tremely thickened and œdematous, and its base of attachment to cæcum fully one and a half inches broad. I now carefully separated the adhesions on the right side of the cæcum which bound it down to the iliac fossa, when I came upon a sac whose anterior wall seemed to be made up of purely inflammatory tissue. Fluctuation in this sac was obtained, the needle of a large hypodermic syringe introduced, and thick pus withdrawn. I then enlarged the opening and evacuated nearly a pint of thick pus having a distinctly fæcal odour. On exploring this cavity it was found to extend downwards below Poupart's ligament, and above as far up as the diaphragm. The cavity was thoroughly irrigated with boiled water and two rubber drainage tubes inserted, one reaching to the upper and one to the lower limit of the sac. The abdominal wound was then closed with silkworm gut sutures.

On dressing the wound on the third day gas was noticed escaping, and on the fourth day fæcal matter escaped.

On the sixth day there occurred a marked elevation of temperature, and on examination of lungs, percussion dulness was found over right apex, extending down as low as lower border of third rib. There was increase of vocal fremitus, and loud course mucus râiles were heard over this area.

Death occurred on the tenth day after operation.

This case has many features of unusual interest; in some respects resembling a case reported by Dr. William Gardner. I am not at all sure that the case can correctly be entitled one of appendicitis. I regret that no autopsy was obtained to clear up the case. The history is rather one of chronic colitis, probably tubercular. There is no history of a recurring subacute appendicitis, much less of an acute attack. *He had never been confined to his bed before admission to the hospital.* At the operation the appendix was not, apparently, more involved than the posterior wall of colon. The pus was entirely retro-peritoneal. I think it quite likely that tubercular ulceration took place in the cæcum or appendix, or both; that there was excited in their peritoneal coverings an inflammatory action that resulted in the union of the vesical peritoneum of the cæcum or appendix with the parietal peritoneum beneath. The ulcerative action continuing, perforation occurred, and escape of pus or possibly a small amount of fæcal matter into the subperitoneal tissue, where suppuration continued until the large cavity described above was formed.

Society Proceedings

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 3rd, 1891.

F. J. SHEPHERD, M.D., PRESIDENT IN THE CHAIR.

Dr. Lapthorn Smith exhibited the following pathological specimens:—

1. *Small Cystic Ovary.*—The patient had been a sufferer for many years with pain in the left side and severe palpitation. Dr. Smith had tried every form of treatment without being able to give her any relief. He then concluded to operate. The appendages were removed, with the result of immediate improvement of her symptoms—the pain disappeared, and she was free from attacks of palpitation.

2 *Double Pyosalpinx.*—This patient was aged 33, married twelve years, and the mother of one full-grown child eleven years ago. Her labor had been difficult, and she had been in bad health ever since. She had recurring attacks of pelvic peritonitis yearly for the past ten years. For the last two years her menstruation had been profuse. On examination, the ovaries and tubes were felt bound down in Douglas' cul-de-sac, and were excessively tender. Removal of the appendages had been advised, and the operation was performed by Dr. Smith, assisted by Dr. Armstrong. The tubes, which were exhibited, were enormously distended with pus. Up to the present time the patient was doing favorably. Dwelling upon the causation, Dr. Smith mentioned the probability of a septic metritis and salpingitis following her confinement eleven years ago. The recurring attacks of pelvic peritonitis could be attributed to the oozing out