well. The abdominal pain was not so acute, but the abdomen was still very tender to palpation. There was a slight icteric tinge in the conjunctivæ. On the 29th there had been no more diarrhoea or vomiting. The patient was gradually sinking; his face was somewhat cyanosed, with the icteric tinge more marked. Great abdominal pain occurred till within a quarter of an hour of death.

Necropsy.—At the post-mortem examination the pericardium was found to be normal, and its cavity contained no excess of fluid. The heart was tremendously hypertrophied, but this was most marked on the right side. The pulmonary artery was seen to be enormously dilated. The pulmonary valves were much diseased and quite incompetent, one valve having been quite destroyed and the others being thickly studded with sloughy vegetations. Inside the right ventricle were vegetations and ulceration, just in the position where the valve that had been destroyed might have flapped back and infected the area. The other valves of the heart were healthy, but the mitral and tricuspid orifices were both dilated, especially the former, and it is probable that mitral regurgitation had taken place during life. The lungs were congested, but otherwise normal; no signs of infarcts, recent or old, were found. From the cardia to the rectum there were signs of a most severe gastro-enteritis, fully accounting for the abdominal pain, diarrhoea, and vomiting. The mucous membrane of the stomach was somewhat atrophied. No signs of emboli or ulceration were observed anywhere in the alimentary canal. The liver and spleen were congested, but otherwise they were normal.

Remarks by Dr. PIDCOCK.—This case presents many features of interest. During the patient's stay in the hospital his temperature, taken twice daily, never rose above normal; nor was there during the last two months of his life or on post-mortem examination any evidence of multiple embolism. The absence of both these most typical signs of ulcerative endocarditis is very remarkable. During his illness (commencing in September, 1896) he certainly had pyrexial attacks, rigors, and occasionally coloured sputum and perhaps an attack of splenitis, all of which were doubtless due to embolism. Still, he had not many of the most usual signs or symptoms of infarction, such as hæmaturia, retinal or cerebral hæmorrhage, or blocking of any of the arteries of the limbs, &c. He had an attack of acute rheumatism at five years of age, which may have affected the endocardium of the right ventricle and pulmonary valves, or, what is even more probable, he may have had endocarditis of the right ventricle during foetal life. Whether this was the case or not, I think there can be little doubt that the endocardium of the right ventricle and pulmonary valves were infected during the attack of pneumonia which he appears to have had in September, 1896. The intensity of the gastro-enteritis from which he succumbed was also very remarkable. From the stomach downwards the mucous membrane was intensely congested. I cannot see how it could have been caused by emboli, and one would hardly expect an error in diet to have been sufficient cause, and yet nothing else could be discovered to account for it.

DERBYSHIRE ROYAL INFIRMARY.

A CASE DIAGNOSED AS ACUTE INFLAMMATION OF THE PANCREAS, IN WHICH RECOVERY TOOK PLACE.

(Under the care of Dr. MILNES.)

THOUGH cases supposed to be examples of acute pancreatitis were described many years ago by several observers, as by Bécourt,¹ yet, as these opinions were chiefly based on naked-eye appearances found at post-mortem examinations, it is probable that in many of the cases the abnormal appearances were the result of decomposition rather than of inflammation. In fact, doubts even of the existence of pancreatitis arose, and so late as 1869 Grisolle wrote²: "We have still absolutely no exact knowledge of either acute or chronic pancreatitis." More recently, however, very many cases have been reported in which certain definite clinical manifestations have been found associated with unmistakable evidences of inflammation of the pancreas, as revealed at the necropsy. Unfortunately, in the vast majority of the cases the making of a diagnosis has only been

possible after death, but in a certain number, where the inflammation of the organ has gone on to suppuration, the abscess so formed has been evacuated by surgical means, and recovery has followed. Many have doubted whether recovery is possible in cases of acute pancreatitis, but there can be little hesitation in admitting that such cases do occur. H. Mollière³ expressly states that at least three cases have been observed in which the inflammation has subsided. Until the disease can be readily recognised by its symptoms, some doubt must always be present as to the accuracy of a diagnosis which has not been verified by a post-mortem examination. Judging, however, from similar inflammations in other organs, it is extremely probable that the disease is much more frequent than is usually thought, and that many cases are missed because they end in recovery.⁴ The diagnosis in the following very interesting case is perfectly justifiable, and is the only one which will account for the course of the disease.

The patient, a man aged twenty-one years, was admitted into the Derbyshire Royal Infirmary on July 14th, 1896, complaining of abdominal pain and vomiting. He had always been a strong and healthy man of sober habits. His work involved exposure to great variations of temperature, and the air he breathed was usually loaded with foul gases. No history of any previous illness could be obtained. Three weeks before admission he began to suffer from pain in the lower part of the abdomen. This usually came on when he started to work after a rest and wore off as he worked. According to his own expression "his belly felt hard." About the same time the bowels became obstinately constipated. He continued to work until a few days before admission, the pain getting worse and his "belly getting harder" all the time. He took a certain amount of purgative medicine without much effect; but he did not persevere with it, and he could not remember when the bowels were last moved. On the night before admission the pain suddenly became violent and he was seized with urgent and profuse vomiting, which continued till he came to the infirmary. Dr. Cassidi, who saw him before he came in, described his condition as one of extreme collapse and as strongly suggestive of gastric or intestinal perforation. On admission, on July 14th, 1896, the patient's temperature was 102.4° F., and the usual symptoms of pyrexia were present; his pulse was 116, full, and bounding; the tongue was dry and brown; and the skin was hot and dry. The mind was quite clear, but the face was much drawn and the expression that of great suffering. He referred all his pain to the region of the epigastrium, and the condition of the abdomen was such that he could not pass urine on account of the pain caused by the attempt to micturate. The legs were not drawn up and he lay flat on his back, maintaining his posture with much stiffness. On examination the abdominal wall was found to be retracted to an extreme degree, so that the abdomen presented a concave instead of a convex surface in nearly every direction. It was stiff and quite unmoved by respiration, which was entirely thoracic and not at all hurried. The abdomen was universally and acutely tender to the touch, especially at the upper part, where even a feather-weight pressure caused severe pain. The urine, drawn by catheter, had a specific gravity of 1030; it was acid, highly-coloured, and contained a trace of albumin, but no sugar. No abnormal signs could be detected in any other organ. A third of a grain of morphia was injected hypodermically, and poppy fomentations were applied to the abdomen. Peptonised milk was ordered to be given in small and frequent doses, also four ounces of brandy daily. At 8 P.M. the pain was still severe, and an eighth of a grain of morphia was injected. On the 15th the patient passed a fair night, the pain being less severe; there had been no more vomiting, and no action of the bowels had occurred. The pulse was 110. The abdomen was still retracted, but was less tender to the touch. He was drowsy from the morphia. On the 16th he had three severe attacks of spasmodic pain in the night, which were relieved by poppy fomentations. He still complained of nausea, but there had been no vomiting. He had no pain while lying quiet in bed during the day, and the abdomen was less tender in the lower half. On the 17th he had one severe attack of pain in the night, accompanied by vomiting of bilious material. A sixth of a grain of

¹ Recherches sur le Pancréas.

² Pathologie Interne.

³ Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques, vol. xxv., p. 718.

⁴ R. H. Fitz, Medical News, vol. liv., p. 310.

morphia subcutaneously appeared to give relief. There was almost no tenderness in the lower half of the abdomen, but the tenderness was still acute in the whole abdominal area above the level of the umbilicus. An enema of warm water brought away a small quantity of hard fæces. On the 18th another attack of pain in the night was again relieved by morphia injection. He still had nausea, but no vomiting. An enema was given, but was returned unchanged. A second enema brought away a good stool. On the 19th the patient had two attacks of pain in the night, one severe, and he also had two attacks of vomiting. His tongue was much cleaner, and the pulse was of good volume and averaged 100. The enema was repeated and acted well; no fat was noticed in the stools, although it was looked for every time the bowels acted. In the evening of this day the patient was suddenly seized with collapse and gasping respiration, the pulse becoming almost imperceptible. A second attack followed the first and was much more severe, and death appeared to be imminent. A hypodermic injection of three drops of liquor strychninæ seemed to revive him and he quickly recovered. On the 20th he had two further attacks of faintness during the night, but they were not nearly so alarming as the two before noted. He also had several attacks of pain, but they were not severe. He had been much better since 4 A.M. The abdominal tenderness was markedly less and was now limited to the epigastric region. One spot about two inches above and to the right of the umbilicus was specially and acutely tender. There was also tenderness in the back on pressure just below the twelfth rib on both sides of the spine. The abdominal walls were still retracted and the muscles were rigid, but not so markedly as on admission. The question of surgical interference was seriously considered, but it was decided to wait. A simple enema was ordered to be administered daily. Chicken tea was ordered to be given in addition to the peptonised milk. On the 22nd, though there had been slight vomiting on the previous day, in other respects there was great improvement. His tongue was nearly clean, the pulse was only 76, and there was no fever. The abdomen was still flat and without movement, but it was quite soft and could be handled freely without pain, except at the one spot above and to the right of the umbilicus. On the 22nd and 23rd the patient had a severe attack of pain each night, culminating in vomiting, which gave relief, and on the 24th three minims of dilute hydrocyanic acid with ten grains of bicarbonate of soda were ordered every six hours. No pain or vomiting occurred after this. The daily enema acted well, but every night the temperature continued to rise until on the 27th it reached 102.4°. The enema was then discontinued, and the evening rise of temperature quickly subsided. After six clear days the bowels began to act without artificial stimulation. On the 30th all tenderness was gone from the abdomen, which, however, was still rather flat, and did not move freely with respiration. From this date recovery was uninterrupted, and he was discharged on Aug. 31st, 1896, quite well.

Remarks by Dr. MILNES.—Those cases in which the existence of acute pancreatitis has been proved, either on the operating table or in the post-mortem room, have presented a combination of the symptoms of acute intestinal obstruction with those of perforation of the stomach or bowel. The cardinal symptoms appear to be (1) violent abdominal pain of a spasmodic character; (2) constipation, usually complete; (3) vomiting; (4) recurrent attacks of collapse during one of which the patient usually dies; and (5) the onset is generally sudden, but in a few cases the existence of colicky pain has been noted for a short time before the attack. All these symptoms were present in the above case except the fatal termination. With the exception of the case recorded by Osler, where the diagnosis was made during an exploratory laparotomy, I am not aware of any case of recovery after a diagnosis of acute pancreatitis. Osler's case, however, proves that recovery may take place. In the present case the diagnosis of acute pancreatitis was suggested to me early in the patient's illness by the acting house physician, Mr. Miles. After mature deliberation and consultation of all accessible reports I have come to the conclusion that this diagnosis is the only one that offers a reasonable explanation of the symptoms. The alternatives appear to be—(1) peritonitis of the so-called idiopathic character; (2) ulceration of the duodenum without perforation, causing sudden acute peritonitis; and (3) the passage of gall-stones, causing acute peritonitis. Intestinal obstruction and perforation of viscera are

put out of the question by the progress of the case. 1. It is now generally recognised that mere peritonitis is not a sufficient explanation of any illness. There must be some local cause. In this case the local cause of the peritonitis which existed was evidently something in the upper part of the abdomen. It is difficult to suggest any local cause for acute general peritonitis in this region which would not have made its presence manifest by some further symptoms. For instance, perforation or sub phrenic abscess must have led to events such as never occurred in this case. 2. Ulceration of the duodenum was naturally suggested by the situation of the point of maximum tenderness. The whole course of the disease, the rapid and complete recovery, and the fact that the man was quite well till a short time before the acute symptoms set in, all make against a disease which must have some period of chronicity in its course. The transient nature of the attacks of collapse and the absence of melæna show that these phenomena were not due to hæmorrhage from an ulcer. 3. Taking all the symptoms into consideration, it appears that the only way in which gall-stones could have caused this illness was by a stone becoming lodged low down in the common duct and there setting up ulceration and acute general peritonitis. If this were the case there must have been jaundice, and something must have been heard afterwards of the stone. This latter could hardly have escaped notice owing to the very strict watch kept on the stools throughout the case. Supposing this case to be accepted as one of pancreatitis, I think it adds one or two useful indications for diagnosis and treatment of future cases of a similar character. The local tenderness near the umbilicus, and still more the tenderness below the lowest ribs in the back may be sought for with advantage in doubtful cases. The history of this case further teaches us to leave the bowels alone. After admission of this patient into hospital no attacks of collapse occurred until we began to worry the bowels with enemata. Then, later, the evening exacerbations of temperature seem to have been due to the same cause, at any rate they subsided when the enemata were stopped. Among the cases recorded one is related in which fatal collapse quickly followed the administration of a purgative.

Reviews and Notices of Books.

A System of Medicine. By Many Writers. Edited by THOMAS CLIFFORD ALLBUTT. Vol. III. London: Macmillan and Co. 1897. Pp. 983. Price 25s.

HAVING referred on previous occasions to the object and nature of the *System of Medicine*, edited by Dr. Clifford Allbutt, our review of the third volume does not need any introductory remarks. The first part of this volume deals with "General Diseases of Obscure Causation," such as Rheumatism, Rickets, Acromegaly, Gout, Diabetes, &c., whilst the second contains papers on Diseases of Alimentation and Excretion.

The first article is on Acute Rheumatism or Rheumatic Fever, and is from the pen of Dr. Church. Acute rheumatism, as Dr. Church remarks, is a disease more easily described than defined, and he therefore considers the disease as equivalent to a synovitis accompanied by pyrexia and generally multiple. Such a description shows the courage of the writer, for by it he admits that the exact nature of the disease has not yet been discovered, although it is so widely diffused and occurs with such frequency, as is shown by some carefully compiled statistics accompanied by tables contained in appendices to the paper. In speaking of the etiology Dr. Church remarks that although no satisfactory evidence has as yet been procured of the constant presence of any single specific micro-organism, yet in not a few of its features the whole course of rheumatic fever resembles an infective disease; moreover, the curves of its mortality statistics in this country approximate very closely to those of pyæmia, puerperal fever, and erysipelas—diseases which are certainly associated with specific micro-organisms. The