washing of the stomach, I opened the abdomen in the median line above the umbilicus. A rapid examination showed that the growth was firmly adherent to the under surface of the liver, and that the neighboring lymphatic glands were extensively involved. Removal was impossible and an anastomosis was therefore done.

The stomach readily came through the incision, and a search soon brought the jejunum on the outer abdominal surface also. Incisions, four inches long, were made in the anterior surface of the stomach, one inch above the greater curvature and well away from the growth and in the jejunum opposite the mesenteric attachment. The edges of these open wounds were brought together and united by a long continuous suture, which passed through all the coats of both stomach and bowel. This holds the edges accurately in place, rapidly stops all bleeding and prevents the mucous membrane from prolapsing and filling up the opening, a continuous suture was next carried around the opening, taking up only the serous and muscular coats, and thus bringing the serous surfaces accurately together a short distance from the lines of incision. A number of Lembert sutures were applied at points which seemed at all doubtful as to exact apposition. The extruded viscera were carefully washed with sterilized water and dropped back into the abdomen. The external opening was closed with silkworm gut carried through all the coats of the abdominal wall.

The healing was by primary intention. Vomiting only occurred once after the operation, and was probably due to too early use of solid food. The patient left the hospital on Feb. 22nd, and lived one month after. The disease had too firm a hold upon him before the operation was performed, and he gradually sank from exhaustion. Earlier interference would have, in all probability, lengthened his life, and would certainly have made the later months more comfortable.

J. K., farmer, age 61, entered the Winnipeg General Hospital under Dr. England in October, 1896. He complained of pain in the stomach, vomiting at frequent intervals, loss of weight and strength. Cancer of the stomach was suspected, and he was transferred to my charge for exploratory incision. This was refused by the patient, who went to Toronto and entered the General Hospital there. Operation was again suggested, and refused. He returned to Manitoba, and his family physician, Dr. R. S. Thornton, of Deloraine, found a very movable tumor in the epigastrium, and thus made certain the diagnosis, which had hitherto only been a probable one. Mr. K. now returned to the hospital for operation, and on Feb. 1st, 1897, I performed a gastro-enterostomy in the same manner as in the previous case. The growth could readily be brought out of the abdominal incision, and appeared to be favorable for a pyloroctomy, but as all the glands in the greater and lesser omenta were involved, I chose the less risky operation. The patient is still alive, five and a half months after the operation, and I trust has many months of usefulness yet ahead of him.

The death-rate from this operation is steadily decreasing with greater experience on the part of individual operators and with an improved technique. If the general practitioner will now aid the surgeon by sending the patients before they are exhausted and unfit for any surgical work, I am sure not only will better results be obtained for our records, but the true test of all medical work will be secured in making life longer and happier for those suffering.

DIABETIC DIAGNOSIS.

R. T. Williamson, Medical Registrar Manchester Royal Infirmary, has found that diabetic blood, even a single drop, is distinguishable from non-diabetic blood by a much more powerful effect in removing the blue color from a warm alkaline solution of methyl blue (1-6000), one part, to twenty of blood in forty of water.