or three times, but slept well that night. On Tuesday and Wednesday he worked as usual and took his meals, which caused him no pain or nausea. On Thursday he took no supper, and during the evening retched two or three times. On Friday at four p.m. he was suddenly seized with severe epigastric pain which radiated along left costal border. He vomited three or four times; no blood in vomitus. He stopped work and went home. He took no supper. During the Friday night the pain was very severe. He was admitted to the hospital at 11 a.m. on Saturday. His temperature on admission was 98 and his pulse 96. His board-like abdomen did not move during the respiration. At 12 noon his temperature had gone up to 101 1-5 and his pulse to 104. I operated at one o'clock, found the perforation and closed it.

In another case when the abdomen was opened the little perforation was found temporarily closed by a firmly adherent layer of lymph, and I found no evidence of gas or stomach contents in the peritoneal cavity.

This and the two cases of chronic perforation already mentioned teach us how, under favourable conditions, such as an empty stomach, and good reparative power, a minute perforation may be temporarily closed by lymph, omentum or adhesions.

The prognosis in perforations of the stomach is much better than in perforations of the small intestine, or vermiform appendix. The infection is less virulent, and possibly as suggested by Treves, the peritoneum here has greater resisting power. In the stomach cases quantities of sero-purulent matter and jelly-like substance may be removed during the operation for closure and the patient recover. Abdominal rigidity occurs earlier and is more general and board-like. In operating a search for other ulcers should be made. In one case after closing the perforation of the anterior wall, I infolded the thin base of a second ulcer on the posterior wall. Closure was effected by a double row of continuous Lembert's or Halsted's sutures; the first row of catgut, the second of fine silk.

If evidences of other ulceration were present, or the perforation was at the pylorus, I think a gastro-enterostomy would be indicated. I have not done it in any of my cases. The results have been satisfactory and there has not been any relapse so far as I know.

In the case of duodenal perforation, a gastro-enterostomy was indicated, as a preventative of recurrence, duodenal ulcers being ascribed to contact with irritating stomach contents, but the man's condition did not warrant it.

If evidence of a generalized spread of infection is present, the pelvis should be drained through a small incision in the median line just above the symphysis pubes.