it would have been if they had remained dilated. But if acute appendicitis requiring operation is diagnosed, it is usually better to operate first and to clear the bowel afterwards. The enema seemed to determine the onset of the condition in which alarming symptoms subside, and therefore its effect was to help the patient not to a cure but to a further stage of the disease, to that dangerous state in which the practitioner is tempted to believe that his patient is better, and that operative interference is not necessary. If this view had been adopted in the case now recorded, it is certain that a few hours' delay would have made the conditions very much more serious, if not altogether hopeless. An operation then, or a *post mortem* examination, would have shown an intense general peritonitis affecting the parts around the appendix region most severely.

Whatever the exact interpretation of the symptoms may be, the case illustrates (1) the imperative need for operative treatment in certain cases of appendix mischief, and (2) the importance of sudden cessation of severe pain as a sign that the conditions have become not less but more urgent. I do not believe that appendix cases can be understood until it is recognized that there are two distinct forms of mischief—one, inflammation commencing in the mucous membrane; the other, gangrene brought about by the action of a necrogenic microbe which causes no inflammation until the dead part is separating, or has separated. Each of these conditions may complicate the other, but typical cases are easily defined. There can at least be no question that, in many cases of gangrene, operative treatment is alone of use, whilst there are other cases in which even severe inflammation causes little real danger.

But the difficulty of recognizing which condition exists is sometimes so great that the surgeon thinks the safest course is to assume the worst, and operate at once, believing that if the patient would recover without operation, an operation will not prevent his recovery, and knowing that if the appendix is ruptured without adhesions having formed, delay in removing it is exceedingly dangerous, whilst a sufficiently early removal is almost always successful.

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TWO CASES OF GANGRENOUS APPENDICITIS WITH UNUSUAL HISTORIES.

BY

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THE two cases of appendicitis the histories of which are given below were met with within twenty hours of each other, and, showing as they do several points of interest, are, I think, therefore worth recording.

CASE I.

J. P., male, aged 9 years, was first taken ill on September 1st, 1912, when he complained of pain in the stomach. He had previously been healthy, although from infancy he had from time to time complained of pain on passing water. When seen first he had no objective symptoms; the pulse was 88, and the temperature normal, the belly soft without any tenderness; a bismuth mixture was prescribed. Between September 1st and September 6th he was seen each day. The pulse remained steady and below 90, and the temperature both night and morning was normal. When seen he was generally playing with his toys and free from pain, though there was always the story that he occasionally would cry out with paroxysmal attacks of sharp pain. His bowels were opened each day. On September 6th I was sent for as the child had been attacked with severe pain while passing a motion. On examining him an hour after the pain had commenced I found his belly wall absolutely rigid. The pulse was 80, and the temperature 98.8°. The tongue was moist, but he wore a somewhat worried look. I diagnosed acute abdomen, and had him removed to hospital. On admission the temperature was 101.4° and the pulse 120. I operated immediately and found the belly full of pus. On feeling for the appendix I found it hanging over the edge of the pelvis. It was adherent to the bowel and bladder, but was separated with ease. It was a long one; the first 2 in. appeared healthy, but distal to this it was enlarged to the thickness of one's thumb. It was gangrenous and had a perforation. On opening it I found a

concretion the size and shape of a "monkey nut." The appendix was removed, the pus swabbed out and the belly drained in four places, in each loin and in each flank. The boy made an uneventful recovery.

CASE II.

J. C., male, aged 32, came to consult me on his way home from work on September 5th, complaining of severe pain in his abdomen; the pain was localized and was eased by pressure. I found no tenderness of the abdomen. I was able to feel the outline of the pelvic brim throughout its whole extent, and no tenderness was elicited on deep pressure; the pulse was 80 and the temperature 98.2°. He was sent home to bed with a simple remedy. I was called to see him on September 7th, and found that he had been vomiting all the preceding night. The pulse was 88 and the temperature 98.6°. There was no tenderness on deep pressure in the iliac region nor in any part of the abdomen. The tongue was moist, but his face had a slightly anxious mien.

I think because of the remembrance of the case of the preceding night more than because of any definite signs or symptoms, although the man's expression was suggestive, I determined to explore his abdomen. On opening the belly a little clear fluid escaped. I felt for the appendix and found it lying in exactly the same position as in the case of the boy, hanging down into the pelvis against the bladder. I removed the appendix, and here again found the first 1½ in. healthy, the distal 3 in. gangrenous and enlarged to the size of a small banana. I put in a large drain, swabbed up the fluid in the abdomen, and sewed the rest of the wound up. This patient also made an uneventful recovery.

On incising the appendix I found the dilatation full of pus and containing six tin tacks and eight little shot. To explain the presence of this medley I subsequently discovered that the patient up to eight years ago followed the trade of a joiner, when he was accustomed to hold the nails in his mouth. The nails, he explained, were thrown from a box which contained small bits of lead and other remnants into his mouth, and he remembered that he often got odd bits of lead, etc., in his mouth with the nails.

From these two cases several interesting and instructive lessons, I think, may be gained.

Neither patient had a raised temperature or quickened pulse, although in both cases we must, I think, presume that pus was present in the appendix before the acute symptoms arose. I think the explanation of this lies in the fact that the appendix in each case was chronically thickened by the presence of the foreign bodies and therefore there was no escape of poison into the circulation and no infection of peritoneum.

In the case of the child the perforation occurred obviously while he was straining at stool, which is an interesting point.

The paroxysmal pain which each patient suffered before the acute symptoms was a true appendicular colic, the organ trying to expel the foreign bodies it contained.

Almost all surgeons are now agreed as to the advisability of operating immediately appendicitis is diagnosed, but here were two cases with an appendix enormously dilated which were not diagnosed before acute symptoms supervened, although both cases were examined systematically and thoroughly with one clinical method omitted—that is, examination per rectum. The excuse for this is obvious; there was nothing to lead one to suppose mischief in the appendix, although it was carefully examined, but I feel confident that, had a rectal examination been made, the local tenderness would have thrown light on the condition one had to deal with, and spared the patients the acute termination which so greatly endangered their life. These cases emphasize the importance of this examination being made as a matter of routine in all abdominal cases.

Another point which both these cases illustrated is the importance of the abdominal facies. When first seen, except for the rigid abdomen in the case of the boy, neither patient had any objective symptoms except this worried anxious look.

THE late Dr. Frederic Bagshawe, of St. Leonards, left estate valued at £80,817, of which £78,534 was net personality.

HEARSEY, in his sleeping sickness *Diary* (Part XVIII) for the Nyasaland Protectorate, states that since the issue of the last number 17 additional cases of the disease have been diagnosed by Dr. Shircore. These, added to the 76 previously recorded, make a total of 93 cases. The value of a new drug, "Dye B. S. (Brieger and Krause)," was tested in some of the cases, but Dr. Shircore finally came to the opinion that it was not only useless as a therapeutic agent, but might even be harmful.