were used daily and iron and ergot given internally. All went well and in eight days I again dilated the uterine cavity, and with a sharp spoon removed all roughened elevations from the posterior walls. There was free hemorrhage, but this was controlled by the application of liq. ferri. subsulph.

Dr. W. T. VanDyck kindly examined the growth microscopically for me and pronounced it an adeno-sarcoma.

In three weeks the discharge had entirely ceased and the uterine cavity was reduced to three and one-half inches, so the woman was permitted to go home, with the prognosis of a probable return of the growth.—*Maryland Medical Journal.*

ROYAL ACADEMY OF MEDICINE IN IRELAND.

ABDOMINAL SECTION IN TYPHOID FEVER

A meeting of the Medical Section was held on May 17th:

Dr. J. H. Nicholas read a paper on Abdominal Section in Typhoid Fever. The histories of two cases were communicated, and specimens shown for the purpose of inquiring as to whether the operation of opening the abdomen was justifiable in perforation of intestine in typhoid fever. It was assumed that the acute peritonitis, which was present in these cases, was set up by the presence of the fæcal matter in the abdomen; and, consequently, that the existence of this diffuse form of acute peritonitis might be accepted as a diagnosis of perforation existing; and as recovery, with fæcal matter exuded into the cavity of the abdomen, was absolutely impossible, it was suggested that an operation might be performed early in the disease before collapse appeared—the operation consisting of opening the abdomen, washing out, and sewing the opening to the anterior wall of the abdomen. Among the many objections the following were mentioned: 1. Difficulty of diagnosis. 2. Condition of the patient. 3. Difficulty of finding the perforation. 4. Diseased condition of the wall of the gut. 5. Many cases of diagnosed perforation having recovered. The author endeavored to answer these objections.—Dr. Ball said the treatment of perforating ulcers from typhoid fever by abdominal section had been adopted on several occasions with results uniformly fatal; and if not uniformly so, yet that such were to be expected was due to the fact that the union of intestinal wounds demanded not only a very accurate adjustment but a very rapid healing of the parts.—Mr. L. H. Ormsby endorsed Dr. Ball's observations; and therefore if he performed abdominal section at all, he should select his case. Indeed, if called upon by a physician to perform the operation he would refuse rather than hold out any hope of success.—Dr. Myles wished to know how an accurate diagnosis was made. The text writers pointed to the disappearance of the area of tympanitic dulness, but he knew of a boy who having been run over by a car, sustained severe injury to his abdominal wall and manifested all the symptoms associated with perforation of the intestine. Though urged to do an abdominal section, the surgeon in charge refused, and the boy next day got well. He did not think it possible to select cases, the operation being one of necessity rather than of selection. The question was whether the operation would shorten the patient's life. He had himself seen patients who had survived typhoid with deep ulceration.—Dr. Nicholas, replying, said, as regards diagnosis, collapse from ulceration in typhoid fever did not come on suddenly, but appeared gradually to increase from an unknown commencement, and was due to the fæcal poison, and was not the result of perforation. The whole theory stood or fell in respect of the acceptance of the condition of acute peritonitis as being a point of diagnosis. The peritonitis was set up by the presence of fæcal matter in the abdomen, and not by the extension of ulceration from the inflammation.

RUMINATION IN MAN, OR MERYCISMUS.

Dr. Paul Gallois has lately had an opportunity of studying gastric digestion, by keeping under his observation for some time a *merycole*—that is to say, a