

glands in the vicinity. There was marked dilatation of the stomach. Pylorectomy was practically impossible owing to the extent of the lesion, therefore anterior gastro-enterostomy was done, the opening being made quite close to the greater curvature, to prevent intra-gastric pouching, as suggested by Mayo. The site of the operation was enveloped in a fold of the gastro-colic omentum, which was stitched over it. On the third day liquids were given by the mouth and the bowels moved naturally. Everything remained quite satisfactory until the sixth day, when patient developed lobar pneumonia and died.

(There is still a fourth class of cases of pyloric obstruction, where the lesion is due to gastropptosis, the weight of the prolapsed organ obliterating the pyloric outlet. In the surgical treatment of this class I have had no experience.)

I have selected these notes of these three cases from my case book because they illustrate the two great classes of pyloric obstruction, viz.: benign and malignant.

In cases I and II the cause of the obstruction is peritoneal adhesions outside the organ, the cause of these adhesions being, in Case I, a cholecystitis; in Case II, a gastric ulcer. My second object is to elicit discussion as to the best operation in a given case.

In malignant obstruction the choice lies between pylorectomy and gastro-enterostomy. The former is the ideal operation and should always be preferred when possible, taking into account the extent of the lesion and the general condition of the patient. Unfortunately, these cases are not referred to the surgeon in the early stages, as a rule, and we must therefore content ourselves with the palliative measure of gastro-enterostomy. In cases of benign obstruction, the following questions must determine the operation:

- (1) Is the pyloric orifice contracted or uncontracted?
- (2) Is the stomach markedly dilated or not markedly dilated?
- (3) If the organ is dilated, is the muscular wall atrophied or normal?

When the pyloric orifice is not contracted, ordinarily all that is necessary is to break down the adhesions, when the function of the organ will be normally resumed. Even in these cases, however, we sometimes find, from long-continued obstruction of the outlet by the inflammatory adhesion, that the organ is markedly dilated and its muscular wall atrophied. If such complications be present, gastro-enterostomy should certainly be done, otherwise the distress of the patient will not be relieved.

In case the pylorus is contracted and the organ otherwise fairly close to normal, pyloroplasty (Heineke-Mikulicz) is our ideal operation. But when the contraction is complicated by marked dilatation and atrophy of the walls, drainage by gastro-enterostomy is undoubtedly indicated.