TENDERNESS.

Gall-stones.	Gastric Ulcer.	Duodenal Ulcer.
During or immediately after an attack, tenderness is frequently marked in the right hypochondrium. Muscular rigidity is also often present.	Is usually quite marked in the epigastrium. Is sometimes diffuse, though usually quite definitely localized.	If tenderness is present, it will be found to the right of the median line. Is marked, however, only in the presence of localized peritonitis.

The treatment of cancer of the stomach is essentially surgical. True it is that many, anxious for surgical relief, must be refused because of the extensive proportions to which the disease has already advanced; there are also many patients who refuse operation. These two classes must be treated palliatively. To the other class, those whose diagnosis is made at a comparatively early period, while yet there is prospect of cure, and who are willing to undergo the risks of operation, surgery will indeed offer good prospects for a long lease of life. Surgery offers the only hope of cure, and the great problem before the medical profession to-day is to evolve some means of arriving at an early and accurate diagnosis, so that surgical intervention may more frequently be instituted at such an early period as to ensure the saving or prolonging of many useful lives. To the man who may thus evolve such a method of early and accurate diagnosis the world will indeed owe one of its greatest debts of gratitude.

Any operation for the radical cure of cancer of the stomach involves in every case the removal of a greater or lesser portion of the stomach wall. In planning the effectual removal of malignancy in this location, several factors must enter into the consideration of each individual case. In the first place the conception of the modern technic is based on the location of the lymphatic glands and the consequent direction of the lymph currents in the stomach wall. On the observance of this fact more than on any other will depend the freedom from recurrence, our highest aim when effecting such a removal. Then again, the involvement of the duodenum is much more frequent than was hitherto supposed. Heretofore it has been the popular opinion that the instant the involvement reached the duodenal wall the disease was abruptly cut short, but recent researches conducted by Borrmann have shown that in at least one case in every three the disease does not stop there, but continues to invade the duodenum. Hence the necessity of making it an invariable rule to remove at least from one to one and a half inches of the duodenum in all cases of cancer involving the pylorus.

The lymphatic drainage of the stomach stands as the most important consideration when deciding on the lines along which resection must take place. Cuneo has exhaustively studied this question from an experimental standpoint, and to him we are indebted for much of our