In a community like this—where there are so many hospitals—it would not be difficult to spend a few hours each month in the operating room. There you will have object lessons presented which will bear greater fruit than any sermon I can preach. Notwithstanding the fact that the literature on this subject has been most exhaustive, the experience of the average hospital surgeon will show that 40 per cent of cases presented for operations are suppurative, and twelve to fifteen per cent of the total present a general suppurative peritonitis. In this latter group there is no effort to wall off the product; the contents of the appendix are poured out into the "abdominal cavity," and are free to travel where they please.

Now, we may ask ourselves—after a study of over a thousand appendectomies—what the conditions are which lead up to the perforation in the greatest number of cases. Perforation into the "peritoneal cavity" occurs most frequently in the primary attack, and is due in a striking number of cases to the presence of a fæcal concretion which once established, increases in size until the lumen of the appendix is completely plugged, and the distal end becomes converted into a closed cavity. The rest of the story is a gangrenous and perforated appendix. In those cases I am positive that very often the first pain a patient experiences is when the rupture occurs.

The localized pain and tenderness, which is so characteristic, unmistakable and ever present, in non-perforative appendicitis, is usually very soon supplanted by tenderness and pain extending throughout the whole abdominal cavity. The patient complains of the left side just as much as the right and frequently greater pain just above the umbilicus than anywhere else. The insidiousness of the condition, from the time of perforation until well-marked general conditions show themselves, may be exceedingly misleading. In many cases a chart is not much use to us; in fact we might better throw it in the waste paper basket and trust to our physical signs, which will not deceive us very often if we only look well. Time and again I have found the patients with a happy expression; no pyrexia or circulatory disturbance; expressing themselves as being very comfortable, when the abdominal cavity contained quantities of pus.

The rupture of any of the abdominal viscera into the peritoneal cavity must always be looked upon as a grave condition. The higher up the rupture, if intestinal—the greater the risk, and the more fatal the issue, if unrelieved. The peritoneum, however, is more tolerant and resistant to pernicious influences than most of us suppose. An opening for drainage is all that it asks to work out its own salvation. The simple