On November 30th, about 9.30 or 10 p.m., I was called in. He said he had eaten an unusually hearty dinner at noon, but felt nothing out of the way until about 5 p.m., when he was suddenly seized with a violent pain in the upper abdomen. In a few minutes he vomited once or twice, but no more after that. In a couple of hours he was a little easier, although pain still continued until about 9.30 or 10 p.m., when it became very severe.

Examination: Inspection—I found him on his back in bed, the abdomen greatly distended all over, but especially in the upper part, so much so as to appear to crowd the lungs upward so firmly as to give him little breathing space. The respirations were very hurried and costal. The face was anxious, but not the true "Facies Hypocrates"; cyanosis was marked. He was very uneasy and restless, some eructations of gas, and complained of great pain in the upper half of the abdomen. The pulse was weak and irregular, the "pulsus celer" variety. The shock (a very important feature) was profound, due, I believe, to the great pressure upon, and distortion of, the solar plexus and nerve supply of the abdomen in general. He complained of great pain in the region of the back, corresponding to the pancreas, the lower dorsal, and upper lumbar region. This latter is a distinguishing point of this trouble, which, I expect, will be fairly constant, and is not mentioned in any text-book or article that I have at hand, and should be of some value in making a differential diagnosis. The temperature was normal. Pulse irregular, 110. Patient was quite rational. Pain increased upon movement or turning.

Palpitation—Tenderness over the whole abdomen, most marked over the upper right abdominal region, but on account of the great distention and tenderness, sufficient pressure to elicit a mass of any kind could not be made.

Percussion—The whole abdomen was very tympanitic. Liver and splenic dulness were absent. Diffuse tenderness over the lumbar and lower dorsal region at back.

Auscultation—Nothing found except apparent absence of usual intestinal sounds. Heart and lungs were normal.

Urine—He passed some which contained considerable albumen, otherwise nothing of importance.

I gave him morphia to relieve the pain, and on account of the great distention and tympanitic condition, gave him repeated enemas at intervals, thinking that I could relieve some of the distention and distress by the removal of the intestinal contents and flatus, but with no result except the return of the enema. The morphia relieved him somewhat, and at times without it he seemed a little easier, but on account of the serious condition of the patient, and the unusual picture before me, and