record by Heusner in 1892. Up to last September, in the neighborhood of three hundred operations were reported in which the mortality was over 45 per cent. Recently the results have been much better. Success depends largely on early recognition and promptness of action, but the size and situation of the perforation, the nature of the infectious material present, the duration of the time after last meal and the perfection of the technique of operation are also important factors.

There are no reliable symptoms that are indicative of impending perforation, but fortunately in over 90 per cent. of the cases there is a previous history of dyspeptic troubles. When it occurs, the most reliable of the early symptoms in the acute form are sudden onset of excruciating pain in epigastric region, shock generally of a severe character, rigidity of abdominal walls, marked suppression of abdominal respiratory movements, arrest of peristalsis, and shortly all those of acute septic peritonitis. At first the pulse and temperature are not reliable, for as a rule they do not indicate the gravity of the trouble until too late for the surgeon to act with reasonable prospect of success. In my opinion this is a very important point to note in order to avoid under-estimating the true condition of things, for in the three cases that came under my personal observation both were at this period in every respect apparently normal. If the pain radiates in a severe manner into the back, it betokens perforation of the posterior wall of the organ, and if it does not do so the chances are that the trouble is on the anterior wall.

It is well to bear in mind that in the majority of patients the situation of the greatest suffering changes, at times rather quickly, owing to the irritating material gravitating downward toward the pelvis. According to my experience it descends more frequently to the right than to the left of the median line, and the anatomical position of the organs favors the course. Thus it is that cases have not unfrequently been diagnosticated as appendicitis. Opiates mask the symptoms more or less completely, and on this account should not be given until the diagnosis is made.

The third person on whom I operated for acute perforation, when first seen by me only complained of pain when firm pressure was made over the appendix. The initial symptoms had been exceedingly severe, but large hypodermics of morphine had given complete relief, and at the time of my visit the patient was quite comfortable, talked, laughed and made light of the trouble. Temperature normal, pulse 76; no noticeable abdominal rigidity, nor pain on pressure over stomach; notwithstanding, an operation immediately afterwards showed a perforation in posterior wall of stomach, general infection of