the peritoneal cavity and more than a pint of pus in pelvis. When the perforation is minute, especially if adhesion protect the part, the situation of pain will not change.

Gastric ulcer may at times be latent and lead to perforation without presenting beforehand a single sign of the impending disaster. The worst forms of the malady belong to this class, for here the ulcer runs too rapid a course to permit the formation of protecting adhesions.

Treatment.—As soon as we are satisfied that perforation has taken place, I believe it is good practice to give morphia hypodermically, while preparations are being made for operation. It relieves suffering, mitigates the shock, and, in the opinion of many, lessens the amount of anesthetic required to produce surgical anesthesia for a given time. Success largely depends on the shortness of the time that elapses before operation,—every minute is of importance, and delay is dangerous.

In the acute form the septic material is widely distributed in the abdomen, therefore the abdominal incision should be made in the median line, and sufficiently large to enable the operator to inspect by sight every portion of the cavity. It is my practice as soon as the incision is completed to at once eviscerate the bowels. This cannot be done satisfactorily when, as is generally the case, there is much tympanites present, but one or more small incisions in the prominent coils soon overcomes the distention. The temporary enterotomies are made in the circumference of the gut opposite the attachment of mesentery, and each one is closed before another is made. The eviscerated bowels are protected with sterilized gauze, which is kept warm and moist by irrigation. These procedures give us relaxed abdominal walls and ample room in which to make a thorough inspection.

Attention is now turned to the stomach; the part perforated is brought as well as possible into or out of the wound, the ulcer excised, and the opening closed with two or three layers of silk sutures. If the pyloric orifice is contracted by the ulcer we proceed as stated above in dealing with the stenosis of the part. When the trouble is in the posterior wall near the esophageal opening, it may be impossible to excise it, in which case it can generally be inverted and closed by layers of sutures. The abdomen should be thoroughly flushed with a large and somewhat forcible stream of normal saline solution, great care being taken with each flank, the pelvic cavity and lesser peritoneum. When drainage is necessary, the tubes or gauze should not be introduced through large wound, but through stabs as far from it as possible. The object should be to have primary union take place in the incision.

On replacing the bowels in the abdomen, it is well before