by incision; secondly, established drainage without washing; thirdly, maintained drainage by posture; and, fourthly, washed the blood by intrarectal injections of salt solution. It is difficult to understand why this difference should exist. Let us for a moment compare the two methods of treatment. We both make an incision and close off the opening through which the septic condition has been originally established. He establishes drainage, endeavoring to drain off the intraperitoneal fluid without washing or sponging the cavity. I wash most thoroughly every atom of septic material that can be removed without using a very forcible stream of salt solution, and instead of draining, close the cavity and leave it full of salt solution. He places the patient in Fowler's position, with the chest elevated, the pelvis lowered, to drain away the poisons from the upper or diaphragmatic zone. I keep the patient lying in a recumbent position, so that the heart may be given as little as possible to do in its embarrassed and enfeebled condition. We both endeavor to wash the blood with salt solution, whether this be accomplished through the subcutaneous tissue or the intestinal tract. Several of my friends have been adopting this method of evisceration, washing and closure of the wound, leaving the abdominal cavity full of saline solution, with good results.

Some years ago I endeavored to explain to myself the *rationale* of the treatment adopted by Alonzo Clark. I found that on post-mortem examination of patients dying from an over-dose of opium, it had been discovered that there were many congested patches, well marked and distinct, studding the peritoneum. I believe that this indicates that large doses of opium delay absorption from the peritoneal cavity, and that it was owing to this fact that Alonzo Clark obtained such good results. If we can delay absorption until a certain condition of immunity to the toxines is produced, we are able to tide the patient over the critical period and save life.