Since adopting this method my results have been infinitely better than they were when I wasted time in flushing out the abdomen.

In regard to drainage, Lücke[26] was the first to insert a large drainage tube in Douglas' pouch in a case of peritonitis. The majority of surgeons are of opinion that it is advisable to make provision for the escape of the septic products left in the peritoneal cavity and of any exudation which may subsequently form, but that the arrangements for drainage should be as simple as possible, consisting of one drainage tube in the area of primary infection, and another in Douglas' pouch. Cigarette drains are preferable to unprotected rubber tubes. Murphy, however, insists on the importance of tubular drainage. At the meeting of the British Medical Association in 1911, Mr. Leonard Bidwell[27] recommended rectal drainage, which I consider very objectionable.

The general rule that drainage tubes should be left in position until secretion ceases, or has at least appreciably diminished in quantity, is not applicable to diffuse peritonitis. It is a difficult question to decide how long drainage should be continued in any given case, owing to the fact that purulent secretion persists almost as long as the drain remains *in situ*, indicating a possibility that its presence may contribute to the continuance of the suppuration. Noetzel recommends that the drainage tubes should be frequently changed, the tube inserted on each successive occasion being of smaller calibre than the one preceding it. He believes that in this way secretion is gradually reduced without mechanical irritation, and that contraction of the granulation canal is rendered possible, without sudden occlusion of its orifice.

According to Hartmann[28], the chief indication for drainage is the presence of non-resorbable particles, such as gangrenous serosa in contact with a gangrenous appendix. Blake[29] gives the following indications:

1. Drainage should be employed only in the presence of necrotic material, which may form a nucleus for infection.

2. If drainage is necessary, a large drainage tube should be used.

3. The drainage tubes should remain in position until all necrotic material has escaped, and then promptly removed.

Gauze tamponnage is contra-indicated in these cases. The softening effects, together with the increase of inflammatory reaction and of secretion, which are so beneficial in phlegmonous processes, are injurious in septic peritonitis. Another harmful result is the compression of the intestinal coils necessitated by the space which it occupies.