peritoneum should be protected and the pus carefully and completely swabbed out and the cavity treated with pure cabolic and alcohol. Having demonstrated the appendix in its entirety, it and its source should be brought out of the wound. Then ligate the mesoappendix by passing a ligature through the semi-transparent space near the base of the appendix. This secures the blood supply, and the mesoappendix may then be cut between the appendix and ligature. At the point where it is decided to amputate the appendix, and this should be nearly flush with the cæcum, the serous coat is circularly incised, the muscular coat exposed and a silk ligature applied to it. The assistant should secure the mesoappendix by forceps and surround the base of the appendix with gauze to protect the field of operation from a possible infection. The scalpel or scissors used to divide the appendix should be put away and not used during this operation.

The puckered lumen is frequently swabbed out with carbolic acid. This is not necessary. About half an inch from it and beginning at the mesoappendix there is introduced a purse string suture of sterilized catgut made to surround the stump. As this suture is tightened the stump is inverted and thus buried out of sight. The ornamental cuff forms a poor covering for the stump alone. All raw surfaces need to be covered with serous coating to avoid adhesions. The intestine is now returned to the abdominal cavity and if the condition of the patient call for it a quart of normal saline is put in the abdomen of clean cases. The peritoneal closure is also important for the comfort of the patient. By this I mean to avoid the possibility of the cut edge of the peritoneum being inverted instead of averted. An adherent bowel to the parietes is very unfortunate for both patient and surgeon. Having secured all small bleeding points so that the field is perfectly dry, the wound is closed by the layer method. Muscle is gently approximated to muscle by sterilized catgut also; fascia to fascia by 40-day chromicized gut No. 2, and if there is more than ordinary tension I prefer mattress sutures placed close together. A fat wall is the better of being gently brought together by small-sized catgut so as to avoid a dead space. A subcuticular catgut or silkworm gut completes the human end of it. I have every confidence in Van Horne and Sawtell's preparations and use no other. In the event of a likely wound infection a through and through silkworm gut suture is preferable as any form of catgut is useless in a few hours in the presence of pus. Dry gauze or any other good aseptic dressing may be used to cover the wound, a many-tailed bandage snugly fitted, the patient's stomach washed out, and he is returned to the ward with the foot of the bed elevated for several hours. In any case requiring drainage the head of the bed should be elevated for the whole period of convalescence. Under ordinary circumstances an uninterrupted recovery permits the patient to return to his home in from one to two weeks.