diagnosis. This is, unfortunately, not the case with those chronic forms of obstruction which furnish the largest quota of cases which require the formation of intestinal anastomoses. I do not know why it is that the general practitioner evinces so much repugnance to operations on the very class of cases in which operations give the most brilliant results.

Cases of obstruction of a chronic nature differ from the acute obstructions, inasmuch as they are, during a comparatively long period, partial in character. Their symptoms develop gradually, and they give to the competent observer long notice of the coming closure. For this reason, the physician is enabled to study the conditions and to prepare, if he only will, for the coming disaster. To the surgeon, who is permitted to operate before the case has become desperate, a field is presented for operation which is free from inflammation, sepsis or gangrene. Stenoses of this character are most commonly caused by tumors or cicatricial contractions. The symptoms vary according to the seat of the obstruction and have to be studied, therefore, with especial relation to their location. When diagnosticating any given case we have to note the intensity and character of the pain or distress produced by the disease, the changes which take place in the form, size and feel of the abdomen, the location of any abdominal swelling, the degree of tolerance with which contents are allowed to accumulate before serious symptoms supervene, and the character of the vomit when it occurs. The movements of the viscera, seen as they affect the abdominal wall, and the gurgle of the fluids as they pass the point of stenosis will also in some cases afford positive evidence as to the seat of the disorder.

We may become best acquainted with the import of symptoms if we study them in turn as they appear in the obstructions of the separate portions of the alimentary canal from the stomach down. A pyloric obstruction will often end in death before the channel is obliterated. It is not at all uncommon to find on post-mortem that death has taken place from a pyloric tumor, in which the pyloric orifice is still large enough to admit the finger, or even the thumb, the patient having died, nevertheless, from inanition, due to the inability of the viscus to force its contents into the duodenum. The explanation of this fact is simple. Under normal conditions, the chyme is forced out of the stomach by rhythmical contractions of its muscular fibres, associated and in unison with a relaxation of the circular fibres which close the pylorus.

It is, in fact, a very complicated process, involving many nerves and muscles, by which small portions of the digested food