through the peritoneum and placed equidistantly round the opening, pressure forceps being applied to each. This prevents the peritoneum sinking down when the stomach is withdrawn. Three inches of stomach, as near the cardiac end as possible, are drawn out; the peritoneum and aponeurosis are carefully stitched to the stomach, using a Reverdin's curved needle; the stomach is then opened and a No. 12 soft catheter is introduced and fixed in position by a fine suture which passes through the whole thickness of the stomach wall and is tied tightly round the catheter. The stomach is now invaginated by pressing upon the firmly secured tube and a purse-string suture is introduced a quarter of an inch below the opening into the stomach. This is drawn up and tightened round the tube; a second purse-string suture is introduced half an inch below the first, the stomach being further invaginated and the stitches tightened around the tube; a third purse-string is introduced half an inch below the second if necessary and tied round the tube. In this way a valve is formed inside the stomach so that the tube can be easily passed in, and when removed the valve comes together and completely closes the opening. The skin incision is united with silk-worm gut. After the wound is healed the patient soon learns to feed himself. Having first chewed the food he passes it into the tube which is inserted into the stomach. Those interested in this subject will see two good plates illustrating the operation in Kocher's recent work on Operative Surgery translated by Stiles.

Glasgow.

A CASE OF INJURY TO THE BACK FOLLOWED BY ALL THE APPEARANCES OF SYRINGOMYELIA.

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A MAN, aged 37 years, was struck on the back by a sack of corn which fell from a height of over 30 feet. He was admitted to the Birkenhead Borough Hospital on June 6th, the day of the accident. There was severe bruising over the back of the neck and chest. No irregularity of the vertebral column could be discovered and there were no symptoms pointing to any injury of the spinal cord. The patient was a very powerfully built man and stated that he had previously enjoyed perfect health.

Recovery went on apparently uninterruptedly till June 12th when he complained of some weakness in the arms and legs. On examination the knee-jerks were found to be brisk. On the 20th there was marked wasting of the muscles of the thenar and hypothenar eminences of both hands and the grasp was distinctly weak. The legs were becoming spastic and there was some diminution of the heat and cold and pain senses on both sides. His condition became worse, the spasticity of his legs increased, and the wasting of the muscles of the fore-arms and hands became very marked. On the 30th his condition was as follows. In the upper extremities there was marked wasting of the small muscles of both hands and of the flexors and to a lesser degree the extensors of the fore-arms. The pronators and supinators were very slightly, if at all, affected. The biceps, triceps, and deltoid were slightly wasted but not nearly to the same extent as the muscles of the forearm. The affected muscles reacted sluggishly to electricity. Both biceps- and triceps-jerks could be elicited. There was no impairment of any of the senses in the arms. In the lower extremities the muscles were spastic, both knee-jerks were much increased, the ankle and patellar clonus was marked, and Babinski's plantar reflex was present in both feet. With great difficulty the patient could raise his legs about three inches from the bed. There was slight delay in the conduction of tactile sensations. The muscular sense was unimpaired. Sensation to pain was diminished in both legs and the difference between heat and cold was not appreciated. There was some weakness of the abdominal muscles, the patient being quite unable to sit up in bed. The bladder and rectum were unaffected.

The further progress of the case was as follows. On July 8th the patient could sit up in bed without assistance and his grasp was slightly stronger. There was some fibrillary twitching of the tongue and his speech was not so distinct as before. There was no improvement in the wasted muscles of the hand.

The case presents most of the symptoms and signs of syringomyelia. The unusual features are the rapidity of the onset and the severity of the affection of the legs. The lesion was evidently in the seventh and eighth cervical and first dorsal segments of the cord. Is it possible that the cause might be a small hæmorrhage in the grey matter, producing destruction of the trophic centres for the muscles of the arms and by its pressure causing degeneration of the crossed pyramidal tracts? If so, the hæmorrhage or the resulting myelitis must have cut off the conducting tracts of the heat and cold and pain senses from the lower limbs. It is possible that the patient may have had a dilatation of the central canal previously. This may have caused no symptoms till the blow on the back produced effusion or slight hæmorrhage into the cavity.

I am indebted to Dr. W. R. Floyd, under whose care the patient was, for permission to use these notes.

Birkenhead.

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.

ST. GEORGE'S HOSPITAL.

NINE CONSECUTIVE CASES OF PERFORATED GASTRIC ULCER
TREATED BY SUTURE, IRRIGATION, AND DRAINAGE.

(Seven under the care of Mr. G. R. TURNER and two under the care of Mr. T. CRISP ENGLISH; eight recoveries.)

FOR the notes of the cases we are indebted to Mr. Crisp English.

CASE 1.—The patient, a woman, aged 24 years, was admitted to hospital under the care of Mr. Turner on Nov. 28th, 1900, with the following history. At 9 P.M. on the previous evening she was frightened by a mouse and immediately after was seized with acute epigastric pain followed by vomiting. On admission she looked extremely ill and was in great pain. The temperature was 99.5° F. and the pulse was 120. The abdomen was rigid, distended, and tympanitic. Acute tenderness was present in the epigastrium. Liver dulness was absent.

Operation.—Median laparotomy was performed above the umbilicus. Gastric perforation was found on the anterior surface of the greater curvature near the œsophageal end. There were much foul fluid and lymph in the peritoneal cavity. The perforation was closed and a counter opening was made below the umbilicus. Three drainage-tubes were inserted. On the fourteenth day after operation thrombosis occurred in the left calf; convalescence was otherwise uneventful and the patient went to the Wimbledon Convalescent Home on Jan. 9th.

CASE 2.—The patient was admitted to hospital under the care of Mr. Turner on March 5th, 1901, with a history of acute abdominal pain for two days. The pain had been sudden in onset and was situated in the epigastrium; the abdomen had become distended and vomiting had occurred twice. On admission the patient, who was sent by rail about 100 miles to hospital, looked very ill, complaining of great pain and thirst; the marked abdominal face was present; the temperature was 97° F. and the pulse was 130. The abdomen was greatly distended, chiefly in the lower part; it was immobile, very tender, and rigid. Liver dulness was diminished. There was moveable dulness in the flanks.

Operation.—A median incision was made. Intense general peritonitis was found. Escape of large quantities of fluid and free gas led the way to a large perforation on the anterior surface of the stomach close to the œsophageal end. As the patient's condition was very bad a gauze plug was passed to the perforation and the peritoneal cavity was flushed out with hot saline solution; drainage-tubes were inserted and the wound was sutured. Death occurred a few hours later.