fixed in its position. If, on the other hand, it be large, not firm, superficial and movable, its bearing on the site of the initial disease is of a general character only. When present, according to Fitz, tumor is detected by palpitation from the first to the eighth day of the attack inclusive. In 24 cases, it appeared in one on the first day; three on the second; four on the third; two on the fourth; four on the fifth; five on the sixth; four on the seventh; and in one on the eighth day.

The third, fifth and sixth days are noticed to be the most prolific ones. Tumor may be present early and yet be not detected till later in the disease, owing to its obscure position. As, when associated with a diseased appendix that is located behind the cæcum (22 per cent.); when placed behind the colon (2 per cent.); when extended into the pelvis of the intra-pelvic portion to the diseased part (14 per cent.); with a tympanitic cæcum, and with general tympanitis irrespective of its location. In the intra-pelvic cases tumor may be detected often there and not elsewhere, by rectal or vaginal examination. Still, in these cases tumor may escape the vigilance of the closest scrutiny. Owing to time limit I have dwelt only on the leading cardinal symptoms, leaving consideration of the rarer and more curious manifestations for another time. In closing, permit me to submit the following conclusions for your consideration:

(1) That the location, direction and extent of the appendix have an important bearing on the clinical history of appendicitis.

(2) That the well recognized variations of the appendix in length, direction and location, and the varying site of the cæcum and of the seat of the disease of the appendix, make the establishment of a definitely seated diagnostic point of tenderness unwise and misleading.

NOTES ON A CASE OF BILIARY CALCULI.

BY SURGEON-MAJOR G. T. ORTON, WINNIPEG, MAN.

Feb. 10th, 1894.—Was called in consultation with Dr. S—— to see Mr. H——, residing some 80 miles from the city, whom I found much emaciated and extremely jaundiced. Pulse normal, 70; temperature, 97½; tongue only slightly brown, coated at back part; bowels occasionally loose, at other times costive, motions clay-colored and devoid of bile, complained of dull almost constant pain, referred to pit of stomach, with occasional paroxysms more severe, causing him to double himself up to get relief and at times a sharp pain shooting up the spinal cord from the usual seat of uneasiness, which made him feel very sick and faint, latterly had required one or two pills of ¼ grain morphia to procure ease and rest. Appetite somewhat impaired, but considering his appearance fairly good, and digestion not bad; urine loaded with bile.

History of Case.—Had suffered dull pain and uneasiness, always referred to the stomach, for over 12 months. Had been treated for dyspepsia and gastrodynia until about a fortnight before I was called in, when he was somewhat suddenly seized with great pain and uneasiness over kidneys, and burning soreness in voiding urine, which became very high-colored. He then consulted his medical adviser, who placed him under appropriate treatment for suppression of bile and consequent renal and cystic irritation. Not proving amenable to treatment, Dr. S. desired a consultation, fearing grave results, and uncertain as to true diagnosis of the case. From his knowledge of the case, and its history, he very reasonably suspected malignant disease either of pyloric end of the stomach extending to the duodenum, and involving orifice of the ductus communis cholidicus, or of the liver itself, extending to gall bladder, with cystic and hepatic duct also affected.

Upon palpation we both felt two nodules, one larger than the other, at lower margin of liver, and also detected considerable enlargement of that organ. I was inclined to agree with Dr. S., that the indications were highly in favor of his view, that it was scirrhus or other malignant disease of the liver, and the more so from the sharp lacinating pains shooting to spinal column. However, I thought it just possible that it might be chronic hepatitis, with some cirrhosis in neighborhood of gall bladder and the hepatic and cystic duct, which had become involved and occluded from catarrhal inflammation, or possibly, notwithstanding the absence of the usual attacks of severe colic, it might be impacted gall stones. We decided to try and reduce any hepatitis and procure absorption of any effused lymp by appropriate external and internal means. Being far from