is, from the third day of the acute symptoms until the sixth or seventh. So far as the former are concerned, it is fairly well agreed now that the line of safety lies in avoiding all delay. The earliest operations are the most successful, not only as regards immediate mortality but as regards rapidity of recovery. It needs no proof that if a septic focus has to be removed the operation is much more likely to be successful if the organisms are still confined within the appendix, than if they have already spread into the surrounding peritoneal cavity. The voice of what is commonly called authority, but what is really often only ill-informed prejudice, opposed this for a long time, but now at last has given way. With regard to the others, however, operations performed in what I have called the intermediate period, there is still some doubt because of their high rate of mortality. It is often said that if the first chance of removing the whole focus of infection has been lost, it is wiser to wait awhile, in the hope that in the few days' time it will become localized again, and walled in once more. I cannot say that I agree with this. I believe that it is much better for the patient to have the operation done at once, no matter if it is in the intermediate period, always provided, and this I think is essential, that too much is not attempted. If a thorough complete operation is performed at this stage, I admit the mortality is too high, and that more patients' lives would be saved if they were let alone. But this is not the case if only what is absolutely necessary is done. The condition of things is very simple. The septic organisms have spread through the walls of the appendix and are infecting everything around. Everything around in its turn is striving to resist the spreading infection. Anything like a complete operation can only do harm, for it must injure and impair the vitality of the surrounding tissues and render them less and not more capable of resistance. What should be done is the least possible. A fairly free opening should be made in the right iliac fossa, down to the focus of infection, and unless the appendix actually comes away of itself, nothing further should be attempted. A drain should be inserted and the wound very lightly packed with gauze to prevent the possibility of prolapse of the bowel, and nothing more. An opening made in this way provides a line of least resistance. So long as the abdominal wall was intact, the germs in spite of the opposition offered by the surrounding structures, kept spreading wider and wider. An opening such as this at once enables the surrounding structures to resist their advance and drive them out. It reverses the balance of pressure. Since I have adopted this plan, I have never had occasion to regret it. I do not mean that I have saved life in every case, but I am sure I have done it in a much larger proportion of cases than I should have if I had adopted what is called expectant treatment, or, in other words, left things to chance. Later, when the patient has thoroughly recovered from the acute septic stage, and the resistance of the tissues is thoroughly well established, the operation can be completed by removing the appendix.

FIBROLYSIN IN CICATRICAL PYLORIC OBSTRUCTION.

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THE point of interest in the following case is that it illustrates the marked property which fibrolysin (a modification of thiosinamin, consisting of a double salt of thiosinamin and sodium salicylate) has of rendering hard fibrous adhesions sufficiently soft to allow them to be stretched.

I. McM., house painter, aged 60.

Family History.

Noteworthy only in respect of patient's father who lived till the age of 70, and who had "stomach trouble" for many years.

Patient's History.

He suffered as a boy at school with "pains in the bowels," constipation and occasional attacks of vomiting.

He began his trade of house painter at the age of 15, and not until he was 25 did he feel pains similar to those from which he has recently suffered, at the level of the umbilicus, along with intermittent attacks of vomiting. These symptoms continued for about five years, after which came a period of comparatively

good health till he reached the age of 48, when he had an attack of plumbism confined to the symptoms of colic, constipation, and a blue line on the gums, the nervous system escaping. When about the age of 50 gastric trouble recurred, and took the form of "hunger pain" coming on two or three hours after a meal, and also markedly in the middle of the night. Vomiting was frequent in the afternoon and in the interval between tea and bedtime, pain being relieved thereby. The vomited matter consisted of undigested but recognizable food, showing lack of motor power in the stomach, narrowing of its pyloric orifice, or probably both. It was not particularly sour, proving that fermentation was not a prominent factor.

Treatment.

The above condition continued, more or less, till he came under my care in November, 1907; at that time there was considerable dilatation of the stomach, splashing being readily elicited.

He was much emaciated, and hardly able to do any work. His height was 5 ft. 7 in. and weight 8 st. 6½ lb. I began treating him by lavage of the stomach and argenti nitratis gr. ½ in pill taken twice daily, diet consisting of milk, raw eggs and meat purées. Under this régime he improved, vomiting ceased, pain was relieved and there was an increase in weight.

Towards the end of February, 1908, he had a recurrence, and similar treatment was again tried, but the symptoms were so severe that I suggested gastro-enterostomy; this he declined.

I then began hypodermic administration of fibrolysin in the epigastric region in doses of 2 c.cm. daily for a month, every other day for a week, and thereafter at intervals of three or four days for three weeks more, at the end of which time all treatment ceased. Massage of the abdomen—especially in the region of the stomach—was carried out daily for a month, commencing on the same day as the fibrolysin injections, and was stopped at the end of that time. Internally a mixture containing liquor strychninae and nitro-muriatic acid was administered and a diet consisting of milk, farinaceous food, raw eggs, and fish.

The result of treatment with fibrolysin showed itself within the first week after its commencement by greater comfort generally, cessation of vomiting after ten days, and of all pain within a fortnight. Constipation from which he had suffered all his life, improved, the bowels acting once a day without the administration of any aperient medicines. He rapidly put on flesh and gained in vigour, and has done his day's work ever since without fatigue or discomfort of any sort. His weight is now 10 st.

There were in this patient obvious symptoms of pyloric obstruction, as evidenced by the persistent vomiting and the "hunger pain." The obstruction was probably caused primarily by some superficial ulceration of the pylorus, leading on to irritation and consequent increase of fibrous tissue in the neighbourhood, the latter finally encroaching on the lumen of the pylorus.

There is one factor necessary to success in treatment of adhesions (wherever they may be situated) by fibrolysin, and that is that they must be in such a position where they can be massaged and stretched. Otherwise, although they are rendered soft, they remain in the same relation to surrounding tissues, and no good result is obtained.

In this patient massage was carried out externally by the hand, the motor power of the stomach being thereby encouraged—and stretching of the adhesions was effected by this power being brought to bear on the contents of the stomach, forcing them through the narrow but now dilatable pylorus.

Had the peristaltic action of the stomach been insufficient to force the contents through its pyloric orifice, no result would have followed the use of fibrolysin and external massage alone, for the contents of the stomach act in the same manner as a bougie, an instrument essential to success in situations where its use is possible. It is therefore necessary in treating such cases as the above by this method that the stomach be capable of some peristaltic action, otherwise operation offers the only hope of cure.

DR. STEPHEN J. MAHER, of New Haven, Connecticut, in a paper published recently in the *New York Medical Record*, stated that tuberculosis was a disease of the Indians before the white man came. It had now occurred in all parts of the State, and there was considerable evidence to show that it had occurred most frequently in badly drained districts, and in houses with damp cellars. Only a minority of the cases had followed other cases in the same house. The density of population of counties bore no relation to the prevalence of tuberculosis. There had been a marked decline in the death-rate from the disease for the past fifty years, and this had been regular before the discovery of the tubercle bacillus.