to discuss subphrenic abscess in a more special way, with reference to the origin of the abscess; *e.g.,* those of gastric origin, those of appendical origin, etc. The length of the article and lack of space prevent our giving further extracts, but the interested reader will find it exceedingly worth reading. Many apt case reports are given; and the whole subject is put in a clear light. *E. W. A.*

CHARLES GREENE CUMSTON, M.D. "Remarks on the Present Status of Surgical Treatment of Hepatic Cirrhosis." *Boston Medical and Surgical Journal,* August 10, 1905.

For many years hypertension of the portal vein has been considered the cause of ascites, but, as a result of laboratory research, pathology, surgical physiology, and exploratory laparotomies, such purely mechanical cause has been shown inadequate to explain many of the cases. It is more in conformity with our present knowledge to attribute ascites to a peritoneal reaction. The large majority of authors attribute ascites to peritonitis in instances of the hypertrophic form of alcoholic cirrhosis. Kelynach's statistics of 1902 show that tuberculosis plays a very important part in the production of ascites, inasmuch as in 131 cases of undeniable cases of alcoholic cirrhosis the existence of tuberculosis was present in 23 per cent. This existence is seen especially in cases of large livers, and in some of these the tuberculosis appears to play the preponderating part. However, tubercular infection cannot apply to all cases, and it would seem reasonable to admit that there is also some disturbance in the peritoneal cells arising from the influence of a defective circulation, or from an intoxication due to hepatic insufficiency. The poisoned cell excreting salts, and particularly sodium chloride, will give rise to an exosmosis of serous fluid, because the presence of the salt in the peritoneum will cause isotony to be defective. With reference to treatment it is all important that an exact diagnosis of the cause and type of cirrhosis be made. Thus in cardiac cirrhosis operation must necessarily be a failure. So also in malarial cirrhosis the results cannot be very successful, seeing that these cases present a general complex process of intoxication and hepatic insufficiency. In the last class, nothing can be hoped for from omentopexy, but if the chronic peritonitis may be considered the cause of the ascites simple laporatomy without drainage should be preferred. Syphilitic cirrhosis will hardly ever be benefited surgically; while in the tuberculous type, if the infection be limited and the peritoneum appears to react, a laparotomy will frequently result in a cure of simple ascitic tuberculous peritonitis. In the hypertrophic type of the so-called alcoholic cirrhosis we find the