However it is probable that the progress of the disease and not the operation, is in many cases the cause of the fatal termination. In the earlier operations, a factor responsible for a certain proportion of deaths, was that the first presenting portion of intestine, was attached to the stomach wall.

In some cases, the point of anastamosis was near the ilio-cæcal valve, leaving a large portion of the intestine, excluded, thus diminishing digestion and absorption, the patient ultimately dying of inanition. Now the circumstances have changed. The surgeon does not satisfy himself with any portion of the intestine presenting, but endeavours to obtain that portion of intestine lying 20-30 inches below the pylorus.

The difficulty of obtaining the proper loop is quite apparent. Most surgeons direct one to seize the first portion presenting and hand it to the assistant. If in following the bowel down it will become thin; if up, it will be thickened and pale.

Another difficulty, and one of very great importance is the union of the intestine to the stomach wall without regard to peristalsis. The result being that the food instead of going into the distal portion of the intestine, goes into the proximal, producing what might be called a vicious cycle.

If the pylorus were not thoroughly closed, it would produce vomiting, of bile, food and pancreatic fluid. If it were not patent then the outcome would be extreme dilatation of this portion of the intestine. To overcome this, several operations have been devised. Von Hacker recommends puckering the proximal end by transverse suture through the lumen of the intestine.

Launenstein's is perhaps the best, but requires considerable time; he advises the anastomosis of the proximal and distal portions of the intestines. In addition to these difficulties another arose. As the intestine was passed over the transverse colon the weight often produced obstruction with disastrous results.

In order to overcome this, a hole was made in the mesocolon, but as the intestine was yet attached to the anterior wall of the stomach, gangrene was liable to occur from destruction to the blood vessels. For this reason Von Hacker in 1875, adopted the method of posterior gastro-enterostomy, thus avoiding the danger of gangrene and at the same time facillitating the passage of food into the intestine, more especially when the patient is in the dorsal position. He prevents a hernia occurrring by suturing the margins of the vent made in the mesocolon to the stomach wall.

Pyloroplasty:—The enlarging of the pyloric orifice was first per-