the patient is taking enough liquid by the mouth. In other cases warm saline solution is continuously and slowly administered by the rectum. The rectal tube should have several apertures, and should not be too long or have too small a lumen. Otherwise flatus cannot escape, with the result that the saline is not retained. This is especially valuable in cases of peritonitis, when as many as five or six pints are often given in twelve hours. There is no advantage in giving more. In most cases the enemata are not required after twenty-four or thirty-six hours. They lessen thirst, shock, and vomiting.

(3) **Thirst.** This is also alleviated by making the patient wash out the mouth with water or a weak solution of bicarbonate of soda, and especially by the frequent cleansing of the mouth by the nurse with lemon-juice and glycerine or glycerine and borax. When nausea has ceased water is given in increasing quantities by the mouth. The teeth are thoroughly cleaned at least twice a day with a clean tooth-brush and an antiseptic solution such as Listerine. The tongue is also thoroughly cleaned with lint moistened with glycerine and borax. These precautions, besides adding to the patient's comfort, greatly diminish the risk of pulmonary complications from the aspiration of septic material into the lungs. They also make ascending septic infection of the parotid gland very rare at the present day.

(4) **Vomiting.** For various reasons vomiting after operations is not nearly so common or severe as it used to be a few years ago. More perfect asepsis; the better administration of anæsthetics, especially the almost universal adoption of open ether following morphia, and atropine or scopolamine, which lessen the amount of anæsthetic used; and the more common use of saline infusion in one way or another, all lessen the severity of vomiting. Keeping the patient's head low and turned to one side during the administration of the anæsthetic in order to prevent swallowing of mucus saturated with the anæsthetic also helps to prevent vomiting from the direct irritation of the stomach by the anæsthetic. It is often a good plan to let the patient take a good drink of warm solution of bicarbonate of soda to wash out the stomach. Repeated doses of about 30 grains of sodium bicarbonate are also valuable, for the vomiting is often due to acidosis. Chloretone 5 grains often acts like a charm. When the vomiting continues after twenty-four hours other causes than the anæsthetic must be considered. In many cases it is due to partial paralysis and over-distension of the stomach. In any case lavage should be tried, the stomach being thoroughly washed out with a weak solution of bicarbonate of soda. If this does not stop the vomiting there is usually a more serious cause, such as peritonitis or intestinal obstruction. In these conditions the contents of the intestine regurgitate into the stomach and vomiting continues. Occasionally it continues for several days after the operation, apparently without any adequate cause. These patients are mostly very nervous women. In addition to washing out the stomach warm applications or even a blister may be applied to the epigastrium, and a dose of potassium bromide 25 grains, and chloral hydrate 25 grains, may be given by the rectum. In some cases the vomiting may be due to acute dilatation of the stomach, and the possibility of this is always to be remembered. At first there is bulging of the epigastrium, and later on the whole abdomen becomes enormously distended. Small quantities are brought up at frequent intervals. The stomach tube should be passed at once and the stomach thoroughly emptied and washed out, and the