were cases of perforation and general septic peritonitis. That the statistics of other observers do not give such a large percentage of previous attacks is possibly due to insufficient cross examination of the patient. Many patients as a matter of fact answer the question at first with a negative, but on a repetition of the question, admit freely that they have had attacks of pain in the same region before, adding frequently explanatory remarks, such as "but not nearly so bad as this time," or "I was only laid up for a day or so, not worth mentioning." It is a matter of general experience that the appendices of such persons show evidences of previous slight inflammation. Not only that but these same evidences are found none too seldom in patients who have denied all previous attacks.

The preponderance of the male sex is striking: males, 55; females, 15.

Chronic constipation or diarrhœa, chronic or acute indigestion, and over-exertion, usually inculpated in text books as ætiological factors, do not seem to have played in the present series any definite rôle.

With regard to the ætiological relation between concretions and perforation, it is worthy of note that of the 38 nonperforated cases concretions were found in 3, while of the 32 perforated cases they were present in 15, and of the 9 cases in which perforation led to a diffuse septic peritonitis, concretions were found in 7.

That the "onset pain" of appendicitis in general is typically "crampy" or "wavelike," as stated by some authors, does not seem to be borne out. It is very variable both in character and degree. The personal equation in the description of pain plays a very great rôle.

Chill is a rare event in all forms of appendicitis, even in those which perforate and go on to general sepsis. Nevertheless, it is possible that the slight indication afforded by the histories of the present series to the effect that in empyema of the appendix chilliness, at least, was present in half the cases—as one expects in conditions of retained pus,—it is possible, I say, that this indication if well worked out in future case reports, may become a diagnostic sign of some value.

That the totally or extensively gangrenous appendix before perforation may not infrequently be diagnosed, is generally allowed. Yet the signs given by some authors (e. g., Deaver) viz:—abrupt cessation of pain, fall in temperature, anxious expression of countenance, and increased pulse rate, were in the four cases of this series, with the exception of the last mentioned, largely absent. One point, however, which has been more especially noted in the present cases, and generally in the Royal Victoria Hospital surgical service, as indicating the probability of a gangrenous appendix, is the occurrence of a treacherous lull in the pain after a few hours of onset pain, the pulse rate, nevertheless, remaining high or going still higher. In this point, naturally, hospital