removed one not infrequently finds the veins of the mesentery lying alongside, and in a position to be easily infected.

The first case of appendicitis that I operated upon presented this condition. In Feby. 1884, I operated upon a young man, 19 years of age, for acute appendicitis on the 24th day of his illness. A large pericæcal abscess was opened and drained. He died on the 6th day after operation, and at the autopsy, performed by Dr. Osler, the mesentery was found forming the inner wall of the abscess cavity and the veins of the mesentery right away up to the liver were found full of pus, and the mesenteric glands involved.

In two cases of operations since that time, Dr. Wyatt Johnston has found a similar condition, pylephlebitis of the branches of the portal vein and liver abscess. One of these cases had been under treatment for a period of about six weeks for malaria before being brought to the hospital, the recurring chills and sweats being mistaken for that condition.

The question, then, what to do in abscess cases resolves itself into, what is the structure, condition and age of the abscess wall. The change in the form of the question does not however, lead to a more ready answer, although I think, it puts the question in a clearer light. These abscess cases call forth the operator's best judgment, and each case must be decided on its merits. I may say that at present I think that as a rule, in recent cases with easily separated adhesions, it is wise to remove the appendix and as much of the abscess wall as in the operator's judgment, can be removed safely, thereby removing the cause and insuring rapid convalescence, freedom from recurrence, and preventing disastrous seqelæ. In cases of long standing, that have lasted over a week, a more conservative course is, perhaps, wiser. The abscess walls are probably at that stage made up chiefly of a thick layer of fibrous tissue, which is not absorptive, or the patient is not in condition to bear a prolonged operation. Such abscesses are often prominent in front or latterly, are not in contact with the mesentery, and are not likely to give further trouble after being incised and drained. The fact that the patient is alive, a week or ten days after the onset of the disease, is evidence of the nature and composition of the abscess wall.

The objections to leaving the appendix, and being satisfied with incision and drainage are several. I have already mentioned the danger of septic pylephlebitis and thrombo-phlebitis. This condition is generally disastrous in its results and the early removal of the septic focus is the rational preventive measure that suggests itself.

Recurrence, due to septic centres being left behind is another not