istic feeling that nothing can be done. I might read you notes of several of my cases. I am happy to say that within the last year, more than at any other time, has the darkness which surrounds this disease been pierced by a ray of light, and it is again the surgeon who has stayed the fast ebbing life, and given us good reason to hope that ere long he will have firmly entered another field of usefulness, adding this achievement to the already brilliant list.

As etiology is the basis of our treatment as well as our classification, let me say a word about it. There is no disease which has been broken up into more varieties or burdened with more differentiation than peritonitis. It has now become evident that peritonitis depends almost entirely, if not entirely, upon infective processes, and that these agencies are at work directly or indirectly in every form of the disease. In the great majority of cases it depends on what has been called continuity infection; that is, direct spreading of the infection to the peritoneum from a neighboring tissue other than the serous membrane. So we have (1) Infection from intestine, hernia, appendix trouble, etc.; (2) Infection from without, puerperal; (3) Infection due to pneumococcus; (4) Tubercular infection: (5) Doubtful origin.

At the meeting of the American Obstetrical and Gynæcological Society in Toronto last September, Dr. W. G. McDonald, of Albany, in his paper on appendicitis, stated that idiopathic peritonitis does not occur, and that many cases diagnosed as such are really perforating appendicitis.

In treating peritonitis, the exhaustion, the rigidity of the abdomen, the pain, the vomiting and the not infrequent signs that the bowel should be relieved of flatus, are suggestions from the therapeutics of nature, and so we have recommended absolute rest, attempts to relieve pain, starvation and purgatives.

Absolute rest in the recumbent position appears to be the first obvious indication.

The feeding is important. The stomach is not in a position to receive nourishment, and what is taken usually remains unchanged and is returned unutilized. Let the patient have as little food as possible by the mouth, and some ice to quench the great thirst, and trust more to rectal feeding.

Opium and morphine should be given as sparingly as possible, and should not form part of a routine treatment. They hamper treatment and mask symptoms.

Aperients, within the last few years, have been revived chiefly by Mr. Lawson Tait. His treatment has been spoken of as "the treatment of peritonitis by aperients," as if it could be used with advantage in every case. What Mr. Tait says is: "I have never said that purgative treatment will cure peritonitis, for once it is established, peritonitis is a practically incurable disease, and almost uniformly fatal."

There is no doubt that there is within the intestine in these cases an amount of noxious matter which becomes septic as soon as the normal condition of the bowel is interfered with, and that these matters can, within certain limits, be got rid of by aperients and enemata. It has been pointed out by Mr. Tait that if an action of the bowel can be obtained at the outset of the symptoms, either by the administration of a purgative or enema, the trouble in a large proportion of cases passes away and the patient makes a good recovery; but a purgative, like an emetic in acute poisoning, can only arrest symptoms within certain limits. Once general peritonitis has established itself, an aperient is without avail.

I might occupy much more of your time on therapeutic measures, but every day peritonitis is becoming more of a surgical disease.

Operative measures are represented by incision, drainage, with or without irrigation, and more recently, puncture or incision of a distended intestine.

Generally speaking we have two series of cases to treat. In one there is a vigorous, well-defined inflammation, the local symptoms are marked, pus is produced in greater or less amounts, and the exudation localized. Examples of this are: Peritonitis started from appendix trouble; pelvic peritonitis and also certain cases started from injury or perforation. In the other series the peritonitis is diffused, the constitutional symptoms are more prominent than the local, the changes in the serous membrane are comparatively slight, and are out of proportion to the general disturbance. This form is illustrated by cases of general septic intoxication starting from the peritoneum, puerperal peritonitis, etc.