which he thought presented sufficient special characteristics to make them worthy of attention.

The first case was that of a young man aged 21. He was taken ill for the first time with symptoms of inflammation in the abdomen. In ten or twelve days he, the essayist, was called to relieve him surgically, the medical attendant having satisfied himself that the patient was suffering from inflammation or abscess of the appendix.

The case was an extreme one, life being in great danger. The abdomen was distended, especially in the lower zone, the point of maximum expansion and resistance being about 1½ inches to the right of the middle line and close above the inguinal canal. The whole surface of the abdomen was resonant on percussion. He dare not palpate with any freedom. Suspected the case was one in which the abscess was in the pelvis; a digital examination of the rectum confirmed the suspicion. In view of the general resonance, it became a question as to where the incision should be made. Finding some slight resistance just above the anterior superior spine of the ilium, I made a small incision through the abdominal wall and found the intestine adherent to the peritoneum. The finger was passed behind in the iliac fossa, downward over the brim of the pelvis, just beyond the pulsating iliac vessel. Did not reach the abscess. He felt the danger was too great to persist further from that point. He then opened, according to the usual rule, at the point of greatest prominence beyond the inguinal canal. Found the small intestines agglutinated, forming the roof of the abscess. By carefully insinuating the finger between the abdominal and pelvic wall, and at the same time approaching the general peritoneal cavity by pressing the anterior wall back against the viscera, he found his way into a large abscess, from which ten or twelve ounces of fœtid pus escaped with great freedom. Exploring the cavity with the finger, he found that the small intestines had been completely lifted from the pelvic basin, the bladder and the rectum forming the pelvic wall. He washed out and drained, and an uneventful recovery followed, except that after 24 hours the abscess drained partly from the first opening, and the first opening was the last to close.

The second case was also a young man about the same age. It was a primary attack and had lasted seven days before the attendant made up his mind that operative procedure was necessary. The patient then was in an extreme condition seeing that a very large amount of septic absorption had taken place. He opened over the point of greatest prominence, resistance and tenderness, about two inches to the right of the umbilicus.

The whole area of the abdomen was resonant on percussion. There was no resistance in the right iliac fossa above Poupart's ligament. Here again he thought the peritoneal cavity would have to be traversed, believing the abscess was behind the colon. He opened the point of greatest prominence above the crest of the ilium, behind the anterior spine, making a short, oblique incision and he found again a free peritoneal cavity. Lifting the small intestines and the omentum, he found the colon and cæcum lifted forward by the pus. The reflection of the peritoneum from the colon to the posterior abdominal wall was protruding, and formed the abscess wall. Was opened fully. The general peritoneal cavity was protected by pressing the anterior abdominal wall against the viscera. Exploring the cavity, he found a gangrenous slough which came away and which was probably the extremity of the appendix. By careful examination, found the appendix lying close beside the cæcum and beneath the peritoneum. The patient made a good recovery.

Dr. Teskey said that he wished to refer to one or two points in connection with the cases. First, as to the delay in diagnosis. Those in the habit of meeting a great number of cases of abscess in the appendix, had very little difficulty in diagnosing the condition almost at its very commencement. But there was a large number of physicans whose attention was not fully drawn to this disease, who let preliminary symptoms pass over, the case becoming an extreme one before the surgeon was called to his assistance. As to the cause of delay in the diagnosis, in certain cases it was due to the absence of a certain feature which was spoken of as being constant in appendiceal inflammation—McBurney's point, midway between the umbilicus and the anterior superior spine of the ilium. However ready we might be to acknowledge that point as being the tender point in connection with the disease, it was not essential to inflammation of the appendix. Very frequently the tender point was not located in that vicinity but some distance from it. In one of the cases he reported, it was low down near the mid line, above the inguinal canal. The attending physician for a considerable time thought he was dealing with an inflamed bladder, there being frequency of micturition. The case was allowed to go on because too much stress had been put upon McBurney's point. In the second case there was no special tenderness in the iliac fossa nor any especial fulness nor resistance. It was two or three inches behind this. In this case the physician overlooked the nature of the disease, believing he was dealing with some kidney trouble. Another rule laid down was that the spot of greatest prominence and tenderness in the place in which the incision should be made. He said it may be found necessary to deviate from that rule in certain instances. Wherever abscess had been diagnosed in the abdominal cavity, it was wise, if possible, to relieve the condition by a sub-peritoneal operation or,