artistic single incision I should inevitably have cut through the bowels in several places, as indeed I once saw Olshausen himself do in a similar case. Even with this precaution I had difficulty in deciding when I had reached the peritoneal cavity. There was quite a thick layer of this organized lymph between the parietes and the omentum, but it was separated without much difficulty, when it became evident that the case was not localized in the appendages. In the right inguinal region there was a space the size of the palm of the hand where the omentum was not adherent, and the intestine could be seen to be covered with miliary tubercle. On the left side the omentum was very adherent to the abdominal wall right down to the inguinal region, but it was carefully peeled off until I was able to introduce two fingers down to the left tube as it came off the uterus. On attempting to lift the left appendages out in order to remove them, I found that they were in a broken-down and cheesy condition, the tube breaking off about three-quarters of an inch from the cornu. A few handfuls of caseous matter were then fished out; but the patient in her exhausted condition was too weak to bear any further prolonged manipulations without great danger, so the abdomen was carefully washed out with several gallons of sterilized hot water, a thin drainage tube was inserted, and the incision was sewed up with silk worm gut A single hypodermic injection of morphia was administered, but after that she had little or no pain, not even the pain in the left inguinal region which she had had for some time before. The temperature also came down from 103 to normal, and remained there for the two days the tube remained in, but gradually rose again after its removal. A few ounces of blood were removed with a sucker during the next forty-eight hours, when the discharge becoming serous the tube was removed. During the next week she had frequently gushes of clear, water-like lymph from the vagina. She made such a nice recovery after the operation that I began to hope that she might eventually be restored to health, but two weeks and a half later she suddenly had a hemorrhage from the bowels amounting to at least a pint of blood. From that time she rapidly failed, dying a week later and three and a half weeks after the abdominal section. A post-mortem was asked for, but refused.

Although the result was ultimately unsuccessful, there is a good deal to be learned from the consideration of a case of this kind. First, there was the insidious onset of the disease. The patient had been in fairly good health ever since her treatment by Dr. Birkett for some affection of the larynx, until a few months before consulting me, and even then she only had the usual symptoms presented in women suffering from lacerated cervix. In fact, had I not taken her temperature I would have had good reason to suppose that that was the cause of her abdominal pain, disturbance of digestion, etc. On the other hand, all the symptoms, the temperature included, pointed to typhoid in the second week. There was only one symptom partially missing, and that was the absence of pain and gurgling in the right inguinal region. There *was* pain there, but not so marked as on the left side. Then, again, after a period of defervescence during which the temperature remained several days normal and even below normal, the temperature arose as in a typhoid relapse, while the profuse hemorrhage from the bowels coming on three weeks later would have rendered this opinion more probable, had I not had the diagnosis of tubercular peritonitis made positive by the abdominal exploratory incision. Judging from the thickness and thoroughness of the adhesion, the disease must have been progressing for many months while the patient was going around and doing her work. Then, again, this point emphasizes the value of an exploratory incision as an aid to diagnosis in doubtful cases. Many cases of tubercular peritonitis are diagnosed and treated as typhoid. I regret very much that a large piece of caseous material which represented the left tube, and which I laid aside for microscopical section and examination for tubercle bacilli, was thrown away by the nurse. However, that might have been negative in its results, for it does not always follow that the bacilli will be found,—in fact, it is the exception to find them in undoubted cases of tubercular salpingitis. They are probably destroyed by the phagocytes, leaving nothing but the caseous debris of dead cells and bacilli. Another interesting question is this: Did the disease originate, or, to be more definite, was the infection introduced by the *genital* tract and carried up the vagina, uterus and tube to the peritoneum? or were the bacilli introduced from the *digestive* tract into the peritoneum and thence into the tube? Numerous cases of both these methods of infection have been recorded. Some maintain even that the spermatozoa from a tubercular husband may contain the bacilli; but the husband in this case was very healthy, and it seems unnecessary to fall back upon this hypothesis when there are so man easier ways for a woman to become infected. This may occur either with tuberculous sputa from her own or her husband's or her neighbors' lungs by means of her, his or their fingers or soiled handkerchiefs. In view of the fact that so many are so biased by the doctrine of the heredity of consumption that they cannot recognize its terrible infectiousness, it is rare that precautions against infection are taken. There are but few out of the thousands of tuberculous husbands, I fancy, who take the precaution of disinfecting their hands and penis before having sexual intercourse. According