very infrequent result of leaving the appendix. The second operation if required, is, as a rule, a safe one, but it is an operation, a thing which a patient once operated upon dreads, to say nothing of the chances of a fatal result.

Another very serious objection to simple incision and drainage in abscess cases, is the danger of leaving a second abscess unopened. It has probably happened in the experience of all operators, that at the autopsy a second abscess, unsuspected and unopened has been found from which the septic absorption which caused death took place.

In one of my recent cases, I was asked to examine a patient who was said to be suffering from a prostatic abscess. The patient gave no history of urethral or bladder disease. Upon examining per rectum the prostate felt normal as to size, consistency and tenderness, but above the prostate in the recto-vesical pouch a distinct fluctuation was felt. This together with a history of abdominal pain, of sudden onset, accompanied by nausea and elevation of temperature, led to the diagnosis of appendicitis. The abscess was readily reached through an abdominal incision, and the pus removed. Nothing was to be seen or felt of the appendix. Search being made for it, a second abscess was discovered situated behind and external to the cæcum and ascending colon, and the appendix was found lying in this second abscess and removed. It is highly probable that had search not been made for the appendix, the second abscess would not have been found and the patient would very likely not have recovered. Such experiences are not uncommon, and they lead one to hesitate, in recent cases, when advised to simply incise and drain.

The other point that I will mention is drainage in cases of septic peritonitis, local and general.

After the fluid has been removed from the peritoneal cavity as thoroughly as possible, how are we to prevent a re-accumulation. If one may judge from what one reads in books and medical journals, gauze, generally iodoform gauze, is very largely used by surgeons for this purpose. Others prefer drainage by tubes, glass or rubber. In my hands gauze drainage in septic peritonitis has never been satisfactory. I have dropped it again and again firmly resolving never to use it in another case. A few weeks or months later an article strongly advocating drainage by gauze written by some one in whom I had confidence would appear, and I would use it once more. But in each instance the same results would be obtained. The gauze would remove some of the most liquid portion, the serum, and leave the thicker part, the pus, behind, in the bottom of the cavity. I have used for drainage gauze prepared in many different ways, different