was impossible without an anaesthetic. There was dullness on percussion over the flanks, and I detected free fluid in these regions by what I call the "staccato touch." To carry out this test the flank is struck lightly and sharply in a staccato fashion with the tip of the finger; if free fluid be present, the sound given out by percussed fluid is distinctly heard. There was no localized pallor of the external genitals, a physical sign which, when present, I have found of great value in the diagnosis of atypical cases of ruptured ectopic gestation.

Operation (September 9th, 1915).—There was a yellow discharge from the cervical canal, and on curettage I could detect no evidence of a decidua, only the "slimy" sensation of chronic endometritis being conveyed through the curette. I therefore ruled out ruptured ectopic gestation, but on opening the abdomen the cavity was found to be full of bright red fluid blood, and the case appeared to be clearly one of recently ruptured ectopic gestation. On freeing and drawing up the adherent left Fallopian tube (enlarged to the size of a finger), pus was seen to be issuing from its outer end. The involved tissues were so friable that the distal portion of the tube came away quite easily in my hand up to about an inch from the uterine cornu. The right tube was also much inflamed, so that double salpingectomy was carried out. Neither in the tubes nor in the ovaries was there the slightest evidence suggestive of ectopic gestation, nor could I discover any ruptured large vessel which might account for the flooding of the peritoneal cavity with blood.

When the blood had been mopped out from the abdomen very acute peritonitis was revealed, the intestines being intensely red, roughened, and marked with patches of yellowish lymph. The abdominal walls were unusually lax, so that by lifting them up we were enabled to bring the intestines into view right up to the costal margin. As far as we could see them, the intestines were involved in exactly the same manner as under the abdominal incision. The state of the patient now demanded prompt conclusion of the operation, so that the kidney pouches had to be left without special cleansing, but there was no more obvious free blood. No drainage was used.

After-Treatment.

The patient was placed in the Fowler position and saline freely administered. A few days later the wound suppurated and opened, and a quantity of blood poured out from the abdominal cavity through the lower end of the incision. It is to be noted that the parietal peritoneum had at the operation been found thickened, stiff, and friable, so that any blood which had not been mopped out from the abdomen, or which had poured out into it afterwards, would probably have a better chance of making its way out than if the parietal peritoneum had been normal. The patient made an excellent recovery.

The absence of serious symptoms in this case was very remarkable. It may be accounted for partly by the preliminary diarrhoea and partly by the large quantity of blood which escaped from the engorged peritoneal vessels in a case fittingly described as "acute general haemorrhagic peritonitis." The conditions found at the operation suggest that acute infective inflammation of the peritoneum is not *per se* nearly so serious as appears to be commonly supposed, and that, providing the focal factor and any free toxic fluid be removed from the abdomen, and that there is no paralytic ileus, the patient may recover with comparative ease from a most extensive acute infection of the peritoneum. In other words, in such a case, if the patient die after operation, she dies of the bowel rather than of the peritoneum. This being so, if the foregoing case had deteriorated subsequent to operation, I would have carried out caecostomy, taking care at the same time to swab out the bulk of the free blood which might have poured out into the abdomen.

To illustrate recovery from extensive acute infective inflammation of the peritoneum, another case of general peritonitis in my care in the Perth Hospital some years ago may be cited. The condition resulted from criminal abortion, and was part of a general septic poisoning. After about six weeks, during which marked diarrhoea was present, the patient, apparently on the way to recovery, grew drowsy and delirious, and died in a couple of days, after vomiting, ultimately faecal, had developed. At the autopsy universal peritoneal adhesions of rather recent date were found, while one of the peritonitic bands had strangulated and cut through into a loop of bowel, with resulting extravasation of faeces. But for this unfortunate complication the patient would undoubtedly have recovered from what had obviously been a universal infective inflammation of the peritoneum.

THE late Professor J. W. White, of Philadelphia, left estate of the value of £200,000. Among the bequests in his will is one of £30,000 to the University of Pennsylvania for the foundation of a professorship of surgical research, and another of £2,000 for prizes for resident physicians and nurses and for Christmas gifts to child patients.

A CASE OF PNEUMOCOCCIC CONJUNCTIVITIS.

BY

J. CROPPER, M.D., LIEUTENANT R.A.M.C.,
EYE SPECIALIST.

THE following case is of interest from the fact that the infection was pure—that is to say, no other organism appeared on culture—and for the short and satisfactory ending on treatment.

A. B., aged 45, a medical man who had previously suffered from a troublesome nasal and pharyngeal catarrh of the left side, was seized on March 18th with a well-marked conjunctivitis in the left eye. The eye was quite well the night before, but on the following morning there was not only pain and irritation, but a well-marked bead of pus collected at the inner canthus, and re-formed every fifteen or twenty minutes.

At 2 the same afternoon I was asked to see the patient; a swab was taken, and slides of the pus showed that almost every leucocyte contained one or more diplococcus. No other organism was seen, nor did any other grow in the culture.

As fresh eusol was not at hand, the eye was thoroughly irrigated with silver nitrate solution, grs. v to 3j (1 per cent.); the upper lid was well raised and the lower brushed with a swab of wool, the silver solution was *not* neutralized with salt.

The lids swelled up considerably, but next morning the pus had entirely ceased. Fresh eusol solution one-third the ordinary strength (that is, 0.16 per cent.) was dropped into the eye, and caused comparatively little pain. This was repeated the same afternoon, but caused considerably more inflammation and pain, the conjunctiva becoming somewhat injected and purple in colour.

At the patient's request and that of his friends I agreed—though with considerable misgiving—to discontinue the eusol and to use warm boracic douches four or five times daily. This produced excellent results, and a slide of the slightly purulent discharge next day—that is, on the fourth day—showed no organism whatever under the microscope.

I append a short report by the pathologist, Captain Rentoul, R.A.M.C., who very kindly examined the slides and made the necessary cultures.

Report by CAPTAIN RENTOUL.

On March 18th, 1916, I was asked to examine pus taken from a case of conjunctivitis. The smear on the slide showed pneumococcus in pure culture. Some were in the pus cells, but most were lying free. They all had marked capsules. The swab was used for planting out. Here, again, I obtained a pure growth of pneumococcus.

The interesting points to notice were:

1. So pure a growth of pneumococci in a direct smear.
2. So pure a growth on culture.
3. On the fourth day I again examined a smear and found no organisms.
4. The fact that severe cases of pneumococcic fever had occurred in the neighbourhood. In these cases the only symptoms were malaise, and a temperature of 102° to 104°, ending in a few days by crisis; in all these cases I grew a typical pure pneumococcus from the blood (5 c.cm.) and urine.

Having suffered for months from a similar attack of conjunctivitis I warned the patient not to be too sanguine about an early cure of his case.

I attribute our success to the early date at which suitable treatment was adopted. Had it been treated for a week with a weak boracic lotion it is extremely unlikely that either silver nitrate or eusol would have proved effectual, for as a friend remarked, the pneumococcus would have had time to burrow into the tissues, in fact, to "dig himself in."

The very thorough irrigation of the conjunctival sac was also of importance. It is too often thought that to evert the upper lid and paint it with a caustic is enough; the fornix is more important than the smooth upper lid.

To my mind the essential point is to be guided not only by the "clinical picture," but also by the pathological evidence at hand. Probably the eye was infected from the nasal duct.

My grateful thanks are due to Captain Rentoul for his ready help and advice.

SIR JAMES GOODHART left unsettled estate valued at £52,217.

THE Rockefeller Foundation has decided to establish a school of hygiene in Baltimore as an integral part of Johns Hopkins University. It is intended for the training of students in preventive medicine and public health work. Professor William H. Welch has been appointed director of the school, which, it is hoped, will be opened in October next.