PERITONITIS.

While peritonitis, as a disease, was well-known to physicians of all ages, a full knowledge of its pathology and an intelligent method of treatment are clearly the work of modern investigators. Its ætiology particularly was very little understood until the phenomenal advances in abdominal surgery cleared the darkness and threw light into the mysteries hidden in the abdominal cavity. Hand in hand with the surgeon worked the pathologist, and their combined efforts brought about a revolution of our views of the disease and its treatment. In no branch of medicine has such wonderful progress been made as in that pertaining to the peritoneum and the organs it invests. It is true this progress has benefited surgery much more than medicine; so it appears that peritonitis, at least many of its forms, is rapidly becoming a surgical disease. The diagnosis of peritonitis does not satisfy the progressive mind of the modern physician; he has learned the importance of striving to arrive at its cause and seat which, though *contained* in that large cavity invested by peritoneal membrane, may *belong to* any of the many organs located there. Peritonitis is, therefore, a general name for many diseases, differing not only in their symptoms, pathology, and ætiology, but frequently also in their treatment. They are only alike inasmuch as they are all accompanied by inflammation of the *lining* membrane of the diseased organs, the investing peritoneum.

To enter into detailed description of all these forms of peritonitis would be a task impossible to me without transgressing the limits of my time. I, therefore, decided to confine my remarks to two large groups of this disease which are by far the most frequent and important, the one affecting with particular predilection the male sex, especially the younger portion of it; the other is, exclusively, a female disease. I refer to peri-typhlitis or, more correctly, appendicitis and pelvic peritonitis.

Formerly most inflammatory conditions in the right iliac fossa were regarded as a typhlitis or peri-typhlitis, the former being a catarrhal inflammation of the mucous membrane of the cæcum, the latter an extension of this inflammation to its surrounding peritoneal covering and especially of the retro-peritoneal connective tissue of the cæcum, which was frequently accompanied by abscess formation in this retro-peritoneal tissue, caused generally by perforation of the cæcum through its posterior wall. These collections of pus were, therefore, thought to be outside of the peritoneal cavity. Disease of the appendix was much less connected with inflammation in the right iliac fossa. Within the last few years our views have experienced a decided change, principally influenced through the experience gained by the numerous abdominal sections made for this disease. Inflammation of the cæcum or peri-typhlitis is now regarded as very rare, at least on the primary lesion, while appendicitis is extremely common. McBurney says that, in a hundred cases of inflammation in the ilio-cæcal region, ninety-nine are cases of appendicitis.

An appendicitis may be a simple catarrhal inflammation of the mucous membrane of the appendix vermiformis, causing few or no symptoms, excepting, perhaps, some slight tenderness over the region, which may be easily overlooked, accompanied by more or less disturbance of the digestive organs and often some febrile symptoms. The appendix in such cases generally contains small fæcal concretions, which act as irritants to the mucous surface and are accused of bringing on the inflammatory trouble, though in eight cases operated by Lewis A. Stimson, in only one were there concretions of sufficient size to be justly blamed for the existing condition. Foreign bodies, such as cherry pits, grape seeds, etc, are much more rarely the cause than was usually supposed, and, according to Jacobi, it is probable that "few, if any, foreign bodies enter the process unless the latter has previously lost its elasticity and contractility by an inflammatory change." This catarrhal inflammation may be followed by a complete resolution and permanent cure, but in many cases frequent relapses occur. The appendix may not be able to rid itself of these irritating fæcal concretions, or the previous inflammation may have left a stricture at its cæcal orifice, followed by retention of its own secretion which may give rise to renewed attacks of inflammation, especially if excited by some traumatic influence. This may not confine itself to the mucous membrane, but extend to the submucous tissues and serous coat. Lymph is thrown out over its neighboring structure and adhesions are formed, encapsulating the original seat of disease, the appendix, and surrounding it by a barrier intended by nature to protect the general peritoneal cavity, should ulceration and perforation result in the appendix. An abscess now forming would, contrary to olden teaching, be intra-peritoneal, though not communicating with the general peritoneal cavity; loops of intestines, glued together, may form the abcess wall, and prevent general septic peritonitis and death. The mass often felt in the right iliac fossa is nothing else than this exudation surrounding the diseased appendix, which may have become organized into a distinct abscess wall. When inflammation and perforation come on suddenly and before nature has time to protect the general peritoneal cavity by such a provisional lymph-barrier, a violent septic peritonitis is the result, with death in two or three days. The autopsy of such a case I witnessed three or four months ago. The