safety, a double drainage tube was used, and the patient, I understand, recovered without a bad symptom.

Case V.—Dr. Henderson's case—ileo-inguinal. A young man about twenty-four years of age, clerk in a dry goods store. Shortly after first onset of symptoms, pain was eased by opium and bowels kept open with salines. I saw him on the fourth day with Drs. Henderson and Garrow, and found unmistakable evidence of tumour, pain on pressure, dullness from the site of the appendix towards the lumbar region about four inches and two-and-a-half inches in width. Pulse rapid and abrupt, temperature 102° and ascending. The temperature being the same on the following day, and the other symptoms unchanged, operation was decided upon. The peritoneum was found healthy. Appendix behind the cæcum, black and distended, with a point of suppuration near the bowel. It was tied with a double silk ligature and removed. Recovery progressed without any undue event.

Case VI.—A spare, healthy boy of 15 under Dr. Lynch, of Almonte. Was taken ill with abdominal pain on Saturday, 10th October, 1891. Symptoms increased, with indications of localization, and on Tuesday morning, when I first saw him, his facial expression was bad, pulse small and rapid, skin clammy, great tenderness over the iliac region, and dullness on percussion. Gave him a full dose of opium, which produced rest, and in six hours we found the general condition much improved, with local symptoms unchanged. Owing to the seriousness of the constitutional symptoms, immediate operation was decided upon. An incision was made over the site of greatest dullness, one and a-half inches to the umbilical side of the anterior superior spinous process. Peritoneum found healthy, and presenting surface of cæcum in the same condition. On passing finger behind the cæcum a lot of stinking pus escaped, and a further examination found the appendix collapsed, highly congested, and firmly adherent to the posterior wall of the cæcum. Washed out the abscess cavity and inserted a double drainage tube. I felt some little anxiety as the peritoneal cavity was exposed, owing to the peculiar position of the abscess, and on that account drew the edges of the wound well together, and ordered perfect quiet, feeling that in a few hours sufficient lymph would be thrown out to protect the peritoneum. The case progressed satisfactorily. At the end of two weeks, the discharge being serous and inoffensive, the tube was withdrawn. Since then, I understand, his progress has been uninterruptedly good. I look upon this last case as one of deep-seated ileo-inguinal abscess, owing to the position of the appendix on the posterior aspect of the cæcum. I have always been opposed to the use of exploratory needles, and this is a case in which such an experiment would have wounded the bowel.

Shortly after the last operation, I was asked to see a case with Dr. Lynch, of Almonte, and unfortunately I have lost the notes of his case; for purposes of illustration, it will, however, suffice to give an outline of it:—J. R., a boy of about 14, with good family history, and a previously good record, was seized with acute pain and vomiting on a given day: soon associated with inceasing temperature and pulse. Symptoms steadily grew worse, and on the third day I saw him. Condition was then grave, pulse small and rapid, temperature 102°, belly flat, great pain and tenderness over whole of right iliac region, with badly defined dullness on deep pressure. Pain and tenderness extended over towards the left side. It was considered necessary to operate at once, an incision was made well above the middle of Porpart's ligament, and though the abdominal cavity was entered, no pus exuded. After some time, by careful digital exploration through the wound, the abscess cavity was entered between the pelvis and the bladder on the right side; offensive pus freely escaped, and with it came into the wound a large mass of suppurating omentum. This, after legatining with catgut, I amputated, then washed out the whole cavity with boracic acid and hot water, put in a double rubber drain and closed the opening. He only lived twenty-four hours, and died of general peritonitis. Were I called upon to deal with such another case as this, I should make a second opening in the median line to secure thorough drainage and to facilitate free irrigation as recommended by Mr. T. R. Jones, of Manchester. Since November I have had, in my own private practice, four cases of acute appendicitis recovering without operative interference. Though important and interesting, the details of such cases are too