No rough manipulation should be used. Every movement should be made with gentle quickness and definite purpose. If we gently pass the hand towards the upper abdomen we will probably find one spot where there is a thick localized deposit of lymph. On disturbing this an extra amount of fluid is liberated. This is a reliable guide to the location of the perforation.

We will suppose that in our hurried, systematic and gentle examation we have located a perforation on the anterior wall of the stomach, which is a common site. We at once proceed to close the opening. This is best done by using a small round curved needle threaded with No. 1 or No. 2 chromic catgut, or fine silk may be used. Two or even three layers of Lembert sutures are employed. The edges of the perforation are not cut away, but merely inverted by your method of suturing. The purse-string suture is not as good as the Lembert, as it is apt to tear out on being tightened on account of the edematous and friable condition of the tissues. In some cases you may be unable to close the wound in the manner described, or you may not be certain of the security of the closure. In this case you may bring over a portion of omentum, without tension, and stitch it over the opening, or the imperfectly closed opening. Then you should place a narrow piece of gauze drain over and around the site of your work and allow the other end to come out of the abdominal wound.

If the stomach wall has been extensively damaged by long continued or extensive disease you should, after closing the perforation, perform at once a posterior gastro-enterostomy, providing your patient's condition will permit of it. This patient you see lying here, on whom we operated five days ago, was too exhausted to allow of the gastro-enterostomy being done, while Mr. S., sitting there, had the perforation closed and a posterior gastro-jejunostomy done at the same operation. We should be very careful to cleanse well, with moist swabs, the upper peritoneum, especially beneath the diaphragm, and thus lessen the risk of subphrenic abscess.

Having completed the operation on the stomach we next make a small opening in the centre line of the abdomen above the pubes, for the purpose of cleansing the lower abdomen and also for drainage purposes. Moist hot gauze swabs on sponge holders are used to clean out the usually abundant collection of turbid fluid which frequently fills the pelvis. Then we place a liberal sized drainage tube into the pelvis with a strip of gauze beside it. The tube is removed half an inch or an inch in about 24 hours lest its end should cause a pressure necrosis by too long continued pressure against a coil of intestine or other tissue.

The upper wound is completely closed unless we have left a small gauez drain down to the stomach wound, in which case it emerges