grumous-looking; has a feculent odor. His distress is dreadful. He died at 4 p.m.

Drs. Hunter, McConnell, and myself, conducted the *post mortem.*

Autopsy.—On opening the abdominal cavity, a dark brown sanious, sero-purulent fluid gushes from the opening. The peritonitis has been diffuse, as the whole peritoneum is engorged. On reaching the right iliac region, a great quantity of yellow but offensive pus is found, between the coils of intestines, such as are not glued together with lymph, for in this region the intestines are for the most part bound together with lymph, and can hardly be separated. The abscess cavity comes in contact with the intestines but at one point, and that is the cæcal termination of the ileum. Here it is in close contact with the anterior wall of the intestine, its transverse diameter being about an inch and a half. The lymph, which surrounds the abscess cavity, extends to the cæcum on the right, but comes in contact with the bowels at no other point. The exudate has entirely surrounded the right ureter. The opening of the abscess into the peritoneal cavity is from its anterior wall, which is nowhere in contact with the anterior wall of the abdomen. No ulceration or gangrene of the mucous membrane of the vermiform appendix, cæcum, or ileum, is found on careful examination.

Remarks.—The pathology of this case is obscure. Yet the numerous and sudden stops of a street car, with their hand-breaks reaching to a level with the abdomen, supply the conditions of an exciting cause in any perityphlitic case in a Toronto street-car driver. But just why the peritoneal covering of the ileum should be selected as the point upon which or from which an abscess should develop, and not the vermiform appendix, which is considered by some, McBurney, and others, in their recent additions to the literature of this subject, and emphasized by L. S. Pilcher in his editorial on the same, as "the primary and essential condition of typhlitis, perityphlitis, or paratyphlitis," I cannot tell. Yet it is evident the vermiform appendix played no part in the pathology of this case.

Treatment.—I believe that Fitz's treatment, viz., an operation not later than the third day, would, very probably, have saved this patient's life. An immediate operation would have been better.

Case 2. John Mc., æt. 19, single; occupation, conductor on Toronto Street Railway.

History: Had crampy pains in the bowels, beginning on the 25th of Sept., 1889. Did not think them of sufficient importance to consult a physician for two or three days. Bowels were loose at first, afterwards constipated. Took "salts" repeatedly, but vomited everything. Consulted Dr. Ross, Sherbourne Street, on 28th. Says Dr. Ross "gave something to relieve the pain, and something to move the bowels." Bowels moved on the 28th; vomiting continued. Pain was very severe all over the abdomen. Was in a boarding-house, and wished to move to an uncle's on Stafford Street, in the west end of the city. Was allowed to move in the ambulance. As he was now too far away for Dr. Ross to give the attention required, the doctor advised the patient to secure the services of a neighboring physician. Dr. Ross diagnosed "acute peritonitis." Dr. Hunter first saw the patient on the 1st day of October—six days from the onset of the disease. I was called in consultation on the 2nd Oct., at 2 o'clock p.m. Found a patient with a pale, pinched, anxious, and distressed face. Hiccoughs were troublesome. Vomiting frequently. Bowels have not moved since the 28th, though he has been taking saturated sol. of salines, mag. sulph. and soda sulph. every 4 hours. Dr. Hunter says patient has been sinking fast since the 1st—even since he saw him in the morning. Complains of very great pain in right iliac region. We have no difficulty in mapping out a tumor, both by palpation and percussion. The upper margin of the tumor was more than an inch below an horizontal line meeting the anterior superior spines of the ilia. The maximum dulness was about two inches and a half internal to the anterior superior spine of the right ileum. Dr. Hunter and myself diagnosed a perityphlitic abscess. I introduced a hypodermic needle in supposed centre of tumor, but drew off no pus. Determined on operation; assisted by Drs. Hunter and Burt, I operated. Made an incision two inches and a half long, parallel to Poupart's ligament, over the point of maximum dulness; scratched a small opening into the peritoneal cavity, and introduced a finger carefully to feel for abscess. At once, without my being aware that the abscess was touched, the pus came welling out