cells may be interfered with. I use no sponges in these cases; after the abdominal cavity has been closed, the fluid remaining becomes sterile. There is a condition frequently met with, and particularly in the pelvis, formerly called cystic peritonitis. This is nothing more than the condition left after a severe attack of peritonitis, where recovery takes place without operation; fluid is poured out, the lymphatic stomata are closed, and the fluid thus remains encysted. It will remain in this condition for years, and is undoubtedly sterile, as can be demonstrated at a subsequent operation.

At one of the meetings of the American Association of Obstetricians and Gynecologists, Dr. Howitt, of Guelph, read a paper, and there advocated evisceration for the purpose of locating any obscure intestinal obstruction. He stated that this was not accompanied by shock so long as the intestines were kept bathed with warm saline solution, and were not allowed to become chilled. It is difficult to keep them from escaping, and it is certainly impossible to wash as thoroughly when they are below the abdominal parietes as when they have been allowed to escape. Pockets that would otherwise evade the cleansing stream are by means of evisceration broken up and cleansed. Two streams of warm saline solution can be used; the one attached to a medium-sized Tait's Ovariotomy Trocar for internal use, and the other to a form of spraying nozzle for external use, that will distribute the fluid evenly and without too much force. The intra-abdominal stream should be made to cleanse the post splenic, post hepatic, the two iliac and the pelvic pouches. One need not consider the condition of the pulse under the circumstances; it is generally rapid, but the washing should be carried on until the operator is thoroughly satisfied that the viscera have been cleansed, that the abdominal cavity has been cleansed, and then the viscera are returned; the abdomen is left full of saline solution, and the wound is closed without drainage. I use no posture for the patient and no drain for the peritoneal cavity. I long since concluded that drainage under such circumstances did not drain for longer than about thirty-six hours; that a very small quantity of fluid, comparatively speaking, was removed by drainage; that there was an added element of danger owing to the fact that this large serous sack was left open to the danger of added sepsis from without. In one case I drained from each loin; the patient recovered, although there was scarcely any discharge from either the central incision in front, from the cul-de-sac of Douglas, or from the wounds in the loin.