ON A CASE OF GASTRIC HÆMORRHAGE.

By HENRY R. OSWALD, M.D. EDIN.

MRS. R—, aged twenty-four, had not felt well for several months (one of her most troublesome symptoms being pain in the epigastrium and back), when, on the evening of Nov. 13th, 1880, she fainted. The following is a record of the more prominent symptoms from the day I first visited the patient:—

Nov. 14th: At 4 A.M. vomited a large quantity of dark blood, and at 8 A.M. about a teacupful of bright-coloured blood. More blood of a bright hue was brought up at 6 P.M. Shortly afterwards the bowels were moved, the stool containing dark blood. Pain in the epigastrium. Mineral acid was prescribed. Ordered ice to be sucked, room to be kept cool, rest in horizontal position.—15th: Blood, fluid and coagulated, vomited at 2 A.M. Gallic acid prescribed.—16th: At 1 A.M. a small amount of bright blood, and at 7 A.M. a large amount of darker blood, fluid and coagulated, was vomited. Copious bloody motion during the day. Patient exsanguine, skin cold, pulse small and feeble. Till now she had taken ice and gallic acid. At this period, on account of the urgency of the case, I deemed it advisable to try ergot. An enema of half an ounce of the solution of the extract of ergot, in water, was used about midday.—17th: Patient vomited several times, but passed no more blood since the injection, either by mouth or rectum. A small enema of beef-tea and brandy given.—18th: Headache and nausea complained of, but no more sickness. A very slight menstrual flow began. Another beef-tea enema administered, and a little slop-food allowed. Bowels unmoved since enema of ergot. Pills of bismuth prescribed.—19th: No sickness; no bleeding; appetite returning. Bismuth continued.—20th: Headache; tongue coated and clammy. Food of a semi-liquid form fairly well taken.—21st: Headache and coated tongue remain. Has been ordered brandy each day since the 17th.—22nd: Still very anæmic. Appetite fair. Partook of whitening to-day, bread, and an egg. Brandy continued. The bowels not having been opened since the 16th, an enema of gruel was administered at 1.30 P.M. without result. Repeated at 10.30 P.M., and followed by a dark motion. No bleeding. Bismuth still prescribed.—23rd: Felt sick, but did not vomit. Appearance of patient still bloodless. Slept little. Ate fish, bread, and butter. Bowels moved without aid.—24th: Partook of some mutton. Late in the evening an injection was given, followed by copious dark motion.—25th: No movement of bowels.—27th: Symptoms gradually improved. Constipation remained obstinate, and required enemata at various dates. Ammonio-citrate of iron commenced on this day, and was taken till the recovery of the patient. In three weeks from the first day of attack she was able to leave her bed, and in six to descend from her bedroom. Nausea returned occasionally, but was amenable to treatment by bismuth. In January, 1881, the patient went to the seaside. No hæmorrhage had occurred since the 16th of November previous. In July, 1881, during my absence from town, Mrs. R— suffered from another attack similar to that just detailed, but much less urgent. It was happily soon subdued by astringents. At the present date Mrs. R— is in fair health. She always complains, however, of constipation, and of a feeling of constriction around the abdomen about the level of the umbilicus.

Remarks.—There can be little doubt this was a serious case of gastric ulcer. I have been induced to relate the symptoms, however, to illustrate the specific action of ergot rather than to give an exhaustive clinical account of that malady. In a comparison of the effects of belladonna and ergot on involuntary muscular fibre, Dr. Brown-Séquard observes that the latter drug acts chiefly on the uterus and the vessels of the spinal cord. I presume he speaks of its physiological action; for, in the present instance, the therapeutic effect of ergot on the stomach was sufficiently distinct and notable. So much blood had been lost—its colour at times leading one to suspect it was partly arterial—that in forty-eight hours from the beginning of the attack the patient's friends despaired of her recovery. No syncope took place after the vomiting commenced. Therefore, the action of the ergot enema was not thus adventitiously helped, and from the date of its administration not a drop more

blood escaped either by mouth or rectum. The dark fecal evacuations mentioned were owing to bismuth. In such a case, then, how does ergot act? Not to enter into its reputed primary action on the sympathetic system of nerves, I conclude that its effects are developed, through involuntary muscular fibre, in three directions.

1. Through the arteries. There is reason to believe the capillaries of the stomach contain in their coat a larger supply of non-voluntary muscular fibre than most arterial vessels. Consequently the contraction of these, after absorption of ergot by the system, is firm, and the flow of blood along them relatively inconsiderable or possibly nil. The chance of its escape at an ulcerated surface is thus materially diminished.

2. Through the veins. From the same cause the venous capillaries are similarly reduced in calibre, but also from their natural tendency to adapt their size to the supply of blood coming from the arteries. By this means the danger, if any, of regurgitation is obviated, and the ulcer left less disturbed.

3. Through the muscular coat of the stomach, which consists of three sets of fibres, longitudinal, circular, and oblique, of the involuntary kind, the influence of ergot is most probably again asserted. By contraction of these fibres the stomach, it may be inferred, is thrown into folds, compression of the bloodvessels passing through the muscular coat being one result, and perhaps some adaptation of the ulcerated parts to each other another. In this manner the muscles of the stomach assist the capillaries, and may also promote healing of an ulcer by approximating its edges.

In the treatment of gastric ulcer it is of extreme importance, especially in case of hæmatemesis, to feed the patient with nutrient enemata and to avoid, as far as possible, the ingestion of any articles to the stomach. For not only does the presence of food or drugs disturb the denuded part, but by exciting the function of digestion stimulates a flow of blood to it.

In conclusion I wish to observe that, whichever may be the organs most affected by ergot physiologically, it exercises in disease a distinct control over any involuntary muscle in which a breach of continuity exists leading to hæmorrhage.

Camberwell New-road, S.E.

REMARKABLE CASE OF INJURY TO THE LEG FROM A FALL.

By DUNCAN ALISTAIR MAC GREGOR, M.B.ED.

THE following case is perhaps of sufficient interest to be put on record in THE LANCET.

On the evening of June 15th, 1881, I was hastily summoned to see a lad, aged fifteen years, who had injured his leg by falling off an outhouse. I was told that the limb was very badly cut, and that a "long worm-like thing" was hanging out of the wound. On arrival, I found my patient sitting on a chair, and at first sight it seemed as if there was little the matter with him, as he was laughing heartily, apparently amused at the serious view his relatives were taking of the accident.

Upon examining the right leg, I found in front a deep longitudinal jagged wound, about two inches in length, almost immediately over the lower end of the tibia, and about a couple of inches or so above the ankle-joint. From the lower end of this wound the tibiælis anticus muscle protruded almost in its entirety, the belly of the muscle lying on the dorsum of the foot. The hæmorrhage had evidently been very profuse, but had ceased when I saw the patient. Fortunately no large vessel had been injured, so, having satisfied myself on this point, I divided the tendon of the tibiælis anticus at the lower end of the wound, and removed the muscle. I then cleansed the wound thoroughly with carbolic water, washing away all dirt &c., of which there was a considerable amount. Upon trying to approximate the edges of the wound, I found, as I anticipated, that such could not be done, chiefly owing to loss of substance. I therefore applied a pad of lint soaked in carbolic oil, and bandaged the limb, enjoining perfect rest. After this point the history is simply that of a granulating sore; therefore I will not occupy space in giving details. The dressings were removed every alternate day. Everything went on

satisfactorily, and in less than three weeks the wound had healed up.

The history of this case (which I shall now briefly give) is, I fancy, almost unique. The boy, it would seem, had been out playing with some companions, when one of their number suggested that they should place a clod of earth upon the chimney of a neighbouring house. Accordingly they mounted upon the roof of an outhouse, from which they could easily reach the roof of the house they intended to attack. My patient's companions all managed to reach the chimney in safety, but he was not so fortunate, for in stepping from the outhouse his foot slipped and he fell back and rolled over on to the road. Unfortunately for him, the "roans" (or channels along which the rain flows at the lower end of the roof) were absent, but the curved hooks which had supported them were still intact. His right leg came violently in contact with one of these supports, which pierced the flesh and hooked round the tendon of the *tibialis anticus*. The boy then fell, and his weight dragged the muscle completely from its origin through the wound in the leg.

The points I consider specially worthy of notice are, first, the almost complete absence of pain. One would at first sight think that getting a muscle torn out in this summary fashion would be extremely painful; but this boy seemed to suffer absolutely no pain. Second, the apparently small loss to the leg by the removal of so important a muscle. The boy I see every day, and he can use the limb, he says, as well as he could before the accident. He certainly walks perfectly, and has neither halt nor limp.

Clayton West, near Huddersfield.

ON A CASE OF BROW AGUE.

By G. STANLEY MURRAY, M.D.

J. C—, a gardener by occupation, about forty years of age, came to me a short time ago, complaining of intense pain over his right eye. He said the pain seized him regularly every morning about 9 o'clock, and ceased at 7 o'clock in the evening, leaving him during the remaining portion of the twenty-four hours perfectly free from all discomfort. The attack commenced as a slight itching or tingling in the eye-brow, gradually developing into pain, which as the day advanced became so intense as frequently to oblige him to give up work and go home.

On examination I found a slight tenderness over the site of the supra-orbital notch (the seat of the pain), but not of any moment. The patient's general health was good, the appetite unaffected, the bowels regular, and the urine normal. In fact, the man complained of nothing but the pain in question. As he informed me that he had been previously treated by large doses of quinine without experiencing any benefit, I put him upon a course of arsenic and iron in frequent and considerable quantities for several days, with chloroform liniment and belladonna to apply on list over the tender spot. This having no effect, I then desired him to try tonga. He commenced taking it the following morning, and in the evening came to say that he thought it certainly did him good, as although he experienced the pain as usual during the day, yet it was much diminished in severity. He determined to continue the drug next day, but left word in the evening (on my being from home when he called) to say that during the day he had been as bad as ever. After this I did not see him for a few days, when he came to tell me that the pain had entirely left him. On making inquiries I learned that finding the pain was as bad as ever during the second day of his taking the tonga he called at my house in the evening to say so, but finding I was out determined to come again the next day. The following morning he was seized at the usual time, the pain becoming so intense that he was forced to leave off work and go home. On reaching home he became very sick, and vomited violently, bringing up at last what he described as a "vinegar plant," when immediately all pain and sickness ceased. He was, it seems, very desirous of bringing that interesting specimen of the vegetable world to show me, but his wife dissuaded him from "making a fool of himself, bothering the doctor with that disgusting dirty stuff!" and so, I suppose, the interests of science suffered! He has since been perfectly free from

pain, the attacks having left him. He has experienced this trouble regularly for the last twelve years, although it has never passed away in sickness of stomach before, nor has he ever felt any nausea or discomfort during the course of any previous seizures. He said the attack always commenced during the last few days of March or the beginning of April, and lasted invariably nine, nineteen, or twenty-nine days.

I may mention his right eye is blind through cataract, with which he believes he was born.

Putney.

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.

WESTMINSTER HOSPITAL.

EPITHELIOMA OF PENIS AFFECTING GLANS AND CORPORA CAVERNOSA; AMPUTATION OF THE ENTIRE PENIS, INCLUDING CRURA; RECOVERY; REMARKS.

(Under the care of Mr. A. PEARCE GOULD.)

THOUGH in the interesting case recorded Mr. Gould introduced an important novel proceeding, the operation was essentially an extension of the method of dealing with tissue affected with infiltrating growths—namely, as far as practicable to remove the whole organ. This Mr. Gould accomplished in an ingenious manner, followed by gratifying success.

P. K—, aged seventy-three, was sent to Westminster Hospital on March 9th, 1882, by Dr. Lloyd, and by the courtesy of Mr. R. Davy was placed under Mr. Pearce Gould's care in Mark ward. He was a feeble old man, and unable to give any clear history of his disease. He stated that he had the "bad disorder" forty years ago, and had had "irritation" at the end of his penis for about twenty years, but was unable to state when the sore first appeared. The glans penis and prepuce presented a characteristic appearance of epitheliomatous ulceration; a considerable part of both structures was destroyed; the surface was irregular, with everted, uneven, indurated edges, and it exuded a dirty serous discharge. The body of the penis was enlarged and of stony hardness quite up to the scrotum. No enlarged glands in either groin; no evidence of visceral disease. The man suffered a good deal of pain in the penis.

On March 11th the patient was placed under the influence of chloroform, and put in the lithotomy position. Mr. Gould commenced the operation by incising the skin of the scrotum along the whole length of the raphe; then with his finger and the handle of the scalpel he separated the two halves of the scrotum quite down to the corpus spongiosum urethræ, which was soon exposed. A full-sized silver catheter was then passed as far as the triangular ligament, and the knife was inserted transversely between the corpora cavernosa and the corpus spongiosum; the catheter was then withdrawn and the urethra cut across. The deep end of the urethra was then carefully detached from the penis quite back to the triangular ligament. An incision was next made round the root of the penis, continuous with that in the median line, the suspensory ligament of the penis was exposed and divided, and the penis separated except at the attachment of the crura. Mr. Gould now laid aside the knife, and with a stout periosteum elevator he detached each crus from the pubic arch; this step of the operation took some time, on account of the very firm union of the parts to be severed. Two arteries only—those of the corpora cavernosa—required a ligature, and the whole amount of bleeding was insignificant. The corpus spongiosum was slit up for about half an inch, and the edges of the cut stitched to the back part of the incision in the scrotum. The scrotum was stitched up, a drainage-tube being placed in the deep part of the wound, and its ends brought out in front and behind. A catheter was not placed in the urethra. The man, although aged and feeble, bore the operation well. The subsequent dressing consisted only