poisoning. During the evening of Friday the 8th, and early on Saturday the 9th, he had a succession of very severe rigors, and as soon as practicable I got Dr. W. Bulloch and Dr. P. N. Panton to examine his blood to see whether microscopy or bacteriology could throw any light on the matter and give us a line for treatment. Leucocytosis was not present. Widal's test for typhoid fever was negative and no micro-organisms could be isolated from the blood. On Sunday the 10th he seemed a good deal better and I had hopes that matters might be quietening down. (In view of the post-mortem examination I omit reference to treatment which could scarcely have had any effect.) However, on Sunday evening he again was seized with rigors and matters seemed as bad as ever. I should say that on Saturday Mr. J. Sherren saw the patient with a view to the possibility of surgical interference but he, like myself, could find no reasonable grounds for operating; in fact, he could not see any guidance as to what to aim at if he did operate. On Monday Dr. Percy Kidd saw the patient with me, but again with the same negative result. So matters progressed till Friday the 15th; sometimes hope but more often despair was in our minds, but on the 15th the cloven hoof betrayed itself, if only I had had the wits to perceive it. I saw him about midday with a normal temperature but complaining of an intense pain that had suddenly seized him at the root of the penis, of all places in the world, and also of a feeling of distension of the stomach and an inclination to vomit (he had previously shown no tendency to vomiting—in fact, not even a trace of nausea all through the illness). The pain naturally made me examine his pelvic region with great care, but I could find nothing—no hardness of the bulb, no tenderness nor redness of the skin, and still no pain on palpating the lower abdomen. Per rectum Douglas's pouch could be recognised, but there was no elasticity nor tension about it; it might have been filled with small gut. Mr. Sherren again examined him, but again he could find nothing to lead him to believe that a laparotomy could help. The pulse by now had suddenly begun to fail and I feared he would die before evening; however, he did not die till Sunday morning, but during the last 40 hours the final illness was undoubtedly acute general purulent peritonitis, constant violently propulsive vomiting, and increasing hardness and distension of the abdomen.

The patient's parents as well as myself were naturally anxious to have the cause of his illness and death cleared up; accordingly Dr. H. M. Turnbull and I did a limited post-mortem examination on the next day, when we found as was certain acute general purulent peritonitis; we found, too, its cause in the appendix. The condition of that organ and the tissues behind it (it was running directly inwards to the brim of the pelvis and closely attached by adhesions to the back of the iliac fossa) was somewhat peculiar. The appendix itself was black and gangrenous but still retained so much of its natural structure as to suggest that the gangrene was quite recent; the terminal portion was swollen and dilated, and there were one or two quite small perforations in it still detectable with a probe. The tissues behind it were black, but the colour seemed more to be due to altered extravasated blood rather than to gangrenous changes. We found in the liver three rather large distinct abscesses of about the size of golf-balls, with greenish slimy contents, not true pus, and also a pathological ante-mortem clot in one of the larger branches of the portal vein. Having cleared up the mystery we did not investigate further, except to verify the fact of pleurisy at the left base detected in the last day of his illness by Dr. R. Hutchison, who kindly saw him then for me in my unavoidable absence.

Remarks.—How easy it is to be wise after the event. The post-mortem examination cleared up in absolutely most astounding fashion the whole case and enabled us to see the exact sequence of events with the utmost precision as follows. On Jan. 2nd there obviously occurred acute inflammation in the appendix. In the following four or five days this slowly extended instead of subsiding, until about the fifth day (it may have been earlier, as the patient may have had slight rigors at home, but the point is immaterial in the light of events, though very material in the light of "might have been") it found its way into a small radicle of the portal vein and thus let loose some septic microbe into that vein, which microbe in turn went up to the liver and started a focus there. For the next week the forces of evil slowly got the better of the fight in the appendix, while in the liver they

rapidly gained the ascendant. By the thirteenth day or a little earlier the local appendical trouble reached and burst through the peritoneum and started the last final picture of acute perforative peritonitis.

What is not made clear by the necropsy is the extraordinary manner in which the case failed to show the usual clinical signs and features by which we have learnt to diagnose the site and nature of such cases, and suggests the reflection that such signs and features are in reality only due to implication of the peritoneum covering the appendix, and may not be found when only the interior mucous and submucous coats are involved. It is true that I diagnosed the pyle-phlebitis which was actually present, but this rather hindered than assisted me in deciding to ask for surgical assistance, for one usually takes that trouble to be inevitably fatal and not to be assisted by surgery. Again, I cannot call to mind a case of appendicitis in which pyle-phlebitis has been definitely present as a diagnosable condition by itself, and in fact I believe its occurrence anyhow with appendicitis is rare.¹

A point of melancholy interest is the "might have been." When was the latest moment that a correct diagnosis and prompt surgical intervention could have saved this valuable life? Beyond any question an operation in the first 24 hours would have saved it, but I think the first rigor certainly put up a notice "too late." But are we to open the abdomen of all those who are seized with colic and diarrhoea? It is a practical impossibility and I fear such sad cases as the above must still occur from time to time, the very record of which, however, may serve a useful purpose and possibly save an occasional life.

Harley-street, W.

A NOTE ON A CASE OF "LEATHER-BOTTLE" STOMACH.

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THE subject of this condition was a married woman aged 56 years. She was admitted to the Kidderminster Infirmary on Sept. 18th, 1908, suffering from dysphagia. She stated that she had been quite well and able to take ordinary food up to the end of June; she then commenced to vomit and had great difficulty in swallowing. The condition rapidly became worse and she lost a considerable amount of flesh. The vomiting occurred immediately after food and consisted of whatever she had taken. She did not attempt to swallow anything but fluids and the act caused her evident discomfort; the fluid immediately regurgitated. There had never been any blood in the vomit. She complained of a continuous aching pain under the ensiform cartilage, which was increased after taking nourishment and after vomiting. She was evidently wasted but her condition was not one of emaciation. She had previously been stout. Examination of her organs did not discover anything. The urine was of specific gravity 1020 and did not contain any abnormal constituent. The bowels had not moved since the end of June. Examination of the abdomen did not reveal anything. Oesophageal bougies could not be introduced into the stomach. The smallest size was arrested at a distance of 16 inches from the teeth.

The case was regarded as one of malignant disease of the lower end of the oesophagus and it was decided to perform a gastrostomy. The operation was performed on Sept. 22nd under ether anaesthesia. A vertical incision was made through the left rectus. On opening the abdomen the stomach was found to be lying under the liver. When pulled down it was found to be very much contracted and its coats hard and thickened. The only portion which could be brought outside the abdomen was the pyloric end, and this allowed a gastrostomy after Franks's method to be performed. The patient bore the operation well. The stomach

¹ Dr. Turnbull and I searched our records in connexion with this point; we found that out of the cases in which pyle-phlebitis was found post mortem rather less than half the cases were associated with appendicitis and generalised purulent peritonitis, but in none of these was the condition diagnosed during life; it was, in fact, what may be termed an agonal condition. Out of some 100 cases of fatal appendicitis we were able to find only two associated with pyle-phlebitis. So far as they go, then, these statistical details support my view as to the inadvisability of invoking surgical aid under the circumstances.

was opened on the 25th and she was fed with liquid nourishment. On the 27th the bowels acted naturally after an interval of nearly three months. She was taking plenty of nourishment by the wound and she was now able to drink small quantities of water (half an ounce) without any discomfort. On the 30th she was up; she looked and felt much better. Her improvement continued and she was to have returned home on Oct. 13th, but on that day she commenced to be drowsy. This condition gradually increased and by the 23rd she was comatose and she died on the 25th.

The post-mortem examination was made on the following day. The stomach was found to be very much contracted. It was removed together with the lower end of the œsophagus and the pylorus. The other organs were all healthy and the œsophagus above the point of division did not present any stricture. The stomach is shown in the accompanying illustration. It measured from the cardiac to

A, The lower end of the œsophagus. B, Incision along the anterior surface. C, Probe passed into the gastrostomy opening. D, The pylorus.

the pyloric end seven inches. The thickness of its wall varied from a quarter to three-quarters of an inch. The cardiac opening was so contracted that it would with difficulty admit a No. 10 catheter. The gastrostomy opening had united perfectly. The total capacity of the stomach was one and a half ounces. A portion was sent to the Clinical Research Association for examination and the report was as follows: "The stomach wall is thickened by new fibrous tissue. In the centre of the section there is an area containing alveoli filled with epithelial cells. This probably represents a spheroidal celled carcinoma."

The diagnosis of this rare condition is exceedingly difficult. In the present instance the symptoms were those of œsophageal obstruction only and there was nothing to indicate the presence of disease in the stomach.

At the operation I had the choice of performing a gastrectomy, a gastrostomy, or an enterostomy. As the pyloric end of the stomach was easily brought out I chose the second of these methods, with the result that the patient obtained relief from her distressing symptoms.

Kidderminster.

THE SCHOOL MEDICAL OFFICER FOR CHELTENHAM.

—At a meeting of the Cheltenham town council, held on Feb. 2nd, the question again came up of the appointment of Dr. J. H. Garrett (who is the "whole-time" medical officer of health of the town) by the education committee to the post of school medical officer at a salary of £50 per annum. It was stated that the approval of the health and education committee was carried only by the casting vote of the mayor as an *ex-officio* member and the council was asked to adopt that minute, although the chairman of the committee dissented. Considerable discussion followed and an amendment was moved to delete that particular minute. Eventually the amendment was lost by 12 to 11 and the minutes were adopted.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF ANÆSTHETICS.

At the adjourned meeting of this section held on Feb. 5th the following special resolution was passed:—

That the Council of the Royal Society of Medicine be informed that the Section of Anæsthetics approves of legislation to restrict the administration of anæsthetics to legally qualified medical practitioners.

During the discussion, of which we are able only to give a brief note this week, it was decided that the section would not oppose permission being given to registered dentists to administer nitrous oxide gas if the Odontological Section considered that such permission should be granted, provided that instruction in the physiological action, administration, and dangers attending the administration of this drug were made compulsory for the Final L.D.S. examination.

MEDICAL SOCIETY OF LONDON.

Exhibition of Cases.

A MEETING of this society was held on Feb. 8th, Mr. CHARTERS J. SYMONDS being in the chair.

Dr. A. F. VOELCKER showed a case of Widespread Peripheral Neuritis of uncertain origin in a child, three years of age. The case was exhibited at a clinical meeting of the society on Nov. 9th, 1908.—Dr. G. A. SUTHERLAND showed a case of Generalised Paralysis of uncertain origin in a boy, three years of age.—These two cases were discussed together and Dr. Voelcker said that he showed the case at the November meeting last year as one of probable diffuse glioma of the cord. He felt sure now that the tentative diagnosis he then made was incorrect and it seemed to be a case of peripheral neuritis. He did not think it post-diphtheritic because neither the eye muscles nor the palate muscles showed at any time any sign of being affected. The case now was steadily but slowly improving. The amount of muscular wasting was very small compared with the degree of paralysis. Possibly it was the result of some toxic agent which was connected with the diphtheritic poison but the nature of that had not yet been discovered.—Dr. F. J. POYNTON said that when he saw Dr. Voelcker's case in the out-patient department it struck him as a peculiar one. The question arose as to the diagnosis between it and anterior poliomyelitis. Recently there had been some remarkable cases of the latter condition affecting a very large area of the body, very symmetrically, and the patients had made a very fair recovery. The onset in this case was gradual but in outbursts, one part of the body being affected and then after an interval another part. When he sent the child in from the out-patients at Great Ormond-street there were marked paralysis and weakness of the forearms, and when she had been in the ward for a day or two and rested it was thought there was scarcely any paralysis at all. That was very unlike the behaviour of a severe case of anterior poliomyelitis affecting a large area of the body. He agreed with Dr. Voelcker's name for the case. He would have been sorry if it had been put down as diphtheritic peripheral neuritis, because there was nothing worse in clinical medicine than, because one did not understand the cause of a disease, putting it down as what it was thought it ought to be. In that way work went on in a circle and no real advance was made.—Dr. SUTHERLAND said that there were some striking similarities between his own case and that of Dr. Voelcker. He agreed with what Dr. Poynton said, but there were cases in which, though definite evidence that the condition was post-diphtheritic could not be obtained, the clinical course was such as practically to convince one that it was of that nature. In his own case there was no proof that the patient suffered from diphtheritic paralysis, but after watching the case four months he thought the course of the illness was strongly suggestive of diphtheritic paralysis. The