in the practice of others. This young lady suffered, in my opinion, from an attack of appendicitis.

The diagnosis of the chronic form of appendicitis in which sinuses from burrowing pus are found in the groin, in the hip and in the loin, is at times difficult. The cases must be differentiated from those of hip and spine disease. Peri-renal abscess may also leave a sinus that may be mistaken for one following chronic appendicitis and *vice versa.*

Tubercular disease of the intestines may produce a matting in the right iliac region that will closely simulate the matting produced by disease of the appendix. Only two weeks ago I explored the abdomen of a woman aged sixty-five, in order to differentiate between cancer of the cæcum and appendicitis. I found the case to be one of cancer and not one of pus formation, and closed the abdomen. A collection of foreign substances in the cæcum may give rise to the idea that we have to deal with a case of appendicitis. I remember one such case in my own practice in which, on account of the peculiar griping pains, the absence of fever and the normal pulse, I diagnosed the lump as a collection of fæcal matter in the cæcum and not due to inflammatory thickening of appendicitis. The constipation was extremely obstinate, purgatives were used without avail, and I succeeded in dislodging the fæcal mass by giving very large enemas of hot water and changing the position of the patient so as to favor the onward movement of the water through the descending transverse and ascending colon. At last, when we almost despaired, a large mass, as large as a small fist, came away, and the patient immediately obtained relief from his pain and constipation. The mass consisted of the indigestible and hard end of asparagus, together with pieces of cartilage bitten off from the ends of the chicken bones; around this was fæcal matter that had become hardened. The patient was particularly fond of fowl, and was in the habit of eating rapidly and picking the bones while held in his fingers. He was so fond of asparagus that he ate the parts that should not be eaten. Fitz, in his admirable paper, mentions this affection as one that must not be lost sight of when making a diagnosis of a mass in the right iliac region.

And, finally, I would say that I believe the aspirator should never be used as an instrument of diagnosis in these cases. It is not to be relied on, and the literature of the subject is filled with cases in which the aspirator needle was used, and, because no pus was found, operation was decided against, and yet, when too late, at the *post mortem* examination a large abscess was discovered.

Physical Signs.—The physical sign that is frequently found, and the sign that is, perhaps, of the greatest value, is the sense of resistance or actual tumefaction in the right iliac region. This tumefaction is not always found in the one situation. I have opened an abscess over an appendix in the neighborhood of the umbilicus. I have seen a secondary collection of fluid to the left of the median line in a child eight years old after an attack of appendicitis. I have felt a collection of fluid in the pelvis of a child between the bladder and the rectum after an attack of appendicitis with general peritonitis. I have opened abscesses accompanying disease of the appendix in the right iliac region and in the pelvis in the same case.

The abscesses are, in many cases, multiple, but there seems to be a tendency toward the formation of a pelvic collection of pus in most of the cases of appendicitis, therefore, the rectal examination should never be omitted, because it often gives very valuable information. One case I show to-night is a man aged sixty-five, operated on for appendicitis a year ago, and eight months after operated on a second time for an accumulation of pus in the pelvis. The second collection of pus was evacuated by puncture through the rectum with a long trocar.

The physical sign mentioned above of matting in the right iliac region, may not be present during the first, second or third attack, but may be present in some subsequent attack; but, when found, it enables us to come to a correct conclusion as to the nature of the previous attacks. The tumefaction may vary from a large dense swelling—and it may contain a large quantity of pus—down to a simple feeling of induration or increased resistance to the examining fingers. Rigidity of the right rectus muscle may also be found, together with McBurney's point of greatest tenderness.

Course and Results.—The course of the disease may vary; the first attack may be the last. The patient may be seized in the midst of health with a sudden attack of peritonitis, and may be dead in three or four days. After the first onset of the