reincurrence in less than three years. In gastric carcinoma probably more than in any other pathological lesion is the truth of the old adage exemplified, "An ounce of prevention is worth a pound of cure."

It is the surgical conditions in the stomach itself which give rise to typical dyspeptic symptoms—ulcer and its frequent accompaniment, Carcinoma—that this article has to deal.

If definite symptoms were always produced by, and the result of, definite pathological lesions, diagnosis would be readily reduced to an exact science, but this is far from being the case. It is but too often we find that a definite pathological lesion in one patient will produce a certain train of symptoms, and to find in another with the same lesion a chain of symptoms of a very different character altogether. This is what makes the art of diagnosis so peculiarly difficult. When a scientific diagnosis has been definitely arrived at, treatment is a comparatively easy matter. The act of removing an ulcer from the stomach wall, of short-circuiting a duodenal stenosis due to a cicatricized ulcer, or even of removing a portion of the stomach itself because it is affected by carcinoma, is a much easier task than arriving at the diagnosis at a sufficiently early period to make such action productive of the best results.

When a patient suffering from definite and persistent indigestion presents himself for treatment, a routine examination of the stomach must invariably be made. This routine examination will include a thorough and complete history of the case, a physical examination, a test of the motor functions of the stomach, a complete gastric analysis obtained from a test meal, and finally a complete fluoroscopic examination of the entire gastro-intestinal tract. There is a tendency now-a-days to lay too much stress on the value of the chemical analysis of the stomach contents, and too little on the mere clinical examination while as a matter of fact either one can only prove of the highest value when corroborated by the other.

The *history* in all gastric cases is of the utmost importance. Very much valuable information will in this way be noted; whether the indisposition has been accompanied from the first by pain, whether the pain was constant or intermittent, whether it was present before or after meals, whether it was confined to the epigastrium or radiated to the right lower abdomen, and finally the character of the pain itself. The majority of gastric lesions have associated pain almost from the first, but this is also true of other lesions affecting the stomach such as gall-bladder disease or appendicular gastralgia. The location and character of the early pain will frequently help to differentiate these conditions, as in cholelithiasis the pain is often agonizing and situated to the right