most likely premonitory symptoms of the disease, including pain on eating, tender stomach for some time preceding, hematemesis, black or coffee-ground stools and anemia, and rather than the fat, robust person in pancreatitis we will have a more emaciated subject.

With regard to the second, intestinal obstruction, in this the vomiting is more persistent, frequent and likely fecal. The onset is not so sudden; the shock is not so profound and not so early. Cyanosis is not so marked, breathing not nearly so interfered with, and tenesmus is often present. Passing of fecal matter and faltus is soon at an end, blood and mucus is often passed. The pain is more in keeping with the peristaltic action of the bowels, and, moreover, the mass of obstruction can often be palpated and defined.

With regard to the latter, *i.e.*, perforative appendicitis, this can usually be detected by evidence to be found in the region of the cecum.

As regards the urinary examination, our knowledge at the present time is too meagre to say that any constituents are prominent or constant enough to aid much in the diagnosis. Glycosuria is said to appear early in the trouble, but in small quantities, and a little later disappears. Undigested fat and muscle fibre in the stools is said to be fairly constant and may be of some aid.

The Pathology—Fitz divides pancreatitis pathologically into (1) hemorrhagic, (2) suppurative and gangrenous. Robson makes a preferable classification clinically into (1) acute, (2) sub-acute, (3) chronic pancreatitis.

The traumatism, eroding action of bacteria upon vessels or ducts, arterio sclerosis, fatty degeneration and syphilitic degeneration cause the escape of blood and the pancreatic ferments into the gland substance. If the injury or hemorrhage is not already severe enough, these cause areas of cell necrosis, and the increasing disintegration of the gland. At the margin of the necrotic area are accumulations of inflammatory products, red blood corpuscles some broken down with deposits of pigment, polynuclear leucocytes and fibrin with the lobules and acini of the gland destroyed.

The Treatment—The treatment of the disease, if at all of any extent, is surgical: opening the abdomen and packing to protect the abdominal cavity, flushing out abdomen if necessary, gauze tampons to control the troublesome and persistent hemorrhage and to have free drainage. Whenever possible drainage by lumbar incision should be made also. Mikulicz states that severe injuries of the pancreas, which are not submitted to operation, terminate fatally almost without exception, and that an exploratory laparotomy should be made