conclusion that this is not often necessary, and that the dryer you leave the peritoneal cavity the better. I have created an axiom that "It is unlucky to see the intestines at all during a laparotomy, and still more, to handle or touch them," and if the nurses have had the patient in hospital a couple of days, the bowels can be so emptied that they disappear out of sight the moment the peritoneum is incised. Although I have no experience with pelvic drainage in men, I think it would be worth the general surgeon's while to employ this method by passing the tube out through the anus or by piercing the perineum.

F. J. SHEPHERD, M.D.—With regard to the term "general peritonitis," I would object to that and prefer to call it "progressive peritonitis," for one does not know how extensive the condition is; as for rigidity being a sign I do not believe it can be depended upon to diagnose general peritonitis. I do not think it is advisable to hunt about to see how much peritonitis there is, but rather to treat the condition as one that may progress. The dose of the poison, the extent of the peritonitis and the virulence of the infection as well as the personal equation are all important bearings in many of these cases. I have operated on cases in the interval where the patient has died of peritonitis with septic infection chiefly because those patients had no resisting power. This is where Wright's method comes into vogue: it tests the resistance of the patient to streptococcus, and if low, the toxine may be injected to bring it up to the required standard. I have given up drainage in general peritonitis where there is no local infection such as gangrene or local abscess; where one can turn in the stump of the appendix and everything is clean, then, as a rule, I do not drain. Where there is a lot of gangrenous tissue one must drain or have an abscess to open later.

F. M. FRY, M.D.—I was hoping Dr. Archibald would discuss purulent peritonitis without visible perforation. It has been accepted, I believe, that in appendicitis germs pass through the intestinal wall to the peritoneal cavity without there being any macroscopic perforation. I have seen infants at the Foundling Hospital with typical signs of peritonitis following chronic intestinal catarrh, and these cases at autopsy show universal purulent peritonitis without visible perforation. While one cannot exclude infection through the general circulation, yet the passage of germs through the diseased bowel must be thought of.

F. R. ENGLAND, M.D.—A paper read by Mr. Bond at the meeting of the British Medical Association in Toronto, on this same subject brought out some very interesting facts. And certainly it does seem that the views of surgeons generally have lately undergone great change