cases where the diagnosis cannot be made, where a number of physicians disagree, and treatment is of no benefit. To this belongs, especially class all cases of abdominal dropsy which are not due to diseases of the kidney or marked disease of the liver. Abdominal dropsy is frequently due to tubercular peritonitis, and 85 per cent. of cases of tubercular peritonitis are absolutely cured by surgical interference. But if cases of this kind are allowed to progress until a secondary deposit has taken place in the lung, tubercular peritonitis may be cured, but pulmonary tuberculosis will go on unchecked and then end in the death of the patient.

The signs and symptoms of diseases of the female generative organs, and our ability to make correct diagnosis by conjoined examination and palpation would virtually exclude pelvic diseases from this paper. I refer to that class where all the trouble is above the true pelvis.

If you ask me what the symptoms would be, I cannot tell, because the symptoms would vary with the trouble. It seems to me that the principle ones are the disturbances of the stomach, occasional spells of vomiting which increase in frequency, sharp coliky pains in a certain part of the bowels. If there is a stricture, or any other thing, causing a diminution in the size of the intestine, gas, when it reaches this spot, will generally cause an excessive distension of this part of the bowels, hence pain; and patients are very often able to localize it and will tell you that the gas rolls around, and when it reaches that spot then they have pain and distress. That, to me, is a very suspicious symptom.

Strictures in the descending colon can be generally diagnosed absolutely without an operation, although the latter may be necessary to relieve the trouble.

I have so far spoken only about chronic cases, as I think it hardly worth while mentioning that naturally, all acute cases of inflammation of the peritoneum, and all acute cases with symptoms of obstruction of the bowels, as indicated by constant vomiting, etc., require the most prompt surgical interference.

In the former as well as in the latter, class of cases, the thermometer is of no avail so far as I can see. I have seen cases of gangrenous appendicitis causing purulent peritonitis with a temperature of only 99 or a little over. It seems to me that the pulse is of more diagnostic importance than the temperature. If that becomes increasingly rapid and feeble, it indicates serious trouble. I assume, of course, that common, simple ailments, acute attacks of indigestion or chronic colic (except lead colic, which sometimes requires an operation) neuralgia, muscular rheumatism, etc., are excluded from the class of cases to which I refer.

You want me to write about the technique. In the present state of our knowledge this has not been settled. I do not know of anything having been written particularly on this question, but from my own experience, I have made it a rule to cut down as near as possible on the place where I think the trouble is located. I will stretch a point and cut down in the median line because there is less hæmorrhage there and better chance for union. If the trouble seems to be on either side, I cut down on the outer edge of the rectus, as I do in operations for appendicitis. I do not like to cut through the rectus muscle or transversely across the oblique muscles; first, because there is constant oozing from the injured muscle; second, the lacerated tissue is soft and is more liable to infection than fibrous tissue.

Whatever point I select, I make the opening small, say about two inches, as I can always enlarge it, if needed, with one stroke of the knife, pass through the skin and all the fatty tissue, if possible, down to the fascia, and with one or two strokes of the knife, through the latter down to the peritoneum. I lift it up and may nick it and enlarge the opening with the knife; sometimes I simply stick my finger through the peritoneum and explore it with my finger first, increasing the peritoneal opening, if necessary, later on. In my incisions in the median line I pay no further attention to the peritoneum. If, however, it is at the outer edge of the rectus, I have found that great retraction takes place on each side, and it is very difficult to get hold of the peritoneum when you want to close your incision. In the latter case I catch hold of the peritoneum on each side with a pair of catch forceps, so that it cannot slip away, and after the exploration or the operation is finished, I have it where I can easily sew it up.