place during manipulation and I had to remove a small piece of the pancreas in order to get beyond the growth. Although the case did not look very promising at the time of the operation as regards the prolongation of life, on May 12th, 1903, I saw Dr. J. Shaw Lyttle of Pontypridd, and he informed me that the patient was enjoying very good health and had not consulted him for some months as she was feeling so well in her general condition.

At the time of the operation I did not know of Professor Kocher's new method of mobilising the duodenum by means of division of the peritoneum immediately to the right of the descending portion of the duodenum. This year he published in the *Centralblatt für Chirurgie* a method of mobilising the duodenum and it would be worth trying it in similar cases in order to unite the duodenum directly to the stomach. I performed a similar operation to the one under observation two years ago upon a man which I reported in the *British Medical Journal*, and I was unable to approximate the duodenum to the stomach on account of the large portion of the duodenum excised. This patient is also enjoying excellent health at the present time and has not had any digestive trouble since the operation, so that whatever theoretical objection there be to closing up of the duodenum and the performance of a gastro-jejunostomy, the results in my two cases are quite satisfactory. I have once come across the existence of "the vicious circle" after an anterior inferior gastro-jejunostomy in a case where pyloric obstruction was only partial. Some digested food would in all probability pass along the normal route and then back into the stomach in such cases. Where pyloric obstruction was fairly complete I have not seen any trouble after the performance of an anterior gastro-jejunostomy and it may be that Kocher's new operation for mobilising the duodenum will be applicable to a few selected cases, as digestive disturbances due to bile flowing into the stomach are not of serious import if time be saved by closing the duodenum and completing the operation by a gastro-jejunostomy.

Cardiff.

XANTHELASMOIDEA IN AN ADULT.

BY A. CHRISTIE REID, M.A., B.Sc., M.B., CH.B. ABERD.

A HOSPITAL nurse, aged 21 years, was at work on Jan. 12th, 1903, in perfect health; on the 13th my attention was called to a small blister on the dorsum of the left hand which she admitted to have pricked with a needle. When I saw it the site of the blister was covered by an ochre yellow scab. A large yellow plaque was noted on the same evening on the extensor aspect of the left forearm just above the wrist. This, she said, had developed of itself, rather suddenly, with pain and itching, red at first, then ochre yellow. On examination the area, of about the size of half a crown, was seen to be on a level with the surrounding skin; at its periphery was a slightly raised hyperæmic areola dotted with numerous vesicles containing clear fluid. Later the same evening a similar patch developed on the flexor aspect of the forearm just below the elbow. She felt slightly out of sorts and disinclined for food. The temperature was normal; there were no enlarged glands in the axilla; and the urine was normal save for excess of urates. On the 14th a raised patch with vivid red angular irregular processes extending into the surrounding normal skin was noted on the front of the left shoulder. She complained of pain "all up the arm," especially in the joints. On the 15th she was still rather poorly but there was no rise of temperature; the lowest plaque or wheal had now extended peripherally to about the size of a five shilling piece. Another was noted on the front of the right shoulder and at night one on the left mamma and one over the sternum. These plaques or wheals were of quite irregular shape, showed no tendency to disappear, and some of them showed a partial ochre colouration. That near the wrist was becoming transparent and in its centre a thrombosed vein was distinctly seen in the subcutaneous tissue. On the 19th the coagulability of the blood was determined by capillary (vaccine) tubes. (For clinical purposes this method is fairly exact if tubes of approximately the same calibre are used and other minor precautions as recommended by Professor Wright are taken.) A "firm" coagulum was obtained (such as could not be blown out) in 12 minutes, my own blood at the same time requiring 21 minutes. She was then put on ten grains of citric acid, one drachm of laurel water, and water to half

an ounce, to be taken every four hours. Previously to the administration of the citric acid some new patches were noticed irregularly distributed on the left flank. A needle introduced into one of the older patches drew nothing (no mast cells could be got). The general condition was better; some joint pains were complained of. She noted a yellow wheal appear and disappear at the spot on the finger that was pricked in obtaining the blood. At 8.45 P.M. (after two doses) a firm clot was got in 13 minutes, a "control" nurse requiring 15 minutes, so that the acid had not as yet produced any change. On the 20th the general condition was good; there were no more wheals, not even where the finger was pricked. At 9 A.M. the clot was firm at 17 minutes and at 9 P.M. the clot was firm at 11 minutes. Hitherto the patient had been in bed and on light diet; now she got up but felt slightly sick. In the more recent patches the itching amounted almost to pain. On the 21st a new patch was noted on the left thigh; after this no further patches appeared. On the 22nd she felt well. There was firm coagulum in six and a half minutes (three-quarters of an hour after the last dose of citric acid); control also at six and a half minutes. On the 23rd she was allowed to engage in light work. She went home on the 24th. The patches on the arm sloughed while she was at home and several scars were very noticeable on her return to duty a month later.

This disease is rare in adults; the patient inquired and could get no history of anything like it in either herself when younger or in the family on the father's or the mother's side. She had not been eating anything out of the common; no one else in the hospital was suffering from the disease at the same time. The exhibition of citric acid may have had something to do with the arrest of the trouble but the observations on the blood coagulability can lead to no definite conclusion. The distinctly seen thrombosed vein (in the centre of two of the patches), however, points to the possibility of abnormally high coagulability and thus may afford a *rational* for the treatment.

If further investigation should prove that in xanthelasmoidea the coagulability is high it will thus be more decisively separated from the urticarias and the name "urticaria pigmentosa" will be abandoned. A milk diet was not rigidly followed, so that the influence of the citric acid was not nullified by the calcium salts in the milk. As other treatment has proved futile I would venture to suggest that citric acid be tried. The previous history of the patient was excellent save for some slight malarial trouble from which she suffered in India as a child. The hæmoglobin index was above the normal; menstruation and other functions were normal. The original plaque being at a spot where a blister had been pricked suggested at first a septic lesion but the subsequent spreading was quite irregular and followed no lymphatic tract. The gradual peripheral spreading of one or two of the lesions gave one the impression of a stream dammed back and overflowing its banks. The yellow-ochre colour has not, so far as I am aware, been explained; if due to an accumulation of mast cells the further question may be asked, where do they come from? Altogether, the extent of our knowledge of xanthelasmoidea is so limited that I have ventured to bring forward this case in the hope that some may find it even more suggestive than I have.

Sheffield.

DEVON AND EXETER DENTAL HOSPITAL.—The twenty-third annual meeting of the subscribers to the Devon and Exeter Dental Hospital was held on May 22nd under the presidency of the mayor. The financial statement was satisfactory and the medical report stated that 2521 patients were treated during the past 12 months. The report alluded to the loss which the institution had sustained through the death of Mr. J. Bankart, the senior consulting surgeon to the hospital.

THE GERMAN MEDICAL TOUR.—The annual German medical tour will commence this year on Sept. 9th in Mayence (Rhine tour by steamer) and will end in Cassel on Sept. 20th. The following watering places will be visited:—Kreuznach, Münster a/St., Assmannshausen, Neuenahr, Ems, Naheim, Oeynhausen, Salzufen, Driburg, Wildungen, and Pyrmont. The journey will cost (railway and steamer fare, 60 pounds free luggage, board and lodging, wine and beer excepted), including the official report of the tour, £8 3s. Programmes can be obtained from the secretary, Dr. W. H. Gilbert, Baden-Baden.

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.

BRADFORD ROYAL INFIRMARY.

THREE CASES OF PERFORATED GASTRIC ULCER.

(Under the care of Dr. C. F. M. ALTHORP.)

CASE 1.—An unmarried woman, aged 23 years, was admitted to the Bradford Royal Infirmary under the care of Dr. C. F. M. Althorp on March 13th, 1902. For seven years she had had pain and vomiting after food. 32 hours before admission, whilst at work, the patient was suddenly seized with acute pain in the abdomen followed by symptoms of collapse. When she was seen at the infirmary the pulse was 102 and the temperature was normal. She complained of abdominal pain. The abdomen was distended, with rigid walls, and the liver dulness was absent. Perforated gastric ulcer was diagnosed and without delay the abdomen was opened in the middle line above the umbilicus. Gas escaped on opening the peritoneal cavity and lymph was seen on the anterior and upper walls of the stomach. Old adhesions fixed the stomach and great difficulty was experienced in obtaining a view of the perforation, which was of about the size of a three-penny piece and was situated in the centre of a large ulcer near the cardiac end of the stomach. A large collection of escaped contents of the stomach had already formed a perigastric abscess. Owing to the position of the perforation and because the stomach was fixed by adhesions it appeared impossible to close the opening by stitches. Several silk sutures were introduced, but they tore out on an attempt being made to tie them. It was therefore decided to trust to gauze packing, especially since the general peritoneal cavity was cut off by recent adhesions. The infected area was mopped dry and gauze was packed around the perforation. The patient stood the operation well and appeared to progress nicely for ten days. The gauze packing was removed on the third day, the cavity was mopped dry, and fresh gauze was introduced daily. The discharge was extremely offensive. Rectal feeding was employed for nine days, then small quantities of peptonised milk were given by the mouth. On the tenth day the patient began to cough and she expectorated a small quantity of offensive pus. There were found to be signs of consolidation at the base of the left lung. An exploring needle introduced into the dull area withdrew a little pus. An anæsthetic was given and the left pleural cavity was explored. There was no pus in the pleura or collection below the diaphragm. The lung was solid. The patient died on the following day from pneumonia.

Necropsy.—The post-mortem examination revealed hour-glass contraction of the stomach caused by a large ulcer in the centre of which was the perforation. Opposite to the ulcer there was an opening in the diaphragm and here the base of the lung was adherent. There were no empyema and no subdiaphragmatic abscess. The lower lobe of the left lung was solid and near the base was a small septic abscess.

CASE 2.—On Jan. 23rd, 1903, a man, aged 23 years, whilst at work was suddenly attacked with severe abdominal pain followed by symptoms of collapse. Two months previously he had vomited a pint of blood and had since been under treatment for gastric symptoms. Eight hours after perforation he was seen at the Bradford Royal Infirmary. Being under the influence of morphia he had no pain; his pulse was 84 and the temperature was normal. Ether was given and on opening the abdomen gas escaped and contents of the stomach were seen spread over the anterior surface of the stomach. A large perforation was seen on the lesser curvature of the stomach near its cardiac end deep down under the arch of the diaphragm. Adhesions were forming between the stomach and liver and a line of lymph cut off the area of perforation in a downward direction. The perforation was the centre of a large ulcer which had

by its contraction given rise to a condition of hour-glass stomach and had fixed the organ posteriorly by adhesions. The stomach could not be withdrawn into the abdominal wound. The stitching therefore had to be done within the abdomen. The stomach tissue around the perforation was extremely rotten and the stitches tore out. A Halstead suture of thick silk passed wide of the perforation drew the edges of the opening together. The area of the perforation and of the ulcer was further closed in by bringing together a fold of healthy stomach wall from each side by means of a row of interrupted silk sutures. A fold of omentum was stitched over the line of union. The peritoneal cavity was washed out with hot saline fluid and the abdominal wound was closed without a drain. The after progress was very satisfactory, except that at the end of the first week an abscess formed in the left flank and required incision and drainage. This appeared to indicate that the left kidney pouch had not been efficiently washed out at the time of operation. Two months after the operation the patient was quite well and was taking ordinary light diet without discomfort.

CASE 3.—An unmarried woman, aged 27 years, was admitted into the Bradford Royal Infirmary on March 14th, 1902, with signs of a perforated gastric ulcer. For five years she had had symptoms of indigestion. The present attack came on in the street soon after a meal—there being severe pain in the abdomen and vomiting. When seen at the infirmary eight hours after the perforation there were abdominal pain and rigidity. The pulse was 112 and the temperature was normal. The abdomen was opened in the middle line and gas and contents of the stomach were at once noted. The extravasated fluid was mopped up both to the right and to the left, but no perforation was found on the anterior surface, the lesser curvature, or the cardiac end of the stomach. The transverse colon was drawn upwards, an opening was made in the transverse mesocolon, and the stomach was drawn out of the lesser sac on the surface of the abdomen. Very little fluid was present in the lesser sac. About the middle of the posterior surface of the stomach was an ulcer of the size of a sixpence and in the centre of this was a small rounded perforation. The opening was closed by two layers of silk sutures. The stomach was returned to the lesser sac and the opening in the transverse mesocolon was closed with a continuous catgut stitch. The pelvis and right kidney pouch were full of turbid contents of the stomach which were removed partly by mopping with sponges and also by flushing out with hot saline solution. A glass drainage-tube was introduced into the pelvis through a suprapubic opening and the right kidney pouch was drained by means of a split rubber tube with a gauze wick inside. The abdominal wound was closed by silkworm-gut sutures passing through all the layers. The patient was very collapsed at the end of the operation and required hypodermic injections of strychnine and saline fluid by the rectum. On the fourth day the drainage-tubes were removed and at the end of a fortnight the patient was taking a fluid diet by the mouth. Some symptoms of lung complication appeared in the third week but they fortunately cleared up and she made a slow convalescence.

Remarks by Dr. ALTHORP.—In Cases 1 and 2 the perforations were in hour-glass stomachs caused by large ulcers near the cardiac end. In Case 1 it was found to be impossible to suture the opening, gauze packing being used; in Case 2 the perforation was closed with great difficulty and no drainage was employed. In both of these cases the stomach was fixed posteriorly and could not be drawn into the abdominal wound. The perforation in Case 3 was in the posterior wall of the stomach, access being obtained through an opening in the transverse mesocolon.

Perforation of the posterior wall of the stomach is rare (9 per cent., Robson) and perhaps an easier way of getting access to the lesser sac in Case 3 would have been by tearing through the great omentum below the greater curvature of the stomach. The extravasated fluid had in this case passed out of the foramen of Winslow into the right kidney pouch and down into the pelvis and, in fact, had spread all over the peritoneal cavity. There was in consequence a good deal of shock. The presence of hour-glass contraction of the stomach in Cases 1 and 2 made the operation very difficult on account of the stomach being fixed and the out-of-the-way position of the perforations. Drainage was employed in Cases 1 and 3. In Case 1, although the length of time between perforation and operation (32 hours) made the prognosis almost hopeless, the gauze drainage