ness should be used, otherwise a stinking septic abscess or a much damaged appendix may be ruptured into the peritoneal cavity. I generally, if there is any indication of the existence of such condition, pack round the cecum with plenty of sterilized gauze, thoroughly coffer-damming off the peritoneal cavity, and then very carefully make my search. If I come upon pus, as it oozes out I rapidly mop it up with pieces of gauze, which I throw away, frequently using thirty or forty such pieces, until I have the septic cavity emptied of pus, and comparatively clean. These are most commonly *post-cecal cases,* that is, cases with an abscess walled in by the cecum and omentum, the appendix perforated and lying in a small pool of stinking pus. I then, after removing the appendix, mop out the septic cavity with bichloride solution very thoroughly, pack it with iodoform gauze, take out my coffer-dam of sterilized gauze, and close the wound only at the ends, applying, of course, the usual antiseptic dressings.

As regards the method of treating the stump of the appendix, about which so much has been written, while I have adopted different methods, I have come to the conclusion that the only really important point is to remove the *whole* appendix, carefully going beyond where it is diseased at any rate. The method which I now adopt, and which renders the healthy or diseased condition of the appendix proper at once apparent is, after ligating the mesentery, to girdle the peritoneal covering of the organ at least one inch from the cecum, strip the peritoneal covering back like a cuff and ligature the stripped appendix close to the cecum with catgut, then cover the stump with the peritoneal cuff and ligature this; sometimes I also treat the open end of the appendix stump with the fine point of a Paquelin cautery, or pure carbolic acid: this seems to make no difference, however. I have had no trouble in any case from the stump, no matter how treated. One method recommended I cannot think safe or scientific, viz.: the invertion of the appendix into the cecum; to deprive the organ altogether, or to a great extent, of its blood supply, and then invaginate it into the cecum to slough, seems to be fraught with danger; the organ, to my mind, *must* necrose, and I should wonder at what point the necrotic process would be arrested.

As regards the general septic peritonitis cases, my practice has been as follows: If I find the peritonitis not general, but pelvic, and confined to the neighborhood of the appendix, cecum, etc., I wall the infected area off with gauze, and trust to swabbing the part thoroughly with gauze, removing all pus and debris, afterwards going over the part with sponges wrung out of bichloride solution and drain with iodoform gauze. If the whole