side, rapid breathing, with dullness on percussion over the base of the right lung, he was slightly jaundiced, under local anaesthesia I resected a portion of a rib and evacuated some 8 or 10 ounces of pus. He left the hospital in 14 weeks, cured.

A physician, when called to attend a case of acute appendicitis, should frankly explain the seriousness of such cases, the dangers and complications liable to arise and advise early operation, pointing out that it is a safe operation when undertaken early, a shorter confinement to bed, a wound closed without drainage and the less likelyhood of hernia following.

By fulfilling this duty to his patient he protects himself at the same time from adverse criticism.

CONCLUSIONS

1. Appendicitis is a surgical disease.
2. We have no medical treatment that will reach an inflamed or diseased appendix.
3. Recovery from one or more attacks does not mean a cure, but usually the reverse.
4. It is impossible to definitely diagnose the pathological condition existing, from the symptoms present.
5. Acute cases should be operated upon if possible within 24 hours of the onset.
6. More attention should be paid to chronic appendicitis.
7. Advanced and neglected cases which are apparently hopeless, should be given the benefit of the doubt and operated upon.
8. The public is becoming educated to the necessity of operation in these cases. This should be encouraged.
9. The physician who delays and does not advise early operations is coming in for a fair amount of criticism from the public.
10. The operator should be experienced and be prepared to meet and deal immediately and rapidly with any complication met with at the operation.
11. The dressings, after treatment and care of the patient, in many cases demand more surgical knowledge and skill than the operation itself. A surgeon must have a knowledge of the complications liable to arise after operations, detect them early and know when and how to deal successfully with them.