Dec. 20th.—Temperature 99° ; pulse 80 to 100°; tongue clean ; tenderness of abdomen nearly gone; gaining strength ; takes plenty of liquid nourishment. Fluctuation not so apparent ; some hardness felt in abdomen on pressure, especially marked about the region of bladder; passed catheter, hardness remains.

Dec. 25th.—Continued to improve till this evening. Had a slight chill ; pulse and temperature elevated ; more pain ; depression. Symptoms continued to grow gradually worse till 1 a.m. December 31st, when he died.

POST MORTEM—Seventeen hours after death. Assisted by Drs. Campbell of Florence, Pickard of Thamesville, and Mr. Charters, a medical student. Peritoneum dark-red, thickened, with many adhesions. Omentum dark-red, attached to abdominal walls, intestines, etc., in many places. Intestines bound together by numerous bands and adhesions. Briefly we found all the evidences of past, universal peritonitis. Small quantity of serum mixed with pus in abdomen, and large quantities of pus scattered throughout the interstices of the intestines. Stomach and duodenum empty. No ulceration of stomach proper, so far as could be seen by a moderately careful examination. Duodenum perforated on its right anterior aspect about one inch below the pyloric orifice ; opening about the size of a ten cent piece, first finger would slip through quite easily. Walls of duodenum thinned for an inch or more surrounding perforation, and darkened by pigmentary deposit. About three inches of that portion of the liver adjacent to duodenum was of a dark red color and softened by inflammation, rest of liver healthy. The other abdominal viscera were apparently in a healthy condition. So far as I am aware, perforation of the duodenum is not a common occurrence. If it were, this case would be remarkable from the early subsidence of the peritonitis, the gradual but marked improvement in all the symptoms, for nearly three weeks, and the length of time which elapsed before death. Dr. Reeves of London, Eng., says "this is a very rare lesion, only one case has fallen under my own observation, and not more than nineteen have been recorded." In sixteen of these cases, in which he has recorded the time life was prolonged, only two exceeded twenty-six hours, one patient survived forty-four hours, and the other ninety hours Dr. Habershon, in his article on the duodenum, gives but one instance of perforation from primary disease.

That the ulcer had been chronic cannot be doubted, both from the history of the case, and from the marked pigmentary deposit found in the thin and ulcerated portion of the duodenum in the vicinity of the circular opening.

This patient had for more than ten years complained more or less of pain or distress some hours after meals, which was generally alleviated by taking food. This would seem to indicate that when the contents of the stomach passed into the duodenum it caused uneasiness or distress. Why food taken into the stomach relieved it, is not so clear. He had often been relieved by taking a teaspoonful of sodæ bicarb,. and possibly the excess of acid in the gastric juice may have passed into the duodenum and irritated the ulcer, and food which absorbed, or soda which neutralized it, would thus give relief. The ulcer being in the first portion of the duodenum would naturally react on the stomach, as that portion of the duodenum is supplied by branches of the same nerves and bloodvessels as the stomach. This would account for the various dyspeptic symptoms so long complained of. No blood was vomited, nor was there any great irritability of the stomach at any time after the perforation. After the subsidence of the peritonitis, hiccough was very troublesome for a few days, which was not allayed by any of the remedies administered, although two other medical men of experience were called in for the purpose. These gentlemen were strongly of opinion that there could have been no perforation, on account of the improved condition of the patient, and I began to hope that the perforation had been very minute, and was closed with lymph, and to entertain some hope of his ultimate recovery.

The early subsidence of the peritonitis was in all probability chiefly owing to the excessive hemorrhage from either the pyloric branch of the gastric or the pancreatico-duodenalis artery—probably the latter, which would be below the opening, and consequently the blood would be carried downward into the bowels, as very little blood was found in the abdominal cavity. The collapse on the third and fourth days was evidently due to loss of blood, as his recovery from it could be accounted for in no other way.

Now that the abdominal cavity, during life, is