placed from the outside through both peritoneum and muscle, encircling the vessels leading to the ulcer. In perforation, linen sutures are used similarly. If the ulcer is located in the duodenum, or at or near the pylorus, the line of suture is transverse to prevent subsequent narrowing through cicatrization. If the patient is in good condition, a gastro-jejunostomy is also performed, if it can be done without spreading the infection. A lower abdominal drain is inserted and the abdomen closed, with or without irrigation, and the patient placed in a semi-recumbent posi'ion. In acute perforation recovery usually follows if the case is operated upon within the first five hours. Chronic ulcer is best treated by gastro-jejunostomy. When there are large vessels showing upon the surface of the stomach at or near the site of the ulcer, they are ligated by a musculo-peritoneal suture. Cases presenting stagnation and retention of food, depending upon mechanical stricture of the pylorus, and those cases with repeated acute attacks, in whom frequent relapses prevent the enjoyment of good health, are suitable for gastro-jejunostomy. Operation in chronic ulcer is not recommended until careful and prolonged medical treatment has resulted in failure to give a permanent cure. There is a large class of cases, according to Dr. Mayo, in which great discrimination is necessary. Atonic dilatation, prolapse, and the many gastric neuroses which may so closely simulate ulcer, are rarely benefited by surgery; while incision is but rarely done, Dr. Mayo inclines to the opinion that the future treatment of chronic ulcer will incline more and more towards the radical operation.

Dr. Mayo does not consider gastro-jejunostomy a cure-all. It is simply drainage, relieving the duodenum and pylorus from irritation, usually giving speedy relief. More than 90 per cent. of the patients suffering from gastric and duodenal ulcer, who have had this operation performed, have recovered. The "vicious circle" has disappeared under the *no-loop* operation, namely, making the anastomosis in the jejunum within a few inches from its commencement, so that, after the operation, the stomach and bowel lie in their previous normal relationship.

The Gall Tract.—The investigations in this clinic will become historical, as one of the great factors in the elimination of "chronic dyspepsia" and "chronic gastric catarrh," as an entity, from our phraseology. These hoary expressions, laden with erroneous notions of physiology and pathology, are being slowly but surely eliminated. Gastralgia is passing, pastrodynia fails to get a hearing in the presence of demonstrations of definite gastric, duodenal and gall-tract pathology at St. Mary's Clinic. More than 90 per cent. of such cases have been proven to be gall-bladder trouble. Dr. Graham says that "were neuralgias of the stomach, gastralgias, cardialgias and acute indigestion forever buried