foration of any of the other hollow viscera, cannot be accurately made.

Now in perforation of the gall-bladder, there may perhaps have been premonitory symptoms of pain in the neighborhood of the liver, symptoms of the passage of gall stones through either the common or cystic duct, before the onset of the sudden severe pain and collapse accompanying the perforation. In perforation of ulcer of the stomach there will perhaps have been symptoms pointing to its presence before the final perforation took place. Such symptoms are frequently acute pain following the ingestion of food with, perhaps, vomiting, and with some blood mingled with the vomited matters. Perforation of ulcer of the stomach has been found in cases in which no premonitory symptoms were present ; this is especially liable to occur if the ulcer be on the lesser curvature. In perforation of ulcer of the intestine there will, perhaps, have been present some symptoms pointing to the intestinal lesion, such as diarrhœa with bloody stools, or a recent history of typhoid fever or dysentery. In perforation of a stone through the ureter there will, perhaps, have been present symptoms of renal calculus and of the passage of renal calculi on previous occasions. The presence of such previous symptoms may enable us to a make more correct diagnosis, but, with all these points kept well in view, we may frequently be mistaken, because disease of the vermiform appendix may closely simulate affections of the gall-bladder, intestinal obstruction, indigestion or the passage of arenal calculus. Escape of pus from a fallopian tube on the right side may closely simulate an attack of appendicitis. This, of course, would only apply to females, and especially to females after the period of puberty. Rupture of of an ovarian abscesss or the strangulation of the pedicle of a small ovarian tumor by twisting occurring on the right side may closely simulate perforation of the ermiform appendix. The presence of a tumor in this locality, and the previous history of the case, would be our chief guide in coming to a correct conclusion.

In one child I mistook the rupture of an abscess in a gland in the mesentery for perforation of the veriform appendix. The symptoms were sudden, although the child had been complaining of feeling weak and miserable for a week or two before the onset of the sudden pain. When I saw her the abdomen was enormously distended with gas, free in the peritoneal cavity and with pus to the extent of about half a patten pail full. The rupture had taken place three weeks before. She lived for two weeks after evacuation of the pus and gas, and, it was only at the *post mortem* examination that the true nature of the disease was discovered. The father of the patient died of phthisis. The tubercular history, usually present in such cases, may be of some value, but we must also remember that tubercular disease may affect the vermiform appendix. As far as I can learn tubercular disease of the appendix is not likely to occur in children, and when it does occur it is usually only found as an accompaniment of tubercular deposit elsewhere.

Appendicitis must also be diagnosed from typhoid fever. I have seen two or three cases of appendicitis treated for four or five weeks as cases of typhoid fever in one of our best hospitals and in the service of some of our best practitioners. There seems to be a tendency on the part of the profession to place all obscure cases of continued fever with abdominal symptoms among the cases typhoid fever. This would also seem to indicate that quite a few of the patients suffering from appendicitis are troubled with diarrhœa. There is no doubt that intra-peritoneal septic conditions are very prone to produce diarrhœa. I have noticed this effect over and over again in the convalescence of patients subsequent to laparotomy when the cases did not run a truly aseptic course. When the fever continues beyond the alloted space of twenty-eight days without a return of normal body heat, the physician should always be on the watch for pus formation in the pelvis.

I have recently been treating a young woman who has a movable kidney. She was suddenly taken with symptoms that might readily have been mistaken for those due to movable kidney. Movable kidney, in some unaccountable way, produces attacks of pain in the neighborhood of the kidney, vomiting, rise of temperature, and slight diarrhœa. I have seen these symptoms accompanying this condition over and over again. If the kidney be on the right side, as it was in the lady mentioned above, it is difficult to differentiate between the symptoms due to the presence of the movable kidney and that due to an attack of appendicitis. Such mistakes have been recorded