what was equivalent to that, opening into the cavity, the collection of pus having been shut in by adhesions so that the general peritoneal cavity was not invaded. In the first operation, he tried to get into the abscess cavity, through the first incision but his finger was unable to reach it. Then he operated directly over the point of greatest prominence, but that he must have been near the cavity in his first exploration was shown by the fact that it began to drain from that opening within twenty-four hours.

In the second case he varied from the rule of incising over the point of greatest tenderness, near the umbilicus, but he made an incision far back near the crest of the ilium, an oblique incision, near the lumbar region to get down to the side of the colon. He expected on account of the condition of the lower part of the abdomen, and the iliac fossa that the abcess was behind the colon where it proved to be. It was what had been called a lumbar typhlitic abscess. Opening the peritoneum in that position, he found himself in the free peritoneal cavity so that in operating he traversed the cavity. This was a dangerous proceeding but it was not necessarily fatal. The cavity was preserved in this way; there was a degree of tension in the abdomen always existing. There was a tension from within outward. If one opened into an abscess and made pressure on the upper part of the abdominal cavity, this continued to make the tension from within outwards. He thought the fresh pyogenic germs falling on the wounded surface, if immediately washed off, did little or no harm. It was when the germs had sufficient time to work beneath the surface and enter the mouths of the lymphatics that the almost irreparable damage was done to the peritoneum. He thought in this case it was unwise to hunt for the appendix or break down the adhesions. He was satisfied with irrigation and drainage. In the second case, of course, he removed the appendix, as it was easily got at.

Dr. Grasett said he thought McBurney's point should always be looked for. If in a certain case the point of greatest resistance and tenderness did not lie in that position, it would be noted somewhere else, as in the two cases reported, in the vicinity of the bladder and kidney respectively. A careful sifting of the other symptoms would help to make the diagnosis clear. The point of greatest difficulty was to know when to operate. He found himself in a very grave quandary in regard to this point.

Dr. Geo. A. Bingham said the question of when to operate was a most important one. We had three methods before us: the modern American one of removing every appendix that came within sight; secondly the conservative English one of waiting for the formation of abscess; and the intermediate one, which he thought was the proper method, first of making a diagnosis and then having the patient under constant supervision until symptoms pointed out the necessity for operation. If the symptoms indicated an increase in the inflammatory condition, or if they indicated a lowering of the condition of vitality, operation should be done at once. If a temperature of, say, 103° or 103½° for several hours with a fairly rapid pulse drops a degree or two suddenly, that was an exceedingly important symptom, and if these symptoms became grave, operation should be done at once. The tenderness of the McBurney point he believed to be due to the fact that the nerve supply was greatest at the junction of the appendix and cæcum. As this was a movable spot the point of maximum tenderness might not be found on or under that spot on the abdomen that carries the name of McBurney.

Dr. Merritt, of St. Catharines, referred to four cases he had recently seen, two of which he had operated upon. They were all different. He had found it difficult to decide just when the moment had arrived when he should operate. He had never found much difficulty in diagnosing the condition. The question of operation in places where expert help was not at hand was one of greater moment than in the large cities where consultation and operation could be secured in a very short time. In one of the cases he had not removed the appendix, for which he had been chided, but he was pleased to know in doing this he was in accord with the views of the leader of the discussion.

Dr. Carstens, of Detroit: I think the only proper place for the appendix is in a bottle of alcohol. (Laughter) It is a very difficult question to decide when to operate and when not to. I think as one's experience increases the more he will gravitate to the opinion one should operate as soon as the diagnosis is made. The many lamentable cases I have seen as a result of procrastination makes my heart ache to think of. I feel like a sinner when I think of my conservatism.

He had seen cases where the temperature and pulse were diminishing and the patient seemed to be improving; he would wait till the next day. But in 24 hours the patient was dead. He had had this experience over and over again. There was very slight danger in cutting down and taking out the appendix before it ruptured. Ordinarily there was no trouble in making the diagnosis. It was wonderful how many cases physicians would see as soon as their attention was called to it. He had been called out to a case in Michigan by a practitioner who had had seven or eight cases during the summer. Ten years ago he never had a case. The cases then died of idiopathic peritonitis; and "The Lord's will be done" was the consolation. The speaker thought there was not one case in a thousand of idiopathic peritonitis Richardson had shown that out of every one hundred