VIRCHOW—Connects the condition with a diseased endometrium.

SCHROEDER connects it with a diseased condition of the uterine wall as fibroids.

Neither of these explanations will suffice for the occurrence of the disease in the chorion of one faetus while that of its twin remains healthy. In this case the disease is of *faetus* origin, perhaps the result of the death of the faetus.

AS TO TREATMENT—It will be mainly directed toward the symptoms. If excessive hemorrhage tampoon the vagina until the is sufficiently dilated to permit the expulsion of the cystic mass. If the diagnosis be made during the pregnancy and if careful examination give no signs of the presence of the faetus, the immediate induction of abortion would be advisable, in order that the chorion may not grow to an inordinate size and push its way into the uterine wall. If after the expulsion there should be symptoms of retention and decomposition of fragments the rational treatment would be to remove the offending substance.

SELECTED.

FIRST COMPLETE EXCISION OF THE STOMACH IN A HUMAN BEING.

History of the case, by Carl Schlatter, M. D., the Operator—The personal observation forming the subject of this paper, relates to a woman, 56 years old. In her case I completely excised the stomach, even beyond its cardiac extremity, and then restored the continuity of the alimentary canal by stitching a loop of small intestine into the lower end of the esophagus, i. e., esophageal-enterostomy.

History of the Present Case.—Anna Landis, aged 56 years, silk weaver by occupation, claims that cancer is hereditary in her family. As a child she recalls having had frequent attacks of abdominal pain. According to her own notion these attacks were due to the poor quality of the food at the orphan asylum where she was brought up. Later on she often complained of severe pains in the stomach, accompanied or followed by vomiting. She never saw bloody admixtures in the ejected matter, but large quantities of bile often came up. Medical treatment had never afforded her any relief. Ever since the spring of 1897 the attacks of vomiting were of daily occurrence. Progressive emaciation also ensued. Several weeks before her admission to the hospital, physicians told her that she had a tumor of the stomach.

I first saw the patient at the surgical polyclinic on August 26, 1897. An inspection of the abdomen revealed a marked bulging between the left hypochondriac region and the umbilicus. The abdominal parietes were flabby and palpitation easily revealed an oval mass of hard consistency in the region of the stomach. The tumor was freely movable. Its size was about that of two fists. Very marked emaciation was found. The patient was unable to retain any kind of nourishment. She clamored for relief by surgical interference.

She was admitted to my wards for further careful observation. I did not feel confident that gastrectomy, or even gastro-enterostomy, could be successfully performed, on account of the large size of the tumor.

The patient continued to reject almost everything, including fluids. The iodide reaction of her saliva (after exhibition of iodide of potassium) required forty-seven minutes for its first appearance. The chemical examination of her gastric secretion showed no trace of free hydrochloric acid. An operation was, therefore, no longer delayed.

Description of the Operation.—On September 6, 1897, acting for Professor Kronlein, I performed laparotomy under morphine-ether anesthesia and with strict antisepsis—incision in the median line, extending from the ensiform process to the umbilicus. As I had anticipated, the entire stomach presented itself in the shape of a hard mass extending from the cardiac to the pyloric extremity. Strangely enough the tumor was freely movable. It was readily lifted out of the peritoneal cavity. Three rather soft lymph nodes were found at the greater curvature near the pylorus. The stomach being diseased in toto, a gastro-