power and imparting strength to the instrument at its point of greatest weakness. The mechanical principal involved requires no vindication.

Perforation of the Gall bladder.—Dr. W. G. JOHNSTON gave an account of an autopsy he had performed for Dr. R. P. Howard. The abdomen was found distended, panniculus and omental, fat excessive. The abdominal cavity contained several quarts of thick sero-fibrinous fluid mixed with bile and of a deep brown yellow color, not fœtid. (A small incision made by undertaker for injecting a small quantity of preservation fluid was found in left loin. This fluid, readily recognized by its aromatic smell, was not found in general peritoneal cavity.) The coils of intestines glued together by recent adhesions formed numerous sacculi. In the right hypochondrium the hepatic flexure of the colon was found imbedded in a mass of firm old adhesions, attaching it to the lesser omentum and tissues about gall bladder, which could not be seen till adhesions were dissected off. Near the neck of the gall bladder a small orifice was found, through which thick greyish-brown bile was escaping. On opening the gall bladder this orifice was valvular in character, its size that of a No. 4 sound, and it corresponded to a spot where the mucosa is eroded and the walls thinned. Elsewhere the walls of gall-bladder are flaccid, somewhat thickened and firm, and contained about an ounce of bile mixed with mucopus. Its cavity was divided into three sacculi by the contraction of fibrous tissues in the wall. The middle one of these contained a gall-stone the shape of a bean and about the size of a pigeon's egg; close beside this is a spot where the wall has been eroded, but was secured against the surface of liver by inflammatory fibrous tissue. In a pocket near the perforation, but not corresponding to it exactly, was a small gall-stone the size of a pea. The cystic and common ducts were thickened. Just at their junction, lying really within the cystic duct, but partly obstructing the common duct by its pressure laterally, was a gall-stone the size of a pigeon's egg. A probe could be passed through either duct beside it. No other gall-stones in peritoneal cavity. Duodenum contained gray, clay-colored fæces, but bile exudes from the papilla on pressure. No signs of bile anywhere in intestines. Some slight intestinal catarrh. Liver a little fibrous and fatty. Other organs normal.

DR. HOWARD, in reporting the case, said its clinical features were of unusual interest. It was a case of acute general peritonitis from perforation of the gall-bladder in a man aged 65. The patient was in good health at the beginning of the month. After four days of epigastric pain, never very severe, patient become jaundiced. Next day there was vomiting; pain in the epigastrium became more marked, especially in region of gall-bladder.

There was not very marked tenderness on pressure, but pain and symptoms of peritonitis extended over entire abdomen. Pain was not sufficient, however, to necessitate an opiate. The tempera, ture on the morning of the sixth day was 100. 8° and 99. 5° at night; on seventh day, 100. 6°; eighth day 100°; and ninth day. 98.8°. The abdomen gradually became enlarged and tympanitic, but still no severe pain. After third day jaundice gradually increased. The diagnosis was very obscure. Cancer could be excluded, and as there was no history of gall-stones, a diagnosis of peritonitis spreading from the gall-bladder was made. It was strange that the escape of so irritating a fluid as the contents of the gall-bladder should have caused no collapse or severe pain. No perforation was diagnosed. It is an important question for consideration whether surgical interference in this case would have availed anything. The gall-bladder was so deeply imbedded in old adhesions that it would be hardly possible for a surgeon to have reached it. The gradual invasion of the symptoms was probably due to the slow oozing out of the contents of the gall-blader.

Dr. WILKINS asked if non-action of bowels in such a case would not be due to spasm of the muscular coat owing to the peritonitis, and whether an opiate treatment would not be most successful in relieving constipation.

Dr. HOWARD stated that the treatment had been mainly an opiate one.

Dr. GEO. ROSS had been struck, on seeing the the case, by the absence of the usual marked features of acute peritonitis, the obstinate constipation and suggested intestinal obstruction. He called attention to the fact that severe acute peritonitis may co-exist with a normal or only subfebrile temperature, the idea that acute peritonitis necessitated a high temperature being quite fallacious.

Dr. SHEPHERD thought that surgically nothing could have been done. The anatomical features of the case placed it out of the reach of surgical interference. Excision of the gall-bladder could