to the setting up of a conservative fibrosis, which might lead to "cure"; but, as a rule, in "cured" tubercles, the bacilli were not dead, but quiescent. The different types which the disease assumed were considered: Acute Miliary with serous or sero-sanguinous exudation; Chronic Caseous or ulcerating, usual with purulent or sero-purulent exudation; Chronic Fibrous. The origin, was, as a rule, secondary to tuberculous conditions elsewhere. A primary tuberculous peritonitis was certainly rare. Localization was most frequent in the pelvis, and this localization might be maintained by adhesions; but localization was possible in any part of the abdominal cavity, depending largely on the primary site of infection.

Dr. M. O. Klotz took up the Symptomatology and Diagnosis. He outlined the usual symptoms of the more rare acute and subacute forms, and of the more frequent chronic form, whether of the dry or adhesive type, or of the type characterized by effusion, general or localized, purulent or serous. As regards *Diagnosis*, he urged that "in view of the excellent results that have been obtained by simple laparotomy in selected cases, it is of the utmost importance that an early diagnosis be made." The value of such diagnostic measures as the injection of *tuberculin*, *Widal's* test and the *leucocytic blood count*, was spoken of. The frequency of evidence of tuberculosis in other regions of the body, to which the peritoneal tuberculosis is secondary was also mentioned. The points of differentiation from Typhoid fever, Ovarian Cyst, and Cirrhosis of the Liver were taken up more in detail, whilst diagnostic features of cancerous growths and other conditions were merely outlined.

Dr. Webster spoke on the treatment of Tuberculous Peritonitis, taking it up, mainly, from a surgical aspect. He recalled the first recorded case of improvement attributed to simple laparotomy, that of Sir Spencer Wells, in 1862. The operation was first systematized by König, in 1884. He also published further results in 1889, estimating that out of 131 cases, 74 were quite cured at the end of two years after operation. Adlebert's results, published in 1892, were not so favourable. In 308 cases, 26.17 per cent. were in good health at the end of two years.

The consensus of opinion at present was in favour of laparotomy in all cases except those of the adhesive variety, and there also operation was advisable when obstructive symptoms occurred. In all, especial care was necessary in order to avoid the production of local injury, owing to the great liability of fœcal fistula. Consequently, only the less firm adhesions were separated and the primary focus, when abdominal, was excised only when easy of access. Drainage was to be avoided, except when there was pus. The most favourable were afebrile cases,