In the course of a few hours the pain will become localized to the region of the appendix and there will then be rigidity of the right rectus over this area. A diagnosis should be made in the majority of cases within twenty-four hours.

The most important of these symptoms is the pain, and when it is very severe in character is usually indicative of a serious form of the disease. The pain usually subsides gradually, but when it subsides suddenly, within the first thirty-six hours, it is of serious import and may be due to gangrene of the appendix, rupture of the appendiceal wall, or to infectious material passing from the appendix into the cæcum.

Secondary pain, that coming on after the first thirty-six hours, is not of a colicky but an inflammatory type, and is due to the involvement of the structures around the appendix. Severe pain after the primary subsidence of pain, is generally due to the beginning of peritonitis from perforation.

As regards temperature—it may be two or three degrees above normal, but I have had several cases in which the temperature was never above one hundred and yet found a gangrenous appendix at operation. After the initial rise of two or three degrees it may drop to ninety-nine or even normal where the appendix has become gangrenous: therefore, the temperature is not a reliable guide as to the condition of the patient.

As to pulse—it is generally increased in frequency, but it is of little or no value in making a diagnosis.

I would now like to make brief reference to some of my cases. I have operated on two-hundred cases in the interval without a death. In another two hundred cases the operation has been done during the acute attack and at periods varying from twelve hours from the beginning of the attack to three weeks and in one instance five months. In this series I have had in all fourteen deaths, *i. e.*, a mortality of seven per cent. In eleven of these cases there was general septic peritonitis, and one of them had been ailing for five months and was thought to be suffering from typhoid fever. When I operated on her, quite half the abdomen was filled with pus and she was suffering from septicemia. After the evacuation of four or five quarts of pus she improved somewhat, but lived only about a month. This case would probably have been saved if the diagnosis had been made even within the first month.

Case 2—The patient had been ailing for three weeks with what was supposed to be typhoid fever, but eventually a mass appeared in the abdomen. and he was sent into the hospital under my care. His tongue was dry, brown and thickly coated, and he had a very fetid breath, temperature 104, pulse 130, with a large swelling on the right side of abdomen. He was too weak to take a general anesthetic, so I opened with Schleich's solution of cocaine and evacuated about two quarts of pus. He