cent period, after the third attack. The appendix is said to have been strictured, to have contained no pus, and to have been surrounded by few adhesions. The operation was in August. In the following October the patient had another attack of appendicitis with fever and was in bed ten days. In December he had another attack of some gravity. He had hardly recovered from this when he was again laid up for the third time after the operation. The attacks which followed the operation differed in no essential from those which had preceded it, except in this, that in the second of the early attacks a small abscess was evacuated, which gave no further trouble, nor did suppuration supervene in any of the subsequent outbreaks. As soon as the last attack had subsided —now two years ago—I opened the abdomen in the iliac fossa. The stump of the amputated appendix was swollen, hard and tense. It measured $\frac{3}{4}$ in. Its distal end was well closed in by sutures which were still in evidence. The little tube was distended by muco-pus, and it was strictured at the very point where it opened into the caecum. It was removed, and the patient has had no trouble since. This case suggests the wisdom of always removing the appendix close to the caecum. A stricture at the actual caecal orifice is not common. It would appear to be always so placed in mucocele of the appendix—in those strange examples where the organ is translucent and is distended with a perfectly clear white jelly. In connection with this matter I may mention that in one operation after I had removed the appendix—as I thought—close to the caecum I found that the proximal end of the tube had been invaginated into the caput coli. The little intussusception was therefore at once reduced and the appendix re-excised.

Two cases, allied to the above, were found by Mr. Lett among the London Hospital records. In one the appendix was removed after the third attack. It was described as "half an inch long and very adherent." The patient subsequently had two more attacks. After the second outbreak the remainder of the appendix was discovered and removed. In the other instances an abscess was opened and "the appendix removed." The patient had another attack with suppuration, when a considerable portion of appendix was found and excised.

I find among the series now under notice no less than 9 cases in which continued trouble after the operation was due to mischief in the right ovary. In some of these examples an inflamed, prolapsed, or adherent ovary had been noted at the time of the operation, but had not been removed. In others a second abdominal section was performed for continued distress, and a diseased ovary discovered and removed. In nearly all these cases the condition before operation would be described as chronic appendicitis supervening on acute or subacute attacks.