

normal appearance or to present adhesions and scarred tubercular nodules. The changes observed in the process of recovery consisted in granular disintegration of the bacilli, phagocytosis by epithelioid cells, degeneration of the cells constituting the tubercular tissue, penetration of the latter by new vessels and connective tissue, leading to its absorption and replacement by scar tissue. The authors quoted point out that the processes described are the same as those observed when recovery takes place without laparotomy, and they express the opinion that the operative interference stimulates or increases the reparative changes by the mechanical influence which it exerts on the impressionable peritoneum.

Both from clinical experience and from experimental evidence, therefore, we may conclude that the beneficial results of surgical interference in peritoneal tuberculosis are due to the making of a wound through the wall of the belly and the attendant manipulation of the parts concerned.

In discussing the bearing of the above conclusion upon practice, it is not to be assumed that all cases of peritoneal tuberculosis are to be subjected to surgical interference.

In view of the natural tendency to spontaneous recovery, no case should be submitted to operation until medical treatment has had a fair (although not too prolonged) trial. Among the local measures included under this head I am inclined to place most reliance on careful massage of the belly, and on measures calculated to restore the normal functions of the intestine.

The inunction of mercurial and other ointments is probably chiefly beneficial because of the mechanical manipulations concerned, stimulating the tissues invaded by the bacillus to grapple with the latter. The inunction of ointment may be regarded as a gentle and safe form of massage.

The securing of regular and copious evacuations of the bowels by drugs, aims at cure of the catarrh, cessation of fermentation processes, and an increase in the eliminating powers of the mucous membrane. Should evidences of recovery not present themselves the question of operation is to be considered.

In all cases of diffuse serous or purulent ascites, operation is very certain to cure and very easy of performance; a free incision is to be made through the belly wall, the fluid is to be evacuated as completely as possible (turning the patient on one or other side for this purpose).

When the fluid is serous, the wound is then and there to be closed by suture, it being optional and perhaps advantageous to insert some iodoform into the parts exposed by the incision, rather with the object of preventing tubercular infection of the tissues of the abdominal wall, and consequent breaking of the scar at a subsequent period, than of influencing the existing peritoneal tuberculosis.

When the fluid is purulent (cold abscess), it is better to insert a drainage tube within the lips of the wound, and to remove it on the second or third day when the amount of discharge is no longer sufficient to soak the dressings.

To leave in a drainage tube for a longer period is injurious, as on the one hand it favors the development of a sinus, and on the other its inner end may, by its mechanical pressure on the weakened wall of the intestine beneath, favor perforation of the latter and the formation of a fecal fistula. As soon, therefore, as the drainage tube has fulfilled its function, it is to be removed, and the space which it occupied filled up with iodoform.

The features of cases with ascites, whether the fluid is serous or purulent, are so well known that of those which have come under my own observation I shall only instance one, because of the individual peculiarities which it presented. The patient was a stout red-faced man fifty years of age; he had a large diffuse lipoma of the neck, and an enormous distension of the belly with fluid; the ascites was supposed to be result of hepatic disease. The abdomen was opened in the region of the liver, and after the fluid had been allowed to escape, the peritoneum was found to present the most diffuse and abundant miliary nodules and pedunculated masses of tissue; one of these latter was removed, and on being examined in the laboratory proved to be tuberculous. The sequel of the case is not known, as he became insane and was transferred to an asylum.

Of cases in which the fluid is encysted or circumscribed by adhesions, I have had no personal experience; but reports have shown that it is in the majority of cases remarkably successful.

It is in the third group of cases, in which fluid is either absent or relatively small in quantity and in which adhesions and matting constitute the predominant features, that more knowledge is required both in regard to diagnosis and to the advisability of operative interference. I have had personal experience of five such cases, in all of which I operated at one stage or another—in two for the purpose of relieving obstruction of the bowels, and in the remaining three with the object of bringing about improvement or cure of the tubercular condition. In all of the cases, the diagnosis was materially assisted by a rectal bimanual examination made under anaesthesia; in all, a tumor or swelling was to be felt occupying the pouch of Douglas consisting of a mass of adherent coils of bowel, filling up the pouch and bulging into the rectum. In one of the obstruction cases, this tumor was so prominent that it was mistaken for an intussusception by the practitioner who sent the case into hospital. This matting of the intestines in the pouch of Douglas is one of the evidences of the fact that tubercular peritonitis is always more marked below than