and Mr. Silcock's suggestion as to the cause of this complication is very ingenious and may serve to explain many at least of the cases, if not all. We consider his recommendations as to the prophylactic treatment to be well worthy of trial.

A girl, aged 20 years, had in September, 1896, an attack of pain in the upper part of the abdomen with vomiting, and kept her bed a week; since then she had been subject about every three months to attacks of the same character, but of less severity and without vomiting. Between the attacks she had been free from pain and had not restricted her diet in any way. She had an attack in February, 1898, and one in May of the same year. There had never been any hematemesis. The attacks were regarded as hysterical. She was unusually well during August and until September 14th, 1898; on the 13th she ate a raw apple as she had frequently done before and had no discomfort after it. On the 14th she ate breakfast as usual, and at 11 a.m. she took some cocoa and bread and butter; one hour later she experienced severe pain in the upper part of the abdomen and lay down on the floor. Soon afterwards she vomited. Dr. A. B. Rendel, who saw her in the afternoon, found her somewhat collapsed, and he had a bed made up for her in the room where she was taken ill. She had peptonised milk and ice to take. The evening temperature was 100° F.; during the night there was pain in the abdomen and shoulders and she vomited twice. She was sent to St. Mary's Hospital on the 15th, at 5 p.m. She was a well-nourished, healthy-looking girl. The face was flushed, there were slight dark areolæ under the eyes, the features were a little pinched, the tongue was clean, abdominal movements were a little restrained, and there was hyperesthesia over the whole abdominal surface. She complained of pain in the right iliac fossa, but there were no dullness on percussion, no tumor, and no tenderness in this region; there was, however, acute tenderness over an area of about two square inches immediately to the left of the linea alba just above the level of the umbilicus; here there was more resistance than elsewhere and slight defect in percussion resonance. Liver dulness could be mapped out in the margin of the thorax. No stomach note could be obtained except in the region of the left axillary line; there was no bell sound obtainable. The pulse was 120, very sudden and jerky, and the temperature was 100.2°. She had vomited just before admission.

The local tenderness and the tension of the left rectus muscle suggested that the lesion was in the situation of the stomach and the symptoms pointed so strongly to a perforation that the pre-existence of an ulcer of the stomach seemed certain, though the history of paroxysmal attacks of pain with intermissions of