me, by a more convenient, rapid, and direct method of administration of the drug. It does not confine the patient to bed or the house, nor is there apparently any disagreeable effect. The cases are only two in number and sufficient time has not elapsed for forming a proper conclusion, but I publish them in the hope that others may be induced to put such a simple method to the test before resorting to operation.

Grosvenor-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF OPERATION FOR ACUTE HÆMATEMESIS.

By ARTHUR H. BUCK, F.R.C.S. EDIN.,

ASSISTANT SURGEON TO THE SUSSEX COUNTY HOSPITAL.

AS operations for acute hæmatemesis are still comparatively rare the following may be thought worth recording.

The patient, who was a woman, aged 39 years, had suffered from heaviness and fulness in the epigastrium after food off and on for six months. She had experienced nausea but was not sick. There was no history of melæna. Dr. F. Robson of Haywards Heath saw her first on Jan. 21st, 1903, when she had vomited one pint of blood and was collapsed. Adrenalin was administered by the mouth and rectal feeding was ordered. On the 22nd there were repeated attacks of hæmatemesis and much melæna. Ergotin and adrenalin were given. On the 23rd further hæmatemesis took place and I saw the patient in the evening with Dr. Robson. Her condition was then one of collapse and she had lost over six pints of blood by measurement in two and a half days. After a consultation with Mr. G. C. Clarke of Lindfield and Dr. Robson an operation was agreed upon for the following reasons: (1) that it was not a proper thing in her condition to advise removal to the Sussex County Hospital; (2) that judging from the repeated attacks of hæmatemesis there was likely to be another; and (3) that to a patient already *in extremis* another attack was likely to prove fatal before assistance could be obtained. The difficulties of the situation were increased by the patient living in a cottage and by the only light being that of a paraffin lamp.

The stomach was opened by a vertical incision anteriorly, as no ulcer could be felt from outside, and the ulcer was found at the cardiac end on the posterior wall by sweeping the finger round the mucous membrane. It was brought into view with some difficulty and proved to be acute, with no thickening around the edges. The diseased area having been excised the aperture was closed posteriorly by a purse-string suture and one or two Lembert's sutures on the peritoneal aspect and anteriorly by a second purse-string suture in the mucous membrane. The anterior incision was closed with Lembert's sutures. Mr. Clarke administered the anæsthetic. The patient was put back to bed apparently no worse for the operation. Dr. Robson, who conducted the entire after-treatment, at first administered strychnine and saline injections and afterwards fairly large nutrient enemata were given, about two pints a day being absorbed. The services of an excellent nurse were obtained on the second day. On the thirteenth day—namely, three days after the first food had been given by the mouth—a somewhat severe attack of parotitis set in on the right side followed by one on the left side. Except during this attack and for some little time afterwards the temperature was normal. The patient, when seen on March 20th, was perfectly well in every way.

The following statistics are quoted from Mayo Robson and Moynihan's "Surgery of the Stomach": A series of 26 operations in acute cases showed 14 deaths and a series of 19 in chronic cases showed two deaths (Hunterian Lectures). A later series in America showed 13 deaths in 32 acute cases and six deaths in 31 chronic cases. Mr. B. G. A. Moynihan in a paper read before the Royal Medical and Chirurgical Society on Jan. 27th, 1903, and published in THE LANCET of Jan. 31st, p. 294, divides the cases of hæmatemesis into those the result of acute and those the result of chronic ulceration and says: "In hæmorrhage from an acute ulcer medical treatment alone will suffice, surgical measures will

very rarely be necessary. If any operation has to be done gastro-enterostomy will probably prove to be the most effective. In chronic ulcer operation should be advised as early as possible." So far as my experience goes I should have said that it was hardly safe to be quite so dogmatic, as besides the above case I have recently come across a case where a girl with a chronic history suddenly died from profuse hæmorrhage from a chronic ulcer. Other cases of perforation have come under my observation where it was quite impossible from the history to say whether the ulcer was acute or chronic before operation. An operation for acute hæmatemesis, whether from an acute or chronic ulcer, seems to me to be an emergency operation in which one would not feel satisfied unless one performed that for which the operation was undertaken and secured the bleeding point. As to whether a gastro-enterostomy was advisable then or later would, I suppose, depend upon the condition of the patient at the time, both generally and locally, and upon the past history of dyspepsia.

Brighton.

A CASE OF IODOFORM POISONING.

By ALAN H. MUIR, M.B., CH.B. GLASG.,

HOUSE SURGEON TO THE SWANSEA GENERAL HOSPITAL.

THE patient, a man, aged 35 years, was admitted to the Swansea General Hospital on March 5th, 1903, with a large non-tuberculous abscess on the calf and the thigh of the left leg. The temperature was 102° F., the pulse was 100, and the general condition was fair. On the 6th the temperature ranged from 98° to 99°. On the morning of the 7th I opened the abscess, irrigated the cavity, and put in a connecting drainage-tube. Whilst my assistant was putting in iodoform quite half an ounce or more dropped accidentally into the large cavity. For 24 hours the temperature remained normal. At 8 P.M. on the 8th the patient had a rigor, when the temperature rose to 102° and two hours afterwards it was 104°, the pulse being 140 and weak and thready and the respirations being 24 and normal in character. The patient, who now became restless and delirious but remained conscious, vomited three or four times. Nothing noteworthy regarding the pupils, the urine, &c., was observed. Quinine and brandy were now administered and at 12 midnight when the temperature was 103° the cavity was washed and swabbed out, the iodoform forming quite a coat. In 12 hours the temperature, which had come down gradually, was normal, the pulse was 120 and fair, and the patient was quiet and sensible. This condition was maintained, the temperature remaining normal, the pulse being 80 and good, and the respirations being 24.

For permission to publish these notes I am indebted to Mr. W. F. Brook, senior surgeon to the Swansea General Hospital.

Swansea.

A CASE OF CHYLIFORM ASCITES.

By GEORGE A. CLARKSON, F.R.C.S. ENG.

IN connexion with the annotation on chyliform ascites published in THE LANCET of March 21st, p. 825, the notes of the following case, which came under my immediate observation while I was house physician to St. George's Hospital, may not be without interest.

The patient was a man, aged 52 years, who was admitted to St. George's Hospital on Dec. 7th, 1895, suffering from carcinoma of the liver. His previous history was unimportant and his health had only begun to fail nine weeks previously. On admission the pinched aspect of the man and the yellowish pallor of his skin were very noticeable but there was no jaundice. The abdomen was protuberant and was specially enlarged in the upper part, where over the region of the liver irregular rounded projections could even be seen. There was a considerable amount of fluid in the abdomen. The liver was greatly enlarged, reaching fully two inches below the umbilicus. It was hard and was raised into a number of nodulated projections. The abdominal walls were covered with enlarged veins, especially marked in the flanks. The urine contained lithates but no bile or albumin. Emaciation and loss of strength were rapid but the pain was

never very severe. By Dec. 26th the abdomen was so distended with fluid and the breathing had become so embarrassed that paracentesis was performed and ten pints of yellow milk-like fluid were removed, but without any very great relief, and the man died six days later.

The fluid removed was yellow in colour and of a milk-like character; it had a specific gravity of 1018 and gave an alkaline reaction. On standing a pinkish gelatinous clot was formed. Microscopically the fluid showed the presence of a large amount of fat in the form of an emulsion and also numerous cells containing fat in their interior. When shaken up with ether, fat was dissolved out and the ether left a greasy stain when dropped on paper.

At the necropsy, when the abdomen was opened, three pints of milky-looking fluid were found in the peritoneal cavity. There was no peritonitis. The glands in the mesentery were welded together with new growth and there was a large mass of growth behind the stomach almost encircling the aorta. The liver, together with some masses of glands, weighed 13 pounds. It was full of firm growths in the form of rounded lumps rising to the size of Tangerine oranges. On the surface they were slightly cupped from contraction. There was very little liver substance left uninvaded by growths. The left pleural cavity was half full of chyliform fluid similar to that in the abdomen. The right pleural cavity contained a similar amount of clear serum. With regard to the fluid in the abdomen, no special leakage could be discovered, but the receptaculum chyli and thoracic duct must have been implicated by growth which was very extensive in front of the first and second lumbar vertebrae. No special cause could be found to account for the milk-like fluid in the left pleura. Microscopically the growth was a spheroidal-celled carcinoma. Leicester.

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. v., Prooemium.

BATH ROYAL UNITED HOSPITAL.

A CASE OF ACUTE ENTERIC INTUSSUSCEPTION CAUSED BY THE INVAGINATION OF MECKEL'S DIVERTICULUM; OPERATION; RECOVERY.

(Under the care of Mr. H. G. TERRY.)

FOR the notes of the case we are indebted to Mr. J. Beattie Dunlop, house surgeon.

A schoolboy, aged 12 years, was admitted into the Bath Royal United Hospital on Dec. 16th, 1902, at about 9 P.M. The history of the case was that the boy had been quite well on that day until noon when he made a hearty dinner, but during it was seized with some abdominal discomfort. He returned to school at 1.30 P.M., but while there he had such severe attacks of pain in his abdomen that he was sent home. Here his pain was thought to be due to indigestion and he was given peppermint water. As his condition did not improve Mr. E. L. Hunt, of Sherston, was sent for and he arrived about 4 P.M. He found the boy crying from pain and rolling from side to side. The patient's temperature was 96.5° F. and his pulse was 60. His pain was found to be most acute below and to the right of the umbilicus and there a sausage-shaped tumour could be palpated three or four inches long and running up towards the liver. He had been vomiting partially digested food and had passed a loose watery motion containing blood. Mr. Hunt diagnosed acute intussusception and sent him straightway to hospital—a drive of over 18 miles.

On admission the boy's facies was not anxious. From time to time he had bouts of pain which were referred to the region below and to the right of the umbilicus. His temperature was 99° and his pulse was 60 and small in volume. The abdominal wall was slack and moved with respiration. There was very little distension. On palpation

a sausage-shaped tumour was to be felt extending from the right iliac fossa to the right subcostal margin. It was firm, moveable, growing harder during the paroxysms of pain, and varying in size from time to time. Manipulation tended to make it smaller. Per rectum a tense swelling could be found in the right iliac fossa. Mr. Hunt's diagnosis was corroborated and operation was decided on at once.

The abdomen was accordingly opened to the right of the median line by Mr. Terry and an intussusception of the ileum forthwith presented itself. The tumour was 12 inches in length; it was tense, shining, cherry-red in colour, and the mesentery was twisted. Reduction was effected gradually and it was then seen that the intussusceptum was black in colour and that there was free fluid between the middle and internal layers. The blackness was dispelled gradually as reduction proceeded. At the end of the reduction, however, the apex of the intussusceptum gave way and was then found to consist of Meckel's diverticulum. The diverticulum was almost six inches in length and was swollen to the diameter of the small bowel, invaginated, and sloughing. Its invagination had evidently caused the intussusception of the ileum. This troublesome appendage was thereupon amputated at its junction with the bowel and the edges of the opening thus left were brought together by means of two layers of Lembert's sutures. The abdomen was then sewn up layer by layer. The boy bore the operation exceedingly well. On the next day he passed blood and flatus three times, and thenceforth made steady progress, his recovery, however, being somewhat delayed by the skin giving way, though the rest of the abdominal wall held well. He was discharged cured on Feb. 6th.

Remarks by Mr. DUNLOP.—The above case is of interest from its bearing on the etiology of enteric intussusception. I must express my thanks to Mr. Terry for his kind permission to record this case, and to Mr. Hunt for the exceedingly good history which he sent us of it.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Acromegaly.—Bilharziosis.—Surgical Treatment of Gangrenous Bowel in Herniotomy.

A MEETING of this society was held on March 27th, Mr. HOWARD MARSH, the President, being in the chair.

Dr. H. A. LEDIARD (Carlisle) read a paper on a case of Acromegaly and Goitre. The patient was a woman, aged 43 years, who was born and had always lived in Cumberland. She had had amenorrhoea and headache dating from the last confinement, ten years previously. The features were characteristic, especially the lips, nose, lower jaw, and tongue, as were also the speech and expression of the face. The thorax was large, the ribs being massive and the hands being broadened. Sugar had been at one time present in the urine. For some years a bilateral goitre had been evident, but in June, 1902, the patient was sent to the Cumberland Infirmary for operation on account of dyspnoea with stridor and dysphagia due to pressure. The left side of the goitre was then removed and all these symptoms were relieved. The patient was exhibited to the society and her feeble muscular power was demonstrated. Radiographs of the hands and other parts were exhibited, together with the goitre which had been removed and microscopic slides. The usual features of acromegaly not present in this case were kyphosis, bi-temporal hemianopsia, sweating, and cyanosis. There was no trace of the general increase in size sometimes present, but the features of the face and the limbs were so greatly enlarged that the patient could not be recognised by her relatives and the muscular power was feeble.—Dr. W. PASTEUR asked whether the operation had in any way modified the character of the acromegalic condition.—Dr. LEDIARD, in reply, stated that there had been no change in the pulse or temperature since the operation, but the patient had gained several pounds in weight.

Dr. ANDREW DUNCAN read the notes of a case of Bilharziosis. The patient was a man, aged 30 years, lately in the 2nd Battalion East Kent Regiment. He had been fighting in the Orange River and Cape Colonies and was in Lord Roberts's march to Pretoria. In May, 1902, he began to experience