done. The loss of human life from cancer casts a shadow over the triumphs of the past. The saddest and most discouraging part of the work of a surgeon is the frequency with which he sees patients suffering from cancer so advanced, that the time for a radical operation has gone for ever. Especially is this true of gastric cancer. In less than 5 per cent of the cases I see, is a radical operation possible. The stomach is affected with cancer more frequently than any other organ of the body, and yet, partial gastrectomy is one of the uncommon operations of surgery. This reproach to our profession would be removed, in some measure at least, were the use of the stomach-tube part of the routine of gastric diagnosis. On this point I feel strongly, and have no hesitation in saying, that the number of cases of gastric cancer treated successfully by operation, ought to be, and could be, increased greatly, if only the cases were recognised earlier. Gastric cancer, contrary to popular belief, *can* be treated successfully, and earlier diagnosis *is* possible, even with the means at present at our disposal.

The operation of gastro-jejunostomy is not a panacea for all the ills to which the stomach is heir, but when performed in cases in which there is a definite organic lesion of the stomach or duodenum, the results are excellent. It is the keystone of gastric surgery.

It has been my aim to present methods of diagnosis and treatment, in a manner which may prove useful in practice to practitioners and students. If in any degree this aim be realised, the time spent by the reader and the author will not have been wasted.

Limitations of space have prevented me from referring to all the views and operative methods of those who have done such admirable work in gastric surgery. While the opinions expressed are based largely on the experience gained from my own failures and successes, doubtless the sub-