of turning down a portion and suturing it over the opening. He had noticed in Dr. Johnston's account of autopsies on three cases, that the sutures had held firm, so probably the patient had died from the effects of the peritonitis.

Dr. F. J. SHEPHERD had hoped that this was going to be one of the successful cases, but the difficulties were very great. It was a question, whether the original peritoneal inflammation had not continued in spite of the careful washing out. Patients suffering from typhoid had not much reparative power, and when there was no tendency to repair, operation was almost hopeless. In most operations of this character the patient was operated on too late and died a few hours afterwards.

Dr. F. G. FINLEY thought the case presented a great number of features of interest. Such as, the early date at which perforation had occurred, the tenth day. This was the third case he had seen operated on, and the other two had died within a few hours from shock. This patient's condition had presented some difficulties, in that the temperature had kept up so long there seemed some doubt whether it was due to the fever or to sepsis, and, acting on the latter supposition, later on it was thought advisable to give him more food to keep up his strength. The autopsy showed, however, that the typhoid had persisted to the fiftieth day.

He considered that the chances of recovery were much greater in these early cases where the patient was not exhausted by three weeks or more of fever.

Dr. ARMSTRONG, in reply, said, in regard to the time at which the operation should be done, that he considered that the opening should be closed as soon as possible after the shock following the perforation had passed off. He also thought it would be good practice to give a hypodermic of morphia once a definite diagnosis of perforation had been made. This would arrest peristalsis, prevent diffusion of the septic matter from the bowel, and conserve the patient's strength.

With regard to an artificial anus, the difficulty would be to provide room for efficient drainage without making another opening.

Dr. Adami's idea of cutting off the typhoid area could not be carried out, as it was impossible to get away from the ulcer area. Perforations occurred over the whole length of the bowel, from the beginning of the ileum to the sigmoid flexure.

Undoubtedly the chances of recovery were better after convalescence was established, and the patient was able to take food to keep up his strength, instead of having both the fever and the operation to contend with at one and the same time.