indicating the presence of acute general septic peritonitis as rigidity of the abdominal muscles extending over the whole of the abdominal cavity. This is a very marked indication, and can be easily made out by the veriest tyro. A short time since I was asked if it did not require considerable courage to close an abdomen after opening it for the relief of acute general septic peritonitis, and I was forced to acknowledge that it did. In my practice my first closure was brought about as a consequence of a discussion that took place with my house surgeon. I had operated on a young girl who had acute general purulent peritonitis following perforation of a gangrenous appendix. I drained the pelvis and drained the loins and placed over the gauze packing and the tubes, moist dressing with rubber dam to facilitate drainage. For a few hours there was a fair amount of discharge from each of the three openings, and then all drainage ceased. The house surgeon asked why drainage was used under such circumstances when the object for which it was instituted was not attained. The bowel soon looked dry over the inflamed area. In the next similar case I closed the abdomen after evisceration or as much evisceration as occurred as a consequence of a very thorough flushing of the abdominal cavity, and the patient made an uninterrupted recovery. I have carried out this procedure in a number of cases since. The same procedure has been carried out by the assistant in my department in the Toronto General Hospital and by several professional friends, and with entirely satisfactory results. Neither drainage nor posture have been instituted. In some cases the wounds healed, in others they broke down either throughout their whole extent or in part, owing to the virulence of the infective material. The intestines should be handled as little as possible, no lymph should be removed, and evisceration should only be permitted as it is considered better to allow the intestines to slip out than to attempt to replace them during a thorough flushing and in order that all pockets may be disturbed and cleansed. If the patient appears shocked during this procedure, the insertion of two fingers on either side of the cut surface and the upward lift of the abdominal wall, as if lifting the patient off the table, by overcoming the rigidity of the muscles, will almost instantly return the extruded bowels. The flow of warm saline solution prevents erosion and damage of the endothelial cells and also prevents the abstraction of heat from the exposed surface. All hidden collections of infected seropus