no further collection of pus was found, nor were any gall-stones discovered in the bile ducts. A microscopic examination of the pancreas showed advanced interstitial pancreatitis.

Cirrhosis or Atrophy of Pancreas.—If the infective catarrhal condition persists and does not assume the more dangerous suppurative form, or even if simple obstruction of the pancreatic duct persists from any cause, with only mild infection, we may have an almost analogous condition to the one occurring in cirrhosis of the liver due to the development of fibrous tissue. This more chronic form of interstitial pancreatitis ends in cirrhosis or atrophy of the pancreas, which is probably inevitably fatal from glycosuria. I think it is possible that if it were discovered at an early stage it might be arrested by the removal of the cause, though when fully developed the condition is probably not amenable to any form of treatment.

Acute Pancreatitis.—If a small gall-stone happens to descend into an unusually large diverticulum of Vater and to lodge there, it will make a thorough channel from the common bile duct into the pancreatic duct, and so set up acute pancreatitis, the infected bile being forced direct into the pancreatic duct, as in Dr. Halsted's case reported in Opie's work on the pancreas.

But the anatomical conditions just mentioned, though evidently potent, are certainly not necessary for the production of acute pancreatitis. Any gall-stone or stones impacted in the pancreatic portion of the duct, or even filling the ampulla of Vater, may produce acute pancreatitis, as in a case under the care of Dr. Fison, of Salisbury (*Lancet*, 1904).

A man, aged thirty-nine, had a sharp attack of diarrhea on March 27th, 1904, having been previously constipated. The next day, about one and a half hours after dinner, he was seized with severe epigastric pain, followed by vomiting. At 5 p.m. he looked anxious and ill, and the abdomen was tense and tympanitic, but there was no jaundice. The vomiting persisted. There was tenderness over the gall bladder, and to a less degree over the stomach, but no enlargement of the liver or any indication of tumor. Temperature, 98 deg.; pulse, 110.

The next day the temperature was 97 deg. and pulse 120, the vomiting continuing; morphia was given. On the 30th the temperature was 96.8 deg., the pulse 125, small, weak and thready, respiration 36. The pain was easier. Urine scanty and dark. Operation on evening of the 30th, fifty-four hours after first attack of pain. Very extensive fat necrosis found in subcutaneous tissues and in omentum, mesentery, etc. Large quantity of brown, inoffensive fluid in peritoneum. Incision