operation may be of greater importance than the method of its performance.

Nevertheless, the fact that in an important meeting such as this the treatment of septic peritonitis has been one of the subjects selected for discussion proves, if further proof is needed, that we neither have, nor expect in the near future to have, the necessary knowledge to deal satisfactorily with this dread scourge.

Some figures, collected for me by Mr. C. F. M. Saint, verified by the Surgical Registrar, Mr. R. J. Willan, and relating to cases admitted to the Royal Victoria Infirmary, Newcastle-upon-Tyne, during the year 1910, convey greater instruction than anything I can say.

Appendicitis.

There were in all 427 cases, with 18 deaths.

Post-mortem examination proved that the cause of 16 of these deaths was general septic peritonitis.

Six of the 18 were not operated upon, and all were suffering from advanced general peritonitis on admission.

Of the 12 cases operated upon, 1 died of portal sepsis 10 days, and one of pulmonary embolism 7 days after operation.

In all the remaining 10, general septic peritonitis was present at the time of the operation.

There were 290 acute cases, and all of the deaths (18) occurred in this series. (There were no deaths in the interval cases.)

Sixty-two of the 290 acute cases had not perforated, and had no associated peritonitis. There was one death from portal sepsis in this series.

Thirty-eight had perforated, but had not yet developed any gross peritonitis. In this series there was one death from pulmonary embolism.

One hundred and fifty-seven were associated with localized peritonitis and abscess. All recovered.

Thirty-three were associated with general septic peritonitis. Twenty-five were operated upon, 13 recovered and 12 died. Eight were not operated upon. Of these, 2 recovered and 6 died.

These figures convey the lessons derived from the mortality, which, of course, is the most important consideration of all, but there are others to remember. For many years in Newcastle we have taught as the ideal that the inflamed vermiform appendix should be removed before rupture or abscess has had time to develop, and that only by this means a serious and prolonged illness, with the possibility of a ventral hernia at the end