out by the new opening. Complicated and time-consuming were these procedures and yet a few years ago many of us were carrying them out with good results, on the whole. It seemed as if surgical endeavor was engaged in trying to devise more complicated short-circuiting methods and each author were suggesting a new kind of knot in which to tie the upper intestine. Vicious circle was done away with, and also the not uncommon chronic regurgitation of bile, by division of the ascending loop, but the operations were so complicated and prolonged as to be dangerous in any but the most skilled hands. Then came the demonstration of Von Mickulicz, that the suture of the very beginning of the jejunum at the ligament of Treitz, the short loop or no loop operation, prevented kinking and therefore regurgitation, and finally the added refinement worked out by Mayo and Munro, of turning the efferent loop to the left in its physiological direction, and the operation of posterior gastro-enterostomy became established in its present safe and simple basis.

At the time when the long loop mentioned was in vogue and regurgitant vomiting was frequent, Finney of Baltimore, introduced his modified pyloroplasty, or gastro-enterostomy in inverted U, a very ingenious and beautiful procedure. It was more difficult to perform than gastro-enterostomy, did not deflect the food current from the inflamed and usually ulcerated pylorus, and could not be done in the presence of great inflammatory thickening in that region. Cases of simple cicatricial stricture of the pylorus, to which it was specially adapted, were rare. For these reasons as time has gone on it has given place to the simple safe posterior no loop gastro-enterostomy.

Now, as these procedures have been applied to strictures of the pylorus, either from scar contraction or inflammatory thickening, it has been found that when a definite demonstrable stricture or inflammatory obstruction existed, the patients have recovered, and ulcers, either in the gastric or duodenal side of the pyloric ring, have healed. On the other hand, success in the treatment of these conditions has led to the practice of the operation in acute medical ulcers, in ptosis of the stomach accompanying a general enteroptosis, in neurasthenic conditions, accompanied by persistent vomiting, etc. It has been thought that the vomiting in these conditions was due to pyloric spasm, which would be relieved by gastro-enterostomy. Many operations have been performed for the relief of uncontrollable vomiting from various causes. These operations upon starved and exhausted patients have often been fatal and have almost always failed to relieve the symptoms. Sometimes the patients have been worse. In fact, some surgeons have been busy of late years in disconnecting the loop of intestine attached to the stomach at former gastro-enterostomies with marked benefit to their patients. In general it may be said that gastro-enterostomy is a drainage operation, pure and simple, and that it relieves and cures with certainty only the cases in which there is a demonstrable obstructive lesion at the pylorus. There is no doubt also that the simple procedure of gastro-enterostomy will cure certain cases of chronic ulcer not directly at the pylorus, but situated on the lesser curvature and posterior surface. There are certain extensive indurated ulcers of the lesser curvature, however, which, in my hands, have not been cured by gastro-enterostomy. These are the so-called saddle ulcers, thick, indurated, with elevated