cretory and eliminative organs are normal and may be relied upon to perform more than their normal share of work, what resources give the greatest promise of success? It matters not whether the peritonitis has resulted from a ruptured gangrenous appendix, a perforated typhoid or other ulcer, or a strangulated hernia, the principles involved in the after treatment are much the same if the inflammation is more than local and further spreading in not prevented by limiting adhesions.

The indications are to arrest the spread of the infection and inflammation by continuity of tissue, to lessen the production of toxines, to favour the elimination of the poison already generated, and to aid the natural recuperative powers. These indications, I think, are best met by arrest of peristalsis and by adapting such means as favour rapid elimination of the toxines.

I have been like some others, perhaps, very much influenced by the teachings of that surgical genius, the late Mr. Lawson Tait. I faithfully withheld opium and as faithfully endeavoured to secure free movements of the bowels, thinking that by so doing I prevented the formation of adhesions that might become obstructive, and that I stimulated the elimination, through the intestinal wall, of toxines. Experience has convinced me that this is a wrong principle upon which to act. I have seen too many peritonitis cases gradually sink and die from toxæmia, while at the same time passing several, loose, watery, diarrhœa stools daily. Those stools were the result of the administration of various enemata and of salines by the mouth. Disheartened by these results, I began adopting an almost opposite course in the after treatment of peritonitis cases. It is quite possible that in his special work Mr. Tait was quite right in his methods. His work was largely gynæcological, a class of work in which there is comparatively little sepsis and that of a mild degree of virulence. I am of opinion, however, that his principles applied to ingravescent and general septic peritonitis, such as comes before the general surgeon, are too often followed by disastrous results to be adopted. I believe better results are to be obtained by arresting peristalsis and endeavouring to promote toxine elimination by channels other than the intestinal tube.

The plan which I have successfully adopted in a few cases, too few I admit to prove anything conclusively, is to arrest peristalsis and promote the elimination of the poisons by:—

(1) Stomach lavage. This may be carried out with the aid of a little cocaine spray in the pharynx; or, if an anæsthetic is adminis-