an anesthetic safely, such as persons with dangerous heart or lung diseases; (5) that there is no after pain, and (6) that it is, as far as I have seen after employing it in a very large number of cases,in variably harmless."—*Medical Record.*

APPENDICITIS.

Catarrhal appendicitis with localized plastic peritonitis begins suddenly with pain about the umbilicus or right iliac fossa, vomiting, constipation, and slight fever. There is some tenderness at or about McBurney's point. A swelling, due to matted coils of intestine, may be felt, and there is always rigidity of the muscles in the right iliac fossa. There may be pain at the end of micturition, due to stretching of inflamed peritoneum as the bladder is emptied. The attack usually subsides in three or four days, leaving adhesions.

Appendicitis with a localized abscess begins in the same way, but one or more of the signs—pains, vomiting, tenderness, and temperature—is more severe. A well-marked swelling is usually present, and the pulse steadily increases in frequency. There is also a steadily-increasing leucocytosis. A persistently high temperature, or a subnormal temperature with an increasing pulse-rate, are strong indications as to the presence of pus.

Diagnosis.—The cardinal signs are pain and tenderness in the right iliac fossa, vomiting and constipation, with some rise of temperature. If a swelling and localized rigidity are present, there can be no doubt.

Treatment.—The cases, as regards treatment during an attack, fall into two groups: (1) Where there is only plastic peritonitis; (2) where there is suppuration. In the first group the patient should be kept at rest, with hot fomentations to relieve the pain. Fluid diet should be given, and the patient not disturbed for several days by purgatives or enemata. On no account should morphia be given, as it masks the symptoms of the onset of suppuration. Where pus is present or suspected, the abdomen should be opened over the swelling, and in most cases it will be found that there are adhesions to the anterior abdominal wall, shutting off the abscess cavity from the rest of the abdomen. A finger should be gently inserted to feel for and remove a concretion or the appendix; but no prolonged search should be made for the appendix for fear of breaking down the adhesions. A large rubber drainage-tube should be inserted, and the cavity will soon become clean and heal by granulation. If, when the abdomen is opened, no adhesions to the anterior abdominal wall are found, the cavity should be protected with gauze packing. The abscess will then be