for numerous adhesions and, perhaps, much confusion in the anatomy of the part. As a rule, the process will be found behind the cæcum pointing upward and toward the left, or else downward into the pelvis.

The more firm adhesions should be cut, not torn, large, flat sponges used to shut off the field of operation from the general cavity, and bleeding arrested at once, by ligature, if necessary. If the process have a mesentery it should be ligatured in sections and cut and the appendix removed after clamping close to the cæcum. The mucous membrane of the stump should be then drawn out and ligated, then carefully inverted into the cæcum. The remainder of the stump may then be buried by a few Lembert sutures taken in the adjacent wall of the cæcum and crossing the face of the stump, thus effectually covering it. The further protecting of this danger point by stitching to the site some loose portion of omentum or mesentery I have not tried.

I have not spoken of the difference between recurring appendicitis and the relapsing appendicitis described by French writers, because it must be often difficult to define and would not materially alter the treatment. Nor have I mentioned the differential diagnosis between appendicitis and other diseases in the locality, such as malignant disease of the ileo-cæcum. Here, at least, exploratory incision would be called for.

The following case may be of interest :

Mr. B., a young married man, æt. 28, has had numerous attacks of appendicitis, extending over a period of 12 months, These would come on suddenly with severe pain in the region of the appendix, followed by elevation of temperature, tenderness in McBurny's point and every indication of local peritonitis. The attacks would last for about a fortnight, during which the patient would be entirely unable to follow his business (that of a miller), and would be in bed most of the time. The attacks became worse and more frequent until the patient greatly dreaded their return, and began to look upon himself as little better than a chronic invalid. His physician, Dr. Niddrie, of Creemore, urged an operation for his relief. This was consented to, and the doctor asked me to go up and operate, which I did on the 12th of the last month. I found the patient otherwise in excellent health, but anxious for any operation that would relieve him from his enemy. As all symptoms of the last attack had subsided, I found indistinct evidence of tumor upon deep pressure over the appendix. Relying confidently upon the diagnostic acumen of the attending physician, I unhesitatingly complied with the wish of the patient and proceeded with the operation. The cæcum was adherent to the anterior wall, and the peritoneum was opened above and external to it when the adhesions could be readily separated. The appendix was found adherent throughout to the posterior wall of the cæcum, and doubled upon itself like the letter V, and considerably enlarged, the distal end especially so.

Yesterday the doctor wrote me as follows: "The temperature on the day following the operation reached 99·4°, on the second day, 100.2°, on the third, 99.1°, on the fourth, 99.1°, on the fifth, 99.3°, and on the sixth, 100.3°, after that normal. Diet for first four days, nothing but buttermilk and cracked ice, then allowed some chicken broth ; at the end of a week allowed some fish, eggs, etc. Administered no sedative but morphia hypodermically. On the sixth day after the operation gave two enemeta of soap and water, followed two hours later by an enema of glycerine. This resulted in a copious evacuation, which entirely relieved the tympanites from which he had been suffering several hours prior to the enemeta. Removed the stitches ten days later. Wound perfectly healed. Patient feels splendidly."

Selected Articles.

INTRA-UTERINE MEDICATION.

Before the antiseptic era this treatment had been associated with various kinds of dangers. The simple passing of the sound had frequently given rise to grave infection, and even fatal peritonitis. A change had taken place with antiseptics, but danger had not yet been excluded, and the consideration was laid on the duty in passing the uterine sound, of proceeding with the greatest caution, and of using it as little as possible. It was less used by most gynæcologists since the introduction of the bimanual method. The proper thing to do was to first disinfect the vagina thoroughly. This could not always be carried out in private practice, but in serious cases it was necessary. The sound should be