not be done without a general anæsthetic. Then ether will be found the safest anæsthetic.

Finney adds the suggestion that in any case in which diagnosis is obscure and there is reason to suspect the existence of a perforation, a small incision be made under cocaine anesthesia and cultures be taken from the abdominal cavity.

This exploratory incision would be followed by very little disturbance to the patient and very slight risk. Still more if we can anticipate both shock and sepsis, by diagnosing the preperforative stage, we have made an important further step in advance.

A very brief summary will be sufficient to indicate the further technic. The incision would be best made in the right linea semilunaris or through the rectus muscle. If such a general peritonitis be present that this will not enable us thoroughly to cleanse the abdominal cavity, a second incision may be made in the left iliac fossa. I prefer a median incision.

The perforation should be sought first in the ileum; secondly, *in the adjacent cæcum and appendix; and thirdly, in the sigmoid.* When found the perforation should be sutured without paring the edges.

Just a word in reference to the subphrenic abscess. The abscess in this case was a posterior one, and the pus had evidently accumulated in the retro-peritoneal tissue, inflammation having caused adhesion of the opposing layers of the lesser sac *of the peritoneum, which formed a very strong barrier against* the pus passing downwards into the general peritoneal cavity.

In the case of a subphrenic abscess developing in connection with ulceration of the stomach or duodenum, pus is most commonly found within the lesser sac of the peritoneum. As regards the symptoms of a subphrenic abscess, there will be, in addition to the usual signs of a collection of pus, elevation of temperature, rigors, perspirations, etc., tenderness over the liver, and often a slight pleurisy, with increased liver dulness and bulging of the right side.

Then we have the "diaphragm phenomenon," which is the existence of a shallow depression which moves with respiration, across the intercostal space to the left side, as the diaphragm ascends and descends. On palpation a collection of fluid may be felt. Greig Smith draws especial attention to the significance of a line or band of induration and resistance felt through the abdominal wall, moving with respiration. This band is due to the presence of adhesions which limit the abscess cavity below.

The patient was present, and said he was enjoying excellent health and had gained thirty pounds in weight since leaving the sanatarium.

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