ally disappeared after many weeks. The pus was discovered in the urine or evacuations.

No. 4.—Mr. C., a painter, was visiting in the neighborhood of Woodstock. He was suddenly seized with severe pain in the right inguinal region accompanied by a chill. Opiates and purgatives were administered, but did not give relief. He came to the city and sent for me. I had attended his family and had often seen him. As he had a horror of lead colic he took the greatest care to prevent the entrance of lead into his system. He had some vague idea of having recently knocked his side. On carefully examining the abdomen I could feel a definite resistance in the right ingunial region. His temperature was high, tongue coated, face anxious and pulse accelerated. His condition did not improve. There was no difficulty in moving the bowels at this time and no vomiting. The feeling of definite resistance increased into a tumor, that could be made out. This was evidently deep and pressing inwards towards the abdominal cavity. His bowels became obstructed and vomiting set in. A consultation was asked for. I felt that unless some operation was done for the relief of the pressure on the bowels, the case would be fatal. They were people averse to any surgical interference and the young man was quite prepared to die. I urged operation, but the voice of the consultant overweighed mine, and the case was left alone. To-day I would operate on such a case or have nothing more to do with it. He went on in this condition gradually dying of starvation. His was one of the most distressing deaths I have ever witnessed. When he became emaciated the lump could be more distinctly felt, now much increased in size. Unfortunately no *post mortem* could be obtained. The case was undoubtedly one of pericæcal abscess, pressing on and obstructing the bowel.

No. 5.—Mrs. T., a woman 60 years of age, sent for me. I found her suffering from the symptoms of acute peritonitis. Some few days previously she had done a very heavy washing in a very open and draughty shed. No history of injury or of any pelvic trouble. I knew her past history and knew that she had been a robust woman. Fearing expense she had deferred sending for me until the symptoms were well defined. The tympanites was very distressing. Volumes of gas would belch up from time to time, but without giving relief. The pulse was very rapid and breathing labored and shallow. For about two weeks she lay between life and death, and then some improvement took place. The tympanites began to disappear, but the bowels remained obstinate. Unfortunately some zealous neighbor gave her a whole bottle (25 cent) of castor oil, and she was soon as ill as when first attacked. The tympanites returned and I expected momentarily to receive a telephone message, to say that she was dead. She convalesced very slowly, and remained a semi-invalid for fully twelve months after. No pus could be discovered in the urine or evacuations, or anytumor be felt. The cause of the attack could not be definitely made out.

No. 6. A very celebrated lacrosse player was throwing an over-hand shot with all his force when he felt a sudden pain in his abdomen. It did not last and was not severe. After retiring for the night a very intense pain seized him about two inches above the navel in the median line. He was in perfect health up to this date. I was sent for and found him writhing in agony. In spite of large doses of morphia the pain remained at times almost unbearable. It was paroxysmal but distinctly localized. The case was a puzzling one, and I tried to make a diagnosis by excluding other diseases. It had some features different to both hepatic and renal colic. No bowel symptoms supervened to point to intussception or internal hernia or volvulus. The bowels moved freely. Typhoid fever could be excluded owing to the previous good health and history of sudden injury. The temperature was during the first week elevated about a degree. The pulse was normal, tongue was, however, from the first furred like the tongue of typhoid. A temporary improvement took place and the patient was so much better that I only visited him every second day. I was once more suddenly called one night to relieve his "awful pain." Had there not been a rise of temperature and the furred tongue, I should have looked on the symptoms as partially nervous. From this second attack, his pulse and temperature both rose higher. No enlargment was to be felt over the abdomen; suddenly the the urine was retained and the catheter was required to relieve the patient. I thought that this was partially due to the long use of the opiate.