March, both of whom recommended exploratory incision. The incision was not made, however, the young man returned home, grew enormously large, was not well and had little endurance. In February, 1870, he entered a hospital in Boston, where Dr. Bigelow made an incision with the expectation of finding dead bone, but the result of the exploration was negative. Incision healed, sinus remained, and after a time iodine was injected. Later he began having pain in upper part of thoracic cavity, and opium was prescribed for it and nervousness. He formed the opium habit and continued it hypodermically until death. He was brought home in June, 1870, much worse with chest trouble. Family physician being absent, Dr. Beech was called and diagnosed hydrothorax, the heart being crowded over so that the apex beat was considerably to right of sternum. In August, 1870, Dr. Newton made an incision in the upper part of the left side, and pus discharged. A second opening low down near the bottom of the thoracic cavity came spontaneously later. Both continued to discharge offensive pus for about five years, when death occurred March 26th, 1874. At the autopsy made by Dr. E. R. Hun, marked evidences of old adhesive inflammation were found in the neighborhood of the appendix vermiformis. On account of great emaciation it was difficult to trace the sinus to this location. Seeds were found which must have been lodged there for a long time, and his constant attendant stated that he would not eat seeds during his entire illness, having formed the impression that his original sickness had been caused by them.

In the cases of peri-appendicitis we have very much the same train of symptoms as I have just described, but in which persistent rest and the use of familiar remedies does not succeed in relieving our patient. At the end of the sixth, eighth, tenth or twelfth day we find the swelling has increased, is more sensitive, the bowels positively inactive, injections have been tried, and only the lower bowel is emptied. In some cases cathartics have been ventured upon, but perhaps only to be returned by the stomach, and possibly a fæcal vomiting threatens or presents. The following case in the practice of Dr. Buckbee, of Fonda, N.Y., illustrates very well the points I desire to reach:

PERI-APPENDICITIS WITH ABSCESS.

Mr. B., aged thirty, farmer by occupation, good habits, and well developed muscular body, weight about 160 pounds; was taken sick Dec. 1st, 1887, with very many of the same symptoms described in my first case (Mr. S.) The swelling could be made out on the fifth day of his illness. On the morning of the eighth day he suffered rather more pain than usual, there was a rise in temperature to about 103° F., his pulse was increased, and marked tympanites threatened. I was telegraphed for and saw him about twelve hours after. He had grown gradually worse in his symptoms in this time, complained of great distention of the abdomen, which was quite apparent, had much nausea, yet did not vomit any great quantity, had an anxious expression of the face, temperature 103.5, pulse 120. There was marked dullness in the right inguinal region, but the prominence Dr. Buckbee stated, was not so marked as the day previous. I advised an immediate operation, which was assented to at once, and the usual incision was made above Poupart's ligament, and after dissecting down quite to the sub-peritoneal fascia I came upon an abscess containing about three ounces of dark, very offensive pus, in which we found two fæcal concretions, and a sloughing appendix, the latter I did not disturb, simply placing in a large drainage tube, with a smaller one along side of it, washing out the cavity thoroughly with antiseptic solutions, and dressing with thymol gauze. The patient reacted well from the operation, began to improve within a few days, bowels moved the next day with the aid of an enema, and he went on to perfect recovery. Here is a case that demonstrates how early an abscess may form; also, I think, illustrates this point, that the appendix was so situated that nature was able to throw out a posterior wall or barrier, so as to protect the peritoneal cavity, and that when he grew worse, threatened perforation presented into the peritoneal cavity, but that this was relieved by a timely operation. Or in the next case of

PERI-APPENDICITIS, ABSCESS, OPERATION, RECOVERY WITH PERMANENT SINUS.

Wm. H., aged seventy, married, father of nine children, butcher by occupation. Called Feb. 17th, 1871, to see him, and found for past week