to be remembered in regard to them as well as to the other types, namely: When an abscess forms and escapes from the body by surgical aid or otherwise, the patient almost invariably makes a complete and permanent recovery.

In appendicitis the time for operation has arrived as soon as you are sure that pus is present. It is seldom absent when the symptoms are severe, and you have an irregular fluctuating temperature and increasing area of dulness.

All precautions known to aseptic and antiseptic surgery should be observed before, during and after operations for suppurative appendicitis, for although the pus is horribly offensive, it lacks something which would make it more dangerous to life.

No arbitrary rules can be given that will cover all indications that may arise. However, in the majority of cases of suppurative appendicitis, the area of dulness in groin is well marked. By examination, under an anæsthetic, aided with finger in rectum, the attachments to abdominal wall are easily defined. If the wall is not unusually thick, all that is neccessary is to make an inch incision through skin and tissue to peritoneum over centre of dull area. A glance at peritoneum reveals the presence of pus beneath it. An opening is made sufficient to admit finger. With finger search for faecal concretion or foreign body, and also define situation and site of appendix. If the appendix lies free in sac, or can be readily reached without disturbing adhesions, you may enlarge incision and ligate and remove it. But this is, in my opinion, not necessary, and the advantages gained by removal of organ in these cases are not sufficient to compensate for the entire freedom from hernia after small opening and the saving of time.

Irrigation, a rubber drain, and possibly a suture or two complete the operation.

If abscess lies deep in iliac fossa, and covered by caecum or intestinal coils, you have the choice of two methods; in one of which you open the peritoneal cavity in the right linea semilunaris opposite the pus sac, protect general peritoneal cavity with soft sponges, and then separate adhesions till the pus escapes. After washing thoroughly, it is a good plan to perforate abdominal wall immediately over site of abscess, and through the perforation introduce rubber drain. This allows you to completely close large incision, by which you run less risk from hernia subsequently. You have also (which is a matter of importance) more direct drainage.

By the other method, which many prefer, the abscess is opened without disturbing the unaffected portion of peritoneal cavity. An oblique incision parallel with Poupart's ligament is made to the outer side of situation of appendix. On reaching peritoneum, it is separated from parietal wall in the direction of abscess till it is reached. An opening with point of finger is now made, and drainage secured in the usual way.

The operation for the removal of the appendix in relapsing and suitable cases of recurrent appendicitis, is done by making a three-inch incision at right angles to an imaginary line drawn from right superior iliac spine to umbilicus, two inches from spine with centre of incision at line. But if the appendix is known to be away from normal site, the incision must be made over it. Adhesions, if present, are separated, and the appendix brought into view.

It may be dealt with in different ways. Robt. T. Morris cuts it off close to the caecum, ligates the mucuous membrane that protrudes, and removes it close to the ligature, then inserts a layer of sutures to close caecal wound, scarifies the adjacent peritoneum of caecum, and sutures it over all. Treves advises, when practicable, a circular division of peritoneum near proximal end and reflection of it towards caecum. Amputation of appendix close to reflected peritoneum and removal of pre-