Assuming then, that influenza is a bacterial disease, of which there is substantial evidence; assuming also, that the symptoms and many of the sequelæ are nervous in origin, which is a widely accepted opinion; assuming also, that the influenzal bacteria do produce a poisonous albumin, as other bacteria do; are we not justified in concluding by analogy from diphtheria, that the symptoms and many of the sequelæ are produced by the circulation in the tissues of a tox-albumin. Further, that the effects, sedative in some cases, irritant in others, sometimes to the extent of producing a neuritis, are produced by the action of this poison on the nerves and nerve centres, with a preference for the pulmonary, gastric and cardiac branches of the pneumogastric. In the case of the heart, the action may be on the circulatory centre in the medulla, on the inhibitory or accelerator fibres of the pneumogastric, on the cardiac plexus or on the ganglia in the heart substance. The result of the poison's action may be as in the case of diphtheria, to produce degeneration of the coronary arteries with consequent mal-nutrition of the heart substance, or to produce areas of necrosis in the walls of the heart or on the endocardium.

Such, Mr. President, is I believe a workable hypothesis of the disease. Such is the only hypothesis, correct or not, which on our present knowledge, we are justified in making. It furnishes a basis for treatment, which if kept in view will produce an intelligent and perhaps a more careful treatment.

APPENDICITIS AND ITS SURGICAL TREATMENT.

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There has been some unnecessary confusion as to the term to be employed in describing this affection. Typhlitis, perityphlitis, paratyphlitis and appendicitis are words that have been used in a somewhat indiscriminate manner so as to convey to the minds, of some at least, of the profession, that these diseases are separate and distinct entities, incidentally attacking the right iliac region. This classification is very apt to confuse the mind as to the pathological condition underlying a given case. The multiplication of terms is also unfortunate in that it is clinically incorrect. Acute inflammation confined wholly to the cæcum probably never occurs. The appendix would soon become involved as well as the surrounding peritoneum, and it would be then that we would have presented the clinical phenomena of the disease. As to perityphlitis, this is a local peritonitis, secondary to the inflammatory process in the cæcum or appendix, with or without suppuration; it therefore should never be used to designate the primary disease.

The term paratyphlitis I apprehend is simply a reminiscence of the time (not long past), when the anatomy of the part was not well understood, and when the appendix was supposed to lie behind the peritoneum, and it was thought that inflammation of the viscus was liable to invade directly the retroperitoneal tissue. There is no longer, I believe, any doubt that the appendix is normally wholly surrounded by peritoneum, and that disease of the organ is at first entirely intraperitoneal and cannot very readily at all events reach the extraperitoneal cellular tissue. In preferring the term appendicitis I am guided also by the statistics at our disposal. Without citing more extensively, I may remind you that in 18000 cases of this iliac disease reported from Germany, 91 per cent. showed decidedly that the appendix was the origin of the trouble. Anyone may readily verify the same from English or American figures.

The question of surgical interference in appendicitis is still being very ardently canvassed on this continent, some going so far as to say that a justifiable operation is a rare contingency; others maintaining that all such cases should be handed over to the surgeon within twenty-four hours of their development.

Both of these contentions are extreme, and yet either might be justified by a limited observation of cases. The disease varies within a very wide area as to its severity, or, perhaps, I should rather say to its course. There are no doubt cases which run a mild course, recover without incident under medical treatment, and do not tend to recur as the result of any surviving leision. Others progress rapidly to suppuration, perforation, perhaps general peritonitis and death. Still a third class of cases though apparently recovering under