cases of peritonitis 96 were due to appendicitis. The others were due to malignant growths, perforation of gastric ulcer, etc., all suitable for laparotomy anyway. As soon as he saw a case of peritonitis he called it peritonitis, McBurney's point or no McBurney's point, tumor or no tumor. And he would not make a mistake once in twenty-five times. Out of forty-five cases he had say three deaths following operation. But if treated medically quite a large per cent. might recover from the primary attack, but many would subsequently succumb. Only last week he was called to see a case where the patient was *in articulo mortis* and was asked by the physician to operate. He asked the medical man if that was fair to ask him in when the patient was dying. Why was he not called two weeks before? Now, when all hope of saving the patient was past the old fossil wanted to shift the responsibility on the shoulders of the surgeon.

Dr. Teskey in closing the discussion said he was disposed to agree that it was wise to operate when the diagnosis was made.

AFTERNOON SESSION.

Dr. P. D. Goldsmith, of Peterborough, read a paper on "Broncho-pneumonia," which appears in this number of THE LANCET.

Dr. J. L. Davison complimented the reader on his excellent paper, particularly on his presentation of the treatment of cases of broncho-pneumonia. Much was seen in these days in our scientific books about the pathology and diagnosis of disease. Old methods of treatment where the *rationale* could not be scientifically explained, were not advocated. What Dr. Goldsmith had recommended, he had found from experience to be beneficial, and that was, after all, the test of a remedy. In regard to poulticing, he, like the essayist, considered it a most useful form of treatment in these cases. It was not fashionable nowadays. Our grandfathers found this did good, although they did not understand the question of reflexes. Dr. Davison recommended whisky instead of brandy as a stimulant, because it was a purer spirit. For the diarrhœa he found nothing better than liquor hydrarg. per-chlor. in five to ten drop doses, particularly where there were mucous and bloody discharges with tenesmus. Its action was not rapid, but it was certain. As a bronchial sedative he preferred codeine to opium. In chronic cases where resolution was slow, as a slow and steady counter-irritant, he found the best results from applications of ung. hydrarg. ox. rub.

Dr. Shaw, of Clinton, believed where poulticing was properly carried on it acted well. But in a country practice where skilled nursing could not be procured, it was difficult to get it done right.

Dr. J. H. Carstens read a paper on "The Exploratory Incision in Abdominal Surgery, Its Indications and Technique," which will appear in the June number of THE LANCET.

Dr. Temple said, in discussing the above paper, that he could not agree that it was a proper thing to do, as the essayist had in his first case—to remove the appendages for hystero-elipepsy. It was generally agreed that operation was not justifiable in such cases. He was not prepared to agree that pelvic cellulitis did not exist apart from puerperal cases and pus tubes. He had seen its existence in numbers of abdomens he had opened, he had observed the condition. He agreed that 96% of cases of peritonitis were due to disease of the appendix. He was sure many valuable lives would be saved by promptly opening the abdomen and looking for the offending appendix. Where cases remained obscure after all other means of diagnosis had failed, he agreed that an exploratory incision was justifiable. In deciding when to operate he said it was not wise to depend on the temperature. The pulse was a far better guide. He had opened the abdomen in cases of appendicitis, and found collections of pus, when the temperature was normal. His practice was to stitch up the incision *en masse* rather than by the tier method advocated by Dr. Carstens.

Dr. Hingston, discussing Dr. Carsten's paper, said he could not agree that 96 out of every 100 cases of inflammation of the peritoneum were from the appendix. He said he also took exception to the statement that an exploratory incision was justifiable to establish a diagnosis. In his experience, of thirty years, he had met with only two cases where he was unable to diagnose the condition. In these days the abdomen was entered with too much impunity. He was at variance with the essayist in saying that the physician should always call in the abdominal surgeon in these cases of appendicitis. That always meant operations. Another thing: he would not remove the ovaries where the symptoms were purely subjective. In closing the abdomen, he used the *en masse* suture. Sir William held that the prevalence of ovariotomy was having a very detrimental effect on social life.

Dr. Teskey thought there was too great a tendency to run into specialties in surgery. The man who could remove a limb and stop hæmorrhage should be able to open the abdomen. The abdominal surgeon should only be one through expediency; he should always be able to do general surgery as well. As to cellulitis, all that was necessary was an irritant in the cellular tissue or lymphatics, no matter how it got there. Mechanical injury to adjacent bone, abrasion of the vagina or the cervix, etc., allowing the entrance of the germ to the lymphatic spaces, would produce pelvic cellulitis. And that was all there was about it. In obscure cases, when other diagnostic means failed, exploratory incision