was found hanging over the brim of the pelvis, and it was in a gangrenous condition. It was folded up on itself, the perforation was situated within the fold and could not be seen until the parts were dissected out; to the feel, the appendix was normal. There was a great quantity of lymph on the intestines, and in the true pelvis the folds of intestines were glued together in every direction.

DR. SHEPHERD remarked that, although he had examined the appendix at the time of the operation with his fingers he had not seen it, and that this case taught him that in cases of general peritonitis the appendix should always be examined by sight, even if the history and symptoms of the case do not point to this part as being the origin of the affection. If the cæcum and the appendix cannot be brought to the surface at the median incision, they should be examined through an incision made in the left iliac fossa. The position of the appendix, viz., pendant in the cavity of the pelvis, explained in this case the absence of local symptoms; although the pelvis was examined before operation per rectum, nothing was made out. Dr. Shepherd also remarked that in these cases of perforating appendicitis in which the peritonitis was diffuse from the first operation, gave much less hope of cure than when there was from the outset a distinctively localized area of inflammation, characterized by the existence of a tumor.

DR. ROSS urged strongly the importance of early laparotomy in these cases, and said that operation should not be postponed beyond the third day. In this case, operation was not undertaken until the end of the fourth day, and consequently but little good could be expected from it.

DR. RODDICK asked Dr. Shepherd whether, if he had recognized the lesion in the appendix, he would have excised it, and would the result have been different.

DR. MILLS said that the position of the appendix was peculiar and might have caused a diminished circulation and finally strangulation; there was no doubt that the position favored the necrotic process.

In reply to Dr. Roddick, DR. SHEPHERD said that if he had made out the gangrenous condition of the appendix he would have excised it, but that he did not think this would have had any influence on the result.

DR. HARVEY, of Calcutta, made a few remarks on the objections to laparotomy prevalent among the natives of India, and said that it was very rare to get a native to consent to any new operation. He related a case which had come under his observation, of perforation of the appendix due to a lemon seed.

DR. WM. GARDNER related a case in which he had lately performed.

ABDOMINAL SECTION

at the request of Drs. Rodger and England. The patient was a lad aged sixteen, who suffered from severe abdominal pain and vomiting a few days before; this was relieved by morphia, and in a day or two he was able to return to his work. When seen by Dr. Gardner he had very severe abdominal pain, vomiting, constipation, and marked distention of the abdomen. There was also an elastic swelling the size of a duck's egg in the region of the right inguinal canal. On examining the scrotum only one testicle (the left) was found. There had been a suspicion of strangulation with peritonitis, and the patient had been put under ether without result. So it was decided to open the abdomen, and this was accordingly done.

An incision was made long enough to admit two fingers; on incising the peritoneum a quantity of turbid serum escaped. All the ordinary hernia regions were examined and nothing found. The swelling in the inguinal canal was in the abdominal wall and extra-peritoneal; nothing else being found, the wound was closed.

The symptoms were much relieved for three or four days, then the abdominal distension began to increase and became very