

cases. Cavities expand to their right dimensions, cysts float out in a way quite impossible to imitate when dry, the most delicate lines and hairs are faithfully represented, and the picture when complete shows the specimen as it was originally seen *in situ* with soft delicate outline and marked contrasts.

The illustrations speak for themselves. The one taken in air (Fig. 3) was the best result obtained after several attempts; the one in water (Fig. 2) was taken at the first trial.

Liverpool.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ROYAL HANTS COUNTY HOSPITAL, WINCHESTER.

TWO CASES OF GASTRIC ULCER FATAL THROUGH HÆMORRHAGE.

(Under the care of Dr. H. E. WINGFIELD and
Mr. T. C. LANGDON.)

THE mortality from gastric ulcer is difficult to estimate as in all probability many cases are never diagnosed. Grünfeldt in 450 post-mortem examinations of patients over 60 years of age found the scars of healed ulcers of the stomach in 92; these figures show a frequency of over 20 per cent. in these cases over 60 years of age.¹ It is obvious, therefore, that gastric ulcer often escapes diagnosis. If we consider only those cases in which a definite diagnosis has been made a high mortality appears which has been given by different authors as between 10 and even 50 per cent. The two cases which are recorded below are remarkable in that the presence of the gastric ulcer was overshadowed by other morbid conditions present. In the former of the two cases it is not improbable that the gastric hæmorrhage was venous in origin. The latter case demonstrates clearly the importance of necropsies in all obscure cases of death after injury and shows how valueless from a scientific point of view is the verdict "Accidental death." For the notes of the cases we are indebted to Dr. T. W. Letchworth, house physician.

CASE 1.—A man, aged 45 years, was admitted into the Royal Hants County Hospital on May 5th, 1901, complaining of shortness of breath and swelling of the feet. On a previous occasion he had been treated for aortic incompetence for several months, but he dated his present symptoms from Christmas, 1900. He had been obliged to leave off work a month before admission. He had been a heavy drinker, but had never complained of more gastric pain or discomfort than this and the condition of his circulation would account for. On admission he was deeply cyanosed and his face and lips presented a blue and bloated appearance. There was œdema of the feet and legs. The area of cardiac dulness was increased on either side of the sternum, and the apex beat was displaced outwards and downwards. There was a double murmur over the aortic area and there was a systolic murmur at the apex conducted into the axilla. The pulse was rapid, irregular, and collapsing, and flushing of the forehead with each systole was very marked. The liver dulness was slightly increased. A diagnosis of aortic regurgitation with secondary mitral regurgitation was made. The urine was scanty, of high specific gravity, and loaded with albumin. He was bled with temporary relief on several occasions. He started to develop ascites about the beginning of June and during the last few days of his life there was evidence of fluid at both bases, rapidly increasing in amount. On the morning of June 18th he suddenly vomited about two pints of blood; he vomited blood again twice. In all about six pints were

brought up, and he died within four hours, evidently from hæmorrhage.

Necropsy.—At the post-mortem examination the body was found to be œdematous and very pale. A large amount of fluid was present in the abdomen and both pleuræ. The heart weighed 22 ounces. Both ventricles were dilated and hypertrophied. The aortic valves were contracted and were covered with calcareous masses, being practically functionless as valves. The aorta was very atheromatous. The mitral valve was thickened and incompetent. The stomach was full of blood. On the posterior wall, near the lesser curvature and the pylorus, there was an ulcer of the size of a shilling, which had penetrated the whole thickness of the stomach wall, which was here adherent to the pancreas behind. Its edges were undermined and enormously thickened. There were numerous vessels exposed on the floor of the ulcer, but the vessel whence the hæmorrhage had proceeded was not apparent. The liver was cirrhotic and the kidneys were cardiac.

CASE 2.—A man, aged 49 years, was taken to the hospital on July 1st, having been upset with a cart which he was driving and which fell down an embankment. The horse was supposed to have rolled over him. He had sustained a Pott's fracture of both ankles and had broken one of his ribs, about the tenth on the left side. He also complained of pain in his back. 36 hours after admission he suddenly vomited about one pint of blood. On inquiry it was ascertained that he had frequently suffered from pain in the back and epigastrium, especially after meals, had vomited often, and had brought up altered blood. The day before the accident he had been laid up with pain and vomiting. Copious hæmatemesis continued for about three days and then stopped. He died from the effects of hæmorrhage on July 8th.

An inquest was held. The coroner refused to order a post-mortem examination although he had been informed that it would be essential in order to arrive at a satisfactory conclusion as to the cause of death. The house surgeon, in giving evidence, stated that death was due to loss of blood but was unable to tell the source. The coroner, having told the jury that in such a case he did not consider a post-mortem examination necessary, advised them to return a verdict of "Accidental death," which was done.

Necropsy.—With the permission of the relatives a post-mortem examination was then performed. No injuries further than those recognised during life were found. The fractured rib had not penetrated the peritoneum and there was no evidence of injury to any viscus. There were numerous adhesions about the stomach and great omentum; otherwise all the organs were normal save the stomach. Besides the scars of two small ulcers there was on the anterior surface, near the lesser curvature and pylorus, a recent and very superficial ulcer of the size of a sixpenny bit. In the centre of this could be seen standing out above the level of the floor of the ulcer a small artery which had been eroded and whence undoubtedly the hæmorrhage had proceeded.

Remarks by Dr. LETCHWORTH.—The peculiarity of the above cases is that in the first the patient seemed, when the fatal hæmorrhage occurred, to be actually dying from heart failure due to aortic incompetence, and in the second that the hæmorrhage commenced 36 hours after a serious accident involving a crush of the chest and a fractured rib, but in which it seemed impossible to attribute the hæmorrhage in any way to the injury.

STATION FAMILY HOSPITAL, CLIFFDEN, MURREE, INDIA.

A CASE OF ACUTE VOLVULUS OF THE SIGMOID FLEXURE; LAPAROTOMY, WITH FORMATION OF AN ARTIFICIAL ANUS; CLOSURE; RECOVERY.

(Under the care of Lieutenant-Colonel H. R. WHITEHEAD,
R.A.M.C.)

VOLVULUS of the sigmoid flexure is practically the only morbid condition of the large intestine which gives rise to acute intestinal obstruction. In most cases simple reduction of the volvulus is insufficient to remedy the obstruction as the volvulus has a great tendency to recur. Colostomy is generally needed, at least for a time. In the following case

¹ THE LANCET, Jan. 27th, 1894, p. 203.

the volvulus appears to have persisted owing to the distension of the bowel and to have disappeared as soon as that distension was relieved by emptying the intestine above. Sufficient time appears to have elapsed since the operation to demonstrate the permanence of the relief.

The wife of a sergeant in the Royal Artillery, aged 36 years, was suddenly attacked on Oct. 7th, 1900, at 1 A.M., with most acute abdominal pain and vomiting. For some years the patient had suffered from flatulence, dyspepsia, and colic. She was seen in the morning by Captain F. M. Mangin, R.A.M.C., who was then in charge of Clifden. She was at this time in great pain, the pain being chiefly referred to the umbilicus. She was vomiting constantly, the vomited matter being the contents of the stomach and mucus. The abdomen was distended and the course of the ascending colon was visible through the abdominal walls. The abdomen was very painful on palpation; the pulse was 100 per minute, thin, and wiry, and the tongue was slightly coated. No purgatives by the mouth were administered, but she was given large enemata. The first enema brought away a small amount of feculent matter from the lower bowel, but no regular action of the bowels took place and no flatus was passed. Captain Mangin diagnosed acute intestinal obstruction and asked Lieutenant-Colonel Whitehead to meet him in consultation on the case. At 3 P.M., when Lieutenant-Colonel Whitehead first saw the patient, she had a typical abdominal expression, her pulse was rapid and wiry, and she was constantly retching and attempting to vomit. The abdomen was acutely painful to touch and was very much distended. Nothing had passed per anum since the night before. The case was evidently one of acute obstruction, and in spite of the short time which had elapsed since the commencement of the attack, her condition was very bad. Lieutenant-Colonel Whitehead recommended immediate operation, and having obtained the patient's consent he proceeded to open the abdomen by a median incision. Captain Mangin rendered valuable assistance and chloroform was administered by Assistant Surgeon Johnstone, I.S.M.D. All aseptic precautions were taken.

The preliminary incision commenced about an inch above the umbilicus and extended in a vertical direction for three inches; this had to be extended at a subsequent stage of the operation. On opening the abdomen a good deal of peritoneal fluid and inflammatory lymph escaped. The cæcum and ascending colon presented in the wound; these were enormously distended. The hand was passed into the abdomen and the course of the large intestine was followed. The upper part of the rectum could be felt empty and collapsed and the sigmoid flexure above full and distended; apparently the gut was bent or kinked on itself at the point of constriction. No constricting band could be made out and the case appeared to be one of this form of volvulus of the sigmoid flexure. As the large intestine was so enormously distended it was feared that any manipulation might rupture the gut and it was determined to evacuate the contents of the bowel. Two stout silk ligatures were passed through the lumen of the gut, just above the cæcum, as in ordinary lumbar colotomy and the bowel was then drawn forward and opened; the sutures were divided and brought out. The gut was pulled as much as possible out of the wound, but owing to the anatomical conditions at this situation this could not be done to any great extent. Lieutenant-Colonel Whitehead then attempted to examine the descending colon in order to untwist the volvulus, but he could not now feel any kink or twist and was afraid that the peritoneal cavity would be much fouled by continuing this procedure. It appeared to him that the relaxation of the intestinal tension by evacuating the contents of the intestine had probably allowed the volvulus to subside, but as he could not be certain that this had occurred, or that the condition might not relapse, he determined to stitch the gut to the skin and to form an artificial anus, which might be closed by a later operation. Before stitching the gut to the skin the abdominal cavity was well flushed by hot boric lotion (2 per cent.) which had been boiled before use.

The patient made an uninterrupted recovery. No signs of peritonitis developed and no rise of temperature occurred after the operation. On Oct. 13th after a simple enema the patient passed a copious formed motion by the natural passage, and almost daily after this a motion was passed per anum after enemata. On the 16th the bowels acted spontaneously, a normal motion being passed. A good deal of feculent matter and intestinal discharge continued to come through the artificial anus.

However, from this date the bowels usually acted normally. On Nov. 4th the patient was transferred to the Station Family Hospital, Rawal Pindi; she continued to do well but had occasional attacks of eczema around the artificial anus, although under the influence of resinol ointment the skin kept in very good condition generally. The artificial anus steadily contracted and nearly all feculent matter was passed by the rectum.

On the patient being seen again in January, 1901, the condition was as follows. The patient was in good health and had gained flesh and strength. The artificial anus had contracted very much, the opening in the abdominal walls being now only just large enough to admit a No. 12 catheter. The bowels acted regularly and naturally and nothing in the nature of a spur could be detected. The skin around the fecal fistula was healthy, but she had suffered from occasional attacks of eczema which were troublesome and painful. The edges of the fistula were cauterised to see if further contraction would follow, but no appreciable change took place. On Feb. 25th the patient was placed under chloroform, the edges of the fistula were pared, and the skin around the edges was freed. The edges of the deep part of the fistula were then brought together by chromic gut sutures, which were cut short and buried, the skin being brought together superficially by salmon-gut sutures. A good deal of vomiting followed the chloroform and on the second day some fecal discharge forced through the wound and the operation failed to secure direct union, but from this date the opening steadily contracted and on April 15th it had completely healed. When the patient was seen at the end of May the cicatrix was firm and complete recovery had taken place.

Remarks by Lieutenant-Colonel WHITEHEAD.—I have to thank Major B. F. Zimmermann, R.A.M.C., Captain Mangin, R.A.M.C., and Captain T. H. J. C. Goodwin, D.S.O., R.A.M.C., for their care and skill in the after treatment of the case which contributed very materially to the satisfactory result, also Assistant Surgeon Johnstone and Assistant Surgeon Bowder, I.S.M.D.

Reviews and Notices of Books.

Lehmann's Handatlas: Band VIII., Atlas der äusseren Erkrankungen des Auges. Von Professor O. HAAB in Zürich. Zweite stark vermehrte Auflage, mit 80 farbigen Abbildungen nach Aquarellen von Maler Johann Fink und 7 schwarzen Abbildungen im Text. (*Atlas of the External Diseases of the Eye.* By Professor O. HAAB. Second edition, greatly augmented, with 80 Coloured Illustrations after water-colour drawings by the painter Johann Fink and seven Woodcuts in the text.) Munich: J. F. Lehmann. 1901. Pp. 256. Price 10 marks.

WE have had on several occasions to draw attention to this useful and well-illustrated series of atlases. No less than 18 volumes have been published and several of them have been repeatedly re-edited. The price is reasonable and many of the illustrations are really excellent. The plan adopted is to give in the text which accompanies the plates a description of a group of diseases—as, for example, those of the lacrymal organs. A typical case is then added with a chromo-lithograph of the appearances presented. In the present instance the chromo-lithographs include one of dacryocystitis, a second of lacrymal abscess which has burst without surgical interference, a third showing a lacrymal fistula, and a fourth showing ectasia of the lacrymal sac and incidentally the condition termed “epicanthus.” In the text the author lays stress upon the advantage, both as a diagnostic and therapeutic means, of injection of a 0·8 per cent. solution of common salt, but the piston of the syringe must not be made of leather or of asbestos. The diseases with which phlegmonous inflammation of the lacrymal sac is most likely to be confounded are a boil in the immediate neighbourhood of the sac and dental abscess. The treatment succeeds best when the case has not been probed by unskilful hands and when false passages have not been made. When injected by an expert a