strongly advocated by one member. Harris, of the Policlinic, uses a very pretty method, the different layers being separately sutured with continuous bronze-aluminum wire. The ends of these are left long and folded over the dressings, and left in some cases for two or three weeks. I saw him use this method in a case of operation for the radical cure of hernia. Three weeks after the operation the wound was dressed for the first time and the wires removed. The patient had been g ing about for some days. The result certainly appeared to be excellent.

I did not see any iodoform or other powder dusted on a clean operation wound. Harris applies silver leaf and a few others collodion before putting on the dressing of plain sterilized gauze and cotton.

The management of appendicitis cases is always a question of interest to the general practitioner. I saw quite a few cases operated upon during the quiescent stage. In most of these cases the McBurney flap splitting method was used for opening the abdominal wall.

Of course the great advantage of this method is that it is almost impossible for a subsequent hernia to form at the site of operation. I saw only two or three patients operated upon while they were suffering from acute symptoms. If they do not get the chance to operate within the first thirty-six hours, I think most of the operators prefer to have the patient nursed over the acute attack, unless decided indications for operating exist. With regard to the medical treatment of these cases, Ochsner thinks that the main point in the treatment of peritonitis, due to appendicitis, is the withholding of all food from the mouth and feeding the patient by the rectum. He argues that nature's method of curing these cases is for the omentum and surrounding coils of intestine to crowd around the local lesion and shut it off from the general peritoneal cavity. As soon as the smallest amount of food has passed the pylorus, continuous peristaltic motion is at once established in the small intestines, and instead of assisting the omentum in preventing the infection of the general peritoneal cavity, this motion will serve to mechanically distribute any septic material with which the intestines may have come in contact. It does not matter how much or how little, or what kind of food is taken, it will always have the effect of starting peristallic motion of the small intestine. Even the lightest kind of liquid or predigested food may suffice to produce a sufficient amount of peristatlic action to carry infectious material over the entire peritoneum, and change what would have resulted in a harmless circumscribed abscess to a fatal general peritonitis. In other words, it frequently requires but a very small amount of food to kill an appendicitis case. It does not matter whether the patient suffers from catarrhal appendicitis, with or without a foreign