cessively severe epigastric pain, which persisted for some three or four hours. When the acute symptoms had subsided a burning severe pain persisted, and from which he failed to obtain any relief.

On examination I found the epigastric region rigid and tense and excessively tender on palpation. The tenderness was just as acute to the left as to the right of the median line. Vomiting was frequent. Temperature 101 1-5; pulse 92.

At operation on August 7th a subacute perforation of the lesser curvature of the stomach, about one and one-half inches from the pylorus, was revealed. On the fourteenth day he returned to his home feeling quite well, and continued to so rapidly improve that in a month he was again attending to his regular business. Since that time he has had no return of his former symptoms. As in the other case, the tenderness here was the direct result of the subacute perforation.

Differential Diagnosis.—The only condition which is at all liable to become confused with ulceration in this location is chronic cholecystitis, due to the presence of gall-stones. The first and chiefest point to be considered in the differential diagnosis is the fact that in ulcer the pain is invariably appeased by partaking of a meal, and just as invariably returns from one to five hours afterward. In cholelithiasis it is in no way affected by food and that sense of comfort and ease which in ulcer is produced by food is wanting.

The character of the pain differs essentially. In ulcer the pain, though severe, is endurable, while in cholelithiasis it is frequently of that excrutiating variety which can only be relieved by the most powerful of opiates, and sometimes chloroform may even have to be resorted to. Once again, cholelithiasis is frequently accompanied by heavy chills and sweats, a condition entirely foreign to ulcer, and the most lancinating pain, suddenly striking the patient unawares, is referred to the right shoulder blade, and frequently disappears just as suddenly as it appears.

Why Operate Early?—A positive diagnosis of gastric or duodenal ulcer having been arrived at, what is the proper course to pursue for its relief? Until within the last few years the frequency of this condition has been entirely unappreciated, mainly because these patients were put to bed with a somewhat hazy diagnosis of "indigestion," "acid dyspepsia," or "hyperchlorhydria"; were treated expectantly until the acute symptoms had subsided, and the patient had either become well, or passed into that most unfortunate class, chronic dyspeptics, when the only opportunity of demonstrating the true pathologic condition was the post-mortem table.

Of late years, however, the surgeon, in the course of other ab-