The following case illustrates the ease with which an erroneous diagnosis may be formed, and also the wandering course of tubercular peritonitis.

Elizabeth B., aged 18 years, had always been a somewhat delicate child, though during the five years which preceded her last illness she had never been seriously ill, and a history of tubercle was not to be found in the family. On the 2nd of June, 1884, she took to her bed, complaining of general lassitude. For the last fortnight she had not been well, though she could not explain from what she was suffering. No pain anywhere; rather pale; gums and conjunctivæ somewhat anæmic; pulse 100; regular temperature 100° in the morning; tongue slightly coated; appetite very poor; bowels somewhat confined; no abdominal tenderness. Typhoid fever was prevalent at the time; indeed some cases had occurred in the same terrace in which she lived. Mentally my diagnosis was made, and the next few days was to fix it decidedly.

June 3rd. No improvement to-day. Pulse and temperature a little increased. Slight tympanites perceptible. Patient says that she has noticed her abdomen enlarged for some months, and that she has for the same period suffered from uncomfortable sensations in that region. (I find this statement entered in my case book. It would have been well had more attention been given to the girl's story, but I attributed it to an attempt on her part to make light of the whole illness). There was no tenderness, and the percussion note was clear throughout the surface of the abdomen.

June 6-8th. Tongue becoming more heavily coated. Diarrhœa. Pulse is now 100-120, Temperature usually 101° to 102° at night. Urine febrile—no albumen, no sugar.

June 10th. Abdomen, though still distended, is not so resonant on percussion. After the administration of an enema, a large quantity of wind was passed, followed by relief to the uncomfortable feeling in the abdomen.

July 23rd. The resonance on percussion over the abdomen has gradually disappeared. It has now become evident that there is fluid in the peritoneum. The girth measurement has fallen from thirty-four to thirty-one inches, and distension is less manifest. The dulness on percussion is not movable, but persists in the left iliac and right lumbar regions when patient is on her right side, showing that probably it may be encysted. The heart is now displaced upwards. At this period of the case it was noted that the diagnosis was "cyst, ovarian or parametric, with mild typhoid fever superadded." The symptoms so strongly impressed themselves on my mind as being the result of the fever, that even at that time I could not rid myself of that idea. And yet there were certain symptoms that did not point to typhoid. After the event one can always be wise, and so on reading the notes I see that there are several features of the case to which due attention was not given. There were no spots perceived, nor was there ever localized tenderness; but more important than these, the appetite was always good, even when the thermometer stood persistently high at 101° and 102°. Every evening at about this time, too, the urine was copious and watery, sp. gr. 1005, no albumen, no sugar. This led me to hope that, perhaps, there might be a distended bladder, but the catheter brought away but half a pint of urine.

Aug. 13th. She had now improved. The appetite was fair, the general strength seemed to return, and it was thought that she was gaining in weight, but on every occasion on which I saw her in the evening the temperature was raised to 100° or 101°. There had never been cough, nor were any physical signs detected. The abdominal distension is diminishing. At present there is flatness in all the regions except the right lumbar. No alteration with change of posture.

Aug. 18th. Abdomen plainly diminishing in girth, and becoming irregular in outline; the left side becoming more prominent. General appearance excellent. She was taken to the country a few days ago, where she finds herself improving rapidly. Walks daily in the garden, and spends her time on the veranda. The high temperature persists. Noted to-day that "I am believing in the chronic peritonitis theory. 1. High temperature. 2. The clear space in the flank due to adhesion of intestine."

Aug. 26th. Mr. Lawson Tait very kindly consented to examine the case. The abdomen