

These cases illustrate the operation of appendisectomy, when performed in the earliest stage of the disease and in the interval between the intermittent attacks. I have yet to lose the first case after operation performed in the interval between the attacks. Some of these operations have been very difficult, involving a large amount of handling of the intestine, the closure of intestinal perforations, and the clearing out of cheesy material and pus in small quantities. The success of the operation, when done early, has also been very great. In some of the cases I have found it impossible to remove the appendix, and been forced to do nothing but make an incision down over the gangrenous tissues and pack the wound with gauze. These cases have also done well.

But a different tale is to be told regarding those in which medical treatment has been relied on, and the dark wall of the abdominal prieties has remained as a barrier between the eye of the observer and the pathological change within. I am tired of the so-called medicinal treatment of appendicitis. I feel satisfied that with proper precautions five hundred healthy appendices can be removed without a death in the hands of a skilled operator. When this is so, and the four cardinal symptoms that I may again enumerate, namely, sudden pain in the abdomen, vomiting, tenderness on pressure, and rigidity of the right abdominal parities, infallibly point to appendicitis, surely medicinal treatment should be shelved. If I myself had the four cardinal symptoms I should send for a surgeon without delay.

The so-called secondary perforation in my experience means rupture of a gangrenous and distended appendix, or the rupture of an abscess in the mesentery of the appendix, secondary to a perforation into the mesentery. After rupture has taken place, the organ quickly contracts, and it is impossible to say, on examining it, that it has been much distended. Case I. I should have placed beyond surgical aid in a few hours by rupture of his appendix and the discharge of the foul poisonous contents into the peritoneal cavity. Case number V. would in a few days have been placed in a similar position by rupture of pus formed in the mesentery of the appendix, from broken down fat cells into the general peritoneal cavity. Operation cannot be done too quickly.

I saw one case in consultation with Dr. McEown, at St. Michael's Hospital, and within an hour we had the patient's abdomen open. Gauze was packed around the appendix, and the swollen, gangrenous organ lifted up. Just as it reached the level of the skin it burst, and the grumous pus fell on the protecting gauze instead of dropping into the peritoneal cavity. The patient's life was saved.