I have seen a patient walk into the casualty room and ask for a bottle of medicine for stomach ache: he said that he had had a good deal of pain three days before, but was now feeling much better: his aspect, however, was that of a dying man, and he did die some hours later. Post-mortem, the abdominal cavity contained several pints of pus, the peritoneum having been infected from the giving way of a cancerous structure of the rectum. Beware then of telling the doctor that the patient is better merely because he says he feels better.

Thirdly, there is (again almost invariably) a quickening of the pulse rate: the pulse wave itself is "small," i.e., it does not make much impression upon the examining finger.

These three are the most reliable signs: when they occur together, the question of operation must certainly be in the nurse's mind.

Remembering what I have previously told you, that a successful operation is not a "one-man show," but is only made possible by co-operation between the surgeon and the nurse, she must at once, therefore, send for the surgeon in order that he may have the opportunity of acting on the result of her observations.

There are other signs. The abdomen usually becomes rigid, board-like, and motionless, respiration being carried on by the muscles of the chest, and not by the diaphragm. Later on, distension occurs, with vomiting, hiccough, rigors, sweating, etc. But these are signs, not of the onset, the hopeful stage, of peritonitis, but are precursors of the end, from which no surgeon who only sees the patient when they have set in, can have much hope of rescuing the patient.

I wish I could impress upon you the hopelessness, the pity of this. To see, it may be, a young woman, after her first confinement, brought into hospital, cold, pulseless, vomiting, and shivering, with a temperature of 104 degrees, a distended, motionless abdomen, and an uncountable pulse, and the nurse handing one the history sheet marked "Rigors, abdominal pain 5 days previously; treatment: vaginal douches and presumably bottles of medicine," and then to have to tell the patient's husband that the only chance lies in a very serious operation, the prospects of which are gloomy at the best—this is indeed a pity. But it occurs not once only, but time after time, and all of you have seen it. Many of these cases have been attended by trained nurses—how many of them have noticed or reported the preliminary pain? How many times have they jumped to the conclusion that it was a stomach ache only? Have they ever felt the pulse? I wonder whether it has struck you, as it has me, how often in very serious conditions that demand action of some sort, the preliminary and most valuable signs are those which can easily be detected by an observant nurse or even, I should say, by anybody who takes the trouble to observe.

So much for clinical signs. I have said that the only possible treatment is a surgical operation, and that this must be performed without delay: usually the abdomen is tender, and the patient cannot bear the necessary scrubbing, so the skin is cleansed when the patient is going under the anæsthetic.

In the operation itself, speed is essential, and this is, as I have often told you, again a matter of co-operation: a nervous, or, as I should prefer to put it, a self-conscious nurse is not only useless, but positively harmful: I have known such a one give me almost boiling water with which to flush out the peritoneal cavity. I need hardly say that it did not go into that cavity. The essential here is to remember that nobody is thinking about you at all, and that you need not wonder whether you are doing right or not: only you must give the surgeon what he wants *directly* he asks for it. After a little while you may get to know what a particular surgeon is likely to require, and then—but not till then—you can anticipate his wants: this is, however, a refinement. Remember that nobody can possibly blame you for not being able to anticipate—only for not responding immediately.

Nowadays the peritoneal cavity is usually not washed out or sponged: as much fluid as possible is drained away by turning the patient chiefly on to the side, and then the cause of the peritonitis is investigated and treated, if possible: thus, a gastric or intestinal ulcer may be sewn up, or a fallopian tube ligatured and removed. Drainage is then made into the most convenient and lowest part—through the vagina usually in puerperal cases, and through the flanks otherwise.

The patient is put back to bed, surrounded by hot bottles, and saline solution is run in from a douche can under the skin of the thighs or beneath the breasts: it may contain from 10 to 30 minims of adrenalin, and sometimes antistreptococcic serum.

When the patient has come round from the anæsthetic he is usually propped up with pillows in the sitting position: this keeps the fluid away from the diaphragm, and encourages it to run out through the openings which have been made. If necessary, strychnine, adrenalin, alcohol, etc., are given hypodermically.

Formerly, it was the practice to allow the

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