some form of catharics, or disturbed the rest of the intestines by giving large enemata, or they neglected removing the stomach contents by gastric lavage. Of course, the slightest amount of food is sufficient to start peristaltic motion of the small intestines, and the same is true of cathartics, and consequently, if either of these features in the treatment is omitted, one cannot hope for the same results. It does not matter what form of appendicitis may be present in any given case, it seems clear that this form of treatment must be useful, because in the milder cases it will result in rest of the affected part, and consequent rapid resolution; while in the severe cases it will guard against mechanical distribution of infectious material, and in all cases it reduces the tendency to meteorism, and stops the pain.

There is, however, one class of patients in which I have found this treatment of the greatest value. I refer to the class in which the appendix is gangrenous, or perforated, and in which there is already a beginning general peritonitis. These patients give the impression of being extremely ill. There is complete obstruction to the passage of gas or faeces. There is nausea or vomiting and marked meteorism; the pulse is small and quick; usually there is a high fever, but the temperature may be subnormal; respiration is rapid, and the abdominal muscles overlying the appendix are tense. The patient is in a condition in which I formerly operated at once, day or night, as a last resort, only to find that it was too late in more than one-third of the number of cases, the mortality increasing with the time that had elapsed since the beginning of the attack. In this class of cases there is still a recovery of over 90 per cent. if the principles laid down above are thoroughly applied.

If peristalsis is absolutely inhibited, as it can be, the infection will soon become circumscribed and the pus can be evacuated with safety. Moreover, the condition I have just described is in itself the result of the administration of food and cathartics. Had these patients received neither food nor cathartics from the beginning of their attack, the condition would never have advanced to this dangerous point. This refers particularly to a class of cases which Richardson has so well described as "too late for an early and too early for a late operation."

If the plan I have outlined above is carried out, the following changes are likely to occur:—The nausea and vomiting will cease after one or two, or at the most three, gastric irrigations. The meteorism and the pain will