me, by a more convenient, rapid, and direct method of administration of the drug. It does not confine the patient to bed or the house, nor is there apparently any disagreeable effect. The cases are only two in number and sufficient time has not elapsed for forming a proper conclusion, but I publish them in the hope that others may be induced to put such a simple method to the test before resorting to operation.

Grosvenor-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF OPERATION FOR ACUTE HÆMATEMESIS.

By ARTHUR H. BUCK, F.R.C.S. EDIN.,

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AS operations for acute hæmatemesis are still comparatively rare the following may be thought worth recording.

The patient, who was a woman, aged 39 years, had suffered from heaviness and fulness in the epigastrium after food off and on for six months. She had experienced nausea but was not sick. There was no history of melæna. Dr. F. Robson of Haywards Heath saw her first on Jan. 21st, 1903, when she had vomited one pint of blood and was collapsed. Adrenalin was administered by the mouth and rectal feeding was ordered. On the 22nd there were repeated attacks of hæmatemesis and much melæna. Ergotin and adrenalin were given. On the 23rd further hæmatemesis took place and I saw the patient in the evening with Dr. Robson. Her condition was then one of collapse and she had lost over six pints of blood by measurement in two and a half days. After a consultation with Mr. G. C. Clarke of Lindfield and Dr. Robson an operation was agreed upon for the following reasons: (1) that it was not a proper thing in her condition to advise removal to the Sussex County Hospital; (2) that judging from the repeated attacks of hæmatemesis there was likely to be another; and (3) that to a patient already *in extremis* another attack was likely to prove fatal before assistance could be obtained. The difficulties of the situation were increased by the patient living in a cottage and by the only light being that of a paraffin lamp.

The stomach was opened by a vertical incision anteriorly, as no ulcer could be felt from outside, and the ulcer was found at the cardiac end on the posterior wall by sweeping the finger round the mucous membrane. It was brought into view with some difficulty and proved to be acute, with no thickening around the edges. The diseased area having been excised the aperture was closed posteriorly by a purse-string suture and one or two Lembert's sutures on the peritoneal aspect and anteriorly by a second purse-string suture in the mucous membrane. The anterior incision was closed with Lembert's sutures. Mr. Clarke administered the anæsthetic. The patient was put back to bed apparently no worse for the operation. Dr. Robson, who conducted the entire after-treatment, at first administered strychnine and saline injections and afterwards fairly large nutrient enemata were given, about two pints a day being absorbed. The services of an excellent nurse were obtained on the second day. On the thirteenth day—namely, three days after the first food had been given by the mouth—a somewhat severe attack of parotitis set in on the right side followed by one on the left side. Except during this attack and for some little time afterwards the temperature was normal. The patient, when seen on March 20th, was perfectly well in every way.

The following statistics are quoted from Mayo Robson and Moynihan's "Surgery of the Stomach": A series of 26 operations in acute cases showed 14 deaths and a series of 19 in chronic cases showed two deaths (Hunterian Lectures). A later series in America showed 13 deaths in 32 acute cases and six deaths in 31 chronic cases. Mr. B. G. A. Moynihan in a paper read before the Royal Medical and Chirurgical Society on Jan. 27th, 1903, and published in THE LANCET of Jan. 31st, p. 294, divides the cases of hæmatemesis into those the result of acute and those the result of chronic ulceration and says: "In hæmorrhage from an acute ulcer medical treatment alone will suffice, surgical measures will

very rarely be necessary. If any operation has to be done gastro-enterostomy will probably prove to be the most effective. In chronic ulcer operation should be advised as early as possible." So far as my experience goes I should have said that it was hardly safe to be quite so dogmatic, as besides the above case I have recently come across a case where a girl with a chronic history suddenly died from profuse hæmorrhage from a chronic ulcer. Other cases of perforation have come under my observation where it was quite impossible from the history to say whether the ulcer was acute or chronic before operation. An operation for acute hæmatemesis, whether from an acute or chronic ulcer, seems to me to be an emergency operation in which one would not feel satisfied unless one performed that for which the operation was undertaken and secured the bleeding point. As to whether a gastro-enterostomy was advisable then or later would, I suppose, depend upon the condition of the patient at the time, both generally and locally, and upon the past history of dyspepsia.

Brighton.

A CASE OF IODOFORM POISONING.

By ALAN H. MUIR, M.B., CH.B. GLASG.,

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THE patient, a man, aged 35 years, was admitted to the Swansea General Hospital on March 5th, 1903, with a large non-tuberculous abscess on the calf and the thigh of the left leg. The temperature was 102° F., the pulse was 100, and the general condition was fair. On the 6th the temperature ranged from 98° to 99°. On the morning of the 7th I opened the abscess, irrigated the cavity, and put in a connecting drainage-tube. Whilst my assistant was putting in iodoform quite half an ounce or more dropped accidentally into the large cavity. For 24 hours the temperature remained normal. At 8 P.M. on the 8th the patient had a rigor, when the temperature rose to 102° and two hours afterwards it was 104°, the pulse being 140 and weak and thready and the respirations being 24 and normal in character. The patient, who now became restless and delirious but remained conscious, vomited three or four times. Nothing noteworthy regarding the pupils, the urine, &c., was observed. Quinine and brandy were now administered and at 12 midnight when the temperature was 103° the cavity was washed and swabbed out, the iodoform forming quite a coat. In 12 hours the temperature, which had come down gradually, was normal, the pulse was 120 and fair, and the patient was quiet and sensible. This condition was maintained, the temperature remaining normal, the pulse being 80 and good, and the respirations being 24.

For permission to publish these notes I am indebted to Mr. W. F. Brook, senior surgeon to the Swansea General Hospital.

Swansea.

A CASE OF CHYLIFORM ASCITES.

By GEORGE A. CLARKSON, F.R.C.S. ENG.

IN connexion with the annotation on chyliform ascites published in THE LANCET of March 21st, p. 825, the notes of the following case, which came under my immediate observation while I was house physician to St. George's Hospital, may not be without interest.

The patient was a man, aged 52 years, who was admitted to St. George's Hospital on Dec. 7th, 1895, suffering from carcinoma of the liver. His previous history was unimportant and his health had only begun to fail nine weeks previously. On admission the pinched aspect of the man and the yellowish pallor of his skin were very noticeable but there was no jaundice. The abdomen was protuberant and was specially enlarged in the upper part, where over the region of the liver irregular rounded projections could even be seen. There was a considerable amount of fluid in the abdomen. The liver was greatly enlarged, reaching fully two inches below the umbilicus. It was hard and was raised into a number of nodulated projections. The abdominal walls were covered with enlarged veins, especially marked in the flanks. The urine contained lithates but no bile or albumin. Emaciation and loss of strength were rapid but the pain was