enterostomy was impossible. I at once decided to attempt to excise the entire organ, or take recourse in a jejunostomy. I first freed the stomach from all of its attachments at the greater and lesser curvature, having previously shut off the general cavity of the peritoneum by sterilized compresses. The omentum was incised between Pean's forceps. Silk sutures were used. The stomach was then forcibly dragged downward so as to enable me to reach the esophagus. The left lobe of the liver had to be constantly held upward by an assistant, in order to permit me freely to manipulate within the field of operation. In this way I finally succeeded in securing the esophagus rather high up by means of a Wolfler clamp. A Stille forceps was next fastened closely to the cardiac end of the tumor. Then the stomach was severed directly beneath the esophageal extremity. As the esophageal incision appeared somewhat oblique, I proceeded to place a small occluding suture at the gastric wound. The same steps were now repeated at the pyloric end of the stomach.

I next mobilized the duodenum as far as possible toward the head of the pancreas. Then, having applied a duodenal compressor, and likewise a tumor clamp, I removed the entire stomach between the two points of compression. I also dissected out the lymphatic nodes above mentioned. The patent lumen of the duodenum was treated like the esophageal opening with iodoform gauze. The broad bridge joining together different divisions of the alimentary canal had now been entirely removed.

I next tried to pull the duodenal opening towards the esophageal cleft. It was only with considerable difficulty that the two could be made to touch. It was manifestly impossible to join them by direct suture. I, therefore, invaginated the duodenal rim, and closed the opening by a double suture. I then searched for a suitable coil of small intestine. Beginning at the duodenal-jejunal fold, I followed down the intestine for about fifteen inches. The presenting knuckle of intestine I grasped, and, pulling it over the transverse colon, I placed it against the esophageal slit.

A piece of this intestine, about five inches in length, was secured between two Wolfler clamps. By means of sutures not going deeper than the serous coat, the intestine was then attached to the esophageal stump. A longitudinal slit about one inch in length was then made into the bowel. Then the mucous membrane of the esophageal end was firmly united with the intestinal mucous membrane, by a continuous circular suture. The material employed was silk. Above this, a second suture, extending through the muscular and serous coats, was introduced. A Lembert suture finally completed the stitching, which now seemed to hold.

The esophageal and duodenal clamps were then removed, the former having remained in position for over two hours. On dropping back the organs into the abdominal cavity, the sutured portions showed marked retraction upward, toward the esophageal part of the diaphragm. The abdominal wound was closed in the ordinary way by silk ligatures. Less than eight ounces of ether had been employed during the narcosis, which had fortunately been a very quiet one.

Pulse after the operation; 96 a minute, steady, and of fair volume.

There had been only a very slight loss of blood during the course of the operation, which, however, had lasted nearly two hours and a half.

Clinical Observations Following Removal of the Stomach—Shortly after the operation the patient received an enema containing brandy and two eggs. Temperature in the evening, 36.4 degrees C.

September 7th.—Two nutrient enemas containing milk, eggs and brandy. Pulse rate has risen to 142, but in volume remains moderately good. Patient has taken per os, in the course of the afternoon a small quantity of tea and milk, which is apparently well borne. No signs of peritonitis. Evening temperature, 37.3 degrees C.

September 8th.—Nutrient enemas no longer retained. Claret wine in teaspoonful doses given, until half a glass has been taken. Patient complains of sudden abdominal pains, which, however, quickly subside. Evening temperature, 38.1 degrees C.; pulse, 160, but of moderately good volume.