Naturally the size and position of the perforation, the date and the nature of the last meal, and the amount of material which escapes into the peritoneum are obviously of moment.

The chief prognostic is the pulse. A rate of 120 is to be feared, 130 and over to be dreaded. Temperature is of less value. The course after operation may be full of anxiety, requiring the exercise of extreme watchfulness and care. The pronounced thirst due to the loss of fluid by the peritoneal effusion may be allayed by rectal salines administered every four hours. The urine should be carefully examined and morphine given as indicated. If the pulse fail in strength and fullness and increase in rate, intravenous saline transfusion is most beneficial. One litre may be given, and when improvement is maintained thereafter for a couple of hours, even if there be a subsequent flagging of the pulse, transfusion may be freely repeated with every prospect of success.

Vomiting, if severe, persistent or accompanied by hematemesis is best combatted by gastriclavage.

There were eighteen cases, thirteen female and four male. The patients varied in age. Most were between twenty and thirty years; the extremes were twelve and a half and seventy-one.

Three to twenty hours had elapsed between perforation and operation in fourteen cases; of these, eight recovered, six died. Between twenty-one and thirty hours, two recovered, one died. One case recovered fifty hours after rupture.

The rapidity of the pulse as a prognostic is emphasized when we observe that in five of the fatal cases the pulse was over 130 before operation. We lost, however, one where the pulse was only 112, but the patient was seventy-one years old.

There were seven deaths in all; four females and three males. It was impossible to save Case 9, whose omentum was already gangrenous, or Case 16, with uremic due to advanced congenital cystic disease of the kidneys.

It will be seen that the mortality is not excessive, and that an early diagnosis may do much to render operation for gastric ulcer highly successful. There is no reason why the judicious country practitioner should not act in emergencies, and by a comparatively simple operation, not in itself dangerous, save lives that otherwise might incur still greater risk were they sent to a distant hospital.

Some points in regard to history, leucocytosis, micro-organisms, and after complications, may be ascertained from the