Minor Pelvic Inflammations) says: "Of half a dozen fatal cases of hystero-trachelorrhaphy and incision of the cervix in which I enjoyed the rare opportunity of studying carefully the sequence, in every instance the cause of death was acute diffuse peritonitis." In regard to the more chronic cases to which circumscribed areas of inflammatory exudations were found, he states that "peritonitis is certainly the most prominent element in most of these cases, so far as the post-mortem appearances afford any light;" and again: "By far the greatest number of these indurations are situated high up in the broad ligaments and consist of cicatricial masses, mostly confined to the peritoneum of tubes and ovaries surrounded by old adhesions or occasionally an imprisoned knuckle of intestine. I confess that I have rarely (perhaps half a dozen times) found such thickening in the cadaver which could be referred to a pure and straightforward cellulitis, and this, too, when I have recognized by the vaginal touch (before and after death) what seemed to be an induration, a distinct band extending outward from a deep laceration of the cervix, or a condition of tension in or above one lateral *cul de sac*, which did not exist on the opposite side."

Joseph Price, who has been in the abdominal cavity oftener than any other American surgeon, says: "The operative gynæcologist does not find any pelvic cellulitis." Lawson Tait is equally emphatic on this subject.

Having established that cellulitis is a rare disease, at least outside of the puerperium, and that what we used to regard as such is in reality in the large majority of cases a pelvic peritonitis from the outset, we will now briefly inquire into the ætiology of the latter. A diseased tube is usually the focus from which the peritoneal infection starts. Disease of the appendages may have preceded the attack of peritonitis for weeks or months, when a leaky tube may precipitate a peritonitis; that is, the secretion pent up in the tube may discharge through the abdominal orifice of the tube into the peritoneal cavity as the result of hyperdistension, trauma, violent exertion, etc. Or the tubal disease may arise acutely, and extend at once to the peritoneum, the most common causes in producing inflammation of the uterine adnexa, being puerperal infection, gonorrhœa, extension of an endometritis to the tubal mucous membrane, a catching cold, especially during mensturation, etc. Unskillful intra-uterine treatment, minor operations about the cervix, such as Emmet's operation, dilatation, etc., especially if not done with the strictest antiseptic precautions, are frequently followed by salpingitis, and, subsequently by peritonitis; the introduction of an unclean sound, especially if it produce a lesion to the mucous or muscular surface of the uterus, frequently results in pelvic inflammation. The symptoms of pelvic peritonitis vary considerably in intensity; while often so mild as to escape our attention, its onset may, especially if due to a leaky pus-tube, be so sudden, severe, and violent as to resemble a peritonitis following perforation. The disease is usually ushered in by a chill, fever, more or less severe pains in the lower part of the abdomen, back, and and thighs, irritability of the bladder, sometimes rectal tenesmus. The hypogastric region is tender on pressure and vaginal examination very painful. Within forty-eight hours a swelling may be noticed on bimanual examination, which in a few days may reach to the umbilicus. It is, at first, soft, baggy, almost fluctuating, but gradually becomes firmer until it often appears as hard as a board.

Under rest, opiates to relieve suffering, hot fomentations and after the febrile symptoms have subsided, the iodides internally and tonics, and the local application of iodine over the abdomen and to the vaginal vault, hot douches, glycerin tampons, iodoform, ichthyol, etc., the exudation gradually decreases until after a few weeks or months it has become imperceptible. The patient's appetite has improved, her pains have lessened or disappeared entirely, she is gaining flesh, and regards herself as cured. The inflammation, however, does not always run such a smooth course. Instead of ending in resolution it may go on to suppuration. Abscesses form and may discharge through vagina, rectum, bladder, abdominal walls, or intestines. They may then heal spontaneously, very rapidly, or they may continue to discharge indefinitely, until the patient dies from exhaustion or sepsis, unless surgical measures are adopted. Even if the disease ends in resolution, this does not always mean cure; on the contrary, it is often followed by a life of misery and suffering. When the patient returns to her ordinary duties she finds that she is unable to fulfil them. She has aching in her back, abdominal pains, increased on slight exertion, disturbance of her gastric functions, and other reflex symptoms. Her menses are more profuse than formerly, and more painful, marital relations are accompanied with suffering, or may become utterly unbearable; in that she presents the picture only too familiar to every physician practising in gynæcology. Examination reveals extreme tenderness over one or both uterine adnexa; perhaps some thickening in the region of tube and ovary; or you may find large masses in the region of tube and ovary and filling up Douglas' pouch. In other words, while all active peritoneal inflammation may have subsided, the focus of the disease, the diseased appendages, have remained, and wait only a favorable opportunity to light up another acute pelvic peritonitis. I have seen three and four such attacks within one year. Such cases will probably go on from bad to worse until these diseased appendages are