sometimes by specialized determination of effort towards particular issues. In relation to tuberculosis both lines of approach have tended towards the decline of mortality.

A Tubercle-free Herd.

My view regarding the control of tuberculosis in the human species is in keeping with the lines on which the farmer can establish and maintain a tubercle-free herd. When the Tuberculosis Trust of Scotland resolved to form such a herd procedure took two directions: (1) towards the elimination of infection within and the exclusion of risk of fresh infection from without; (2) towards the maintenance of the herd under completely physiological conditions of environment. The first requirement was met by the institution of careful antituberculosis measures and application of tuberculin tests, and the second by scrupulous regard to air, sunlight, space, nutrition, cleanliness, and the education of farm and dairy hands. Incidentally, it may interest members of the society to know that the young immature stock (prior to milking age) passed the whole of last summer—wet though it was—and the whole of this winter—cold and stormy as it has been—on a hill pasture at an elevation of 800 to 1,000 feet, in the open air, day, and night, without one case of sickness. We began operations five years ago, and for the last three years the entire stock, numbering 109, has stood the rigid tests imposed by the chief veterinary inspector of the city.

In handling the more complex problem of tuberculosis in man, medicine has in view both sides of the shield: first, the limitation (exclusion?) of infection; second, increase of resistance. The tuberculosis scheme, as built up in this country, rests largely on those foundations. On the one hand, every fact in the natural history of the infection comes to have value, along with facts from comparative study of other endemic and epidemic diseases. On the other hand, the great physiological principles which preventive medicine has known how to harness and hitch to her wagon on other roads have been adapted to the problem of tuberculosis, and have been expanded by the convincing lesson of the sanatorium and open-air school.

Scientific Patience.

For the appraisal of results patience is necessary—scientific patience. It is essential to remember that tuberculosis differs from other infective diseases in respect of duration and of clinical expression. It is a disease of a lifetime—it may be from infancy to old age—and its protean manifestations change with the seven ages of man. Assuming that our antituberculosis measures are sound, we cannot expect the entire effects to be registered quickly. The gains can be gradual only, with acceleration of the pace as time goes on. More marked reduction is likely to be evident at certain ages in relation to certain aspects of intensive activity. That is pretty much what we are finding—a postponement of death, a saving of life in childhood and in early adult life.

The Registrar-General for Scotland, Dr. J. C. Dunlop, to whom I am indebted for invaluable co-operation on the statistical side, has drawn my attention to the remarkable fact (Table V) that, out of a total saving of life in Scotland between the ages of 15 and 35 during the year 1921, as compared with 1891 (three-year mean), more than half was due to reduction in mortality from pulmonary tuberculosis.

To me, as a fairly seasoned hand, the outcome appears satisfactory. In so complex a situation it is hazardous to attach rigidly cause to effect. Rather than try to credit the result to this or that particular factor it is, in my opinion, more just and sound to admit that there have been numerous contributory factors. The continuous decline in mortality, the recent acceleration of that rate of decline, and the displacement of tuberculosis from chief place in the list of killing diseases, have been due to a combination of influences and activities which have found practical expression in the tuberculosis schemes of the country. To this it should be added that, when all is said and done from the side of medicine, another factor of governing importance must not be lost sight of—namely, the determination of the nation to face the issue, cost what it may.

THE TREATMENT OF ACUTE APPENDICITIS.*

BY

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In a consideration of the treatment of acute appendicitis it is relevant to point out that the number of deaths from this disease in England and Wales has not diminished during the past fifteen years, yet it is certain that the proportion of favourable cases—that is, the early cases—that are submitted to operation is much higher now than it was fifteen years ago, and also it is fair to assume that the improvement in operative technique during the same period must have helped to reduce the case mortality.

It may be suggested, therefore, that the maintained national mortality rate is due to an increase in the number of cases—an actual increase or an increased recognition of the disease. An examination of the annual statistical reports of the Manchester Royal Infirmary shows a steady and substantial increase in the number of these cases during the last fifteen years, but during the same period at this hospital the case mortality of the disease has fallen to such an extent that the gross number of deaths per annum at the end of the period is much less than it was at the beginning. Thus in the practice of one of the largest general hospitals in the country a steady increase in the number of cases during the past fifteen years synchronizes with a substantial fall in the actual number of deaths from this disease, and, that being the case, the maintained national mortality rate of acute appendicitis ought to be a matter of concern to the surgeon, particularly if he is also a teacher of surgery.

The foregoing remarks are based on the following statistics.

Acute Appendicitis and Perityphlitis in England and Wales.

(From the Registrar-General's Returns.)

Average annual number of deaths per million persons during the four years ending 1914=70.

Average annual number of deaths per million persons during the four years ending 1926=72.

Manchester Royal Infirmary.

(a) In the three years ending 1915 the average annual number of admissions of acute appendicitis = 550, or 5.4 per cent. of the total admissions to hospital.

Average annual number of deaths from acute appendicitis in same years=69.

(b) In the three years ending 1926 the average annual number of admissions of acute appendicitis=830, or 7.6 per cent. of the total admissions to hospital.

Average annual number of deaths from acute appendicitis in same years=48.

POLICY OF IMMEDIATE OPERATION.

An account of the treatment of acute appendicitis cannot ignore the divergence of opinion among surgeons on the policy of immediate operation in all cases irrespective of the duration and pathological development of the disease. Surgeons in this and in all other countries in which appendicitis is prevalent agree in advocating removal of the appendix in all cases in which the disease is still limited to the appendix, before perforation or before the onset of a local or spreading peritonitis, and no one with any experience of abdominal surgery, I think, would venture to criticize this policy. It may be asserted with confidence that there is no more beneficent operation in surgery than the removal of a gangrenous or tightly distended appendix whilst this is still intact. So, too, at the other end of the scale, when a case is seen for the first time late in the course of the disease, and on the one hand there is clearly an abscess, or on the other hand the disease is manifestly subsiding without suppuration, no one would dispute the propriety of operation for evacuation of the abscess in the one or of a policy of masterly inactivity in the other. But it is in between these two stages that the surgeon first encounters the great majority of his cases; in this large group peritoneal infection has taken place which may be localized or diffuse, and even if

* A paper read before the Manchester Surgical Society at December 6th, 1927.

localized the intensity of the infection varies considerably according to the type of appendicular lesion. It is in the treatment of cases in this group that there is some difference of opinion; though it is probably correct to say that the great majority of surgeons advocate immediate operation, and that those who advise postponement of the operation are decidedly in the minority.

The advocates of postponement, amongst whom are Sherren,¹ McNeill Love,² and some of the surgeons of St. Thomas's Hospital, advise that in those cases of acute appendicitis which come under the notice of the surgeon only after perforation and the onset of peritonitis, local or spreading, no operation should be performed until the patient's response to careful non-operative treatment in hospital or nursing home has been observed; that approximately in two out of three such cases the disease either will subside entirely or will terminate in a well-localized abscess which may be safely and simply evacuated after the acute phase has passed; and that those cases in which, after a period of one to three days, the disease appears to be extending, the operation can be carried out without more risk to life than obtains when the operation is carried out at once. In all those cases in which the disease subsides without operation, appendicectomy is carried out as soon as it appears wise to do so. In support of this policy of delay is it urged: (1) that the mortality rate in this large group as a whole is reduced; (2) that the incidence of post-operative complications is substantially reduced; (3) that the period of illness and disability is shorter and less trying to the patient.

My own opinion in this matter is largely influenced by the experience of a recent series of 245 consecutive cases of acute appendicitis, all of which have been under my care and have been closely observed by me. No cases which were manifestly settling down at the time I first saw them have been included in this series. In 52 of these the operation was postponed, and it should be said that in selecting these at the time of the first examination I chose them from the large group of local peritonitis cases, and in no case was operation deferred for spreading or diffuse peritonitis. All of them were treated in hospital or nursing home. The results in these 52 can be grouped in three classes:

A.—Twenty-eight settled down completely within one to two weeks. All but 3 had appendicectomy performed a few weeks after settling down. There were no deaths and no complications. There is no doubt in my mind that many of these cases scored heavily by this policy.

B.—Twelve cases terminated in the formation of a local abscess which required operation for drainage; in 8 of them it was impossible to remove the appendix, but of these all save one submitted to appendicectomy a few weeks later. There were no deaths and no serious complications in this group, though the healing of the drainage track occupied four to six weeks in three of them.

C.—Twelve cases required operation during the acute stage after periods of delay varying from one to four days. There were 3 deaths; of these, 2 were due to intestinal obstruction, which in one case was present at the time of operation and was the reason for the operation, and in the other it developed three weeks after the operation when the patient was ready for discharge from hospital; one death was ascribed to acute toxæmia a few hours after operation; in this case the operation was not performed by me, but as I advised delay in this case, and two days later advised operation, it is right to include it. Of the 9 cases that recovered the appendix was removed in 8. In one of them the condition of the patient unquestionably became much worse during the period of delay, owing to toxæmia from a progressive abscess and to associated ileus. He was only retrieved by operation for evacuation of the abscess and mobilization of the terminal ileum, followed by assiduous after-treatment.

In 193 cases (approximately four-fifths of the whole series) the operation was performed without delay after the first examination irrespective of the duration or stage of the disease. These may be grouped into the following types.

GROUP A.—Appendix not Perforated (65 Cases).

Many of these cases were instances of gangrenous appendicitis, and several yielded a history that covered more than two days—the conventional duration of the pre-perforative stage.

There was one death from pulmonary embolism eleven days after operation, in a stout woman of alcoholic habits.

Complications.—One patient developed panophthalmitis twenty-eight days after operation; two weeks after operation, when apparently well, he was allowed to get up; the temperature rose the same night and assumed a septicæmic type for the next four weeks. The eye was eventually removed. In the notes on the operation made by me the same day it is stated that the appendix, a high retrocolic one, was entirely gangrenous, and

during extraction some leakage of its contents was unavoidable; the wound suppurated a little. There was one case of minor pulmonary embolism. In 6 cases there was a mild degree of wound suppuration. There were no cases of post-operative pneumonia.

GROUP B.—Local Peritonitis (84 Cases).

The cases in this group had pus in the peritoneal cavity around the appendix, usually associated with perforation of the appendix, but in several there was no visible perforation.

There were two deaths, one from intestinal obstruction that began six days after operation for pelvic peritonitis—a case with a history of only twenty-six hours' illness before operation. The other death was from septicaemia (? portal pyaemia) eight weeks after operation and two weeks after discharge from hospital. This man was in good condition when discharged home, but there was a clean sinus in the wound; his home surroundings were very bad, and the dressing was done by his aged wife.

Complications.—There were 7 cases of post-operative pneumonia (4 of these were in children under 12 and all except one were on the right side). One patient had intestinal obstruction, subacute, and recovered without operation. There was one case of pelvic abscess requiring drainage by the rectum fourteen days after operation, and there was one case of subphrenic abscess.

GROUP C.—Spreading or Diffuse Peritonitis (31 Cases).

The condition was always associated with a visible perforation in the appendix or with a leaking appendicular abscess. In the former type the history in 17 cases did not exceed forty-eight hours; in the latter type the history clearly fell into two phases—the first phase of moderate pain and vomiting, often not causing total incapacity, and the second phase, beginning two to four days later, marked by sudden onset of very severe pain and more or less collapse. Only 2 cases could be classed as having general peritonitis, and these account for 2 of the deaths.

There were 4 deaths in this group, as follows: One case of ileus and secondary haemorrhage of undetermined origin despite *post-mortem* examination—case of general peritonitis. One case of general peritonitis four days after operation—case of general peritonitis at operation; *post-mortem* examination. One patient died under the anaesthetic—ether convulsions. The fourth death was that of a patient with ileus plus pulmonary oedema supervening on chronic bronchitis and emphysema. After admission of this patient to the home the operation was delayed for twelve hours because of his bad general condition; in addition to chronic bronchitis he was very fat and heavily addicted to alcohol. His condition appeared to be worse, locally and generally, after twelve hours, and I regarded his chance of recovery as very small with or without operation, but as slightly higher with operation.

Complications.—One case of acute intestinal obstruction seven days after operation; the patient recovered after enterostomy. One case of pelvic abscess requiring drainage by the rectum. One case of subphrenic abscess drained two and a half months after operation. Four cases of pneumonia of the lower lung—on the right side in three and bilateral in one. Two cases of breakdown of wound with extrusion of bowel on to the abdominal wall on the seventh and eleventh days respectively. Both were associated with severe wound infection and persistent cough. Both recovered after re-suture and support of the abdominal wall by adhesive strapping.

GROUP D.—Abscess (13 Cases).

This group consisted of patients with a history of seven to fourteen days' illness. There were no deaths. The appendix was removed in 4 cases only. The one complication was in a patient with a minor type of pulmonary embolism.

The summarized results in the whole series is as follows:

245 consecutive cases with 10 deaths, or mortality rate of 4 per cent.

193 cases were operated upon at once with 7 deaths, or mortality rate of 3.6 per cent. All these, except those admitted in the terminal abscess stage, had the appendix removed.

52 cases had their operation postponed with 3 deaths, or mortality rate of 5.7 per cent.

In 24 of these operation had to be performed during the acute stage or because of abscess, and in 9 the appendix was not removed.

It may be that it is misleading to compare these two mortality rates, for the cases operated upon at once include 62 in which the appendix had not perforated and in which there was no marked degree of local peritonitis, whilst all the deferred ones presented clinical evidence of local peritonitis; on the other hand, the deferred cases do not include the more severe types, for in no case was the operation postponed in diffuse or widespread peritonitis. Remove the non-perforated cases altogether and the mortality rates are 4.6 and 5.7 per cent. for immediate and deferred cases respectively.

In attempting to measure the value of the policy of delay I attach more importance to consideration of the features of the more severe cases in each group. Of the 7 patients who died in the immediate class, in 3 the duration of the illness before operation did not exceed thirty hours; 2 of these had perforated and had pelvic peritonitis, and I think it very doubtful if the advocates of delay after perforation would have elected to practise the method in

such early and severe cases; one (death from pulmonary embolism) had not perforated, and is therefore irrelevant in this argument. Of the 4 remaining deaths, one, a youth in relatively good condition, died of ether convulsions during the operation, and the 3 others presented at the operation such widespread peritonitis, coupled in 2 with a very unfavourable general condition, that there is not the slightest ground for thinking that delay would have altered the issue in any case. As already stated, in one of them a delay of twelve hours was made on account of the patient's unsuitability for anything but imperative surgery. Now of the 3 deaths in the unsuccessfully delayed cases, one died of acute intestinal obstruction during convalescence, and his death cannot, in my opinion, be attributed to the delay in operating; but in the matter of the 2 other deaths I felt at the time that their prospects of recovery had been reduced by waiting. Then of the 9 who recovered after a delayed operation done in the acute stage, one at least ran a much greater risk than he would have done if he had been operated upon when first seen. Deterioration of the patient undergoing non-operative treatment for appendicular peritonitis is not merely due to extension of the peritonitis or an increase in size of the abscess, but often is the outcome of ileus caused by implication of the lower ileum in the walls of the abscess cavity, and to the resulting inflammatory infiltration of the bowel wall.

Of the 115 cases with local or diffuse peritonitis which were operated upon at once the majority of these made rapid recoveries (70 of them were soundly healed within two and three weeks), and all without exception had the appendix removed. It seems highly improbable that the delayed method would, if it had been employed in all of these, have given results nearly so good. I am therefore opposed to the policy of delaying operation in all those cases of acute appendicitis in which perforation and peritonitis, local or diffused, has occurred. I think any policy based on a sharp distinction between the periods before and after perforation is unsound. Some of the worst cases in which operation is urgently required are those that begin with perforation; I have operated upon several such cases within four to six hours of the first symptom and found a large perforation, whilst in the less acute types it is frequently not possible to determine with precision whether perforation has or has not occurred—particularly so in pelvic cases. So, too, any policy based on the duration of the disease—that is, a policy which lays down that cases seen within the first forty-eight hours should be operated upon at once, but that in those seen after the second day and up to the fifth or sixth day the operation should be delayed—is ill founded; observations at operations, if correlated with the history of the case, will show that time and pathological progress do not keep pace. In my belief some of the third-day cases are those in which the immediate operation is most essential, in view of the pathological conditions revealed at operation, and, in the hands of an experienced operator, the great majority of such cases do very well. To hold these opinions is not to believe that every case of acute appendicitis should be operated upon at once simply because the disease is regarded as active. It is certain that a considerable proportion of cases, even after the occurrence of peritoneal infection, will subside under proper treatment without operation, and that if we were able to pick out these cases we might in many of them defer the operation, with great advantage to the patient, to a quiescent period. But to make this distinction in all it is necessary to keep the patient under observation for one to three days, and most surgeons feel that the advantages to the patient who does settle after this period are outweighed by the increased risk to the patient who does not. However, I believe it is possible to exercise discrimination in some without adding to the risk of the others.

After all, the tendency in the past twenty years has been to put the operation for acute appendicitis almost on the same footing in the matter of urgency as the operations for acute intestinal obstruction and perforated gastric ulcer, and in 10 per cent., or possibly 20 per cent., of the appendicitis cases this is correct. But is it right on that account to abandon all effort at discrimination in regard to the 80 per cent., especially in view of the commonness

of the disease and the consequence that the operative work must therefore at times be performed by those whose training and experience do not fit them to undertake such an important and serious operation? In seeking a basis for this discrimination, though I have argued that it is unwise to attempt a hard-and-fast division into classes according to lapse of time or occurrence of perforation, I think we may from our clinical experience and observations at operations recognize certain types in which it is safer, and in other ways better for the patient, that immediate operation should not be undertaken. Such, for example, as the following.

1. The patient who presents a firm hard mass in the right iliac fossa, in the right loin, or over the fore part of the iliac crest; the mass is ill defined at its edges, is often extensive, and is free from marked tenderness. The history shows a duration of four to eight days, and during much of this time the patient has had insufficient or no treatment; he has been out of bed and possibly at work. Such a case will commonly subside entirely under proper treatment; much less frequently the mass will slowly resolve itself into a well shut off abscess, which can be easily and safely opened. An immediate operation in such a case is likely to prove difficult and unsatisfactory to the surgeon, and the convalescence following it will be protracted and troublesome. Furthermore, an operation performed as an emergency in this type of case will now and again disclose a mistake in the diagnosis—a mistake which may involve the surgeon in an operation for which neither he nor the patient is suitably prepared.

2. The patient in an earlier stage of the disease, with a history of two to four days' illness not marked by a severe onset, who presents an area of well-localized muscular rigidity, without extreme tenderness, over the appendicular site. His temperature is raised, his pulse moderately accelerated; the increase of both is often accentuated when first seen by recent transit to hospital or home. Such a patient is by no means always best dealt with by immediate operation, and the following circumstances should be regarded as indicating a temporizing policy in this type:

(a) Retrocolic position of appendix as shown by position of rigid area and of maximum tenderness.

(b) Condition of patient unfavourable for an abdominal operation without a period of observation and preparation, by reason of stoutness, chronic bronchitis, especially if there is much emphysema, alcoholic habits, and senility.

(c) History of many attacks of approximately equal severity in the few years preceding this attack.

(d) An environment unfavourable for a serious abdominal operation and for the necessary after-care of the patient.

On the other hand, a patient of healthy type who presents localized but well-marked rigidity accompanied by extreme tenderness, and whose history indicates a severe onset or a severe exacerbation since onset, should generally be operated upon without delay. So, too, evidence of a pelvic position of the appendix or of spreading peritonitis is strong ground for the performance of an immediate operation.

Finally, I would suggest that in those cases in which the disease is allowed to subside without operation it is wise to allow an interval of three to eight weeks before undertaking appendicectomy; a long duration of the process of settling down demands a long interval before appendicectomy.

TECHNIQUE OF THE OPERATION.

Incision.—There is no incision that can be called the best; of the three—the gridiron (McBurney's), the Battle, and the paramedian—which are in common use I prefer the paramedian in most cases. I particularly employ it in cases of diffuse peritonitis and of pelvic peritonitis, and if in such cases drainage of the peritoneal cavity is required it can be satisfactorily employed through this incision without making an additional stab wound. The tube should be made to pass through a slit in the rectus muscle so as to allow this structure to fall back into its natural position. In the case of suppurative peritonitis localized in the right iliac fossa this incision may be objected to on the ground that the operator crosses clean

peritoneum to reach the infected field; as a matter of fact, an approach to an infected area which at the outset allows the boundaries of this area to be determined and maintained by suitable packing is often better than an approach which conducts at once to the centre of the affected area. The McBurney incision is well established and its advantages well realized. In easy cases it is admirable, but the clean removal of a pelvic or a high retrocolic appendix may present considerable difficulty through this incision; so, too, the exposure of the pelvis in cases of pelvic peritonitis is inferior to that obtained either by the paramedian or Battle's incision. Incision for drainage of an abscess should be made as small as is compatible with good access, and in such a position as to afford the most direct route to the abscess cavity. Pelvic abscesses which are pressing down on to the anterior wall of the rectum should be opened through the rectum in either sex.

In the performance of the operation, after the protection of uninfected areas of the peritoneum and as far as possible of the edges of the wound, and the gentle wiping away of any pus that may be present, the location of the appendix is determined. The extraction of an unperforated but friable or even gangrenous appendix without rupturing it or allowing the slightest leakage of its contents is by far the most important step in the operation for acute appendicitis in its preperforative stage; if the appendix is firmly embedded in a retrocolic or pelvic position it is generally better to remove it by first dividing its base, invaginating the caecal stump, and then dividing the appendicular attachments from base to tip. For this procedure a free exposure is required. The intact removal of a gangrenous but unperforated appendix is followed by a recovery indistinguishable from that following a quiet appendicectomy, but rupture of such an appendix during removal is likely to have a serious sequel during the period of recovery, though the association is easily overlooked. In cases of pelvic peritonitis, particularly the type in which the pus is confined to the right posterior quarter of the pelvis by the terminal ileum and its mesentery, which together overlie the appendix and surrounding pus like a hood, it is important after removal of the pus and appendix to set the ileum free from the fibrinous adhesions that bind it to the post-pelvic wall. The condition of the ileum must also be carefully inspected; in the presence of a foul-smelling abscess around a gangrenous appendix the ileum may be intensely hyperaemic and its walls swollen and rigid and here and there covered by plates of necrotic lymph; bowel so affected is often contracted and flattened. Such a state apparently indicates an absolute incapacity of the bowel to transmit its contents, but rarely is it necessary to do more than insist on a rational plan of after-treatment. There is no need to short-circuit the bowel or to perform enterostomy, but for the next forty-eight hours or more the patient should receive practically the whole of his fluid requirements by means of the subcutaneous injection of saline solution—by mouth only a minimum quantity of water to allay thirst should be allowed. After forty-eight hours gradually increasing quantities of water may be allowed as the subcutaneous supply is withdrawn. In widespread peritonitis this plan of after-treatment is also of the greatest value.

In regard to drainage of the peritoneum, the tendency of the majority of surgeons to employ drainage less and less has been a feature of the surgery of acute appendicitis during the post-war period; and it would seem that the results on the whole amply justify this tendency. Space forbids me to say more than that dispensation with drainage should depend, not on boldness of spirit, but on good technique in the performance of the operation. This subject has been ably dealt with by St. Leger Brockman³ in a recent Hunterian Lecture.

After-Treatment in Cases of Pelvic and Diffuse Peritonitis.

(a) The amount of water allowed by mouth should be severely restricted during the first forty-eight hours because of the functional impairment of the lower small intestine; fluid must be given freely, but by rectal or subcutaneous routes—by the latter more particularly when the ileum is known to be badly damaged.

(b) Purgatives should not be given; a simple enema every day or on alternate days will suffice to empty the colon of its contents.

(c) Abdominal distension, gripping pains, and vomiting of intestinal contents on the third to fifth days are often due to failure to realize the importance of measures (a) and (b). In the presence of these symptoms stomach lavage should always be tried before contemplating operation. If operation proves to be necessary, then enterostomy, by a self-closing method above the highest inflamed loop of small intestine, is probably the best measure.

(d) Lastly, beware of the patient who has a persistent cough and a badly infected wound—as sometimes follows operation for a virulent and widespread peritonitis; if the sutures are seen to be cutting deep slits in the skin, then the wound edges should be firmly approximated by adhesive strapping (this is laced across the wound so that the plaster is not removed for dressings). Timely resort to this device will prevent a catastrophe.

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SOME NOTES ON DIAGNOSIS.*

BY

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WHEN invited to read a paper at this meeting I recognized an opportunity for discussing some rather unconventional views on diagnosis—views which in one form and another I have held since my student days, and which have by no means been dispelled by the great additions made to medical knowledge during the intervening years.

Diagnosis is our first object when seeing a fresh case. Our patients demand a diagnosis, and our teachers have ever impressed on us the prime importance of making one, while from time to time an eminent authority deplores the lack of diagnostic accuracy in some widely read journal in a way which would seem to imply that an accurate diagnosis is possible in every case. In hospital diagnosis is at its easiest. The cases are mostly advanced examples of well-marked disease, and the means and methods of exhaustive investigation are at hand. Yet difficult cases are seen; and, in my younger days, a fairly regular attendance in the *post-mortem* room revealed much that had not been anticipated—just as it so often does on the operating table—and I early learned that the most confident diagnostician is seldom the most reliable.

It is well to recognize our limitations as well as our advances. Unless a case is trivial or transient or obvious, we are at once in difficulties. The clinical pathologist, the radiographer, and the expert specialist often help us to a conclusion, but we are perhaps as often left in doubt. The same may be said of the general consultant, whose knowledge, experience, and authority, though of signal value in confirming an opinion already reached, or in bolstering up our ignorance, too often fail to carry us much further. Still, we may generally trust the man who is not afraid to say he does not know; when he thinks he does know he is generally right. But the pronouncements of the pundit who courts the reputation of being able to diagnose every case are necessarily unreliable; the fact being that, up to the present time, a diagnosis that is more than a guess is, at the stage of the disease when it would be most helpful, often quite impossible.

The Relative Value of Clinical Methods.

The aspect and demeanour of the patient are sometimes so characteristic that a diagnosis can be made at a glance. No one can mistake the tabetic, the Parkinsonian, or the fully developed case of Graves's disease. The history of the patient's complaints and sensations can hardly be too carefully elicited, for the key to the trouble

* An abridged version of a paper delivered before the Tunbridge Wells Division of the British Medical Association.