felt that if anything was to be done, it would have to be done now. It seemed on the whole more prudent to take the risk of what might turn out to be a purely exploratory operation, than to wait longer until the time for successful intervention would be past.

The patient was accordingly removed to the operating theatre about 10 p.m., and under ether, Dr. Armstrong made an incision about three inches long in the median line about one inch below the umbilicus. On opening the peritoneum, no fluid or gas escaped, and the surface of the bowel seemed normal. Thickenings in the course of the lower part of the ileum, due to the typhoid ulcers, were distinctly felt, but no perforation could be found, or even any sign of local peritonitis. In the angle formed by the junction of ileum and cæcum, there were two very red lymph glands, the size of large hazel nuts, swollen, it seemed, almost to the point of rupture, and standing out prominently from their peritoneal investment. Two quarts of warm normal saline solution were introduced into the peritoneal cavity, after the bowel had been returned, and the abdominal wound was closed. During the operation hypodermics of camphor and strychine were given, as the pulse was very rapid and weak. Recovery from the operation was uneventful, with exception of a sharp attack of bronchitis with muco-purulent expectoration. From the 33rd to the 41st day of the illness, there was a slight recrudescence of the fever, and November 21st, the patient left the hospital for her home where she made a complete recovery.

I have dwelt at some length upon the details of this case, as it offers a good example of the difficulties that underlie the diagnosis of perforative intestinal lesions. In many instances the diagnosis of perforation is comparatively easy, but many instances occur, such as I have related, in which there seems to be a reasonable probability of perforation. What are we to do in such cases? There seems to be two alternatives —on the one hand to await developments, until possibly the symptoms disappear and the condition is proved not to be a perforative lesion of the bowel, or until absolutely unequivocal signs of perforation and possibly of general peritoneal infection occur, when operative intervention will be too late—or, on the other hand, to operate immediately, even though there may be a reasonable doubt as to the perforation, and the intervention may turn out to be of the nature of an exploratory operation. I believe the latter course to be the proper one, and that the risk should be assumed, provided that skilled surgical assistance can be obtained. On future occasions I shall certainly lay more stress upon the presence or absence of rigidity of the abdominal walls in the diagnosis of perforation in typhoid fever, which is such a valuable sign in perforative appendicitis. I confess I was disappointed by the ab-