Though the criticism should be friendly, I trust that it will be severe; no rash statements should be allowed to go from this Association unchallenged.

I would like for a few moments to call your attention to some unsettled questions: First, let us consider the question of peritonitis. Are we able to do more to save the lives of patients suffering from peritonitis in its acute form than we were ten years ago? Are we not but little better off, with all our antiseptic and aseptic washes, gauze and tube drains, and purgatives? I am satisfied that surgery can carry us no further when battling with this disease. Something else must come to our assistance. Perhaps it may come through serum therapy, or through our materia medica in the form of an antidote. We know that a poison is formed, that it is rapidly absorbed into the system and rapidly reformed. We know that we may wash it out, but that we are unable to prevent its reformation. We know that in some cases we are able to minimize its effects by using the two drainways—namely, the drainage tube and the intestinal canal. But in spite of this drainage large numbers die. I intend to try direct venous infusion of salines. The sulphate of magnesia seems to produce a peculiar effect in some of these cases. We know that ordinary salt is a preservative of meat and other albuminous materials. It may be that absorption of these salines into the blood may act as a harmless antiseptic, and may destroy the ptomaine poison present. I am speaking now, of course, of the peritonitis that we are unable to prevent, or peritonitis from contamination from within. When least expected, the *post mortem* examination will frequently reveal some hidden source of internal contamination.

I operated on a child for fecal fistula, following the necrosis of a large portion of the ascending colon. The opening was closed with as little disturbance of the parts as possible, and the abdominal wall closed over. The patient did not do well, appeared to be intensely shocked, and died within thirty-six hours. The wound looked well, all fecal discharge had ceased, and there was nothing in the outward appearance of the child to give any clue to the cause of this shocked condition in which she was found. The *post mortem* examination, however, revealed the fact that a small pus pocket existed at the time of operation, deep down between the mesentery of the colon and the spine on the right side, and that during the separation of the colon from its surrounding attachments a few drops of this pus had been permitted to ooze into the general cavity of the peritoneum unnoticed. Sterilized gauze had been carefully packed around the seat of the operation to prevent fecal contamination of the peritoneum. This extra care prevented the observation of what was taking place deeper down, and, as a consequence, death resulted.

I give this as but one instance of the relief of conscience that may frequently be afforded to the surgeon by a *post mortem* examination. He is relieved from the charge of having introduced the poison from without.