The blood count shews about four million hæmocytes and sixty-five per cent hæmoglobin. The abdomen is of normal contour, and no evidence of fluid or friction can be detected and it is not tender. The scar is wider and weaker than it should be, apparently from the dragging of adhesions. This symptom has given a little trouble all along, but is improving. It may have been due to errors of technique. She is slowly gaining weight (102 pounds). Appetite is very fair—the bowels regular and menstruation normal. She is still highly nervous. Temperature normal.

Some points on the operative treatment.—An examination of all my available literature on the subject is the basis of the following statements, for many of which I am indebted to Watson-Cheyne's lectures on tuberculous disease, Dec., 1899. (B. M. J.) Taking the recovery rate of tuberculous peritonitis generally under medical treatment as about eight per cent. (Pick's statistics), we may state that of published cases of tuberculous peritonitis so treated 75 per cent. are improved or cured by laparotomy; but, if all cases of the disease were subjected to the operation fifty per cent. of improvement or cures would represent the outside limit.

Suitable cases for operation.—The cases may be classed roughly as suitable for operation in the following order:—

(a). Localised ascitic cases.
(b). Generalised ascitic cases.
(c). The dry fibro-adhesive forms.

Whilst those with large caseating masses (often associated with intestinal ulceration) and those secondary to disease of the Fallopian tubes are regarded as unsuitable.

The tables worked out by Aldibert and Roersch shew however that success may occur in any variety.

The outlook is best in the group with localised ascites, and next in cases like the one I have described; but the outcome is often better than the most sanguine operator would expect from the condition of the particular peritoneum before him. It is justifiable to be fairly sanguine. Slight pulmonary tubercle often improves for a time at least after the operation, and pleuritic effusion is not considered a contra indication. Opinions differ as to the best course in tuberculous salpingitis; but obviously if the tubal disease be detected before the peritoneum is involved, the right course would be prompt removal of the infected tubes to save the peritoneum.