false membrane being thrown out over the entrance of the oviducts.

(When speaking of the causes of pelvic peritonitis and cellulitis, I overlooked one very important cause of the condition, viz., gonorrhœa in the female. This disease is more likely to produce perimetritis than parametritis and sterility is very often brought on by it, and, as a consequence, of the changes occurring around the womb.)

When pus forms, the destruction of tissue is usually very great.

I remember being present at a *post mortem* examination made at Bellevue Hospital some twelve years ago, and I never saw such destruction of tissue as had been produced by the disease in that instance. It was utterly impossible to discover an ovary, or broad ligament, and we had to pass a sound up the vagina to discover the womb.

Sometimes abscesses are formed without the knowledge of the physician. If an abscess opens into the rectum, the result will be a collapse with sudden stools. If an abscess bursts into the bladder, the results are very serious, since the urine finds its way into the pus-containing cavity. The prognosis is also grave when an abscess opens into the small intestines. In some cases I have known the pus from an abscess to dissect its way into the tissues above the pubis and open in the groin.

GASTROTOMY FOR MALIGNANT STRICTURE OF THE ŒSOPHAGUS.

The following case is reported in the *British Medical Journal:*

A cachetic emaciated man, aged 55, had presented himself for relief at the out-patient department of St. Bartholomew's Hospital a month before the consultation. Mr. Langton then detected a dense obstruction just behind the cricoid cartilage, and a probang passed beyond the pharynx returned stained with blood. There was severe dysphagia; but the patient could swallow fluids with tolerable ease. At the date of the consultation, his condition had become much aggravated. It was with the greatest difficulty that he could swallow fluids, and any beef-tea, that he managed after painful efforts to get down his throat, soon returned. This indicated that dilatation probably existed above the seat of stricture. An induration could be detected to the right of the cricoid-cartilage, pushing outwards the sterno-mastoid muscle. The patient was rapidly losing flesh, and suffered from the constant pain in the epigastrium observed in cases of starvation.—Mr. Langton remarked that one of three methods of treatment might be reasonably proposed. The patient might be fed by a narrow tube passed beyond the stricture into the stomach. Then, too, he might be fed by the rectum. Or gastrotomy might be performed under antiseptic spray, the peritoneum first being laid open, the stomach stitched on the abdominal wall, and opened a few days later. This appeared to be the only satisfactory way of averting the pangs of hunger for the rest of the patient's life.—Mr. Holden believed that the disease was situated lower down than the cricoid cartilage. He would first feed the patient by a narrow tube, and, when that became dangerous, he would perform gastrotomy in the manner recommended by Mr. Langton.—Mr. Savory considered the disease to be epithelioma at the junction of the pharynx with the œsophagus. He objected strongly to the passage of a tube through the diseased part, and feeding *per anum*, always unsatisfactory, would be necessary; but it would be best to perform gastrotomy.—Mr. Willett considered that gastrotomy was in this case quite justifiable; though it was but palliative, it would promote euthanasia. At present, the patient was in misery, and considerable risk might be incurred to relieve him from hunger.—Mr. Baker was in favor of feeding by a tube until much pain was produced; then the stomach might be opened.—Mr. Marsh thought that, although gastrotomy was one of the most fatal operations in surgery, this was a case where it was really necessary.—Mr. Langton, in conclusion, stated that he was very loth to feed by a tube or by enemata, and intended to recommend the unfortunate patient to submit to the operation of gastrotomy.

Result: On Monday, February 10th, Mr. Langton performed the first steps of the operation of gastrotomy. A vertical incision about two inches in length was made through the abdominal walls, corresponding to the segment of the left linea semi-lunaris immediately overlying the stomach. That organ was fixed to the edges of the wound by wire sutures, the wires on the right side passing through the substance of the edge of the rectus. Mr. Langton considered that there would be less inversion of the margin of the wound than if he had not included muscular tissue in the suture; nor did he fear that the transfixion of the muscle would produce any ill effects. The operation was performed under carbolic spray. The patient was fed with essence of beef, brandy, etc., *per anum* till Wednesday, February 19th, when Mr. Langton opened the stomach and introduced a vulcanite tube, through which greenish bile immediately escaped. The patient's temperature, which was 94 deg. before the operation, rose to 96 deg. in the evening. On the next day, the patient retained most of the nourishment introduced through the tube under the superintendence of the house-surgeon, Mr. Bruce Clarke. Though greatly emaciated, the poor sufferer appeared to be somewhat the better for the operation; but he gradually