the disease to be most depressing, while on the other hand patients with disease of the lungs are most hopeful.

If a patient who is apparently going on well is suddenly seized with a severe pain in the abdomen, and vomiting and collapse come on, then you most likely have either a ruptured abscess or a distended appendix. Such a case demands immediate surgical attention, and it is your duty to warn the medical attendant without delay—of course without needlessly alarming the patient.

The same holds good for typhoid fever. A sudden, severe pain in the abdomen, with faintness and collapse, means that an ulcer has eaten its way through the bowel, and the contents of the intestine are escaping into the peritoneum. Prompt surgical interference is the only hope, and on you rests the responsibility of giving warning—and a heavy responsibility it is.

To return to our appendix: There are no drugs which can affect the course of the disease. Symptoms as they arise may be treated, but there is no specific.

After operation the treatment is practically the same as in all abdominal operations. The first indication is rest, and to secure this we must first control the vomiting, which usually occurs after the anæsthetic. The most effective way of doing this is to give nothing by the mouth for several hours. In that way the stomach is not irritated and gradually becomes quiet.

Thirst may be relieved by allowing the patient to rinse his mouth with cold water, but not to swallow it. A rectal injection of saline solution is also helpful, as it is rapidly absorbed. This is prepared by adding a teaspoonful of common salt to a pint of warm water. In cases of collapse the same solution is injected into a vein in order to fill the blood vessels and keep the heart going, for its specific gravity is about the same as the serum of the blood. After a few hours an occasional teaspoonful of *hot* water may be given by the mouth to relieve the thirst.

Opium is not usually given, as it is found that the patient does better without it, but no absolute rule can be laid down about this. After twelve or twenty-four hours a little milk or lime water may be given at regular intervals; until that time nutrient enemata may be given every three or four hours.

The patient at first must be kept lying upon his back, especially if a drainage tube has been used. If allowed any liberty he will toss and turn in a vain endeavour to find an easy place, and the pulling on the wound will not aid in the healing.

The legs may be drawn up, or extended, as the patient desires. If they are drawn up, place a pillow beneath them.

I need scarcely mention that the sheet should be pulled tight so that no wrinkles will distress the patient. If a change of position is earnestly desired, a slight turn to one side or the other, and a pillow slipped under the back and shoulders will afford considerable relief. Avoid twisting the body when turning, as this would tend to open the wound.

It is usually advisable to obtain an early movement of the bowels, as much to relieve flatulence and distention as to favour the removal of more solid contents.

An enema consisting of a pint of soapy water and an ounce each of castor oil and turpentine will frequently stimulate the bowels to contract and expel the gas which is apt to accumulate. This measure, however, depends so much on the exact nature of the operation, that no attempt must be made to move the bowels without instructions.

Washing out the stomach by means of a tube passed down the æsophagus is occasionally made use of to check persistent vomiting, and also to get rid of gas in the stomach. This, of course, is only occasionally necessary.

In private cases it will be your duty to assist at the dressing of the wound. I can give you no general directions, for each surgeon does his dressings after his own fashion. But one point we all insist on—nay, more; we have been accused of making a fetish of it and bowing down in a worship that is by no means silent; that is asepsis, or absolute surgical cleanliness. Be certain that no act of yours introduces any dangerous element in or about the wound. Your motto must be *wash and watch*.

In conclusion, let me say a word on how to diagnose when it is not appendicitis. The good, old-fashioned colic is just as prevalent, just as painful, and no more fatal than of yore. Do not jump at the conclusion that your appendix has gone wrong just because you have a pain. Just wait a little while and think it calmly over before you rush for the thermometer and scare yourself to death, because in your perturbed state of mind you have forgotten to shake it down and find it standing at about 110°.

Appendicitis is not a *very* common disease, and it is probably because it is select that it is so fashionable, but that is no reason why you should be desirous of acquiring it, because, to change the saying a little, you may be out of the world although you are in the fashion.

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