little value in the treatment of shock. Strychnine and alcohol should be avoided, as they only act temporarily and exhaust the heart. The best method is to inject saline fluid into the veins, but this is the surgeon's—not the nurse's—duty. The nurse, however, may be asked to inject saline solution (a teaspoonful of common salt to a pint of water) into the rectum, in which case the fluid must be at a temperature of about 110 degrees F. It should be injected very slowly (taking about twenty minutes for two pints) by means of a rubber catheter (8 to 10) with a filler attached. The buttocks may be raised on a pillow, and the filler should be raised only about six inches above the anus; a higher head of fluid will only prove irritating, and the fluid may be rejected. The fluid may be allowed to flow, if need be, for hours, and in this slow method the patient may be able to absorb the fluid as quickly as it is given. It is often an advantage to put five to ten minims of adrenalin chloride (1 in 1,000) into the first saline injection. This raises the blood pressure, by acting on the walls of the arteries and raising their tone. The adrenalin chloride must, however, be used with caution, and only under the doctor's instructions. The quantity of saline given may be one, two, or three pints, according to the manner in which it is retained by the patient, and this may be repeated every hour or two till the shock has passed off. Nutrient enemata are of no use in the treatment of shock, as they are not absorbed.

Vomiting is a common symptom after operations. To prevent it, it is important to prevent shaking up the patient as he is going back to bed. While the patient is vomiting the abdomen should be supported by lateral pressure, taking care not to press or otherwise disturb drainage tubes. The nurse should observe carefully the nature of the vomiting. If it is only bile and mucus post-anæsthetic vomiting it is not dangerous, and usually stops in three or four hours. In these conditions a big drink often does good, even although the patient vomits after it. Give a half pint of hot water with a litte sodium bicarbonate. This washes out the stomach. Strong, hot coffee is often useful; and champagne sometimes settles the vomiting when other means have failed. A seidlitz powder, if not contra-indicated, may do good. Ice seldom does good, and often makes the patient worse. Locally, a hot mustard leaf or a hot fomentation may be applied, and it has been found that if a hot drink is given at the same time these local applications are more effectual. Vomiting of black "coffee-ground" material, in which the patient brings up a mouthful at a time, in gulps, without retching (regurgitant vomiting) is always an indication of serious complications, particularly of septic peritonitis, and should always lead the nurse to call the doctor. It may sometimes be relieved by washing out the stomach with weak Condy's Fluid. When the vomiting is stercoraceous or "fæcal," it indicates obstruction of the bowel.

Pain is often complained of after abdominal operations. If it is only the pain of the operation wound, it is not serious, and will settle in an hour or two. The nurse should note the character of the pain, whether colicky, flatulence, continuous, stabbing, and report to the doctor. If the pain is inside the abdomen and persists for some hours it usually means that something is wrong, and the nurse shoud inform the doctor at once. On no account will she give any drug for the relief of pain without definite instructions from the doctor.

Thirst is the call of the blood for more fluid, and, unless contra-indicated, is best relieved by giving the patient a good drink of tepid fluid, such as hot weak tea. Ice is not good, as it only aggravates the thirst. If fluid is forbidden by the mouth, a half to two pints of saline solution, injected into the rectum, may alleviate it, as thirst is not a local but a general blood condition. Washing out the mouth with a mouth wash may help, or lubricating the mouth with boro-glyceride or vaseline and peppermint. Little sips of water are of no use in relieving thirst. To prevent thirst after operation, the surgeon often leaves one or two pints of saline solution in the peritoneal cavity before closing the abdomen.

Feeding.—The sooner we can begin to feed the patient the better. The prolonged starvation methods stil in vogue in some quarters are not advisable. Albumen water is one of the best things to give at first, as it serves both as drink and nourishment. It consists of the whites of three or four eggs added to a pint of water, with lemon and sugar to taste. Plasmon (three teaspoonfuls to a half pint of water) is also useful. These should be slowly sipped, half to two ounces at a time, the patient getting about two pints in the twenty-four hours. Later the patient may have peptonised milk, raisin tea, etc., and, after the bowels have moved, boiled egg, custard, jellies, etc.

Rectal feeding is not so useful as was at one time supposed. As very little nourishment

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