of peri-cæcal abscess which perforated into the bowels. The patient had for some years after, and may still have for aught I know, persistent enlargement of the right leg, due, undoubtedly, to chronic venous stasis consequent upon the narrowing of, or perhaps the obliteration, of some of the large veins in the pelvis. A third and almost necessarily fatal mode of termination, is when the local circumscribed abscess perforates the peritoneum, setting up a diffuse, virulent and septic inflammation.

I have never yet seen instances of perforative appendicitis in which there were not attempts made to limit the inflammation. Even when the appendix has been free in the peritoneum, walls circumscribing the abscess are formed by the adherent mesentery, retro-peritoneum and intestinal wall. Symptoms of perforative appendicitis are fairly well defined. A number of cases begin with intestinal trouble, constipation or pain in the iliocæcal region, lasting for a variable time. A more characteristic mode of onset is a sudden, sharp pain in the right iliac fossa. This may be followed by collapse symptoms, or more usually by an aggravation of the intestinal disturbance. It is worth noting, that strain, such as sudden lifting or jumping, may be followed by an acute pain, and may, apparently, be the starting-point of appendicitis. The local symptoms are rarely as well marked as in typhlitis Tenderness is usually present; there may be fullness, or even induration, but in my experience, these signs are more frequently absent. The leg is usually drawn up, thereby relaxing the psoas muscle. Irritability of the bladder, as shown by frequent micturition, not infrequently occurs. The fever is moderate; the tongue is furred, but constipation is not so constant a feature as in stercoral typhlitis. Abdominal distention (tympanites) comes on early, and may interfere with proper examination. A rectal examination may indicate fullness towards the roof of the pelvis, but unless the whole hand is used, the ordinary digital exploration is practically worthless. Practice on the cadaver, with the pelvis exposed, shows how futile is the attempt to reach, even with the longest finger, those higher portions of the pelvis which the peri-cæcal inflammation usually affects. Increasing tympanites, diffuse tenderness on palpation, aggravated constitutional symptoms, indicate the spread of the peritonitis. It must not be forgotten that the peritonitis may be limited to the lower portion of the abdomen, even confined to the coils of the small intestines situated within the pelvis. Such abdominal distention may be extremely slight. I saw, with Dr. Musser, last year, a case of perforation of the appendix with peritonitis, in which the abdominal walls were flat and presented a hard, board-like resistance to palpation.

In a considerable majority of cases, I think the sudden onset with sharp intense pain, indicates, not the perforation of the appendix, but the extension of an already existing inflammatory process. As I have stated, extensive ulceration, distention, adhesion and obliteration of the tube, may occur in persons in whose history there is no account of localized abdominal inflammation. It is not impossible that ulceration, leading to perforation and local abscess, may occur without exciting severe symptoms. I have so often seen, about the perforated appendix, signs of chronic inflammatory mischief indicated by fibrous bands and pigmentation, that the process has certainly ante-dated the onset of the acute fatal illness of only a few days' duration. Marked tendency to recurrence finds also its explanation here, in the temporary aggravation of the condition. Surgeons have repeatedly, in these cases of recurring attacks in the peri-cæcal region, cut down and removed an adherent, chronically inflamed and even perforated appendix.

In many instances the diagnosis of perforated appendix presents great difficulties. Perhaps, of all the symptoms, the most important is the sudden agonizing pain occurring either at first, or after gastro-intestinal symptoms have lasted for some days. Its importance may be gathered from the fact, that of 257 cases analyzed by Fitz, it was present in 216. Abdominal pain and distention are more marked, and occur earlier than in ordinary typhlitis. Induration in the iliac fossa is also less common; indeed, a very considerable proportion of the cases present no local tumor. The diagnosis in such cases rests largely upon the mode of onset, the development of symptoms, the previous history of the patient, the absence of signs of hernia or of internal strangulation. The occurrence of frequent micturition and the characteristic decubitus of the patient, are highly suggestive symptoms. Cases occur in which it seems impossible to accurately determine the condition, and the patient