Our knowledge of the causes and treatment of dysphagia has grown in recent years both through continued clinical observation and also through advances in the technique of oesophagoscopy, radiology and surgery. The majority of cases of difficulty in swallowing due to causes at the lower end of the oesophagus are the result of carcinoma, or of achalasia of the cardia (cardiospasm). In both of these conditions there has been some progress in therapy mainly owing to improved surgical procedure. The various modern operations devised for removal of oesophageal growths have for the most part utilised the thoracic approach, whilst in cases of cardiospasm excellent results have followed mobilisation of the oesophagus via the transperitoneal route, and section of the cardia down to the mucous membrane, similar to the pyloroplasty operation associated with the name of Rammstedt.

In any case in which medical measures fail and gradual loss of strength occurs, radical operation must be most carefully weighed up as compared to the alternative of continued efforts at dilatation with bougies.

Beyond these two important conditions is a less well known but far from rare one, namely that of short oesophagus. This abnormality probably occurs in some 1 to 2 per cent of all individuals, but gives rise to dysphagia in only a proportion of these. As compared to carcinoma and achalasia the