preferred silver wire to silk for sutures, although the latter also answered very well. The needle with the eye near the point and attached to a long handle was what he found most convenient for introducing the sutures, which were passed, the first anteriorly and working back towards the uvula. The edges of the flaps ought to be carefully everted before tying the sutures. Chloroform was the anæsthetic preferred.

Remarks on Appendicitis with Report of a Case of Recovery in a Pregnant Woman after Rupture of Abscess into General Peritoneal Cavity. By Dr. HOLMES, Chatham. Herewith is a synopsis: Until five or six years ago the treatment of appendicitis was almost entirely in the hands of the physician; to-day it is acknowledged that many cases are available only to surgical treatment, and some maintain that all cases should be operated on at the earliest possible moment after a diagnosis is made. In this, as in controversies generally, time and accumulated experience alone must decide the question. Dr. Murphy, of Chicago, operates on every case as early as possible, and his rate of mortality is 9.6 per cent. Dr. J. W. White, of Philadelphia, declines to operate on those cases of general septic peritonitis with intestinal paralysis, and on many cases of first attack, and he thinks by doing so the rate of mortality will be from five to eight per cent. Treves holds somewhat similar views. Of forty-nine cases under my own care, eight have died from rupture of abscess into the peritoneal cavity, and four from general septic peritonitis; sixteen have been operated on with one death four months after the operation, and from causes that cannot fairly be attributed to the operation. Twenty-one recovered without operation, but five of these still have some tenderness at McBurney's point and are doubtless still in danger. It may be fairly estimated that of the twenty-one cases of apparent recovery not more than one would have died had they all been operated on, and it is almost certain that of the twelve who died without operation eight could have been saved by timely surgical interference. This would have made the mortality about ten per cent. instead of twenty-five per cent. The surgeon who believes every case should be operated on, and who acts in accordance with this belief, escapes a great deal of harrowing perplexity and frequent disappointment, as everyone will admit who has had an apparently favorable case suddenly die from rupture of an abscess into the peritoneal cavity or from the sudden development of general septic peritonitis. At present, however, I am not prepared to admit that operation in every case is best. The high mortality in the forty-nine cases here referred to was not due to delay in doubtful cases, but to