system, and most important of all, it arrests peristalsis and by so doing limits the spreading about of the septic fæcal matter. One must, however, not be misled by the apparently comfortable condition of the patient, due to the morphia and be persuaded to delay operation.

The perforation is best closed by a double row of Lembert sutures. The abdominal cavity must be thoroughly cleansed. This is best accomplished by irrigation, using a soft rubber tube which can be carried into either loin or into the pelvis, the return flow washing out the septic matter. Any attempt to wash out the peritoneal cavity with a pitcher will result in miserable failure. The stream from the pitcher will not enter far enough to accomplish the object desired.

Sterilized normal saline solution ($\frac{6}{10}$ of one per cent.) seems to answer very well. It cleanses as well as any fluid, and is non-irritating and does not injure the epithelial coverings of the peritoneum. It is important that this should remain functionally active. Thorough drainage should be established from either loin and from among the intestines. This is well accomplished by introducing strips of iodoform gauze, and a large rubber or glass tube long enough to reach the bottom of Douglas pouch, surrounded by strips of iodoform gauze is very efficient.

The dressings need to be very frequently changed during the first 24 or 48 hours, and for this purpose a nurse who fully appreciates the principles of antiseptic surgery and can be trusted to carry them out in every detail is essential. Although the results so far are anything but satisfactory, the surgical treatment of this condition is based on sound principles and it is to be hoped that better results will be obtained in the future than have been in the past.