and two other cases of the same kind that I performed gastro-enterostomy for and which terminated fatally, I have made it a rule that the patients must be able to stand up and walk without help; otherwise they cannot possibly survive the shock.

The other two cases lived on an average of over eleven months, and in both the growths returned in other organs. The duration of life in some of the recorded cases of pylorectomy reaches eight years and over. It is possible that some of these were really cases of pyloric ulceration with extensive infiltration of the adjoining parts. In one of my own, which I shall refer to later on, I performed posterior gastro-enterostomy because the adjoining structures were involved and a radical operation was out of the question. She is still alive, now three years since the operation, and the large mass felt previous to the operation has disappeared. This case, at the time of the operation, was thought to be pyloric cancer.

Gastro-enterostomy: Is the most frequent, most useful, and most simple of all the operations performed upon the stomach. The frequency of the operation is evident when we think of the number of conditions under which it is done—pyloric cancer, pyloric ulceration and stenosis (non-malignant), gastric ulcer, dilatation of the stomach, and for intractable chronic dyspepsia and hyperchlorydia.

Its usefulness is beyond question; the relief it affords in all these conditions is striking, and in some absolute. Nothing can be simpler than this operation, performed with a Murphy button; and considering the relief it gives it should be more frequently and earlier resorted to. Personally, I have used this method in fourteen cases, and in only one of these was there any drawback to its employment—and that was in a case where the button fell back into the stomach. In my two patients who died from the shock, I examined the lumen and found it perfect.

In intestinal anastomosis I have not found the button so successful, as in one case, the lumen of the button became completely plugged with feces, which produced great dilatation of the proximal portion of the intestine, leakage, and death. In several other cases I have had leakage, but as I generally make a point of bringing the anastomosed gut into one or other loin, and place a drain on both sides of the gut, the general peritoneal cavity becomes walled off in three or four days, by which time a fistula will have formed. This fistula closes without operation in a week or two. Contraction of the orifice has not followed any of the operations up to the present.

In the earlier operations, the intestine was united to the anterior wall of the stomach (Wolfer); but, unfortunately, by