a band was seen in a woman transferred from Dr. Finley's ward. There were present a demonstrable dilatation of the stomach, indigestion, pain after eating and on two occasions a mild degree of jaundice. She was unable to take care of her house and children. An exploratory incision revealed the pylorus hitched up to the neighbourhood of the neck of the gall bladder by a strong thick band 1 inch long and ½ inch wide. When this was divided the pylorus became normally mobile. It was not cicatricial nor narrowed. The symptoms were relieved, and the patient for a year or more, when heard from was quite well. The band was probably secondary to an ulcer about the lesser curvature, just outside the pyloric ring. Then developed an adhesive peritonitis and later the stretching of the adhesion into a band.

Another most interesting case was that of a young woman in whom there was demonstrable considerable gastric dilatation and indigestion, and imperfect nutrition. A palpable and visible tumour the size of an orange was observed in the pyloric region. It moved up and down during respiration. The diagnosis was gastric dilatation, secondary to gastric ulcer in the neighbourhood of the pylorus, and the accumulation of an unusual quantity of inflammatory and fibrous tissue.

On opening the abdomen I found that the tumour was a clear, thin wall serous cyst projecting from lower border of liver, and not attached in any way to the stomach or pylorus. The pylorus, however, was held closely up by short dense adhesions to the under surface of the liver, near the gall-bladder the cyst was easily enucleated and the pylorus separated and lowered to its normal position. The opening not being narrowed, no gastro-enterostomy was done. Patient made an uninterrupted recovery.

More frequently the chronic ulceration is followed by the development of a mass of cicatricial tissue that narrows the pylorus to the extent of causing an obstruction to the escape of stomach contents, or if situated at a distance from the pylorus, may cause by its contraction and cicatrization, the deformity generally named "hour-glass stomach."

The pyloric stenosis is followed sooner or later by gastrectasis, muscular weakness, motor insufficiency and gastroptosis. A careful analysis of stomach contents is of the greatest value in determining the degree and nature of the altered conditions present. In this group of cases gastro-enterostomy is followed by the most happy and satisfactory results. Patients who had been chronic dyspeptics for years, weak, thin in flesh, living on a spare diet and slops, after the pyloric obstruction is short circuited, gradually increase their diet list, their digestion and assimilation improve, and in a few months have exchanged a condition of chronic