taken from my case-book, November 29, 1902: At 11 P.M. I saw, in consultation with Dr. Charles E. Simon, Miss K. G., aged twenty-four years. The day before she had indefinite pains in the region of the appendix. They were, however, not very severe and lasted but a short time. To-day she did her work as usual and prepared supper, but shortly afterward was taken with severe pain in the right side and was forced to go to bed. At 9 P.M. Dr. Simon saw her. There was marked rigidity of the right rectus over the appendiceal region. There was little temperature. On examination of the blood Dr. Simon noted that all eosinophiles had disappeared and that there was an evident leukocytosis.[1] When I saw her two hours later the rigidity of the right side had in part disappeared, probably as she was slightly under the influence of morphine. The general condition was good; pulse full and regular. Nevertheless, I advised immediate operation.

At 1.30 A.M. the abdomen was opened and a thin, watery pus immediately escaped from the peritoneal cavity, and the pelvis was found to be completely filled with pus. The intestinal loops, however, on the whole, presented a fairly normal appearance. Here and there they were covered by a few flakes of fibrin. The appendix was easily recognized and was bound down by adhesions. It was tied off from tip to base. As the distal extremity appeared to be normal, we expected to find a perforation near the cæcum, but on complete removal of the appendix it was found that, apart from adhesions, no alteration was present. After removing the pus from the abdomen a sponge was passed into the right renal pocket to see if any pus was there, and, to our surprise, some dark fluid escaped. This was entirely different from that found in the pelvis. The abdominal incision was continued upward to the ribs, and we immediately saw a perforation, about 4 mm. in diameter, in the ascending colon. As there was a good deal of fluid escaping, I temporarily closed this fistulous opening with a purse-string suture. I then drew the ascending colon out and made a longitudinal incision, and on introducing the finger into the colon found total obstruction a short distance above the ileocæcal valve. The lower third of the ascending colon, the cæcum, and a small portion of the ileum were tied off and removed, together with some enlarged glands in the mesocolon. The ascending colon and ileum were then united by end-to-end anastomosis. Lateral union would have been preferable, but we had no choice, as the tissues would have been on too great a tension. A Connell suture was employed for two-thirds the circumference of the gut, the remaining third being turned in with rectangular mattress sutures. The entire line of suture was reinforced by running mattress sutures. The pelvis was carefully sponged out, the intestinal

[1] Simon lays much stress on the frequent absence of eosinophiles where pus is accumulating, and thinks that this sign is of more practical value than the degree of leukocytosis.

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