

intense inflammation, but the local depletion consequent upon the operation, and the relief of congestion produced by hot water, irrigation would have been beneficial. Another question that suggests itself is, "Are not many of these cases due to a traumatic hæmorrhage?" If not, why should such a great amount of hardness supervene in so short a time after the injury. We open the peritoneum, we cause a peritonitis by our operation, but we do not notice such brawny hardness unless we have hæmorrhage from needle puncture in applying sutures, or from some bleeding vessel left unsecured from some part of the wound. This blood burrows in the planes of the connective tissues and occasionally suppuration occurs. I have seen blood tumors form in this way, and, fortunately for the patient, rupture occurred through the wound after the commencement of suppuration and not into the peritoneum. Pure blood is undoubtedly harmless to the peritoneum.

It has always puzzled me to explain traumatic peritonitis in any other way. With this traumatism no germs are admitted so that there can be no septic element in the cases. If we exclude, according to present beliefs, the septic element as a causative factor in the peritonitis following operation, we will not have many cases left to classify. If the mere injury to the peritoneum produces peritonitis, we should have peritonitis after every abdominal section. We tear this formerly dreaded membrane, we cauterize it, we swab it with iron, we injure it with pressure forceps, and yet it escapes inflammation. My own belief is that more is to be dreaded from a stripping off of the peritoneum from the preperitoneal tissues, from which it receives its nourishment, than from any mechanical injury to it, and I believe that what is identical to this stripping off occurs in cases of direct traumatism, by the rupture of small vessels of the peritoneum and the neighboring connective tissue. Another lesson to be deduced from these cases is that there are many cases in which the symptoms are not severe enough to justify operation. This was the case in the post-peritoneal abscess. The patient made a good recovery without operation. But the case of encysted pus in the little girl might at first thought be placed in the same category. The issue was good, but cases in which pus finds its way through the bladder, do not all have such a

happy ending. Only two weeks ago I saw one in consultation, and in spite of operative treatment she died. If the abscess had been opened early, her life might have been spared. In such a case as that of the little girl, I should open the abdomen and drain. Then again, the old woman of 60 could not have been injured by opening her abdomen. By this method of treatment all doubt is dispelled, a perforating gall stone is found, a suppurating ovarian cyst is discovered, a perforated appendix brought to light, and the cause of the disease is at once removed, while the disease itself is having the very best treatment. It is only two weeks since I operated upon a case of peritonitis sent to me, unfortunately too late. Her temperature was 103 and pulse very rapid, but I thought it best to give her the one chance of saving her life by finding out the cause of the inflammation. Through the vagina nothing but a fulness binding down the uterus and ovaries, such as was formerly supposed to be due to that "will o' the wisp" pelvic cellulitis. On opening the abdomen I found the peritoneum thickened and studded with nodules of inflammation, similar to the nodules found in a case of tubercular peritonitis, I had just opened and drained half an hour before. The cavity of the peritoneum was filled with serous fluid. On the left side I found a suppurating ovarian cyst about the size of an orange, and a large suppurating hæmatocele of the broad ligament on the right side. The cyst was very adherent, and with difficulty removed; the hæmatocele was opened, washed out and drained through the abdomen. The patient almost died on the table, but rallied fairly well and lived for 10 hours. Under such circumstances one cannot wonder at the result. Pulse and temperature both dropped after the operation, but the temperature soon rose again and the patient died. How useless it would be in such a case to wait for a spontaneous cure? And yet how often it is done. I believe that it should be the rule of practice to open the abdomen in every case of acute peritonitis. I will relate two other cases to qualify my assertion.

Two years ago I removed a small ovarian cyst bound down by adhesions, and put in a glass drainage tube. The tube was removed within twelve hours, and the patient became suddenly worse. Acute peritonitis set in, temperature and pulse