umbilical, or sub-hepatic, but it is quite exceptional for it not soon to become localized in one spot, usually at or in the immediate neighborhood of McBurney's point. It is not only sensitive to pressure, but the pain is there always. The wall is tense, rigid, and the least pressure accentuates the muscular resistance. We may get iliac tenderness at the onset of typhoid, and sometimes this tenderness assumes the character of genuine pain, but it is more diffuse, less fixed, it is specially marked on pressure, and when it is sought for the wall remains supple. Gurgling, of course, signifies little or nothing.

We know that diarrhœa is by no means rare in appendicitis, and that it is especially common in the very grave septic cases. It is consequently a grave element of prognosis. But diarrhœa from the onset usually indicates the crisis of entero-colitis, in the course of, or following which, the appendicitis has developed. It may be very copious during the first few days, and this is unusual in typhoid, in which the diarrhœa as a rule only sets in after a preliminary period of constipation. We meet with every variety, however, and no hard and fast rule can be laid down, but the significance of this inaugural diarrhœa must not be lost sight of.

The insomnia, headache and mental depression may, of course, be merely due to the fever, and we must not forget that these symptoms occasionally assume a very grave aspect, closely simulating, in fact, the symptoms of typhoid.

We must be on the lookout for the other signs, which, however, may be lacking—epistaxis, rose-colored spots, which anyhow do not make their appearance until the eighth day; and the sero-reaction which, if positive, settles the question, but if negative, merely leaves it open.

Albuminuria is commoner and more marked in typhoid fever than appendicitis, and the presence of albumen early in the case is not without significance. Then comes the blood examination, and its value is extreme. In non-complicated typhoid fever hypoleucocytosis is the rule; in appendicitis, especially when tending to suppuration, we find hyperleucocytosis. The existence of this hyperleucocytosis is a fact of the greatest importance in assisting us to arrive at a correct diagnosis. In my case it oscillated between 19,000 and 28,000, and this result, in the ascertained absence of any pleuro-pulmonary mischief or other focus of inflammation, militated strongly in favor of appendicitis. Of course, numerous examinations of the blood will be necessary for this information to possess its maximum value, but when the hyperleucocytosis persists and increases *pari passu* with the local mischief, there remains no room for