toward the *left* iliac fossa. Vomiting soon came on and was several times repeated during the day. The attack was looked upon as similiar to those previously suffered from and was treated in the same way. Opium and poultices were prescribed by the medical attendant.

Dr. Ross first saw the patient four days later. At that time the face had the characteristic abdominal expression, but was not specially anxious-looking. Color good. He complained of great pain in the lower part of the abdomen and on the *left* side; no pain on right side. Flatulence was considerable and the belly was moderately distended, chiefly in its lower half: parietes very firm and resisting; tenderness not great, but well marked, chiefly in the hypogastric, umbilical, and *left* iliac regions. Pressure was better borne in the right iliac fossa than in almost any other part, and palpation of that region failed to detect any deep-seated fulness or resistance. Vomiting was frequent. The evening previous the bowels had been moved by an enema. Pulse 120 and weak, temperature 98°.

The diagnosis lay between an acute obstruction and acute peritonitis, the latter view being favored by Dr. Ross. The cause of the peritonitis was the difficult point to decide; the sudden onset and rapid progress of the case suggested perforating appendicitis, and this was considered probable. The history gave some support to this idea, the difficulty being that the pain had always been referred to the left side, and on this side was also the greatest degree of tenderness. The ultimate diagnosis was acute purulent peritonitis depending on some previous disease in the lower part of the abdomen and that this might be an appendicitis, but the evidence on this point was inconclusive.

Dr. Ross gave it as his opinion that the boy would not live twenty-four hours if unrelieved, and strongly advised laparotomy. He fully realized the fact that four days had already elapsed and that the peritonitis was very extensive, and that in consequence the chances of relief by operation was very small. The boy was removed to the General Hospital and, after consultation with Drs. Shepherd and Bell, laparotomy was decided on.

Dr. Shepherd said that when he saw the case with Dr. Ross, the patient was in a very helpless condition; he had a pulse of 150 and of much volume; vomiting was continuous. There was no tenderness on deep pressure on the iliac region, nor was there any fulness. The only very painful point was a little below and to the left of the umbilicus. It was decided to give the patient the very small chance offered by operation.

An incision some two inches long was made in the median line below the umbilicus and two fingers introduced; nothing could be felt but distended intestines, and the cæcum could not be reached, so the incision and enlarged and the hand introduced; no collapsed intestine could be felt, but quantities of lymph covered the intestines, and some fetid pus escaped from the wound; the left iliac region was explored, the appendix was found hanging over the brim of the pelvis, and was apparently normal, though somewhat distended. For purposes of further exploration some of the intestines were drawn out of the abdomen and the cavity washed out with hot water. A large quantity of pus and lymph was evacuated from the bottom of the pelvis. In order to return the distended intestine an incision was made in it to allow the gas to escape; this incision was closed by Lembert sutures. The abdominal wound was now closed, a glass drainage tube being left at the lower end. At the end of the operation the boy was much collapsed and his pulse had failed markedly. He rallied somewhat but died next morning. After the operation there was no more vomiting.

An autopsy was made by Dr. Lafleur who found that the cause of peritonitis was a perforation of the appendix. This appendix