tympanites, usually vomiting, tongue furred and inaction of the bowels. Added to these symptoms is generally an abnormal temperature.

A perforated gastric ulcer may be mistaken for appendicitis. Here there is usually a history of indigestion with perhaps vomiting of blood. There may be dullness in flank changing with position of patient. There will be general abdominal distension with rigidity and a loss of liver dulness, and vomiting will be early, be brown or stercoraceous.

An intestinal perforation will be similarly differentiated excepting for the preceding history, which will be one of intestinal disease or typhoid fever. Occasionally appendicitis occurs during the course of typhoid fever.

An obstruction of the bowel is usually preceded by a history of constipation. The temperature and pulse are not as in appendicitis, and the differences in pain and tenderness are important. Then, there is the fæcal mass as evidenced by an area of dulness.

Volvulus and intussusception are sudden in onset, but fever is delayed if it appears at all. Vomiting is generally more persistent. There is lack of a definite tender spot. The degree and area of tympanties is suggestive, and in intussusception there may often be felt a tumor, while the frequent attempts at defæcation resulting in the passage of a little bloodstained slime is all but conclusive.

Lead colic differs in the absence of fever, rapid pulse, tenderness, while generally there is a history of exposure to lead poisoning and obstinate constipation. The blue line at the edge of the gums may also be observed.

Acute indigestion has no abdominal rigidity nor tender point. The patient throws himself about. In most cases there is absence of fever, while there is perhaps a history of neglect of the bowels or injudicious feeding.

Bilious colic has generally a previous history. There may be a report of the taking of improper food. The tenderness will be over the liver and gall bladder. The subjective pain is from gall bladder to epigastrium. A pain at the right shoulder is frequent. Fever is usually absent in early stages. If there be fever it is generally preceded by chills. Vomiting is usually persistent.

Renal colic is not accompanied by rise of temperature or the pain and tenderness of appendicitis. Frequency of micturition with burning in urethra and aching and retraction of testicle is characteristic. The pain on pressure if it exists is over the kidney or ureter. There may be blood in urine. Vomiting may occur, but is less frequent than in appendicitis.

Colitis will be marked by colicky pain and mucous diarrhœa. It has not the sudden onset, pain or tenderness accompanying appendicitis.