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.