and note the following fallacies: Vomits cannot be used as duodenal enzymes are frequently present. Bile points similarly to duodenal regurgitation. Blood vitiates the test, and while this would appear to render the test useless, yet this requires future consideration. The acidity of the gastric contents must be definitely below .18 HCl.

The test, which depends on the breaking up of glycyl-tryptophane by supposedly cancer ferments into tryptophane is hardly on a sound basis yet. The fallacies appear very powerful objections to its use in practice, yet the results in cases require its consideration. G. W. H.

A Contribution to the Diagnosis of Duodenal Ulcer. By M. GROSS, M.D., New York. *N. Y. M. J.*

Duodenal Ulcer is gradually being recognized as a common disease, and the characteristic symptoms may be wisely recalled.

Alternating gastric health and disease, with shorter or longer intermissions; hunger pain, relief by food; rigidity of rectus; painful area on hammer percussion; pylorospasm, mild icterus; and varying acidity to HCl tests,—are all the common signs.

Absence of blood from the stools is more common than the oft-vaunted presence, which is considered diagnostic. Einhorn lets his patients swallow a miniature bucket, and expects a blood-stained rope to diagnose ulcer and its site; the value of the test lies in its interest rather than the result. (It is a wonder that no gastrologist has advised the patient swallowing a leech in a non-soluble gastric capsule, with a bridle around its head, which, being set free in the duodenum, will forthwith attach itself to the sore area and produce the characteristic pains; and when well filled may be forthwith removed by its reins and its suckers examined for traces of the submucous or muscular fibres of the ulcerated area.)

G. W. H.