the intestine. Early Saturday morning assisted by Drs. Blanchard, England and Hutton I opened the abdomen. The bowels were found universally adherent by recent lymph-exudate. By careful separation of adhesions I reached the pelvic mass which proved, as expected, to be a large collection of pus. The abscess cavity extended into both ileac regions. After wiping out very thoroughly these regions I found a large opening in the calcum where the appendix had sloughed off. Because of the adhesions it was impossible to bring the calcum to the surface and efforts to close the opening in situ proved unavailing. Drainage by iodoform gauze and glass tubes was provided not only in the original central incision but also through a secondary opening in the right side. The contents of the bowel were poured through the median line for ten days when the fistula closed. The patient now weighs more than ever before and is able to take athletic exercise freely.

J. M., age 12 began his illness with vomiting, abdominal pain and rise of temperature. I saw him repeatedly in consultation with Drs. Blanchard and Macdonnell and we all agreed that it was not appendicitis. The pain was in the *left hypochondriac* region. Pressure, even though quite deep, in the right ileac region caused no discomfort there but produced pain high up on the left side. While uncertain as to the exact diagnosis, pain in micturition developed and a rectal examination revealed a mass in the pelvis. Previous examination of the lower bowel had proved negative. We decided to operate on the following day but shortly after the above examination a severe chill and violent pain came on and at Dr. Blanchard's request I operated at once. Pus poured through the wound as soon as the peritoneum was opened. The appendix was found sloughed in two pieces, the outer being held in position by a very small piece of mesentery. A fæcal mass was found free among the intestines. The patient is now in the east recuperating after the severe illness through which he passed.

S. T, age 14 was taken down on Saturday with the ordinary symptoms of appendicitis. For a week there appeared to be no reason for surgical interference. The temperature only once went above 101° the pulse never reached 100. There were no chills, no mass could be felt in the right ileac region and his general condition appeared excellent. He then began to complain of rectal tenesmus and mucous discharges from the anus. An examination of the lower bowel disclosed a small swelling in front of the rectum. The following day the mass was larger and I therefore transferred him to the Winnipeg General Hospital for operation. On Monday I opened the peritoneal cavity and found four or five small collections of pus in the pelvis. He has made an uninterrupted recovery and will get out of bed today.

Dr. J. W. Macdonald in his recent work, "A Clinical Text-book of Surgical Diagnosis and Treatment" says "It is customary to mention palpation by the rectum as a means of detecting a tumor. I have never been able to derive any information from this method and have long ceased to employ it." Such a statement seems to be unwarranted in view of the last three cases which I report. In each of these cases, unusual in other respects, the real clue to the diagnosis was given by the rectal examination. I could easily add to these cases, the histories of other patients where while the symptoms pointed to appendicitis, the only tumor which could be discovered was found on examination of the lower bowel. I do not think for a moment that this is the ordinary site for tumor but am firmly convinced that increased grounds for diagnosis can often be found by examining the rectum.