the uterus, the sponge tents, and steel dilators were other factors in bringing about inflammation of those organs. Gonorrhœa, tuberculosis, neoplasms, and malformations lead to a similar condition.

The different inflammations were accompanied by a single pathological process, congestion with effusion. On the rapidity of this depended the extent and virulence of the condition.

Dr. Rosenwaser (Cleveland) discussed the treatment. First, as to the treatment of an acute pelvic peritonitis medically, all decomposition should be removed from the interior of the uterus. Hot douches were helpful, saline laxatives would often be followed by the relief of pain. He did not believe in the use of the iodides and mercury. The principle of dissolving the exudate was wrong.

As to the surgical treatment, he advised curetting if the tubes were not affected; abdominal section if abscess formation had developed.

In the chronic pelvic peritonitis rest in bed was essential; the bowels should be attended to; boro-glyceride tampons were useful in some cases; gentle pelvic massage; tonics; local electricity was also helpful. Curetting where not contraindicated, abscess opening, removal of the ovaries and tubes, would include most of the surgical measures.

Dr. Carstens advocated preventative measures. He thought if the men who had the gonorrhœa cases to treat did their work properly, the gynæcic surgeon would not have so much to do.

Dr. Price said that suppurative disease must be encouraged to evacuate itself. In these cases concurrent inflammations and adhesions were always present, and adhesions must be broken down completely in order to do a complete operation. Many ovaries had been unnecessarily sacrificed.

The Present Status of Pelvic Inflammation. Read by Dr. Dorsett. Surgery of the pelvic viscera had made enormous strides during the past ten years. Electricity had made a feeble light, but would soon die a natural death. Often a foul uterine cavity was the seat of the trouble, and when cleaned symptoms were relieved. Total ablation was necessary when the pus was found hemmed in in the tube or ovary. Pus deep in the pelvic cavity was hard to deal with. Pus sacs near the uterine end of the tube could be evacuated by packing the uterus.

The Relations of Renal Insufficiency to Surgical Operations. Dr. C. C. Fredrick (Buffalo) characterized renal insufficiency to be any state of the urine showing deficient elimination of the waste products, whether from functional inactivity or lesion of the kidney. In such cases it was necessary to consider the amount and nature of the urine, the character of the lesion for which the operation was necessary, and the causal relation the disease bears to the insufficiency. Minor degrees of insufficiency were not a contraindication to operation. The graver forms were contraindications, except for growths that had a causal relation to the kidney lesion. Patients with kidney disease were more liable to shock and complications. There was little choice between ether and chloroform in these cases of renal insufficiency.

Some results of Ether Anæsthesia in Abdominal Operations. Dr. I. S. Stone (Washington) took the ground that ether was not the safe anæsthetic it was generally believed to be; that albumen was often harmless, at least its presence was not always a contraindication to operation; that our methods for detecting nephritis were at fault. He proved the position he took from the citation of illustrative cases.

The Cause of Thirst following Abdominal Section. Dr. E. Boise (Grand Rapids, Michigan), after stating the generally accepted proposition that