In answer to the first of these questions many American surgeons have urged the operation at the earliest possible moment after the diagnosis of the appendicitis is even reasonably clear; while the more conservative practice in European countries has been to wait until the presence of pus has been defined. In this country the latter method is, I believe, generally favored. Arguments may be advanced in favor of both views, but as my paper threatens to become quite too long for your kind indulgence, I shall dismiss the early operation entirely (trusting to hear its advocacy in the discussion) and say just a word in defence of the later incision.

The great objection that has been urged against this method is the danger of perforation of the abscess into the general peritoneal cavity. Now the appendix being entirely surrounded by peritoneum the abscess is intra-peritoneal at first, but is shut off from the general cavity by inflammatory adhesions through which the pus must penetrate before invading the peritoneal cavity. I think experience will bear me out in saying that this is an incident not likely to occur earlier than the fourth or fifth day of the disease. Besides, this is not the only avenue of escape for the pus. It may, and has, burst into the bladder, the adjacent intestine, or through the anterior or posterior abdominal wall, and thus a spontaneous cure may result. Although this is not the most desirable termination of the disease, yet we should consider its possibility before resorting to the too early use of the knife.

I would also remind you of the difficulties in the way of making an absolutely certain diagnosis, and of the fact that appendicectomy is not a trifling operation to be lightly undertaken by the general practitioner. For these reasons, while the possible necessity of a very early operation in the more acute cases should not be lost sight of, it seems to me the preponderance of evidence is in favor of judicious and watchful delay.

In answer to the second question, viz.: how to operate, there is more unanimity. The incision should be over the cæcum, parallel with, and one and a half inches above, Poupart's ligament, three or four inches long, terminating externally to the deep epigastric artery. Should any evidence exist of adhesion to the anterior abdominal wall one extremity of the incision should enter the peritoneum outside the dull area, otherwise the bowel may be wounded. Indeed the whole incision may be made at a higher level if there be an extensive dull area. When the pus cavity is reached, infinite care should be taken to avoid breaking down adhesions. With this object in view, no rough handling of the parts should be indulged in for the purpose of finding the offending process. Should it be readily discovered, it may be ligated off close to the cæcum and removed. The abscess cavity should be carefully washed out, a drainage tube inserted and the wound closed. Liquid diet in small quantities. Bowels restrained for six days, then opened by enema.

Now, briefly in reference to the third class of cases, viz,: those of relapsing appendicitis. Here, too, the appendix is the offending member. It is true we do meet with recurring attacks of typhlitis due to accumulation of fæces in the cæcum, but each of these cases is in its nature primary, and obviously due to constipation or errors in diet, and the attacks do not tend to increase in severity. They are, in short, avoidable cases with a more or less distinct history as to cause. The pathological condition underlying true recurring appendicitis, however, is, as a rule, some abnormal position of the appendix. It has become twisted or bent upon itself and has become fixed in the position by adhesions, and its lumen has become either greatly narrowed or entirely shut off from the cavity of the cæcum. The natural secretion of its mucous membrane accumulates and distends the process, with the result of a local peritonitis, which gradually passes away only to recur on exposure to cold or slight injury, or even without any apparent cause. The attacks are apt to increase in severity until finally the patient dies or is obliged to consider himself a chronic invalid. Here there is little tendency to suppuration, and we may wait for complete subsidence of an attack before resorting to the use of the knife. The question as to how many attacks should qualify the patient for the operating table is a difficult one to answer. Each case must be decided upon its merits, and the patient himself must assist in the decision. Certainly, if he has had two or three attacks of increasing severity one should no longer hesitate. Then an incision of three inches in length may be made in the usual position and the appendix sought for. We must be prepared