Another important point in judging of the advisibility of immediate operation is the character of treatment, if any at all, that has been tried.

I am suspicious of copious haæmorrhage 7, 6, 8 or 10 oz., recurring every 8 or 12 hours, after the patient has been put to bed, the stomach emptied by vomiting and all food witheld, together with ice locally, and perhaps morphia hypodermically. A correct decision must depend upon careful correlation of the different factors and individual judgment in each case. I cannot better express my own view than by saying that after two or three hæmorrhages recurring at intervals 7, 8 or 12 hours, and after the third or fourth hæmorrhage recurring at intervals of 12 to 24 hours, surgical resources are advisible, are less hazardous, and more conservative than these included under the term "medical." Anything, however, more than a suggestive working rule is impossible at present.

Somewhat more crystalized is opinion regarding the particular surgical method to be adopted

The autopsy reports of the Montreal General Hospital show that fatal gastric hæmorrhage takes place under varied conditions. Sometimes the opening in the artery is large enough to admit a silver probe, sometimes water or milk injected into the hepatic artery, flowed in a stream into the stomach. In some instances the opening in the artery is in the thickened wall of an old chronic ulcer, not permitting of closure by contraction. In other cases the source of the bleeding could not be found at all.

In the morbid anatomy of the fatal unoperated cases are suggestions as to the surgical method. Open the stomach, find the bleeding point and arrest the hæmorrhage by ligature, cautery, excision or suture, if possible. If the source of the hæmorrhage cannot be found, do as Mr. Moynihan has done with such uniform success, do a gastro-enterostomy. The search for the bleeding point in the first instance is indicated by autopsy findings, and is based on sound surgical principle, and although Mr. Moynihan has not had a recurrence of hæmorrhage after gastro-enterostomy, in any of his cases, others have not always been so fortunate and the reason is obvious.

CHRONIC ULCERATION OF THE STOMACH AND SEQUELAE.

Not less interesting and for the most part satisfactory are the results obtained by surgical methods in the chronic invalidism and indigestion secondary to gastric and duodenal ulceration.

Among the more common sequelæ are adhesions and bands, pyloric stenosis, hourglass contraction. A good example of displacement by