

generally gangrenous. These form a large proportion of the tumor cases—the sausage-shaped tumor of former times—the cases which were considered before the days of abdominal surgery to be impacted, inflamed cecums. Of this class my list contains thirteen cases. The appendix was removed in every case, and all recovered.

*Class 3.*—Acute non-perforating cases, each presenting different pathological conditions as detailed. Many of these cases presented conditions of the appendix which no doubt would have been temporarily recovered from; in many cases, on the other hand, with slight symptoms, hardly any acceleration of pulse, and only slight elevation of temperature; or again, with all the symptoms positively subsiding, an appendix on the verge of perforation, or with gangrenous interior or stenosed and full of septic pus, has been exposed as the result of operation, making one only too thankful that the damaged organ has been looked at, and the condition of affairs plainly and beyond all doubt threatening the life of the patient demonstrated, and at the same time made amenable to common-sense treatment. Of this class there were 42 cases, with 41 recoveries and one death—No. 22. I believe in this case I failed to remove the whole of the damaged portion of the appendix, and the necrotic process extended to the cecal wall afterwards, hence the failure to save this case.

*Class 4.*—The general septic peritonitis cases from perforation of the appendix into the general peritoneal cavity with no limiting adhesions, the class of cases in which all surgeons expect to have fatal results, death occurring not so much from the peritonitis but rather from general septicemia from the absorption of the septic products of the peritoneal inflammation.

Beyond all doubt the chief factor which determines whether the patient will live or die in such a case depends upon the *time* at which operation is performed after perforation has occurred. I am inclined to think also that the character of the fluid found in the peritoneal cavity greatly influences the result. My opinion is that if the fluid be purulent, other conditions being equal, there is a fair chance of recovery. I think the condition of the appendix determines the character of the peritoneal exudation, and in this class of peritonitis case I have most frequently found the appendix perforated from ulceration of its interior. On the other hand, where the peritoneal cavity is full of thin, dirty-colored, stinking, serous fluid, the outlook is exceedingly bad. This condition of things I think will be found most frequently in connection with a perforated gangrenous appendix. One can easily imagine the thinner fluid more easy of absorption and containing more deadly toxins than that of a more purulent character. Of