Pain in the epigastrium of varying severity usually follows the ingestion of a meal, sometimes almost immediately, but its time of onset varies from a few minutes up to two or more hours. Robson and Moynihan (6) believe that such variations depend upon the situation of the ulcer, claiming that the nearer a gastric ulcer is to the pylorus, the longer is the pain deferred, and that when the duodenum is alone involved the most frequent time of onset is after one to two hours. Early pain, a free interval, and then again late pain may suggest the presence of non-continuous ulcers of both stomach and duodenum. Relief from pain usually follows the occurrence of vomiting which most frequently ensues in from one to two hours after a meal, but may come on almost immediately. On the other hand when hyperchlorhydria is a prominent element of the disease, relief of at least a temporary character often follows the ingestion of food.

Hæmorrhage of varying degree is estimated to occur in about eighty per cent. of cases and manifests itself by hæmatemesis or by melæna or both together. Slight degrees of melæna are frequently overlooked, and when unassociated with hæmatemesis its likely origin is duodenal. Gastrorrhagia of a degree insufficient to give rise to vomiting is often only revealed by a microscopical examination of the stomach contents.

Epigastric tenderness is generally well defined and is capable of being elicited immediately below the ensiform cartilage and between it and the right costal margin, and when the duodenum is involved it is often more distinct to the right of the middle line and at a slightly lower level. Dorsal tender points have frequently been observed in the region of the tenth, eleventh and twelfth dorsal spines. Tenderness is also a characteristic of the benign tumor formation which is not uncommonly present.

Symptoms or signs attending the abundant complications are sequelæ to which this disease is liable need not be mentioned here, save one so commonly considered to be essentially present to warrant the diagnosis of perforation, namely the obliteration of liver dulness. With regard to this, Robson and Moynihan (7) state that "its presence or absence is void of any significance and is unreliable as an aid to diagnosis." In the few available records of perforated cases where note of this feature has been made, one finds that in only about half of the cases was liver dulness absent, but it is a feature that has been made note of so rarely that its precise value cannot be judged.

In the clinical picture of this disease the association of pain, vomiting and hæmorrhage is decidedly characteristic, but there are many cases of intractable dyspepsia in which the evidence of ulceration is not so clear and it is only by a most careful and exhaustive enquiry concerning the history and present condition of the digestive system, a thorough physical examination, and by chemical and microscopical examination, preferably repeated, of the stomach contents, that a diagnosis can be made,