organ becomes a pathological exhibit. If it seems to have returned to its ordinary size and sensation—and we cannot deny its power to recover at times—it should be considered normal and left alone.

The preparation of the patient is quite as important as the operation itself; and, in this matter, surgeons of recognized ability differ greatly. This subject is too extensive to receive even a hasty review now. I wish, however, to enter a protest against excessive purging with calomel and salines. One or two free actions of the bowels, each day for two days, will insure the absence of distention; and this may be obtained by mild cathartics taken at bedtime. Purgation before operation causes paralysis of peristalsis after operation, depletes the fluids of the body, and produces excessive thirst, lengthening the period of convalescence, which should not be more than two weeks in uncomplicated cases and may be only five or six days, provided the patient has fairly good recuperative power.

The kind of incision and its position can easily be determined, if we can locate the appendix.

McBurney's muscle-splitting operation will suit nearly all cases. This incision can be enlarged by separating the muscular fibres in their normal direction behind the rectus muscle, almost to the median line, as suggested by Fowler. The smallest incision that suffices for satisfactory work, gives the best results. From $1\frac{1}{4}$ to 2 inches, according to the thickness of the abdominal wall, is ample for uncomplicated cases, provided the appendix is located and the opening made immediately over

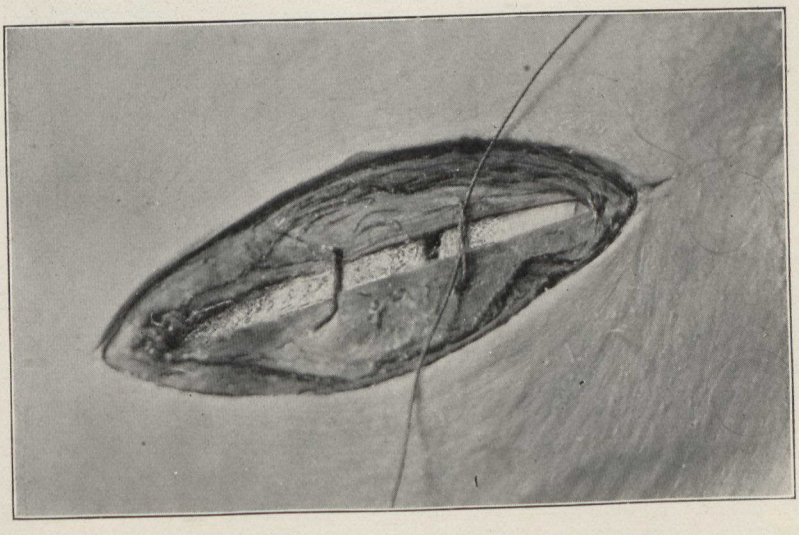

FIGURE SHOWING THE SUTURE PARTIALLY TIGHTENED