

one makes only a right-sided incision and a small one at that, it is practically impossible to see the left side or to determine whether pus is present there or not. And it sometimes happens when one makes two lateral incisions, that when there are clinical signs of pus on both sides, no pus is found on the left; *per contra*, clinical signs may be wanting when there is pus. Hitherto, upon a diagnosis of widespread bilateral peritonitis I have made two lateral incisions, and, if necessary, a third one above the umbilicus, so as to wash thoroughly from above downwards. As regards the cases of peritonitis without discoverable lesion I have had no experience with this class; I think we are reduced to mere theory in these cases; they are either hæmatogenous, or are due to an insignificant trauma. As to the Fowler position after operation, to a modified degree, yet not so much to favour drainage as to give comfort to the patient. It certainly assists circulation and respiration by relieving the diaphragm, and contributes just so much to his well-being and to his recovery; but for drainage I do not think it is of very material assistance. With regard to the Fowler position I would point out that in experiments the upward current of saline and of particles of carmine may be slowed, but it still goes on. There is a current in the upper direction against gravity. Experimentally, streptococci form an exception to the general rule with regard to lavage, in this infection thorough and early lavage apparently does good, but not, if we are to believe the laboratory men, with the bacillus coli. I would say, however, that one must use caution in making a direct application of laboratory results to the human. The B. coli infection in animals, as experimentally produced, is nearly always by a massive dose, with the production of acute toxæmia, without the slow later changes, which one sees in man, due to peritoneal reaction, exudate, pus, abscesses, and adhesions. The effect of lavage in such acute toxæmias may be very different from that seen in the slower process in man.

ELECTRICAL EXAMINATION AND TREATMENT OF OPTIC NEURITIS AND ATROPHY.

D. A. SHIRRES, M.D., read this paper.

G. W. MATHEWSON, M.D.—These cases of optic atrophy have always formed a sad chapter in ocular therapeutics. The commonest mode of treatment has been the hypodermic injection of strychnine, which generally produces temporary improvement. Of late years Longworth and Würdeman have each published a series of cases treated by electricity, in some of which improvement was marked. In one of Longworth's cases vision improved from 6-36ths to 6-12ths. The most important point is whether such improvement is permanent.