having an opening 1¾ inches long. The surfaces were then brought together and the threads tied, and another line of Lembert sutures was carried along the superior border of the rings to connect with the extremities of the one already introduced. Towards the pylorus this was continued for about an inch to prevent the too abrupt flexion of the distal extremity of the bowel. These manipulations were conducted practically entirely outside of the abdomen, and the whole operation, from the first incision until the closure of the abdominal wound was completed, occupied fifty-six minutes. The anastomosis was completed in forty minutes. The original intention was, of course, if the condition of the parts had justified it, to excise the pyloric end of the stomach, invert the edges, and close the wounds in both stomach and duodenum, and then to establish the anastomosis as above described. As already stated, the intention of excising the tumour was abandoned on account of the extensive involvement of the neighbouring lymphatics. The patient's condition remained good throughout the operation. She was allowed nothing whatever by the stomach for 48 hours. She was then allowed a little water and a little peptonized milk alternately in gradually increasing quantities. On the fifth day she was allowed plain milk, and on the eighth day chicken broth and porridge. For three days after operation the beef-tea enemata were continued, and for the first 48 hours saline injections were given by rectum to relieve thirst, which was not excessive. Patient had a small stool on the night of the 5th (day of operation), and passed flatus by rectum freely next day. On the 7th there was some hiccough and patient vomited twice small quantities of dark liquid with a heavy, offensive odor (not fæcal). Bowels moved again in the night.

*March 8th.*—Coughed some during the night. Vomited once 18 ozs. of yellow liquid with offensive odor. Temperature, which had hitherto been normal, rose to 99½F.; pulse also rose to 100. Bowels moved three times. Complained of great pain in right side of pelvis after last enema.

*9th.*—Patient much disturbed by cough, otherwise comfortable and inclined to sleep. Bowels moved once. Pulse 108; Temperature 101°.

*10th.*—Cough very troublesome. Bowels moved three times. Patient slept well in intervals of coughing. Temperature reached 100°; pulse 96.

*11th.*—Cough continues troublesome. Temperature reached 99.2°; pulse 108. Patient slept well.

*12th.*—Temperature 99°; pulse 108. Patient comfortable except for cough.

*13th.*—Temperature 98½°; pulse 104. Patient slept well; still coughing.

*14th.*—Vomited porridge, first vomiting since the 8th (five days). Slept well. Temperature reached 99½°; pulse 104.

*15th.*—Vomited again. Slept well.

*16th.*—Vomited 28 ozs. fluid. Temperature 99.3°; pulse 110.

*17th.*—Patient woke up in the night complaining of severe pain in the abdomen, which lasted 25 minutes. Slept two hours and awoke feeling cold, but had no chill nor rise of temperature. Pain continued at intervals. From this time till the afternoon of the 24th, when she died, the course was gradually downwards. Pain, requiring morphia for its relief, weakness, emaciation some vomiting (not frequent nor severe), cough and perspiration were the symptoms observed. The pulse became weaker and ranged from 100 to 112, and the temperature remained practically normal, sometimes reaching 99.5°.

There were thus two distinct events occurring in the twenty days during which the patient lived after the operation. First, a troublesome cough coming on on third day, accompanied by rise in temperature and rapidity of pulse, but which gave rise to no physical signs; and second, sudden seizure of pain in the abdomen on the night of the twelfth day after operation, at which time, I have no doubt, the fatal peritonitis began.

The following is Dr. Lafleur's report of the autopsy made four hours after death:—

*Report of Autopsy in Case of Carcinoma of the Stomach, Operated on by Dr. Bell.*—"Body emaciated, sallow and anæmic. Visible tumor in right hypochondrium and epigastrium. Linear scar in median line, in epigastrium and upper umbilical regions. On opening peritoneal sac the peritoneal coat of the intestines was found reddened and turbid. Loops of small intestine adherent to the floor of the pelvis. Adhesions recent, and composed of yellowish fibrinous material; a few fragments of the same material were found on the surface of the spleen. A firm tumor mass, freely moveable, occupied the pylorus and the part of the stomach immediately adjoining it. The operation-wound between the first portion of the jejunum and the lower and anterior part of the stomach was completely united and in a healthy condition. The jejunum, a short distance above the anastomosis, is adherent to the transverse colon, and, on tearing through a few recent adhesions, a small pocket of thick, yellowish-green pus, about 2 x 1 inches, was exposed, which lay partly in the meso-colon, which was thickened and infiltrated. In doing this a portion of the proximal jejunum, which was softened and necrotic at this point, was torn away. At this point the end of the duodenum appears to have been twisted into a sharp S-shaped curve, and was slightly strangulated. On opening the stomach the little finger could be forced with some difficulty