The differential diagnostication between pyloric stenosis and hour-glass contraction of stomach presents difficulties, and may be impossible when the latter is situated near the outlet, for here the clinical history and symptoms are nearly alike in every respect. But ordinarily, by noting the amount of fluid that can be introduced, and that which can be obtained shortly afterwards with siphon tube, by observing the contour of epigastric region when the organ is distended and otherwise, and by the intelligent use of the X-rays when the stomach contains subnitrate of bismuth in suspension, we may generally distinguish between the two conditions. However, it is not of great importance, for both, when severe, are amenable only by surgical means, and the technique of which is nearly alike.

Stenosis of Pylorus.

The operative procedure to be adopted depends wholly on the state in which the pylorus is found on examination. If the location of the ulcer can be easily determined, and there are neither extensive adhesions nor great thickening of the tissues, a pyloroplastic operation should be done. The part is first brought as well as possible into view, the peritoneal cavity guarded with sterilized gauze, and then the ulcer is removed by an elliptical incision running in the long diameter of the parts, the length of incision depending on the amount of contraction. It is then sutured in such a manner that when closed the line of union is at right angles to original incision. When correctly done, this procedure effectually removes the trouble and gives excellent results; but in a large percentage of cases adhesions and inflammatory changes in the parts render this ideal operation impracticable. Under these circumstances, what should be done? Pylorectomy is too severe a measure to be considered, unless we fear malignant changes. It is better to resort to gastro-enterostomy. The ulcer, or its cicatrice, is removed provided this can be easily accomplished, and then the jejunum, preferably by means of a Murphy button, is anastomosed either to the anterior or posterior wall of the stomach, as near the pylorus as the state of the tissues will permit, and a little above the line of greater curvature. There are objectionable features in the button, but on the whole it has fewer of them and more good qualities than any of the other methods.

In a paper read before the American Association of Obstetricians and Gynecologists in September last, I believe I had the honor of first calling attention to two practical points bearing on the matter. The first is to make sure before anastomosing that the proximal arm of jejunum is sufficiently long to pre-