vent tension in any possible movement of the stomach, and the other is to anchor the same arm to stomach wall with sutures just above and an inch or more to the right of point of anastomosis. The object of the first mentioned is obvious. The anchorage of the proximal arm in position stated does away with the spur or acute angle of the bowel, and prevents untoward events which frequently prove detrimental after gastro-enterostomy.

Hour-Glass Contraction of the Stomach.

In it, as in obstruction of the pylorus, the operator will have to be guided in the choice of procedure by circumstances. However, as a rule a gastro-plastic operation is the one to be preferred. In the performance of it the very same principles govern that do in pyloroplasty. The extent and irregularity of the constriction may make two or more incisions, instead of one, advisable in order to regain the normal contour of the organ.

A number of operators prefer gastro-anastomosis; that is, making a communication between the two compartments of the organ near the normal position of the greater curvature. It gives results that leave little room for improvement, and should the precarious state of the patient be such as to forbid a prolonged operation, it is undoubtedly the best course to pursue in the majority of cases. Gastro-enterostomy is the only safe procedure when the hour-glass contraction is near the pyloric orifice, and complicated by adhesions and inflammatory thickening of the parts.

There are instances on record of local peritonitis resulting from gastric ulcer leading to the formation of adhesion so placed as to cause serious interference with the function of the pylorus, the division of which was followed by complete relief.

As yet it is a moot question for future developments to decide whether it is ever justifiable in the disease to operate with the sole object of arresting hemorrhage. Although successful operations have been reported by Roux, Guinard, Kuster and others, still on the whole the results have not been good. The same may be said in regard to operations for the relief of pain and vomiting in uncomplicated ulcers.

We now come to perforating ulcer of the stomach. According to different authorities, the frequency of it is estimated at from 6 to 18 per cent. of all cases of gastric ulcer; probably 8 per cent. is not far from what actually occurs. It is not by any means of rare occurrence, and few medical men have been long in practice without having some experience with it.

The first successful operation upon this continent was performed in Toronto by Dr. Atherton in 1894, and the first on