I make no apology for coming before you tonight with a tale that has been already many times told. My excuse, if I need an excuse, is clear. The incidence of carcinoma of the stomach, like the incidence of all malignant disease, is increasing, and not all of the increment can be explained away on the basis of a longer life expectancy and a more effective application of preventive medicine. The curability of carcinoma of the stomach has in the last twenty-five years shown no such improvement as we might reasonably anticipate in the light of improved methods of diagnosis and treatment. It is no exaggeration—it is, if anything, an understatement—to say that of every 100 patients with this disease, at least 50, when they are first seen, have reached the stage at which no type of surgery can help them; that not more than 25 of the remaining 50 can be considered as subjects for gastrectomy, the only procedure which offers the faintest hope of permanent cure; and that if 10 of these 25 live beyond the five-year period, the surgeon may count himself fortunate among men.

Here and there, of course, results have been achieved that are decidedly better, that even are relatively brilliant. Balfour has recently reported on 128 patients upon whom resection of the stomach had been done for malignant disease and who were alive and well ten years or more after the operation. But such a report is rare. Much more typical are the figures of A. J. Walton, a distinguished British surgeon whose experience in gastric surgery is certainly as wide as that of any living man, and for whose clinical judgment and surgical skill I have, as all must have, unbounded respect. Writing in 1929, Walton said that of the 262 patients whom he had personally treated for carcinoma of the stomach, only 9 (less than 4 per cent) had survived long enough to be regarded as even probable cures.

A closer study of Walton's cases naturally changes the perspective. Of these 262 patients 171, more than two-thirds, exhibited lesions for which gastrectomy could not be considered,
and the percentage of probable cures in the other 91 immediately rises to 10 per cent. If these 91 patients could be still further subdivided into early and late groups, into favorable and unfavorable ones, the percentage of cures would undoubtedly be doubled or tripled. But statistics cannot be made up in that fashion. They must be based not on selected cases, but on the run of all cases. When they are so figured, the damning truth is that surgery, even in the best hands, which holds out any prospect of a cure, is possible in not more than 25 per cent, at most, of all patients, and that considerably less than half of this pitiful minority survive for five years.

The much maligned medical profession does not deserve all of the blame. We cannot treat men and women who do not come to be treated, we cannot operate on men and women who refuse to submit to operation. But at that, much of the responsibility must still be laid at our door. We are guilty of sins of commission and sins of omission alike. We err, not because we do not know, but because we do not think. Let me illustrate. No more illuminating study of cancer of the stomach has been published within my recollection than Alvarez' recent paper dealing with 41 physicians who were treated at the Mayo Clinic. Physicians are supposedly aware of the devious ways of this treacherous disease, are supposedly on the alert for its recognition, are supposedly convinced that in the battle against it surgical treatment and immediate surgical treatment offers the only hope of salvation. Yet what did this group of physicians do when they themselves were the victims? Did they promptly suspect cancer when they developed symptoms of gastric discomfort, of prolonged and progressive digestive disturbance, of actual obstruction? Did they promptly submit to radiologic study? Did they promptly demand surgical exploration? Most of them did none of these things. Most of these men and women who had every opportunity for knowing better either ignored their symptoms entirely or permitted themselves to be treated for indefinite periods of time by vague medical measures, apparently without suspecting that they had set their feet on the way that leads inexorably to death. Small wonder that laymen procrastinate. When the shepherd strays, it is not to be marvelled at that the sheep wander from the path.

The average physician either forgets entirely that carcinoma of the stomach cannot be diagnosed by rule of thumb, or tries to diagnose it by the trial and error method, and the tragic outcome of
both courses is plain to be seen. Howard Kelly, an extraordinarily observant clinician, once said of ectopic pregnancy that the most typical thing about it was that it was atypical, and the remark might be transferred bodily to gastric carcinoma. There is absolutely nothing typical about it, at least in its early and curable stages; when typical signs and symptoms develop, the patient is usually beyond hope of cure. And yet it is the exceptional physician who does not look for typical findings, chiefly because those are the findings he has been taught to look for. We continue to show students, just as we ourselves were shown, the terminal picture of the disease rather than the initial sketch, just as we show them the appendicitis which has gone on to peritonitis, the intestinal obstruction in which fecal vomiting is the outstanding feature, the biliary disease which has already involved the liver, and we stultify ourselves by reproaching them for their future performance.

I teach the surgical side of a clinicopathologic conference, and I am actually deeply regretful every time we have an autopsy for carcinoma of the stomach. That day is the pathologist’s, not mine. I know that no words from me can make my students comprehend that the body that lies before them, that emaciated, dehydrated old man with the fixed mass in his epigastrium, represents the price either of his own delay or of some physician’s blunder. I know that no words from me can make them realize that the patient upon whom they should focus their attention is nothing like the tragic sight they are seeing.

How are we to recognize the disease in its initial, curable stages? We might begin by reminding ourselves that the patient with carcinoma of the stomach is not necessarily the man or woman in middle life or beyond it. We may dismiss briefly the surgical freaks, the child of ten days, the boy of eleven years, even the girl of seventeen. But we cannot dismiss so blithely the 21 patients under twenty-five whom Sullivan was able to collect from the literature, for the sum total is more impressive than its component parts. We cannot forget that 3 of the 262 patients reported by Walton were under thirty years of age. We would do well to remember Alvarez’ unqualified statement that one of every 9 patients with cancer of the stomach is under forty-five years, and that this is an incidence considerably over 10 per cent within the age limits in which we do not ordinarily suspect cancer. We would likewise do well to remember that because of the activity of the
lymphatic system in the young, and the vascularity of their tissues, literally every day of delay counts against them in their fight for life. The most rapidly fatal case of gastric malignancy I ever saw was in a woman not yet forty. She had been aware of her symptoms for less than two months when I operated on her, and she presented an appearance of superb health. Yet not even a palliative procedure was possible; she had what might be termed an acute carcinomatosis of the entire stomach, almost identical with the impressive illustration Finney has contributed to the Lewis System of Surgery, and death, mercifully, ensued just six weeks after she had first consulted me.

The early case of carcinoma of the stomach frequently shows little more than a slight deviation from normal health. Many times gastric symptoms are lacking. The patient, often, is more likely to realize that he is not perfectly well than to think that he is sick. He is without energy, he sleeps poorly, he concentrates on his work with difficulty, he tires quickly, he complains of a general malaise, accompanied, perhaps, by a trifling loss of weight or a slight degree of anemia. Gastric disturbances he may deny entirely, even when, by explicit questioning, one endeavors to arrive at what Moynihan has described as "the very earliest departure from health of which he is aware." If a young person presented himself with such symptoms, the thermometer and the sputum bottle would promptly be called into use, but the older person nine times out of ten is given a tonic and nothing more, whereas what he needs most of all is prompt x-ray investigation of the gastro-intestinal tract. It may, and probably will, prove a needless precaution in 9 cases, but in the tenth case, which has no signs to distinguish it from the others, it may save a life.

Moreover, gastric symptoms, even when they are present, may not amount to very much or may be actually misleading. The illness may date from a dietary indiscretion or a digestive upset from which the patient has never fully recovered, or even from an extragastric illness. Loss of appetite, epigastric pain and discomfort, and vomiting are all symptoms of cancer of the stomach, but not in the early stages. The anorexia finally amounts to a positive distaste for food, but in the beginning it is little more than a lack of desire, especially a lack of desire for meat. Pain, which even in the late stages is not acute if other structures of the abdomen are not involved, is never marked in the beginning, when it is little more than a feeling of discomfort after meals.
Obstructive vomiting and coffee-grounds vomitus are terminal phenomena; the patient is fortunate if they develop early, for they are manifestations of a pyloric obstruction which cannot be ignored, and they call loudly for relief. As a rule, however, in the type of case we are now discussing, stagnation is not a feature, and the vomiting is little more than the regurgitation of small amounts of fluid, which is frequently acid and which is sometimes offensive.

While progressive loss of weight is quite typical of the disease, it is not typical of its early stage, in which the physical findings are often entirely negative. The patient with early carcinoma practically never has a palpable tumor, and even advanced disease may exhibit no demonstrable signs, since tumors located on the lesser curvature or tumors of the linitis plastica type cannot be palpated. Too much stress, therefore, must not be laid upon what can and, even more important, what cannot be felt in tissues which do not exhibit pain in response to palpation.

Laboratory studies may also be misleading. Anemia is characteristic of the disease, but the degree is by no means constant. It is naturally marked if acute hemorrhage has occurred, and it is sometimes so profound as to suggest a primary anemia, in the mistaken treatment of which precious time may be lost, but it may likewise be slight or absent. The physical manifestation, as Lord Moynihan reminds us, is frequently more noteworthy than the laboratory evidence; a gradually deepening pallor, often with a tinge suggestive of jaundice, is, if it is present, very suggestive indeed. Occult blood in the gastric contents or in the feces may be taken unreservedly as significant of ulceration somewhere in the intestinal tract, though the ulceration is not necessarily carcinomatous in character.

Gastric analysis should not be omitted in any case, though increasing experience has shown that too much reliance cannot be placed upon it. The absence of free HCl is by no means pathognomonic of cancer; I would hazard a guess, to mention but one condition, that achylia was a feature in at least 15 per cent of my own personal cases of gall-bladder disease. Moreover, a perfectly normal acidity is not incompatible with gastric malignancy; Hartman reports free HCl in 50 per cent of the cases studied at the Mayo Clinic.

Blood studies, gastric analyses, and similar investigations, therefore, helpful as they frequently are, especially from the standpoint of confirmation, cannot be accepted absolutely. With
the x-ray, however, we step at once on to surer ground, so sure, in fact, that there is not the shadow of an excuse for instituting without it any sort of treatment in any patient over the age of forty—and preferably younger—who exhibits any type of digestive disturbance which does not respond promptly and permanently to routine simple measures. Positive radiologic diagnoses vary from 60 to 75 per cent, and in 20 or 25 per cent of the remaining cases the findings are so strongly suspicious as to be almost positive, so that this method, when it is wisely used in combination with clinical observation, is obviously the most accurate one at our command. Granting that the technic is not always adequate and that the radiologist is not always competent, there are still not more than 10 or 15 cases out of every 100 in which either a positive or a probable diagnosis cannot be made, and the conscientious radiologist is usually the first to request that his negative diagnoses be considered relatively. In other words, the clinical interpretation of the history—of which the radiologist should be fully cognizant—is even more important than the radiologic investigation, and each should be studied in the light of the other. I am inclined, however, to agree with Christian, that few cases of cancer are unexpectedly revealed by the x-ray in patients whose full histories and systematic general physical examinations are recorded.

The radiologist, it might be well to emphasize, should not be asked to do the impossible. He can, naturally, demonstrate large filling defects. He can demonstrate pyloric obstruction. He ought to focus his attention, even without the warning that cancer may be present, on minute ulcerations and other abnormalities. He can by careful study of his films detect in the early case the sign that is generally granted to be very early indeed, the absence of peristaltic waves over some portion of the stomach. But if neither defect in contour nor abnormality in peristalsis is present, as frequently happens when the tumor is small and has not yet infiltrated the muscular coats of the stomach, he cannot do otherwise than report his investigation as negative, and the clinician is driven back to his purely clinical findings, from which, I might add, no matter how excellent the radiologic study may be, he ought never to depart very far.

The gastroscope, the esophagoscope and similar instruments of diagnosis to my way of thinking are of little value in the investigation of gastric carcinoma. The man who employs them, as Bland Sutton aptly says, requires "the instinct of a sword swallower
and the eye of a hawk," and I have no doubt that it was of them Orton was thinking when he said that one must be very robust indeed to be a patient in these modern days.

So much, then, for the patient who has been well up to the onset of his present illness, whose disease may be manifested suggestively by gastric symptoms or insidiously by extragastric symptoms, but who tells no story of a former illness. There is another type of patient, however, who demands equally earnest consideration, the patient with a long story of previous indigestion which has, perhaps, responded well to previous medical treatment, but which now remains obdurate to it, or which suddenly exhibits an exacerbation of symptoms or a change in symptoms. He stands in the center of the storm which rages over the question of the relation of gastric ulcer to gastric carcinoma, a question upon which authorities of equal eminence hold opinions that are diametrically opposite. MacCarty from the Mayo Clinic precipitated the controversy some years ago, when he reported that in some 70 per cent of the gastric carcinomata he had studied the tumor originated on the basis of a chronic ulcer. Moynihan reports such a transition in two-thirds of his personal cases. Twenty-one of the 41 physicians reported by Alvarez (see above) had histories which introduced either the certainty of a previous ulcer or the strong probability of one, and I agree with him when he says that the man who can ignore such facts has a mind that is impervious to evidence of any kind.

I am not forgetful of the work which eminent pathologists have done in this field and which has resulted in figures that are far lower than these—Ewing's proportion, for instance, is approximately 5 per cent—when I take my stand on the side of Moynihan and of the Rochester group. I cannot see why the transition is not a perfectly logical one; cancer develops elsewhere in tissues that are long irritated, why should it not develop in the stomach in tissues that have been similarly insulted? The origin of malignancy, however, is an academic consideration, as is the question of the exact percentage of gastric ulcers which exhibit carcinomatous changes. The microscopic, radiologic, and clinical criteria which have been invoked to solve the problem fade into insignificance beside certain undeniable facts: that some ulcers end as cancers, and that some supposed ulcers are cancers from their inception. If these facts are accepted, and no surgeon can deny them, no internist and no gastro-enterologist ought to deny them, then the
prolonged medical treatment of supposed gastric ulcers is not safe. It is always, as Alvarez points out, based on the fallacious assumption that differentiation of gastric ulcer from gastric carcinoma is possible by clinical and radiologic methods, whereas it is not even approximately accurate. In the 507 cases reported by McVicar and Daly the diagnosis could not be made positively in 30 per cent, and other studies parallel theirs. A widely general belief to the contrary—I quote Alvarez again—an ulcer does not always show up as a crater, and a cancer does not always show up as a tumor. The larger the defect as demonstrated radiologically, the higher the chances of carcinoma; that much we know positively. According to Alvarez, if the lesion is the size of a dime, the chances are 1 to 15 that it is benign; if it is the size of a quarter, the chances are 1 to 10; if it is the size of a 50 cent piece, there is a 2 to 1 chance that it is not benign; if it is the size of a dollar, carcinoma is almost positive. With the larger defects, which are invariably considered from the point of view of possible malignancy, that is safe reasoning, but what of the small lesions, which are not generally so regarded, and their chances of error? Eusterman reports 218 gastric cancers in which the average size of the crater was little more than 3 cm. How are these lesions to be differentiated?

A guess, which in at least 30 per cent of all cases is the best that the most experienced clinician and radiologist can offer, is a poor peg, as Lord Moynihan says, on which to hang a man's life. And make no mistake, it is a life that is in the balance. The medical treatment of gastric ulcer may be considered relatively safe, perhaps, even if it does not cure the patient, but the medical treatment of gastric cancer is equivalent to manslaughter or suicide, depending upon the point of view from which you happen to be regarding it. Gastric ulcer and gastric cancer must be distinguished positively, not probably, before the medical treatment of the supposed ulcer is undertaken. The physician—it is not unfair to say that he is very frequently the gastro-enterologist—must be absolutely certain that he is really dealing with an ulcer before he keeps the surgeon out of the case, regardless of how uncommon he feels the transition to carcinoma to be. The Mayo figures may be too high, but there is a factor of safety in them that is ignored by those who refuse to accept them. Walton, very correctly, points out that the reaction against them, which has strengthened the case for the medical treatment of gastric ulcer, is not free from danger. Its disastrous results he is able to prove
personally. His percentage of operability, which by all the laws of averages ought to have shown a progressive rate of increase, actually regressed some 10 per cent in the third of the three five-year periods upon which his study is based, and his explanation is that many cancers were diagnosed as benign ulcers and were treated medically until they were beyond surgical aid.

Lahey and Jordan have set down excellent criteria for the safe medical treatment of supposed gastric ulcers; they require, within a period not longer than three weeks, that the symptoms must be completely relieved, that the lesion, by repeated x-ray study, must show definite improvement and final healing, and that blood must disappear from the feces and from the gastric contents. But even these criteria are not always safe. "A degree of clinical silence," as Moynihan well puts it, may follow rest and diet in gastric carcinoma as well as in gastric ulcer, and in patients with a long story of digestive disturbances it may be dangerous to delay surgery even for the three weeks which these authorities conservatively suggest.

The only safe plan is to regard as cancer any indigestion, with or without other symptoms, which appears after middle life in a previously well person; to regard as cancer any acute digestive disturbances in this period which are superimposed upon chronic digestive disturbances and which do not respond promptly to routine measures; to regard as cancer or as highly suspicious of it vague general symptoms of fatigue, malaise, mental indifference, insomnia, etc., even though associated gastric disturbances are lacking; to continue to regard as cancer any one of these clinical syndromes until it is proved beyond shadow of doubt not to be cancer; and to resort without delay to exploratory laparotomy if the diagnosis cannot be made otherwise.

The suspicion that cancer exists is the crux of the question; in malignant disease the certainty of diagnosis is frequently also the certainty of death. "The salvation of human life," says Lord Moynihan, "is a greater thing than the establishment of a convincing, irrefutable clinical diagnosis," and Arthur Curtis remarks in another connection that "it is better to have a less accurate diagnosis and a more favorable prognosis." Operation on mere suspicion is not, as a rule, to be encouraged, but it is more than justified in this disease, in which one can scarcely foretell what a day will bring forth or at what moment an operable growth will become an inoperable one, and in which the battle must be waged
against an enemy who knows no laws. Accurate diagnosis is most devoutly to be wished, but in the presence of doubtful positive findings, or in the absence of incontrovertible negative findings, the surgeon is entirely justified in exploring without hesitation every person in middle life or before middle life who exhibits a dyspepsia which does not respond promptly and permanently to established methods of treatment: cancerous indigestion has no hallmarks, while it is still amenable to cure, to distinguish it from indigestion of other origins. A properly performed exploratory incision never killed anyone, and the multitudes whom it has saved from death cannot be counted.

The studies of Warwick and of Saltzstein and Sandweiss indicate quite clearly, as Horsley points out, the most certain mode at our command of bettering our end-results in cancer of the stomach. Warwick, in 176 cases which came to autopsy, noted that in 23 per cent there was no evidence of metastasis, and that 42 per cent of the growths were confined to the pyloric and the prepyloric regions, while the greatest number of cases, 35 per cent and 29 per cent respectively, occurred in the fifth and sixth decades. Saltzstein and Sandweiss, in 365 consecutive deaths, found that resection had been done in only 28 cases, 7.7 per cent. Now these figures may be assumed to be representative, and their interpretation, as Horsley remarks, is very significant. A high percentage of cases exhibit no metastasis, a high percentage are located in an area favorable for resection, and a high percentage occur at a period of life when the lymphatic system, by which malignant extension chiefly occurs, is increasingly inactive, and when malignant processes are for some reason less virulent. To these favorable circumstances should be added at least one other, that pyloric cancers are far more likely to begin with symptoms which demand relief than are cancers located elsewhere, which tend to begin with atypical and less prominent manifestations of disease. Yet less than 10 per cent of all unselected cases, in spite of these favorable factors, are apparently subjected to the only procedure which offers the smallest chance of cure. The percentage of resections is undoubtedly mounting steadily. It has increased approximately 5 per cent in the last ten years at the Mayo Clinic, and approximately 10 per cent in the Eiselberg Clinic in Vienna over practically the same period. But even 30 or 40 per cent of resections, a percentage which is seldom if ever generally achieved, still means 60 or 70 per cent of diagnoses made too late.
The indication, therefore, is clear, to resort to surgery more often and more promptly, even though x-ray diagnosis and physical findings seem conclusively to contraindicate it. The exploratory incision very frequently proves resection possible when radiologic and clinical evidence seems to prove it impossible. The size of the tumor is not necessarily a contraindication to radical surgery. Large tumors, as Balfour reminds us, are usually colloid, and, in spite of their size, often lend themselves admirably to removal because they are sharply demarcated, the walls of the uninvolved portion of the stomach are flexible, and extensive resection and safe anastomosis are therefore practical. The same writer also makes the point that a seemingly inoperable tumor is often converted into an operable one when complete relaxation has been secured under anesthesia and when adhesions have been freed. Nor is age a contraindication. We have already commented on the decreased lymphatic circulation and the lessened virulence of malignant disease in old people. The practical application of these considerations is found in the cases reported by Schwyzer and by Horsley, of men well beyond the biblical span of life, who had months and years of comfort and in some instances, at least, apparently permanent cures, because their surgeons had the courage of their convictions.

Histologic study as a criterion of surgery I am rather dubious about. Only 10 per cent of all growths, according to Balfour, are grade IV and highly malignant, while 55 per cent are grades I and II and relatively benign, but I should have to be very certain of my pathologist, for one thing, before I was willing to base my surgical procedure on a histologic report, quite aside from the fact that the biopsy to secure the specimen necessary for diagnosis is frequently the height of unwisdom.

It is folly to deny that gastrectomy is a procedure in which a high mortality is inherent. Balfour’s record of 200 cases with only 10 primary deaths is a performance that is not likely to be duplicated often. In the average hands we must expect an immediate death rate that is considerably higher, though the average hands, we may say frankly, have no right, in these days of many expert surgeons, to be undertaking such surgery as this, surgery which demands an unusual degree of knowledge and judgment and dexterity and which should be left to the surgeon who possesses these qualifications. The patient’s chances are increased in direct proportion to the skill of his surgeon—about that there can be no
argument—but no matter how poor his surgeon may be, they are still better than they would be if surgery were withheld, for without operation the mortality of gastric cancer is precisely and inevitably 100 per cent. It is a safe working rule to offer the hope of surgical relief, however faint it may be, to any patient who is not so far gone in his disease that the mere act of operation would kill him. It is a safe working rule to remove all tumors, even if total gastrectomy is necessary, which are mobile, which are not associated with metastasis to the umbilicus, the head of the pancreas, and the rectal shelf, and the removal of which seems to promise the possibility of relief if not of cure.

For it is the surgeon's duty to relieve as well as to cure. Walters expresses it well when he says that we should apply to gastric malignancy the principle established by Sampson Handley in carcinoma of the breast, that we should extend our field of usefulness not only to early cases but to late cases and recurring cases if by so doing we can make the patient's life more comfortable. I know no other disease in which the aphorism "Guérir quelquefois, soulager souvent, consoler toujours" is more applicable than it is in cancer.

Gastrectomy is of value even when a cure cannot be looked for or hoped for, because the removal of the primary growth usually eliminates permanently the possibility of future obstruction, and makes the burden of illness more tolerable, since metastases in the liver, lungs and other structures tend to progress relatively slowly and painlessly. W. J. Mayo mentions one such case. The patient, after resection of the stomach, lived nearly four years and worked in real comfort until within a few weeks of death, although his liver became a huge mass which filled the whole right and median abdominal regions.

Gastro-enterostomy is of value when gastrectomy cannot be done, and is, in many ways, preferable to jejunostomy, the alternative procedure, which in my opinion should be reserved for those patients in whom feeding can be accomplished in no other way. I recall one case in which I performed gastro-enterostomy as an emergency operation after profuse gastric hemorrhage, the patient having suffered from the attentions of a gastro-enterologist for a supposed gastric ulcer for something like six years. He died two years after I had operated on him, with an enormous metastasis to the liver, but he had twenty months of perfect comfort and normal life in the interim. Other things being equal, however, gastrectomy
is the operation of choice, for general experience bears out the correctness of Kocher's claim that it gives the patient a three times greater chance of comfort without a much greater immediate risk to life. In the occasional case the end-to-end gastrojejunostomy, with exclusion of the growth, as suggested by Balfour, may give better results than either gastrectomy or gastro-enterostomy.

Finally, there is the patient in whom surgery cannot be considered, or the patient in whom surgery has failed. He taxes all our resources, he demands our best efforts, and yet we are prone to ignore him entirely, not because we are heartless, but because, in sheer despair at our own helplessness, we lack the courage to meet his need. As a matter of fact, much can be done to make his lot more endurable. He should be encouraged to live his regular life as long as he can keep on his feet. He should be taught the rules of hygienic living if he does not already know them. He should be stimulated physically in every possible way, and he should be stimulated mentally by an atmosphere of cheerfulness and hopefulness, no matter what the cost may be to those who are attending him; when courage goes, all goes. He should not be permitted to suffer—what earthly difference does it make if a dying man becomes a drug addict? Sometimes, as the end draws near, sensibility diminishes and pain cares for itself, but if it does not, the doses of opiates should be as large as are necessary to control it, though in anticipation of the final need the initial dose should be kept as small as possible.

Last of all, when death draws close, the patient should be permitted to die. There is no thought of kindness, no hint of mercy, in keeping in his misery the man whom we can no longer succor, whose tortured existence we are simply prolonging an hour or a day. We have not the right to terminate life, but there can surely be no condemnation for the truly merciful physician who refuses to institute active treatment merely to keep in the world a little longer a sufferer who has already borne too much. R. B. Wild, to whose compassionate paper on the subject of hopeless malignant disease I would direct your careful attention, closes with a quotation from Clough, which I repeat here because it expresses a sanity of outlook urgently needed in a situation which is not always handled with judgment:

"Thou shalt not kill, but need'st not strive
Officiously to keep alive."
Carcinoma of the stomach, at its best, is a cheerless theme. I have little patience with the writers who paint in roseate words what we could achieve if we only would. It is folly to close our eyes to the fact that we are dealing with a disease which is always insidious in its onset and which may not manifest itself at all until death is close at hand. It is folly to close our eyes to the fact that we are dealing with a disease which frequently baffles the diagnostic acumen of our best clinicians and laboratory men, and which almost as frequently baffles the surgical skill of our most expert surgeons. The public has much to answer for in its fatal habit of delay, but the physician has much to answer for, also; he is careless when he should be careful, slow when he should be swift, cowardly when he should be courageous. The outlook in gastric malignancy will be very much improved when the medical profession does its full duty and does it from beginning to end, and the principles upon which its performance should be based are few and simple: Cancer is to be suspected in the unlikely as well as in the likely case. Operation on suspicion is in this disease not only justifiable but commendable. Surgery which promises relief is to be done just as readily as surgery which promises cure, regardless of the effect which it may have on one's statistical average. Amelioration of suffering is possible up to the very moment that death brings release. The picture, as you know only too well, can never be anything but cheerless, but it will become decidedly brighter when every physician, no matter what his specialty or his field of practice may be, bases his treatment of gastric carcinoma on these perfectly practical rules.

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