been no melaena, there has been no hematemesis. The possibility of ulceration, therefore, must be very slight.

In considering the possibility of malignancy in the hepatic flexure of the colon, we must remember that tumor is a late symptom, and that diagnosis, in order to give prospects for complete relief, must be made in its absence. The diagnosis must be made from a combination of general and local symptoms. If there is increasing anaemia, if there is any cachexia, and if the patient is above forty years of age, malignancy, in the absence of any other apparent cause, must be suspected.

In cancer of the hepatic flexure we would expect to find stenosis, obstinate constipation, pain, ascites, cachexia, and emaciation.

Stenosis at some point in the alimentary canal is evidently present, as evidenced by the fact that vomiting is frequent, and that it almost always gives relief. Obstinate constipation is not necessarily always present in cancer of the intestine, in fact it frequently alternates as in the present case with excessive diarrhoea. Emaciation is also present in this case.

Two symptoms which we would expect to find are absent, ascites and cachexia. As these are very important, one would in their absence be very loath to pronounce carcinoma of the intestine. One further condition, the presence of slight jaundice would at least lead one to look for implication of the biliary tract in the location of the disease.

Is this clinical picture due to pyloric spasm, and if so, what is the direct cause of the spasm? We know of four definite pathological conditions which will produce spasm of the pylorus—appendicitis, cecal tuberculosis, gall-stones and malignancy of the pylorus itself.

At twenty-eight years of age, and again at thirty-six, this man had suffered from inflammation of the bowels. In the first attack he nearly died. Was one, or were both of these illnesses due to appendicitis? The first attack was thirty-one years ago, and the second twenty-three. At that time appendicitis as a disease was practically unknown. We now know that ninety per cent. of all cases of acute peritonitits in the male are directly due to appendicitis. It would appear that we are quite safe in supposing that these two attacks were due to a common cause—the appendix. It is now twenty-three years since the last attack. During these intervening years no symptom of appendiceal trouble had appeared. It would not therefore appear likely that this condition, even if pyloric spasm, could be caused by the appendix.

Are there any symptoms of cecal tuberculosis which might produce such a spasm? In tuberculosis of the ileocecal region we would expect to find a tumor, fixed, hard and more sensitive to pressure than a carcinoma. We would also look for periodical attacks of severe pain and alternating diarrhoea and constipation, as a result of the enterostenosis