

The condition is characterized by intermittent attacks of pain in the region of the stomach associated with nausea and vomiting, and occurring at a time when ingesta are usually no longer present in the stomach. The attacks usually begin suddenly and unexpectedly, most frequently in the early morning, and the first symptom is a more or less severe pain in the region of the stomach. Shortly after the onset of the pain, vomiting usually begins and both the pain and vomiting may continue several hours.

The quantity of fluid vomited within a few hours may vary from a few hundred cubic centimetres to as much as two or three litres. The vomitus, which possesses the characteristics of gastric juice, is of a greenish or yellowish color, and is, as a rule, quite acid, free hydrochloric acid usually being present. The total acidity may vary from 10 to 50, and occasionally, as in the case reported, free hydrochloric acid may be absent. In other instances intermittent gastric hypersecretion appears to be associated with marked hyperacidity.

Food is usually not present in the vomitus, unless the attack should begin shortly after a meal. In rare instances the vomitus may be slightly blood-tinged, and in such cases the possibility of the existence of a gastric ulcer would have to be considered.

The intensity of the pain varies; in some cases it is not especially distressing, while in other cases it is most severe and often requires large doses of morphine, and these are the individuals especially apt to develop a morphine habit. Vomiting usually affords considerable relief from the pain and in many instances when vomiting does not occur spontaneously, the patient will induce it. There is complete loss of appetite and inability to retain food during the attack, and the patient may emaciate rapidly. The duration of the attack varies from a few hours to several days. In some cases the patient will have a paroxysm every day or perhaps every second or third day, for a period of two or three weeks, and this will be followed by an interval lasting perhaps several weeks, during which time there will be absolutely no gastric symptoms. The cessation of an attack may be sudden or it may be more gradual, the symptoms slowly abating and a normal state of health being gradually established. The appetite usually returns immediately after the cessation of the attack. During the interval between attacks the patient usually feels quite well and there may be absolutely no indication of a gastric disorder, food of all kinds being well retained. If, during the interval between attacks, the stomach tube be passed when the stomach is in a fasting condition, it will be found to be empty, thus proving that there is no chronic hypersecretion. Examination of the gastric contents after a test meal given during the interval between attacks usually demonstrates that both the secretory and motor activity of the stomach are normal. Physical examination during an attack usually reveals but little, aside from some tenderness in the region of the stomach.

The diagnosis as a rule offers no difficulty, for the symptom complex is characteristic.

The occurrence occasionally of attacks of intermittent gastric hypersecretion in association with gastric crises in tabes may be a source of confusion. In such cases careful examination will usually reveal other signs of tabes and preclude the possibility of an error in diagnosis.

Treatment.—The treatment of intermittent gastric hypersecretion is not especially satisfactory. There are two essential points to be borne in mind: (1) treatment during the attack, and (2) treatment between attacks. The treatment during the attack is the relief of the accumulated secretion by means of the stomach tube and lavage of the stomach with weak alkaline solutions or 1-to-1,000 silver-nitrate solution. When the pain is very severe, morphine hypodermatically or cocaine internally is indicated. Food should be allowed only between the paroxysms and that in small quantities, and preferably in a fluid form. Subcutaneous infusion or rectal enemata of normal salt solution are the best means of allaying the thirst, which is at times most intense. Since the disease appears to be a functional neurosis, the predisposing factors are constantly present, and hence constant tonic treatment of the nervous system is indicated during the intervals between attacks. The cold water treatment will often be followed by most satisfactory results. Strychnia, nux vomica, quinine, phosphide of zinc, arsenic and other well-recognized tonics are indicated, and the necessity of their almost constant use should be emphasized. Since the attacks are often precipitated by certain immediate factors, great care should be exercised in protecting the patient from all such factors, as over-indulgence of all kinds, and all psychical excitation. In addition a carefully arranged diet should be prescribed and insisted upon. Only in this way can one hope to render the attacks less frequent and less severe, and in some instances perhaps cause their entire disappearance.

BIBLIOGRAPHY.

1. Reichmann. Berl. klin. Woch., No. 40, 1882.
2. Rosenthal. Magecatarrh und Magen-neurosen. Wien und Leipzig, 1886.
3. Boas. Ueber periodische Neurosen. Deut. med. Woch., No. 42, 1889.
4. Boas. Magenkrankheiten, Leipzig, 1896.
5. Bouveret. Les Maladies de l'estomac, Paris, 1893, S. 680.
6. Leube. Specielle Diagnose der inneren Krankheiten, Leipzig.
7. Ewald. Die Magenkrankheiten, Berlin, 1897.
8. Riegel. Die Erkrankungen des Magens. Nothnagel's Specielle Pathologie und Therapie, Bd. xvi, 2.
9. Rossbach. Deut. Archiv f. klin. Med., Bd. xxv, 1885.

A NEW NEEDLE-HOLDER.¹

BY GEORGE H. MONKS, M.D., BOSTON.

SOME two years ago I devised a needle-holder the clutch of which, so far as I know, is quite new. I have used this holder ever since, making a few changes from time to time. I have found it to be entirely satisfactory in actual work.

This holder has, I think, the following advantages over the instruments now in common use:

(1) When the jaws close upon the needle, the latter at once assumes its proper position *automatically*.

(2) The needle retains its exact position at right angles to the holder so long as the jaws grasp it; in fact, the needle and holder become for the time one instrument, as it were.

(3) Only slight pressure at the handles is required to hold the needle. This fact makes it possible to manipulate the instrument with a degree of delicacy and accuracy hardly possible with any instrument requiring a firmer grasp.

¹ This instrument was shown at a meeting of the Surgical Section of the Suffolk District Medical Society, December 6, 1899.

(4) The needle is released at once by relaxing the grasp and allowing the jaws to open.

The instrument is made by Codman & Shurtleff, of this city, and the Kny-Scheerer Company, of New York. A reference to the cuts, especially to Fig. 2, will make clear, I think, its construction and action.

screwed firmly. When it is necessary to refill this bottle, the upper part of the attachment only is unscrewed, and, after the bottle is filled, this is screwed on again.

To administer ether one has only to tip up the bottle and press the valve handle, thus opening the valve,

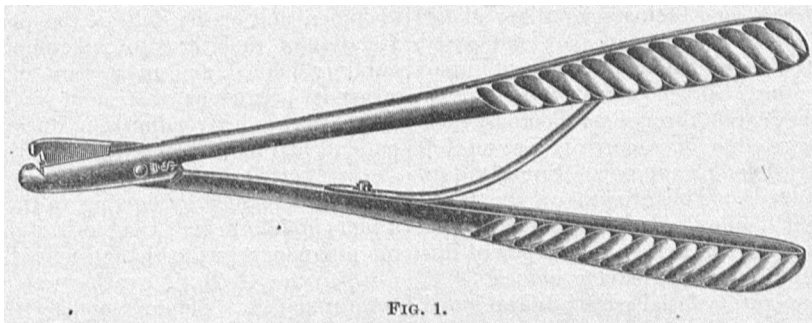


FIG. 1.

Fig. 1 shows the instrument just as it lies, with open jaws on the instrument table; and Fig. 2 presents these jaws on a larger scale.

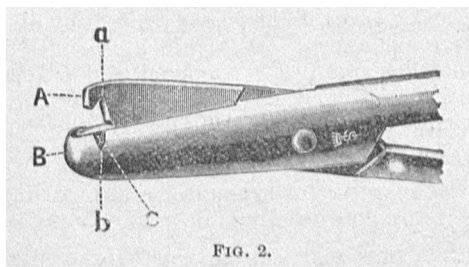


FIG. 2.

The lower jaw (see Fig. 2, B) consists of two pieces with an interval between, in which interval the upper jaw (A) plays, as the instrument is closed and opened. There is a V-shaped depression (a) in the upper jaw, and corresponding depressions (b) in the lower one. When the jaws close upon a needle, the V's of the lower jaw approach the V in the upper jaw until the needle is grasped between them. If Fig. 2 be examined closely it will be seen that the V's in the lower jaw seem to be filled up, as it were, by a tongue of metal (c) projecting from a part of the upper jaw. This projecting portion acts as an ejector, throwing the needle out of the V's of the lower jaw whenever the instrument is allowed to open. Though different kinds of handles have been used on the needle-holder, I think that shown in Fig. 1 is the best.

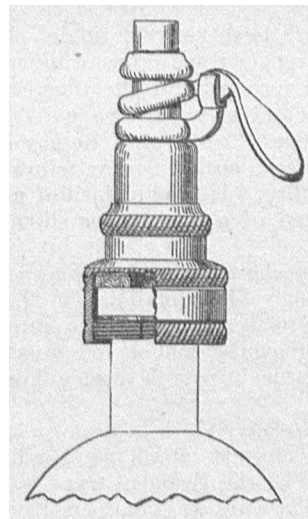
A SELF-CLOSING STOPPER FOR AN ETHER BOTTLE.¹

BY L. R. G. CRANDON, M.D., BOSTON,
Senior Surgical Intern, Boston City Hospital.

For the purpose of saving ether and facilitating the work of the etherizer, I recently devised a self-closing stopper, which has been in practical use for the past six months on the surgical side of the hospital, and seems to have answered the above requirements. The stopper which is shown in the accompanying figure will exactly fit the common flat-topped sixteen-ounce bottle, to which it is to be

¹ Exhibited by Dr. G. H. Monks at a meeting of the Surgical Section of the Suffolk District Medical Society, December 6, 1899.

and a continuous stream of ether is directed into the cone. When the pressure is relaxed, the valve closes automatically, and remains closed. The stopper is



manufactured for the hospital at the Grundy Brass Works, 50 Sudbury St., Boston.

Clinical Department.

MASSACHUSETTS GENERAL HOSPITAL. CLINICAL MEETING OF THE MEDICAL BOARD.

(Concluded from No. 11, p. 276.)

REGULAR meeting, December 15, 1899, DR. C. B. PORTER in the chair.

DR. C. B. PORTER showed the following cases:

I. SARCOMA OF TONSIL.

V. A., age forty-nine. Iron foundry laborer. Four months before entrance noticed a tight feeling at base of tongue. The left tonsil had been enlarging since that time. Has some pain on articulation, which has become more and more indistinct. Mastication is difficult and there is considerable dysphagia, the food seeming to catch behind the growth to drop later and cause choking. He has lost six pounds in two months.