the bladder, rectum, peritoneum, uterine appendages or uterus, and, lastly, surgical interference or appliance may do more harm than good, and inflammation result from this source.

From whatever source the disease may come, the cellular tissues of the pelvis being large in quantity and loose in texture, extensive spread of the disease is the rule, and recovery is generally slow.

A glance at the female pelvis will suffice. The uterus and its appendages (ovaries broad ligaments, Fallopian tubes, round ligaments), with the vagina in the centre, the rectum behind, and the bladder in front, are practically imbedded in the cellular tissue, which helps to support and nourish them, at the same time binding them to the pelvic walls, whilst the peritoneum covers all like a roof, sending folds down between the bladder and uterus, and between the uterus and rectum. Now, although as above stated, inflammation may be derived from numerous sources, such is the resistence of nature's powers to the attack of disease, that seldom do we have serious attacks of cellulitis save as a sequelæ of abortion or parturition, and then the symptoms are very much like those of pelvic peritonitis, with which it is often associated ,just as pleurisy and pneumonia accompany each other.

The first notice given of the disease is a chill, accompanied by rise of temperature, with pain over right or left ovary, followed (in puerperal cases) by lessening or cessation of lochial discharge, with a peculiar fœtid smell. The pulse is increased, and usually rises to 100 or 120. Vomiting may be present, but not often. Dysuria is often a prominent symptom. The pain may remain over the right or left side or it may spread, and pelvic or even general peritonitis result. In about one week from the onset, hardness is felt in one or both illiac fossæ, which gradually increases for some time, then one or two things happen; either the swelling or other inflammatory symptoms subside, and absorption takes place, with a general and rapid recovery, or the swelling localizes itself, pus is formed, and a pelvic abcess is the result, if in the meantime the patient has not succumbed to the severity of the disease. The length of time a patient may suffer from pelvic abcess is most variable, lasting for, from a period of six weeks to six months, one year, or even eighteen months, and then making a good recovery.

As to the frequency of the disease, I may state that it is not a common complaint in itself, and by itself, but as a concomitant of peritonitis, metritis, ovaritis, salpingitis, general septicæmia, or as a result of operative interference and surgical appliance, it is by no means infrequent. Of the idiopathic cases, most, if not all, are a result of septic absorption. In traumatic cases I believe, induced abortion is the most frequent cause. I have been able to secure a record of about 150 cases from my own practice, and that of Dr. Moorhouse, Niven, Eccles, and others, of the city of London. Of these five died, fifteen resulted in pelvic abcess discharging into the bladder, rectum, vagina, carpass, triangle, and right and left illiac fossæ, but none into the peritoneal cavity. The cause of death in all was exhaustion. Nearly all these cases of abcess were in strumous persons with a family history of pthisis or other scrofulous disease.

Now, as to treatment, I will simply give you my own practice in a typical case, knowing full well that there are many other methods equally good if not better. First and foremost of them all is absolute cleanliness, not only of the patient herself, but of the bed on which she lies, and of everything in the room or coming near her person. This is not only as a curative but as a preventative measure, and if the case is a puerperal one I use carbolic acid injections, one part of the acid to 60 or 70 of hot water; or sometimes bichloride washes, one in 5,000. These I use for two purposes: First, a disinfectant, and, secondly, as an emollient. Indeed, in all cases hot water injections afford marked relief to the patient.

Secondly, rest, absolute rest, if possible, of both mind and body is a *sine qua non* in the treatment of these cases.

In the third place I use turpentine stupes, followed by poultices, and about the third week a blister, to be again followed by poultices.

Fourthly, I use as medicine a pill of opium, calomel and quinine in the early and acute stages of the disease; following this generally with a tonic and supporting system of medicine, stimulants as required, and a diet suited to the exigencies of the patient and the stage of the disease. The bowels are occasionally to be well moved, either by a purgative or enemata.

In treating cases in which the abcess has formed