the peritonitis could be found. Dr. Gow refers to one of Sir James Simpson's cases in which also no local cause could be found at the post-mortem. Dr. Matthews Duncan reports two cases of a similar kind, in both of which death took place, and no local cause of the peritonitis could be discovered. One of the patients suffered from enteritis. In not one of the cases cited by Dr. Blackader could the exciting cause of the peritonitis be discovered.

The diagnosis of the cases will lie between peritonitis, concealed hemorrhage, rupture of the uterus, and perhaps rheumatism of the uterus. Dr. Blackader said that he much regretted being unable to procure a post-mortem in his fatal cases, but that he had not the slightest doubt that his diagnosis of peritonitis was correct.

Dr. J. C. Cameron said that he did not see why pregnant women should not have peritonitis; their condition would predispose to it than otherwise. The great defect in the paper was the fact that no autopsies were held, and whether the peritonitis was idiopathic or not could only be determined by a post-mortem examination. He himself was rather sceptical as to the occurrence of *idiopathic* peritonitis. *Peritonitis* may, in these cases, have been caused by a perforating appendicitis, ruptured cyst or tube, abscess, etc.

Dr. Harvey, of Calcutta, related a case in which post-partum hemorrhage was caused by adhesions of the uterus to the parietal peritoneum, this prevented contraction of the uterus. He saw no reason why pregnant women should be exempt from peritonitis, as the same causes which produce it in the non-pregnant would be found in the pregnant.

Stated Meeting, November 2, 1888.

The President, William Gardner, M. D., in the Chair.

Dr. Bell exhibited a case of

EXCISION OF THE KNEE

in a man aged forty-five years, cured in one dressing. The femur was rounded off to fit into a concavity in the tibia, as recommended by Dr. Fenwick, and the bones were held together by two nickel-plated nails. The first dressing was removed in five weeks. The specimen of diseased bone removed from the knee-joint was also presented; this showed large pieces of necrosed bone in several parts of the lower end of the femur.

Dr. Bell also exhibited a patient who had received an injury of the knee which had caused a

SEPARATION OF THE LOWER EPIPHYSIS OF THE FEMUR.

This had united in a bad position, so that the knee was very much bent inward, and the lower end of the shaft of the femur protruded through the skin. The parts were cut down upon, osteotomy performed, and the leg straightened. The result, as shown to the Society, was an admirable one.

Dr. Shepherd exhibited a patient who had suffered from

COMPOUND FRACTURE OF THE OLECRANON.

The separated fragments of bone were sutured with silk, the result being bony union. The patient, a man aged twenty-five years, whilst working on board a ship, was struck on the elbow of the left arm by the fan of the ventilating apparatus; this split the olecranon process vertically, and opened up the joint. When he came to the hospital the wound was covered with dirt, and on separating the lips of the wound it was seen that the olecranon process was split into two portions longitudinally, and the joint was opened. After cleansing the wound, the separated fragments of bone were brought together with two silk sutures and the wound closed, a small drain being left at the lower end. The dressings of gauze and jute were left on for three weeks, and when removed the wound was perfectly healed and the bone found united. The patient went to work a month after the accident, but for some time the movements