considerable weight. After returning from church Sunday evening, experienced severe pain in stomach. Monday his physician administered sedatives, but without relieving the pain. Was called following day to see patient; temperature, 100½; pulse, 80; some tympanitis, abdomen rigid and hyperæsthetic, bowels costive; was unable to lie down, and in severe agony, no vomiting. Salines failed to cause action of bowels, as also did calomel and croton oil. Next morning patient appeared cheerful, had taken considerable food, but pulse more rapid and compressible. Considering that the gravity of the case justified a section, at least, as an aid to diagnosis, if not to relieve the cause of the trouble, I requested consultation, with this end in view. This was refused, and not until the following day, when patient was in an extreme condition, was my request granted. Patient was removed to Jubilee Hospital, and coeliotomy was performed by Dr. Davie, on afternoon of Thursday. Intestines deeply congested; general peritonitis; appendix normal; abdomen obtained about a pint of greenish, opaque fluid, some pus, and few large flakes of greenish lymph. The anterior part of stomach, liver and parts in contact, were united by adhesive inflammation, and formed an abscess wall complete, except in one part, through which the contents of this cavity passed into the general peritoneal cavity. Upon the anterior surface of the stomach, within one inch of pylorus, was a circular perforation, one-third of an inch in diameter, through which the gastric contents poured into the abscess cavity. There were no additional indications of ulceration, nor were any cicatrices to be seen. The pylorus was found somewhat thickened and contracted, but, to the naked eye, presented no indications of malignancy. The pylorus was dilated by the finger: the abdomen flushed with sterilized warm water: the stomach was brought in contact with the abdominal wound, and the margins of the ulcer united with the surface, thus making a gastric fistula opening externally; an iodoform drainage inserted, dressings applied, and patient removed to bed: passed a satisfactory night; food and stimulants given by rectum. Wound dressed following morning: perfect adhesion had taken place, completely cementing the peritoneum; some little discharge from stomach upon the dressing. Patient expressed himself as feeling comfortable, notwithstanding the continuance of the general peritonitis. Towards evening heart showed evidence of failure, and death ensued following morning. No *post mortem*.

It seems reasonable to suppose that, had surgical measures been used previous to rupture of abscess wall, which nature had formed by adhesive inflammation of contiguous viscera, and this before the peritoneal cavity had been infected by the contents of the stomach, a satisfactory result might have been obtained, as death was the direct result of general septic peritonitis.

In reflecting upon these two cases it seems opportune to call attention to the fallacy of depending upon the thermometer as indicating the intensity of intra-abdominal inflammation. The history of appendicitis is teaching us this lesson, and goes far towards convincing us that it is not without reason that some of the most successful abdominal surgeons have excluded thermometers and temperature charts from their wards. Again, *re* opium, it may not be unnecessary to repeat what has been so often told us, yet with such little effect upon our daily practice. We are too apt to resort to opium, as some practitioners of ancient prestige resort to alcohol, as a mantle to cover our ignorance, a sweet nepenthe which, while it may temporarily soothe, renders the patient incapable of giving us that assistance in diagnosis that we too often require. Our mortality would be lessened if opium and its preparations were erased from the pharmacopœia.

The hypodermic syringe, which has become the boon companion of some of our practitioners, should be placed high up on the shelf, and labelled "dangerous." The administration of opiates, if not wholly proscribed, should be used with the greatest caution until a satisfactory diagnosis has been made: and especially should this procedure be followed, where the indications are those of intra-abdominal lesion. In such cases where tenderness or rigidity is too great to allow a satisfactory examination, it is better to give an anæsthetic and make a complete examination. The cases will then usually divide into two classes, the one indicating salines, the other indicating surgical measures. Whatever is done delay is inexcusable, and lives should not be jeopardized by the delay which characterizes the action of many younger practitioners in hesitating to call the assistance of