admission. Stupes and poultices were applied, and large enemata were given; no opium, as the pain was not excessive. The injections brought away a number of hard fæcal masses. The temperature on the third day was normal, the induration and tenderness gradually disappeared, and on the sixth day the sense of resistance in the two sides was equal, and the patient said that he felt quite well. He had had a similar attack six weeks before. Such cases we have all seen, and whatever the morbid condition may be, I think they possess features which separate them from the next group.

Appendicitis.—In the second group of cases the lesion proceeds from the appendix vermiformis, which is liable to various affections—catarrhal inflammation, catarrhal ulceration, obliteration, obliteration of the proximal end, dilatation of the tube, and perforation. Foreign bodies may also lodge in it, and fæces moulded to the tube may become hardened and calcified so as to form small enteroliths.

In a recent report (*Med. and Surg. Rep.*, Oct. 6th, 1888) I gave notes of eleven cases in which I had met with ulcers in the appendix, usually in connection with phthisis or typhoid fever. I have never met with foreign bodies in the appendix. On one occasion five apple pips were brought to me as having been found in, and removed from the tube, in a dissecting-room subject; and in one of the cases in the post-mortem books of the Montreal General Hospital, Dr. Sutherland (who was acting as Pathologist in my absence) records the presence of six or eight snipe shot in the appendix of a man dead from Bright's disease. The resemblance of the small enteroliths to date-stones, frequently leads to error.

Inflammation and ulceration of the appendix vermiformis (so long as it is confined to this tube) may produce no definite symptoms. There may be the most extensive ulceration, the lumen may be completely obliterated, there may be extreme distention, without the patient manifesting any signs of abdominal disorder.

If the appendix is quite free, it is possible that ulceration may go on to perforation, without the tube forming attachments. This, however, is very exceptional. More commonly adhesions form and the perforation leads to localized abscess, the situation of which will depend upon the position of this extremely variable structure. It is most commonly situated in the right iliac fossa, and is either within the peritoneum, when the appendix is entirely surrounded by this membrane, or it is behind the peritoneum, when the appendix (which is rarely the case) has only a partial serous covering. I have seen perforation occur with the formation of localized abscess, within the pelvis in the neighborhood of the broad ligament; in another instance immediately upon the sacrum, the tip of the appendix lying to the left of the middle line; and, in a third instance, the abscess was high up behind the mesentery upon the psoas muscle.

I do not think that sufficient stress has been laid upon the fact, that this local inflammatory process almost invariably precedes the graver manifestations. That healing may take place at this stage, is shown by the occurrence of an obliterated tube closely adherent with fibroid thickening and much pigmentation of the surrounding tissue. Once perforation has occurred with abscess formation, the course is extremely variable. It is within the experience of almost every physician to have seen the pus appear anteriorly in the neighborhood of the groin, where it may open spontaneously. The presence of gas, or even small fragments of fæces, may show that there is open communication with the bowel. Two such cases I saw with my preceptor, Dr. Holford Walker, of Dundas, in 1868 and 1869. One of these cases made a good recovery; the other, with much more extensive abscess formation and perforation in several places (through which gas discharged), succumbed to septic fever. That the tube of the appendix is not always obliterated at its cæcal end before perforation occurs, as is claimed by some writers, is shown by such cases. The pus may burrow and appear in the lumbar region, or it may pass down and appear in the peritoneum and form a peri-rectal abscess. A more favorable event is, when the abscess perforates into a neighboring viscus—the colon, the cæcum, the rectum or the bladder. In a recent report of a case in a French Journal, in which the abscess perforated into the bowel, the characteristic oval enterolith was found with the discharged pus and fæces. Perforation into the bladder is less common. At the Montreal General Hospital, in the Summer session of 1882, I lectured upon two cases in which this event occurred with recovery. I met with a curious sequel in a case