coming on suddenly should be regarded with the gravest suspicion, and if no other cause can be found, one is justified in making a tentative diagnosis of perforation and treating it as such, even without any other symptom. If added to this there is rigidity or tenderness, the diagnosis may be made positive.

The leucocytic count, or at least our present interpretation of it, is entirely unreliable.

The essential point in treatment is early operation, and nothing should be allowed to interfere with this procedure. To wait for positive symptoms is to court failure. "When in doubt, OPERATE," should be the surgeon's motto in these cases. If no perforation be found, which will be very exceptional, the operation need only be very brief and practically void of danger.

During the period covered by the above series, two cases were operated on in which the diagnosis was found to be incorrect. One proved to be a ruptured pulmonary abscess, while in the other no abnormality could be found, although there had been the sudden pain, tenderness, extreme rigidity, rise in temperature and pulse rate. This case made an uneventful recovery.

Although cholecystitis is now found to occur fairly frequently as a complication or sequel of typhoid, it is only within comparatively recent years that typhoid has been recognised as a causal factor, Bernheim, in 1889, being the first to call attention to the possibility that the typhoid bacillus might cause gall stones.

It is now definitely known that typhoid bacilli are nearly always present in the gall-bladder during the course of the disease; that they may persist for many years after an attack, and that they occasionally form the nucleus of gall stones.

The time of onset varies greatly, but it is usually later on in the course of the disease. The extent of the process may vary from a mild catarrhal cholecystitis to perforation.

The symptoms usually arise suddenly, the most prominent being pain in the region of the gall-bladder. There may be a chill, high temperature, rapid pulse, vomiting, tenderness and rigidity of abdominal wall; the latter symptoms indicating a localized peritonitis, which may occur even without perforation. In cases of perforation, the symptoms are quite similar to those of intestinal perforation.

The treatment in a mild case should consist in local measures for relief of pain, while in case of perforation immediate operation gives the patient the only chance of recovery.

In the intermediate group of cases, each must be treated on its own merits. Opium should be avoided if at all possible, and tapping the gall-bladder should never be attempted. Local measures