region. Such cases, after the removal of the appendix, are relieved and recover from the gastric symptoms. In these cases the stomach and duodenum present no lesion recognizable on exploration. These clinical and laboratory experiences are sufficiently striking to warrant further study and experimentation in regard to the possible production of pyloric spasm, gastric anæmia, hyperacidity, and necrosis or ulceration of the mucosa."

RESUME.

1. Ulcers may be single or multiple and in different degrees of extension in the same specimen.

2. After the initial destruction of the mucosa, there is definite deepening of the ulcer by necrosis.

3. This deepening is sufficiently slow to allow a dense connective tissue barrier against perforation to be formed.

4. Ulcers heal, perforate and become malignant.

5. Perversion of the glandular elements occurs in the mucosa, and the cells then invade submucosa.

6. One cannot say positively that all carcinomata of the stomach have developed on ulcer, because carcinomatous tissue in the base of an ulcer may be ulcerated primary carcinoma.

7. The length of the clinical history is no positive index of the extent of the lesion.

8. The absence of blood in the vomitus or gastric contents at the time of laboratory analysis when associated with gastric symptoms is not evidence against the presence of ulcer.

9. Clinically, with our present means of diagnosis, it is impossible to say that a gastric ulcer is not malignant.

10. The intimate relationship between irritation in the appendix or