thus helping to prevent the spread of the inflammation. It almost looks, I say, judging from the facts here thus far recorded, as though this were the case.

But there are other considerations to be brought forward before passing judgment. Although I have been able to adduce so many cases of localized abdominal inflammation, followed by omental adhesions, there were numerous examples in our 150 cases in which no such adhesions had been found, although similar lesions of various organs had been present. Naturally a table of these conditions would be much shorter, for it could only include acute and recent cases of local inflammation, in which the local lesion was progressing. Previous local disease without adhesions, followed by recovery, leaves little or no record. Add to this that it is much more difficult to wade through our somewhat voluminous post-mortem records and note every case in which there has been superficial inflammation of abdominal organs. I have, however, noted in them two cases of cancer of the stomach, with perforation and perforative peritonitis; two cases of extensive cancer of the stomach and cancerous peritonitis (without perforation); two cases of very extensive tuberculous peritonitis, all without signs of adhesion anywhere; a similar ease of perforated tubereulous ulceration of the small intestine and perforative peritonitis, and at least two eases of well-marked subserous intestinal tuberculosis, without noticeable reactions of any kind in the omentum and neighboring parts. In a case of enteric fever with perforative peritonitis, as is the general rule, there

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