regarding the treatment of so-called general septic peritonitis. In the discussion which followed Mr. Bond's paper the statement was made by Dr. J. B. Murphy, that until five years ago statistics (Dudgeon & Sargeant) showed a mortality of from 83 to 85 per cent. in cases of general septic peritonitis, but that during the past three years, since adopting a change in the method of treatment, his mortality, in a series of thirty-five cases of the same kind, had been only three per cent. Mr. Bond in his paper referred to the upper dome of the abdomen or sub-diaphragmatic area as being the part of the peritoneal cavity where absorption of bacterial poisons took place most rapidly, and that when this area became infected the case was most likely to prove fatal. Mr. Bond was a strong advocate of the Fowler position, maintaining that the toxines gravitated to the lowest part of the abdominal cavity where absorption occurred more slowly than it did in the upper zone, allowing time for the patient's resistance to overcome the poisonous toxines as they were absorbed.

Since Mr. Bond's paper I have had an opportunity of treating three cases of diffused or so-called general peritonitis. The treatment followed consisted of open irrigation, pelvic drainage for two or three days, Fowler's position and the slow introduction of normal saline solution into the rectum. All three cases made rapid and perfect recoveries, and this notwithstanding the fact that in two of the cases the bacteriological report showed streptococci in pure culture.

Murphy holds that the variety of organism makes very little difference in influencing the prognosis and that any organism may be virulent at times. He places more importance upon the personal factor of the resistance of the patient and the evidences of toxicity present.

GEO. FISK, M.D.—In connection with the Fowler position I may say that it certainly does aid the circulation; we all know that in depressing heart conditions with hypostatic congestion it helps to have the patient frequently change his position and to assume the semi-upright attitude. With regard to drainage I must say that I have used it in all bad cases of progressive or general peritonitis, and as my results have been so far very good I have hesitated to close in these cases without drainage. Irrigation too I have used.

E. W. ARCHIBALD, M.D.—With regard to the diagnosis of general peritonitis I can hardly agree with Dr. Garrow that the clinical findings of so-called general peritonitis are sufficient in all cases to give an absolute anatomico-pathological diagnosis. While the experienced clinician will not very often make a mistake in this direction, I am sure that he is sometimes exposed to such errors where, as with Murphy,