tality of 27 cases. The infection was general, extending to all departments of that institution.

The epidemic was brought to the institution by two employees who had been away from the school for a few days and returned to the institution ill. The first employee returned on September 12, and the second, on the 15th. Neither of these cases was seriously ill and at first were considered severe colds. In a few days, however, many of the inmates and employees of the institution became suddenly ill, manifesting influenza symptoms, and by the 20th, the invasion had reached the epidemic stage, there being on that day 122 persons ill of influenza at the institution.

As soon as we learned we could secure influenza vaccine, we began to vaccinate our employees. Through the kindness of Dr. Leary we were able to obtain vaccine to use for prophylactic purposes for all our employees who cared to avail themselves of this treatment. We vaccinated 71 employees. Out of this number five afterwards contracted the influenza. Fifty-eight employees were not vaccinated, and out of this number 38 contracted the disease. We also vaccinated 30 of our high grade girls who constantly assisted in the care of the sick, and out of this number three contracted the influenza.

In a building in which lived 156 inmates, 28 inmates were vaccinated. Out of these 28 vaccinated cases, only one contracted the influenza. Of the 128 unvaccinated cases in this building, all equally exposed with the vaccinated cases, 64 contracted the disease.

A NEW INCISION FOR APPENDECTOMY.

BY LEIGH F. WATSON, M.D., CHICAGO.

MANY writers have noted that in the cadaver the base of the appendix is found at McBurney's point, while in the living subject it is below this point, usually on a level with the center of Poupart's ligament. A number of operators have called attention to the ease with which the appendix can be removed when operating for right inguinal hernia. Since 1910, I have used a new incision, with its center over the base of the appendix, and believe that in

many cases it is an improvement over those in general use.

Incision. A point one and one-half inches from the right anterior superior spine, on a level with a line connecting the two superior spines, is selected for the beginning of a vertical incision which extends directly downward for two or three inches to a point just above, and to the inner side of the internal abdominal ring.

Advantages. Traction to expose the appendix is avoided, because this incision, in the external oblique and its aponeurosis, the most resistant structures, is directly over the base of the appendix. It can be enlarged without weakening the abdominal wall. The ilio-hypogastric and ilio-inguinal nerves are not injured because the incision lies between them. Because this incision is made over the cecum, the small intestines do not crowd into the wound as they do when the McBurney and lateral rectus incisions are used.

PNEUMONIA AND EMPYEMA.

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[From Medical Service, Base Hospital, Camp Devens,
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(Continued from page 424.)

37. *Consolidation Clinically*, yet not at autopsy has several times been the dismay of the ward surgeon. Fluid and a *compressed lung* were all that were found. This may have been the pneumococcemia without pneumonia, as just discussed. On the other hand, we cannot yet exclude (sceptical though we may be) the possibility that the lung may have been truly solid and later resorbed. Such a process is, however, indicated by a case report by Cole (p. 1150) of "typical lobar pneumonia during convalescence from measles. The blood culture showed the presence of pneumococcus type I. He developed fluid in the left chest which was purulent, and contained pneumococcus type I. and S. haemolyticus. He died three days after the tapping, and at necropsy no pneumonia was found, but several small abscesses in the left lung and a very large amount of purulent exudate in the left pleura."