tions, articles appear on what Mr. Treves, the author, prefers to term perityphlitis—in reality appendicitis. The article in Allbutt's "System of Medicine" has been re-issued as a monograph by the author, thereby emphasizing and re-iterating the views expressed.

I confess I have been astounded at the views advanced in these articles as regards treatment and other points, and after laying before you the series of cases which have come within the range of my own knowledge and operation, I will make some criticisms and comments on these two articles, as in this way I shall perhaps more plainly place before you my own views concerning this disease.

The cases which comprise my list have been operated on in St. Joseph's and the Jubilee Hospitals of Victoria. In no single instance have I refused to operate because of the desperate and apparently hopeless condition of the patient. The cases constitute, without selection, all those which have come to my notice from 1893 to the present time. It is not my intention to read an exposition on appendicitis, but rather to give my personal impressions on the subject.

Analyses of Cases.—The list shows that I have operated on 105 cases of appendicitis, with 99 recoveries and six deaths.

From a surgeon's point of view there are five distinct classes of cases in the accompanying list, viz.:

Class 1.—Abscess cases, the pus lying immediately in contact with the peritoneal peritoneum, walled off from the general peritoneal cavity by adherent intestines and omentum. These cases require only direct incision as a rule, washing out with some antiseptic fluid and drainage, no attempt being made, as a rule, to remove the appendix. Of these there were six cases, five of which recovered and one died. The death was No. 15 of the series, readmitted as No. 24, as an abscess case.

Class 2.—Cases which some surgeons, for convenience sake, term *post-cecal* abscess cases. The abscess is generally in this position, though in one case of the series it was in the pelvis in contact with the right ovary and tube, and in another case the pus was walled in by the side of the cecum by small intestine and omentum—intraperitoneal abscess would be a more correct term to use, though not strictly so, but serving to distinguish this class of case from abscess in contact with the parietes. In operating on this class of case the general peritoneal cavity is of course opened, the abscess is, as a rule, situated behind a much thickened and inflamed cecum—the cecum I have always found empty—the appendix lies in the abscess, is of course the cause of the abscess, and I have always found it perforated and