him of the first one; but medical help not being available in the village at night, the mother came to me in her distress.

On asking the girl to show me the seat of pain, again I was misled by her showing me a tender spot just above the midline between the symphysis pubis, and the iliac crest, which appeared to me to be more ovarian than anything else.

The patient was lying in this case on her back with her knees slightly drawn up, twisting from side to side with pain. She had been very sick, first bringing up her mid-day meal in a very undigested form, and then some very offensive smelling stuff. The girl was subject to bilious attacks but this was evidently not an ordinary one.

"I am afraid I cannot help you," I said, "you must send for the doctor." But this was impossible, so I sent for some of the laudanum and chloroform mixture I had used for Case No. 1 and told the mother to apply fomentations during the night. Next morning I found the patient lying on her back in comparative ease, but I told the mother to send for the doctor should the pain return. The pain did return in another few hours, and the father came to me begging me to remain with them until the doctor's arrival. I found the poor girl in intense pain, turning all colours and vomiting violently; her eyes were sunken, her face drawn; she, too, was cold, clammy, and collapsing. The Spartan mother stood by her like a rock, but her lips quivered as she remarked, "I have taught my children to bear pain, and not to make a fuss, but she can't help herself." Poor woman; she was almost apologising for her daughter being so weak as to be at death's door.

Hot water bottles and some brandy restored the patient to such a degree that on the doctor's arrival he thought I had been unnecessarily alarmed. He ordered a soap and castor oil enema which resulted in four copious motions of the most offensive excreta imaginable; in fact, for several days after, she had four, five, and six loose motions, which made one anticipate typhoid. But what was strange was that the day following the enema a universal rash, as red as scarlet fever appeared. The doctor thought it was an "enema rash," which I could not account for, as I felt sure of the asepsis of my syringe, but wondered whether it could have been the cottage soap I had used, but in reading up about appendicitis, much to my joy, I saw that D'Arcy Power spoke about the "so-called enema rash," and stated that he had known of cases of appendicitis who had never had an enema and yet had the rash. This seemed to me very easily explained by the absorption of the fœtid matter in the intestinal tract, and which had probably caused the inflammation of the appendix. Strange to say, I had never heard of an enema rash before, and in discussing the point with others, they told me that it was not an unusual thing in operation cases, which invariably have an enema beforehand, but as far as I recollect, in my hospital we called it the "anæsthetic rash," which seems a more feasible explanation.

It took one week before the rash disappeared, and though the first few days the patient had several attacks of pain and sickness, yet her Spartan upbringing, the splendid constitution and the iron nerves she had inherited, stood her in good stead, and she rose in ten days, "ready for service," having completely escaped the nervous shock her more highly-strung fellow sufferer had undergone.

The lessons I learnt from these cases were:—

1. Difficulty of early diagnosis.
2. Danger of collapse.
3. Nervous shock.

The difficulty of immediate recognition of the condition is as great as it is important. The intensity of the pain is so severe that it is almost impossible for the patient to localise it, and thus the physician may be misled into regarding it as gastric, cystic, uterine, ovarian, or renal; in fact, D'Arcy Power states that one surgeon mistook the condition for a psoas abscess in a child, and not until he operated did he find out his mistake.

Early diagnosis is most vital, as a simple inflammation may end in suppuration, perforation, collapse, and death. I knew of a case in Paris of a young man who went on suffering for weeks, being examined by physicians and surgeons, and the diagnosis was not made until serious symptoms developed, and they hurriedly operated. They found the appendix lying *upwards* instead of *downwards*, and accompanied by a large abscess, so that the seat of tenderness was in a most misleading place, pointing to liver trouble instead.

The principal symptoms which seem to lead to diagosis are a moderate temperature of 100 to 101, a rapid running pulse of 110 to 120, distension, and tenderness, usually accompanied by sickness and constipation.

It is therefore obvious that the diagnosis being such a difficult one, the nurse's duty, pending the doctor's arrival, is to notice and report all symptoms accurately, to apply fomentations to the abdomen, to cope with collapse by the administration of brandy and hot water bottles, and to mitigate the nervous shock.

E. R. W.

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