vomited in smaller quantities, and may then be thought to have come from the lungs; when the bowels are moved the blood appears in the stools in the form of a black tarry mass.

Or the complaint may even be ignored until the ulceration has penetrated right through the stomach wall, and perforation, as it is called, occurs. Here there is sudden intense pain in the abdomen, with collapse, cold extremities, a small, quick pulse, and rigidity of the abdominal wall; later on, unless prompt treatment is secured, peritonitis sets in, as shown by vomiting, swelling of the abdomen from the presence of free fluid in the abdominal cavity, rigors, tenderness of the abdominal wall, and ultimately death from septicæmia or blood poisoning. As the pain of perforation almost always becomes easier when peritonitis (or rather effusion of pus into the peritoneal cavity) supervenes, the patient often thinks she is better, and does not seek relief, but it is the merciful ease which is so often the precursor of death in dangerous illness.

Gastric ulcers, however, do not always perforate, and it often happens that the attack is followed by recovery for a short time, but the pain after food continues, and the patient passes into a condition of intractable dyspepsia, which is often due to the parts round the ulcer becoming matted together by adhesions, so that the stomach is, as it were, tied into knots and bound down to neighbouring organs so that it cannot move properly. Or if the ulcer is near the outlet of the stomach, this may become narrowed, and the stomach then stretches behind the obstruction until it becomes a thin walled sac in which the food lies and putrefies until the accumulations of three or four meals are vomited, and the patient feels better until the stomach fills up again.

What are we to do for our patient? This depends largely on the time at which she gives in, for in the early stage, when there is pain and sickness only, it is usually possible to cure her by rest, appropriate diet, and treatment by drugs. Firstly, it is a great advantage, even in apparently mild cases, to start by confining the patient to bed and insisting on the provision of a trained nurse, who will be sympathetic but absolutely rigid in restricting the patient to the prescribed diet, the essential feature of which is that the food should be given in very small quantities and frequently, so that the patient never satisfies her hunger. The food should be fluid only, and if the patient can take milk this will suffice, but, if not, albumen water, whey, and so on may have to be substituted; the bowels are opened freely by saline aperients and preparations of bismuth with alkalies are given before the food. A gradual change is subsequently made to a solid diet and the normal mode of life, and when the stomach can digest ordinary food the anæmia is treated by whatever preparation of iron is found to agree best with the particular patient.

But if hæmatemesis (vomiting of blood) occurs, the patient must be kept flat in bed and all food by the mouth withheld; nutrient enemata will now be necessary, and the thirst which always follows a loss of blood must be combated by the administration of large quantities of salt solution by the rectum, and I need hardly add that it depends very much on the skill of the nurse whether the rectal injections of food and fluid are retained or not; without the presence of a trained nurse, feeding by the rectum is impossible.

If perforation occurs, the only possible treatment lies in prompt opening of the abdomen and suturing of the ulcer, with drainage of the peritoneal cavity for a few days.

Apart, however, from this now well recognised necessity for surgical intervention, much good can often be done in intractable ulceration of the stomach (when perforation has not occurred) by the operation of gastro-enterostomy, which consists in the making of openings in the stomach and the upper part of the intestine and sewing the margins of each hole together, so that the food and secretions pass straight from the stomach into the intestine without irritating the ulcerated surface; at the same time any adhesions interfering with the movement of the stomach can be dealt with also, but there is no doubt that were patients with indigestion to present themselves for treatment earlier than they usually do, the necessity for surgical procedures would often be obviated.

TREATMENT OF INJURIES OF THE HEART.

Mr. J. Bland Sutton, in a lecture on the treatment of injuries of the heart, delivered at the Middlesex Hospital, and reported in the *British Medical Journal*, said that severe injuries to the heart are still as fatal as formerly because life is destroyed so quickly that surgery has no chance; punctured wounds of the heart leading to hæmo-pericardium are submitted to surgical treatment with fair prospect of success, and if there be no concurrent wound of the pleura the chances of success are great. The method of saving life in such circumstances may be definitely formulated; it consists in exposing the pericardium by fashioning an osteoplastic flap from the chest wall and turning it to one side so as to expose the pericardium; then, in opening this membrane and exposing the heart, finding the wound, and closing it by means of sutures.

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