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ORIGINAL ARTICLES.

CASES OF APPENDICITIS.

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I offer brief clinical histories of some cases of appendicitis presenting unusual features. The majority of cases of this disease are easily diagnosed but occasionally great difficulty may be found in reaching a conclusion as to the character of the changes taking place in acute inflammatory attacks within the abdominal cavity. A rough and ready rule has been enunciated by several writers as follows; "In all cases of inflammation in the peritoneal cavity where no other cause is apparent diagnose appendicitis." My experience would certainly justify the injunction, "suspect appendicitis" in all such cases.

H. E., a stout healthy man of 55 years was seized on Monday night with the ordinary symptoms of appendicitis. The next day he was removed to the Winnipeg General Hospital. By Wednesday all signs had apparently ceased. The temperature was normal, the pain gone, the tenderness rapidly disappearing, the appetite returning. On account of the thick layer of subcutaneous tissue no mass had been made out. On Thursday and Friday his condition steadily improved and I promised that he should leave the hospital in a couple of days. While at dinner on Friday evening I received a telephone message that the patient had fæcal vomiting. On hurrying to the hospital I found that he had had several attacks of vomiting of thin foul-smelling fæcal matter. As quickly as possible I arranged to operate and with the assistance of Drs. Blanchard and England opened a large abscess containing nearly a quart of pus. Patient made a rapid recovery. The thick abdominal wall hid the abscess, the complete cessation of all symptoms for two days and a half lulled my anxiety and yet the pus was steadily increasing in amount until by its pressure intestinal obstruction was produced.

W. S. C., a banker, had been confined to bed for ten days with slight abdominal pain and tenderness in the umbilical region and with a continuous but slight range of temperature. His appetite had remained good and his bowels were readily moved by injection. On Friday morning tympanites began and on attempting to use the enema it was found that the bowel would not retain more than two or three ounces of fluid. I saw him first on Friday evening and found him suffering with extreme abdominal distension which gave a clear percussion note everywhere. There was no one point on the abdomen more tender than another and the statement was made that all pain and tenderness before my visit had been around the navel and never in the right ileac region. A rectal examination revealed a large elastic mass between the bowel and bladder which completely closed the lumen of