weeks or more all congestion, inflammatory thickening, and danger of sepsis will have disappeared.

I always use a gauze-drain except in cases of general septic peritonitis; then, in addition to abundant gauze-drainage, I use a long glass tube, which extends down to the floor of the pelvis. I use a ten-per-cent. iodoform-gauze. I have never seen iodoform-poisoning after packing the abdominal cavity with iodoform-gauze.

Formerly I was more willing to operate during the attack than I am now. My feelings have changed, because now we can offer the patient an operation without danger of hernia, if done between the attacks, and this, in addition to the other advantages of the intermediate operation, has led me to prefer it, and to always endeavor to obtain it.

What is the cause of death in appendicitis? In the acute cases, in which operation is done as soon as the diagnosis is made, it is very rare that the result is fatal. This is true of operations in the hands of all operators who have reported their cases. Also when done in the intervals of attacks operations are enormously successful. Judging from the results, this operation seems like a light and easy thing. Operations done on patients after two or three, or even four, attacks are very successful. When an operation is undertaken on a patient who has suffered from very numerous attacks of inflammation, when there are adhesions and broken-down tissue to embarrass the surgeon, and to increase the risk of sepsis, we get an occasional bad result.

The chief cause of death is, therefore, delay of one sort or another. If the cause of death be general septic peritonitis, this comes late in the attack, and after the time when a good diagnostician should have recognized the disease; therefore, had there been no delay, there would have been no septic peritonitis, which is, as you know, one of the principal causes of death in appendicitis. In the cases which have gone on to the formation of abscess, each day's delay increases the difficulty and the danger of an operation which at first might have been easy and safe, so that finally it may become an impossibility. Again, then, *delay* is the principal cause of death.

After an abscess has formed, the proper time to operate has given rise to considerable discussion. Treves, for instance, maintains the view that when suppuration has been walled in, the longer one waits before operating the nearer the pus will come to the surface. This is, in my opinion, an unscientific and unwarranted statement, because instead of approaching the surface the pus may be traveling upward toward the liver or downward into the pelvis. My own opinion is, as I said before, that in abscess-cases the sooner the operation is done the better. In such cases, if the appendix has not yet softened and broken down, and where only a small area of the peritoneum has become involved, the organ can be easily removed in most instances; but in older cases, where we meet with more advanced peritonitis, with adhesions and formation of much pus, the softened and broken-down appendix may be unrecognizable, or if recognized it cannot be safely handled or removed. An abscess opening into the gut results in one of two ways: either the disease is cured, or the appendix remains and another abscess is set up, which may discharge in