be produced by a calculus in the gall bladder, but these generally pass into intestinal tube. The mont *common* seat of perforation is at the vermiform appendix. In this sac a great quantity of substances taken with the food have been found at the post-mortem examination. The most common cause is fæcal accumulations, which fill the sac and cause ulceration, though I cannot recall a case of peritonitis in children under 14 years which did not occur from perforation at vermiform appendix.

The pain begins at R. I. fossa and extends along the transverse colon; this disease always yields to treatment and seems subdued, but soon breaks out again with greater severity. In healthy persons there is a tendency to adhesion and to form a sac to contain the effusion for a day or two, but as it accumulates the sac breaks and so produces the symptoms over again. This feature seems to be distinctive of perforation at vermiform appendix. The effusion which is purulent gives rise to dullness. In a few instances the disease is not fatal, the pus being discharged by some opening.

Peritonitis is apt to be confounded with *bilious colic;* this is not an inflammation, and is not attended with any paralysis of muscles of intestines, but depends upon an unusual contraction of the muscular fibres. There is no increase in the frequency of the pulse for some hours, while in peritonitis this happens early. Colic is relieved by pressure in beginning, but there is some tenderness after a while. No tympanites as in peritonitis. Obstruction of intestines is taken for peritonitis, but here there is no increased pulse.

Under proper treatment a considerable number will recover, but whatever is done must be done with energy, as the natural duration of the disease is "*four days.*" Blood-letting both general and local has been practised to a considerable extent in the treatment of this disease. Dr. Armstrong proposed blood-letting, followed by a full dose of opium, as the latter perpetuated the effect of the bleeding; but, while he looked upon both as necessary, if he could have but one he preferred the opium. Drs. Palmer and Child of Vermont treated their patients by the Armstrong method in 1844 with success. When I first adopted this mode of treatment eight recovered, the ninth died. The rule is to give as much opium as the patient can take without being narcotized. Begin with grsij. to iv. every two hours until the symptoms of narcosis begin to show. In the case of a hospital patient grs. iv. were given and the dose increased gr. j. every hour until a gr. xii dose was taken. One objection to this plan of treatment is that it requires the attention of the physician, who should always administer the opium himself. It is not important which preparation of opium you use, but use the same from beginning to end. If pills are used they should be freshly made up every twelve hours. You are to give the opium by its effects and not by quantity; these effects are *sensible contraction* of the pupils, marked reduction in the frequency of respiration, diminished frequency of pulse, gentle perspiration of skin, *itching* of the mucous membrane of the *nose*, and easy but very much protracted sleep, from which patient may be easily aroused. The pain first disappears. Tympanites continues until inflammation is subdued. Let the bowels alone for one week longer, as they will move when inflammation subsides. The influence of opium is to be kept up until peristaltic action is re-established. The dose may then be diminished and when a spontaneous movement occurs it may be suspended altogether. A full dose may be required at night to produce sleep. I believe I have seen peritonitis from perforation cured by opium. In this form there seems to be a tendency for sealing up, and the opening gives time for this healing process to be more complete. No other mode of treatment has been successful. Strong coffee and the cold effusions are to be used as antidotes in poisoning from opium. With a fair amount of caution and these two antidotes you will not likely be to lose a patient. I do not know of a single death produced by opium in this disease.

PUERPERAL PERITONITIS.

This form of the disease, called also *puerperal fever* and *metro-peritonitis*, occurs in lying-in women, although it may occur independent of *parturition*. It is liable to happen within thirty days of the occurrence of parturition, but generally within the first week, and greatest liability on the *second or third day*. This disease and its associate metritis are believed to be contagious for those in the same condition. There is no doubt but that it may be conveyed by the physician, although this is denied by Dr. Meigs, of Philadelphia. This disease has some connection with the cause which produces *erysipelas*. We rarely hear of one case alone, it is much more apt to be *epidemic*, and the effusion is *purulent*. The fatality of the disease, until lately, was enormous. In Bellevue Hospital not more than one in twenty-eight recovered. Now we have much better results, and the disease is much more manageable in private practice. Metro-peritonitis is much more commonly attended by a chill. It is far less often attended by pain, and this leads to mistakes in the diagnosis. The paralysis of muscular coat of intestines is not so great, and hence constipation is not so obstinate, and cathartics are not forbidden. The other symptoms are quite regular. The inner surface of uterus is always inflamed in puerperal peritonitis, so that I have given the name of *endometritis* to this condition. On examination there is found a pasty secretion on the walls of the uterus, which resembles thick *glue* and of the color of *beef brine*. Sometimes the whole interior of the organ is lined with this adventitious material, made up of blood, pus, and fibrin, formed into fibers, not unfrequently with cells. This indicates a most *intense* form of inflammation. The uterine sinuses may be inflamed and purulent matter deposited in their cavities. Pus is then mingled with the blood, and all the symptoms of pyemia are present. From this symptom it