

abscess cavity elsewhere. After healing has taken place, the appendix may be removed with practically no danger to the patient.

In general septic peritonitis we have a very different proposition to deal with. Here the enemy has succeeded in passing the first line of defence, either by breaking down the inflammatory barricade or by the suddenness and virulence of its onset it has taken the phagocytes by surprise so to speak before the defenders could be organized and now the fight must be waged over the whole peritoneal field. Now, before deciding on our line of action, let us frankly recognize the fact that the person's own organism must be largely responsible for success or failure. Then in the light of our knowledge of physiology and pathology let us carefully consider in what way we can best assist nature, remembering always that there is quite as much danger in doing too much as in not doing enough.

Realizing the fact that the invading army is entering at one given point, the wise surgeon sees that it is his first duty to check that invasion by quickly removing the diseased appendix or gangrenous gall-bladder or by closing the perforation in the stomach or intestine. After the opening is closed or the offending organ removed, a cigarette or gauze drain down to the point of invasion will, by removing the diseased exudate, stimulate a flooding of the part by healthy serum loaded with leucocytes.

Then one must recognize the tremendous importance of maintaining the integrity of the endothelium. Hence there must be no unnecessary handling of the intestines. As Murphy has tersely put it "get it quick and get out quicker."

In this connection, the question of *irrigation* must be decided. Personally I prefer not to irrigate unless foreign matter, such as the contents of the stomach or bowel, is present in the peritoneal cavity. Some objections to irrigation are that it injures the delicate endothelium, thus allowing the direct absorption of toxins; it is impossible to wash away all the pus