

For the notes of this case and the following one we are indebted to Mr. G. Victor Miller, late resident surgeon.

A man fifty-one years of age was admitted into the North Riding Infirmary on Aug. 14th, 1893, complaining of abdominal pain, constipation, and sickness; in fact, symptoms of intestinal obstruction. He stated that about three weeks previously, when at work and in the act of lifting a heavy bar of metal, he felt a peculiar sensation in the lower part of his abdomen. This was followed by pain and a feeling of weakness, which necessitated his leaving work. On the same evening he passed from half a pint to a pint of blood by the bowel and the following morning he again passed about half a pint. He was away from work for a week, during which time he experienced, more or less constantly, colicky pains in the abdomen and also suffered from constipation, necessitating his taking a purgative. This latter fact was especially noticed by the patient, as he had been previously very regular in his bowels, rarely ever requiring opening medicine. He returned to work, but only for four or five days, the general weakness and abdominal pain compelling him to give it up. From this period up to the day of admission into hospital he said that his bowels had not been moved at all. He had taken purgatives himself and his medical attendant had also administered them, but without effect. He had been vomiting more or less the whole time and from what one could gather it was of a feculent character just prior to admission. The colicky pains were constantly troubling him and varied in severity; sometimes being very severe and then confined more to the region of the transverse colon. On admission the patient looked somewhat pale and exhausted; the tongue was foul and the temperature subnormal, and remained so, gradually falling up to the time of his death. The abdomen on inspection was found to be markedly distended, and the large bowel, especially the caput cæcum, appeared to stand out distinctly from the rest of the abdominal contents, and in the region of the left iliac fossa a distinct fulness was noticeable. On palpation the caput cæci could be felt to be extremely distended; also in the left iliac fossa a hard mass about the size of a large orange could be felt, which on percussion over it gave an obscure tympanitic note. There was no sign of a hernia, and nothing abnormal in the rectum. Dr. Munro at this time suggested embolism as a cause of the patient's condition, but the mass in the iliac fossa also inclined him to think it was possibly, or even probably, due to a tumour of a malignant character. Several copious enemata of soap-and-water were administered, but without any result. A grain of opium was also occasionally administered and fomentations applied to the abdomen to lessen the pain, and by way of nourishment small quantities of milk and soda water, frequently repeated, were given. The milk was retained, and, in fact, he did not vomit again until after the operation. This treatment was continued until Aug. 16th, but the patient's condition remained unaltered, and having obtained his consent to perform an operation it was decided to open the abdomen at once. Dr. Munro on opening the abdomen found the following conditions. The mass in the left iliac fossa was due to a large decolourised infarction in the mesentery of the sigmoid flexure. There were two infarcts also in the mesentery of the small bowel; these were smaller and retained for the greater part the dark colour of the blood and thus were more recent than that in the mesentery of the sigmoid flexure. The infarct in the sigmoid flexure was adherent to the anterior abdominal wall and to the iliac fossa. The ascending, transverse and descending colon were enormously distended and very dark in colour; the walls appeared to be thinned by the distension to which they had been subjected, and they had a doughy feel to the touch. The caput cæci was also enormously distended, but otherwise not so much altered. The small intestines were red and deeply injected, which, together with the more recent appearances of the infarcts, proves that the inferior mesenteric artery was first affected. The patient stood the operation well and progressed favourably for twenty hours, but then rapidly sank and died. Any further examination of the abdomen after death was unfortunately prevented.

Remarks by Dr. MUNRO.—I have taken the following from articles by Gerhardt and Kussmaul giving the diagnostic points of these cases: (1) a source of origin for the embolus; (2) profuse, even exhausting hæmorrhage from the bowels; (3) severe colic-like pains in the abdomen; (4) tension and tympanitic swelling, sometimes very marked; (5) considerable and rapid reduction of temperature; (6) demonstration of embolism in some of the other

arteries; and (7) demonstration by palpation of infarcts between the mesenteries. In the case described it will be seen that nearly all the classical symptoms were present, and No. 7 in so marked a degree that its firmness and immobility simulated a tumour, and so led to the operation.

As there have been only two or three cases of iridodialysis recorded in which healing subsequently occurred, the following case may not be uninteresting.

IRIDODIALYSIS, FOLLOWED BY UNION AND RECOVERY.

(Under the care of Dr. McCrindle.)

A man thirty-four years of age was admitted into the North Riding Infirmary on June 21st, 1893, suffering from an injury to the eye. He stated that whilst chipping a bolt-head a piece flew up and struck him in the left eye. The condition on admission to the infirmary was as follows. There was a wound one-sixth of an inch long towards the outer margin of the cornea. The iris at the same side was torn from its attachment for about one-sixth of an inch, a distinct gap being observable. The anterior chamber contained a quantity of blood. The eye was carefully washed with a 1 in 3000 perchloride of mercury solution, atropine was instilled, both eyes were bandaged, and the patient was confined to bed. In three days the anterior chamber was clear, and the patient could count fingers. On the fourth day the anterior chamber was found to be filled with blood again; it rapidly cleared, however, under the application of leeches, but a clot remained between the torn edge of the iris and the ciliary border. In the next few days the clot became decolourised, and union began to take place to all appearances through the medium of blood-clot. Iodide of potassium was at this time administered internally, and appeared to assist the healing process. From this time the case progressed well, and the patient left the hospital on July 27th. He started work a week afterwards, and has been at work since. The patient can count fingers, but cannot read print unless very large, such as the heading of newspapers and the large print of posters. The field of vision is contracted slightly at the upper and inner side, suggesting that there was probably some damage to the retina near the equator of the eye. The eye is perfectly quiet, the patient has no pain in it or tenderness on pressure, and tension is normal. The portion of the iris that was detached has a thinner appearance and seems to have a more open texture than the rest of the iris, and is somewhat frayed out at the pupillary border. The damaged portion of the iris does not contract to light. It is difficult to say whether there is a foreign body in the eye or not. It could not be seen on ophthalmoscopic examination, but that may be on account of its peripheral situation. If there is one present the eye may at some future time give the patient trouble and therefore a guarded prognosis was given.

PETERBOROUGH INFIRMARY.

A CASE OF GASTRO-ENTEROSTOMY FOR PYLORIC CANCER.

(Under the care of Dr. THOMAS JAMES WALKER.)

THE operation of gastro-enterostomy has been performed many times in this country and abroad, and has now taken a definite and important position in the limited list of means at our disposal for the relief of symptoms arising from pyloric obstruction. Of the various procedures advocated for dealing with constrictions at the pylorus this is the one which is most generally applicable, and which most undoubtedly affords benefit—sometimes great benefit—to sufferers, whether the obstruction be of a malignant character or not; in the former class of cases not only is life prolonged, but it is rendered enduring. It is impossible to give any statement of authority as to the length of time that life may be prolonged by the operation; this must vary in the individual cases, and depend on factors difficult to estimate. The operation under anaesthesia usually requires from twenty minutes to half an hour for its performance aseptically and with due precaution against leakage by careful suturing, and cannot be looked upon as formidable when we consider the advantages offered—relief of the pain, of the vomiting, and of the condition of starvation. That it has not attained to the position to which it is entitled is due, we think, to the fact that the patient is frequently not advised to submit to it until he is not only half starved in body but very generally depressed, and in no condition to undergo any procedure involving the administration of an anæsthetic. If the operation were performed at an early stage of the disease the mortality from shock

the immediate result of operation or from lung complications should be small. At present we are not able to say that there will not be a return of symptoms consequent upon contraction of the opening; therefore, even if life should be prolonged for some months, anything which should enable us effectually to prevent this misadventure is eagerly sought for. What the result of suturing the edges of the opening in the manner adopted by Dr. Walker may prove remains to be seen. It is important that this result should be recorded. For the notes of this case we are indebted to Mr. P. Hope Murray.

A widow forty years of age, the mother of eight children, was admitted into the Peterborough Infirmary on April 29th, 1893, suffering from symptoms of pyloric obstruction, distension of the stomach, vomiting of long-retained food, and emaciation. A tumour was felt and cancer of the pylorus was diagnosed. The left mamma showed hardenings from accumulations of milk, as she had been suckling her youngest child. These disappeared upon the application of belladonna. After admission her general condition improved with rectal feeding and milk by the mouth, the quantity of milk being gradually increased. On May 18th the stomach, which had been much distended for several days, was washed out with a solution of salicylate of soda, forty ounces of fluid were introduced, and eighty ounces were returned. This washing out was done somewhat hurriedly before the operation, and was not entirely successful, as subsequent events showed. On the same day the operation was performed. The table was heated, the carbolic spray was used and strict aseptic precautions were taken, and an enema of brandy and soup was given. Ether was administered by Dr. Payne. An abdominal incision was made, about five inches long, half an inch to the left of the middle line and running down to half an inch below the umbilicus. On examination the pyloric cancer was found to involve part of the small curvature of the stomach, rendering removal out of the question. The omentum was thin and scanty, and was easily pushed over to the left side out of the way. The greater curvature was opened, and the stomach found to contain a considerable quantity of fluid; most of this was evacuated, but it was not found feasible to completely empty it, nor did this seem necessary. The peritoneal and mucous edges of the opening were stitched together, with the idea of preventing contraction. The jejunum was opened and the edges treated in the same way. Senn's plates were introduced, but before drawing the silk tight the peritoneum of the stomach and jejunum near the posterior edges of the plates were united with silk, thus forming a semicircle of stitches, guarding the opening posteriorly; the plates were then drawn tightly together; an anterior semicircle of stitches was now inserted, thus completing the circle of guarding stitches. The parietal peritoneum was closed with silk. The abdominal wall was united also with silk. After the operation the patient was fed by the rectum every four hours; tincture of opium was added to the enemata. On May 19th the patient had passed a good night. The morning temperature was 99.8° F.; the evening temperature was 99.6°. After this the temperature was not found above 99°. Morphia was given hypodermically once for sharp pain coming on occasionally. The patient vomited some of the contents of the stomach, previously imperfectly emptied. The next day she vomited again, bringing up some fig-seeds and orange septa. The same evening, at twelve midnight, she had a very serious cardiac attack, which seemed likely to prove fatal, the radial pulse being 80 and the heart beats 234, only every third beat or so reaching the radial; there were great prostration and pallor of the face, but no lividity of the lips; cardiac pain was also present and the heart was beating in a very flappy manner, the first sound being for some time hardly audible. After stimulation by the mouth and rectum and the administration of ether subcutaneously the heart improved a little. At 3.30 A.M. she was still very prostrate, but at 7.30 A.M. she had almost entirely recovered from the attack. The patient afterwards stated that she was liable to cardiac attacks, which appear to have been of an anginous nature. On the 23rd she vomited again, bringing up some whole figs, which had been surreptitiously eaten on May 14th or 16th, and which, owing to the deficiency of teeth, were not masticated. On the 25th the wound was dressed and the stitches removed; a little superficial pus was found around the stitches. On June 3rd she was discharged, the obstruction being cured.

Subsequent note.—In December, 1893, it was reported that the patient had been very well for some time after going home, and had gone out washing, besides looking after her family of eight children. It was also said that she had not been so well lately, but in what way is not known.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Acute Phthisis following Destruction of Mucous Membrane of the Stomach by Corrosive Fluids.—Suppurating Hydatid of Liver opened through Chest Wall.—Membranous Inflammation of the Throat during Scarlet Fever.

AN ordinary meeting of this society was held on Jan. 12th, Mr. HULKE, President, being in the chair.

Dr. SOLTAU FENWICK read a paper on two cases of Acute Phthisis following Destruction of the Mucous Membrane of the Stomach by Corrosive Fluids. A man aged thirty-four years was attacked with the symptoms of severe gastritis after swallowing some oxalic acid. Six weeks' pain and vomiting ensued, but the patient's strength was fairly maintained by means of nutrient enemata. After two months the stomach was found to be considerably dilated, the lower margin extending below the umbilicus. There was tenderness over the pyloric region, and vomiting of a sour, fermenting fluid with no trace of free hydrochloric acid occurred at intervals. Under lavage considerable improvement manifested itself. The patient gained flesh, and in two months his weight had increased by nearly eighteen pounds. The vomiting and pain were lessened in severity. Four months after the onset of the disease the patient contracted a cold and shivered, and the temperature, which had previously been subnormal, rose to 102° F. Cough, sweating, and rapid emaciation, with recrudescence of the gastric symptoms, developed, and death ensued within six weeks from acute phthisis. The necropsy revealed a condition of caseous tuberculosis invading both lungs from apex to base, with a small vomica in the right upper lobe. The stomach was greatly dilated, and its lining membrane was converted into a shining layer of fibrous tissue with numerous radiating bands. No trace of glandular structure could be detected by the microscope. In a second case a man aged thirty-two years, swallowed some nitric acid. Three months later he was suffering from some degree of dysphagia, with pain in the epigastrium and occasional vomiting. The stomach extended about one inch below the umbilicus, a splash was audible on palpation, with tenderness over the pyloric region. When a tube was passed a slight constriction was encountered at the lower end of the oesophagus. The stomach contained a brownish-coloured, sour-smelling fluid, with no trace of free hydrochloric acid. Under lavage and regular feeding by a tube the patient rapidly improved, the vomiting and epigastric pain became less severe, and the body weight increased. Seven months after the accident the patient began to suffer from cough and night sweats, and the temperature, which had previously been subnormal, rose to 102° F. These symptoms increased in severity, the gastric phenomena returned, and the signs of progressive consolidation of the lungs became manifest. Death ensued from exhaustion at the end of seven weeks. At the necropsy the lungs were found to be the seat of acute tuberculous affection from apex to base. The mucous membrane of the stomach was completely destroyed and was represented merely by a thin layer of fibrous tissue. The lower few inches of the oesophagus showed evidence of superficial cicatrization of its mucous membrane, and at the pyloric end of the stomach a chronic ulcer was discovered, the contraction of which had caused stenosis of the pyloric orifice. Dr. Fenwick pointed out that in the Bulletin de la Société Anatomique de Paris M. Robert had given details of a very similar case. The cases were of interest from the fact that in each a corrosive fluid had completely destroyed the digestive activity of the stomach, while a fatal issue occurred after an interval of a few months from acute pulmonary phthisis, in spite of the fact that there existed no family tendency to this disease. It would, therefore, seem that the sudden impairment of nutrition had so diminished the resistance of the tissues as to render them peculiarly vulnerable to tuberculous invasion.—Mr. BARKER inquired what means were taken to ascertain the presence of free hydrochloric acid in the stomach.—Dr. GLOVER asked whether in the history of the first case there was any tuberculous element either in the family or the individual.—Dr. W. J. TYSON asked whether phthisis frequently followed gastric ulcer or abrasion of the mucous membrane of the stomach.—Dr. LONGMORE said that, in the absence of any history of tuberculous disease, it was