Dr. Tubby saw her the collapse had disappeared, the abdomen was not distended, there was no tympanities and no vomiting, but there was still pain. The liver dullness was normal. He decided not to operate then because the acute symptoms had passed away, the liver dullness was present, and he said he was aware that some of these cases of gastric ulcer occasionally have attacks which are extremely like those of perforation, except for signs showing the presence of free gas in the abdominal cavity. The patient recovered without operation. The presence or absence of liver dullness has helped men to a decision on more than one occasion.

The treatment of these perforations is surgical—there is no medical treatment. When a patient takes this sudden pain, like the thrust of a dagger—perhaps coming on during sleep or after some slight exertion, and if to this be added the history of some stomach trouble, we should at once think of perforation. In such a case even the delay of half a day to "carefully watch the case" is scarcely justifiable and certainly reduces the chance of recovery. Every hour you delay increases the danger to your patient.

Our diagnosis having been made and our line of procedure decided upon, we may give our patient a quarter or half a grain of morphia to relieve the awful pain. Morphia should never be given before the diagnosis is made, and the relief and comfort which it brings to the patient should never make us weaken in our decision to operate. The patient should now be placed in the semi-sitting position and removed to the hospital if one be nearby. I once brought a patient in this way, in the winter time, seven miles in a taxicab, with comparative comfort. I mention this to emphasize the fact, which I consider very important, that to remove these patients very carefully in the semi-sitting posture is not serious; in fact, it is much safer than to undertake to operate even in the homes of the well-to-do.

We make our incision through the right rectus muscle above the umbelicus. During every step of the operation we should keep a sharp lookout for any sign that would be likely to be of help as we proceed. On opening the peritoneum proper, note if a puff of gas escapes, which would indicate the rupture of some air-containing viscus. This is frequently quite audible, as I have been able to demonstrate more than once to visiting doctors. However, it is not constant. A little thin clear and cloudy liquid may also escape. In gastric perforation the fluid encountered will contain lymph or particles of food. The fluid may be bile-stained if the duodenum be perforated. This is in contradistinction to the offensive gas and fluid which escapes when the appendix is the offending organ. Introduce the fingers or perhaps the hand, into the abdominal cavity with the greatest possible gentleness.