knees drawn up; there is brawny redness about the right crista ili.

Oct. 1st: No fluctuation detected anywhere, iliac region less discoloured, temperature still over 101° .—3rd: Abdomen distended; slightly tympanitic on the right side, though there is still a dusky red look in the skin about the anterior superior iliac spine. Great restlessness; inability to sit up. When not on his back always lies on the left side, and to-day he is complaining of pain in the left axillary region. The superficial veins of the left side of the trunk are enlarged. Temperature still keeps about 101° , yesterday it was 102° , to-day 101.6° .—4th: Abdomen more distended but less tender; redness of skin disappeared; breathing healthily.—5th: Sweating freely; left side of abdomen dull and distended; pulse feeble; cannot yet attempt to sit upright.—8th: Sat him up to examine chest; lung and heart sounds normal; left side of abdomen still distended and to-day very painful. Something broke internally in the evening and he passed a horribly offensive motion, quite unlike a child's stool but more like liquid putty. The child remarked "it came away all cold;" he was much easier afterwards. Slept fairly well during the evening; took but little food and felt sick after taking anything.—10th: Temperature yesterday and to-day normal or subnormal; pulse 104; urine normal; bowels fairly relieved; still complains of pain at the side but he seems better and "as if he was about to turn the corner."—13th: A very copious offensive motion, very slimy like thick butter and adherent to the slipper, was passed to-day; temperature has again risen above 100° ; this morning it was subnormal, 97.5° ; abdomen now resonant on left side and not tender. From this time he made steady progress; on Oct. 19th he was moved on to the couch and could sit up. On Oct. 27th he was eating well, and sleeping without his anodyne; his bowels were acting regularly, his temperature kept normal, and he could sit up alone. For the first two days in November the temperature rose to 100° and a little higher; he still looked very pale and ill, but he progressed slowly; had been up and dressed two or three times and could walk a little way but not uprightly. The convalescence was slow, but he had quite recovered by the beginning of the present year.

Mansfield-street, W.

ON TWO CASES OF TOBACCO AMBLYOPIA.

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FOUR years ago, A. B—, a gentleman, aged thirty-two, who had previously suffered from nervous symptoms associated with uric acid dyspepsia, complained that at a certain distance he could not see people's eyes, and that in reading he now and then lost sight of some of the characters. He came under the care of Mr. Brudenell Carter and myself. The patient was slightly myopic, and his unaided distant vision amounted to only eight-fiftieths of the normal; but was raised by a concave glass of one dioptré to eight-thirtieths. He had been feeling depressed and wanting in energy for some months. By the ophthalmoscope his discs appeared pale; but he is a dark-complexioned man, and it was doubtful how far the pallor might be apparent only, and due to contrast with the darkness of the fundus. His organs generally were healthy; the urine contained no albumen or sugar, but abounded in urates. He had never had syphilis. The pupils contracted to light. On inquiry he complained of having suffered from sudden darts of pain in his arms and legs during the past winter. These pains sometimes lasted as long as a week, and then did not trouble him again for a month or so. His description fairly corresponded with that of the shooting pains of tabes of less than usual severity. The patellar-tendon reflex was found to be normal at each knee. In spite of this, his symptoms were so suggestive of incipient optic nerve atrophy of sclerosal character as to give rise to grave anxiety. His habit was to take about a pint of claret and three or four ounces of whisky in the twenty-four hours, and to smoke six or seven pipes of tobacco daily. His tobacco was cut down to one pipe a day, his alcoholic stimulant was reduced by half, and some strychnia was ordered. In one month the unaided distant vision had increased to eight-thirtieths, and was raised to eight-twenty-fifths by the same concave glass formerly used. In the hand,

by the aid of a convex of one dioptré, the best he could do was to read 0.6 of Snellen's test types. The treatment was continued, and by the end of three months the distant (aided) vision of the left eye had increased to eight-sixteenths, while that of the left remained at eight-twenty-fifths; but Snellen's 0.5 could be read with either eye without the aid of a convex glass. The pallor of the optic discs was less conspicuous. The improvement has been maintained, and at the present time his sight is reported to be perfect.

In May, 1882, C. D—, a gentleman aged thirty-one, was attended by Mr. Carter and myself in consultation on account of amblyopia, which he had first noticed in the preceding March. The patient was a man of very active habits, leading a country life, but had been a somewhat free liver. He had never suffered from syphilis. The distant vision was eight-fortieths with either eye, and No. 3 of Jaeger's types could be read with difficulty by the aid of a convex one-fiftieth lens. The tension and colour-sense were normal, and at that time there were no very manifest disc changes. The tongue was foul and loaded, but the organs generally were healthy, and the urine was free from albumen and from sugar. He was put upon iodide of potassium, with blue pill and compound rhubarb pill every night, and in a fortnight his condition had improved. The tongue was clean. He read No. 3 of Jaeger unaided, and the distant vision had increased to eight-thirtieths. The iodide was continued, and the pill given twice a week. In another fortnight there was a still further advance, the distant vision being eight-twentieths, and No. 2 of Jaeger being read without assistance. At this point he remained stationary for a time, and then fell back, while at the same time the discs became pallid, and the sight of the left eye failed rapidly. He owned to some "rheumatic" pains at times, but at first said that he had never experienced any of a sharp and momentary character. Later he described having had a few attacks of this kind. The knee phenomenon was present on each side; but in August it was supposed (erroneously, I think) to be diminished, and at that time a very gloomy prognosis was entertained. We expected the knee phenomenon to disappear, and regarded the case as being probably one of tabes in which the optic nerve symptoms were dominant. Various treatment had been adopted without success, and for two months from August he took strychnia to the full production of physiological effects. At the end of this time the sight of the right eye remained much as it was when its acuteness was deliberately measured; but it had lost a little even in this respect, and decidedly in quickness of perception, while the left eye had lost in acuteness to the extent of being practically useless, and its disc was much more pallid than formerly. Careful examination showed the knee phenomenon to be normal on each side. The patient had been advised in May to diminish his tobacco; but the advice had not been strongly pressed, and in October his acknowledged habit was to smoke ten or twelve times a day, pipes or cigars, but mostly the former, and to drink eight or ten glasses of beer, with a few glasses of wine, daily, and a couple of "groggs" at night. At this time, being then quite unable to read, he yielded to the advice given him, and left off smoking and "groggs," but continued to take eight glasses of beer and two of sherry daily. Arsenic and quinine were prescribed for him. At the end of three months he could read *The Times* comfortably, and had read a couple of books, but his optic discs continued very pale. Four months later he wrote: "You will be glad to hear that my sight since I last saw you has improved immensely. If not quite as good as ever it was, it is nearly so. I have, as instructed by you, left off smoking, except perhaps a cigar a month. I have also decreased the amount of alcohol; but I place the smoking as the principal cause. Although at one time I could not read the clearest type, I now read any book or newspaper apparently as well as ever I could."

These cases, and especially the second one, are calculated to support the view that changes in the appearance of the optic disc, closely resembling those dependent upon the atrophy so often associated with tabes dorsalis (locomotor ataxy), may have their origin in the excessive use of tobacco, excess being possibly measurable by the idiosyncrasy of the patient, rather than by the actual quantity consumed. In both instances, but most markedly in the first, the sudden pains which were described inclined us towards a diagnosis of sclerosal atrophy, and it was chiefly the continued presence of the patellar-tendon reflex which prevented the too confident expression of an unfavourable prognosis. In a case

of optic nerve atrophy already published¹ no symptom of tabes has been associated with the intra-ocular change except that the knee phenomenon disappeared in succession from each leg while the patient was under observation. He is now irreparably blind.

Grosvenor-street, W.

A CASE OF GASTROSTOMY, FATAL ON THE TWENTY- THIRD DAY FROM ACUTE PARENCHY- MATOUS GASTRITIS.

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THE operation of gastrostomy was undertaken in this case, in circumstances apparently most favourable, on account of impassable organic obstruction at the lower end of the œsophagus; and although the condition of the patient immediately and for three weeks after the operation gave every promise of success, death then took place from a sudden and acute attack of purulent inflammation of the walls of the stomach. The case is therefore a most important one, for apart altogether from the rarity of this form of gastritis, I am not aware of any instance in which a like unforeseen and unfortunate result has attended gastrostomy so long after all the risks of peritoneal inflammation have been avoided.

W. M.—, aged fifty-four, hitherto a perfectly healthy man, came under observation at St. Mary's Hospital in December last, complaining that for two months he had been getting weaker and thinner in consequence of difficulty in swallowing and the constant vomiting, or regurgitation, of his food. The man looked starved and ill. There was no sign of disease in any of his organs, nor any evidence of thoracic tumour, but a small bougie passed down the œsophagus was arrested at the cardiac end. The diagnosis was made of malignant œsophageal stricture, and he was accordingly taken into the hospital to be under closer observation, and that if it were found needful gastrostomy might be performed. He was an in-patient under the care of Dr. Sieveking from Dec. 9th to Jan. 12th; and although during this period the stricture remained as impermeable to bougie as before, he was certainly better able to take the food very carefully prepared for him, the sickness and regurgitation were controlled by a bismuth mixture, he gained five pounds in weight, and looked and felt decidedly stronger. He was enjoined to come back if he had any fresh trouble, and in a fortnight after his discharge he made his appearance again, all his old symptoms having recurred in a worse degree, and himself looking thoroughly exhausted and ill. It was resolved, therefore, that before opening the stomach some attempt should be made to restore his strength by careful feeding and nutrient enemata, and this had been so well accomplished by Feb. 21st, and the sickness now occurred so seldom, that the operation was performed on that day.

As to the operation itself there is but little to be said. Following the careful directions of Mr. Bryant,² an oblique incision three inches long was made about three-quarters of an inch parallel to and below the margin of the left ribs, and ending opposite the tenth cartilage. The soft parts were divided down to, but not through, the peritoneum, and all oozing of blood was arrested. The peritoneum itself was opened for an inch, and the stomach, seen lying immediately beneath the incision, was seized and drawn out by a pair of forceps. By means of two loops of fine carbolised silk then inserted into the peritoneal covering, about one-third of an inch apart, the stomach was brought and held well forward through the wound, and was stitched by a dozen fine silk sutures passed just into the muscular coat to the divided edges of the parietal peritoneum. The operation was conducted under the carbolic spray, and presented only this difficulty or trouble, that in putting in the last—happily the last—suture, a vessel was wounded, and bled so persistently as to necessitate plugging the wound with a sponge before applying the dressings. In the after history there were few points of special moment. On the evening of the 22nd, the

temperature rose to 100° F., but gradually sank thereafter to normal, and continued so until March 11th, with the exception of one day, Feb. 28th, when it rose to the same height in consequence of some slight parotid swelling from cold. The stomach was opened on the fifth day by a small incision with a tenotomy-knife, and great help in this second part of the operation was derived from the silk loops which had been left in the peritoneal coats. The opening in the stomach gave exit for two days to a profuse quantity of dark, greenish, sour fluid, but afterwards the escape of gastric juice was greatly lessened, although for a week the oozing was sufficient to cause a good deal of redness, swelling, and tenderness at the lower margin of the wound. This, however, was relieved by poulticing. He was fed by the fistula as soon as it was made, and from that time forward he was fed without the least difficulty, and usually, though not always, without any regurgitation. By March 2nd all feeding by enemata, and by Slinger's nutrient suppositories, which had been found of the greatest service, was stopped, and he was so well as to be able to sit up in bed. His hunger was satisfied, he felt stronger every day, felt better in fact than he had done for some time before the operation, and was obviously gaining flesh. The wound was contracting naturally, he had not vomited since the operation, there was no indigestion, and the motions were well formed. By no possibility could he have been doing better, and it was hoped that in a few days he would be out of bed. But on the evening of March 11th his temperature rose to 101° F. without more obvious cause than constipation. It became normal again both night and morning until the evening of March 14th, when it rose to 101° F. He had been somewhat depressed all day, and that night he began to feel sick. He felt sick for several hours, and early on the morning of the 15th he began to vomit. The efforts at vomiting, for he brought up but little, were very violent, and afterwards he had intense pain. The vomiting ceased at 10 A.M., but the pain increased and was limited almost entirely to the region of his stomach, and here also there was undoubted tenderness. From this time onward he rapidly failed, the pain increased, the temperature rose to 103° F., he passed into collapse and died on the afternoon of the 16th, thirty-six hours after he first began to feel sick, and after the temperature had begun to rise.

From the more extended post-mortem record of Mr. Silcock the following facts are taken:—"Eight and a half inches below the level of the cricoid cartilage was a hard white growth resembling scirrhus cancer, about the size of a chestnut, forming a ring around the œsophagus, and greatly constricting its lumen. The mucous membrane over it was eroded and ulcerated. The lymphatic glands adjacent thereto were enlarged. The edges of the gastrostomy wound, which had been made in the anterior wall of the stomach, appeared healthy; the peritoneal surfaces were in perfect coaptation, and the adhesions were firm and organised. About a pint of yellowish effusion, in consistence like melted butter, was found in the peritoneal cavity. No lymph was to be seen on the surface of the intestines, which were, however, greasy to the touch and injected, their coats being softened and easily lacerable. The only plastic deposits found were a few spots of lymph on the outer surface of the peritoneal coat of the spleen. A large quantity of gelatinous lymph was effused into the meshes of the subperitoneal tissues in the neighbourhood of the stomach, especially around the œsophagus as high as the diaphragm, beneath the posterior layer of the small omentum, around the left kidney, and between the layers of the transverse meso-colon. The walls of the stomach were a third of an inch thick, and of an opaque yellowish-white colour. This was most marked on the posterior surface in the neighbourhood of the greater curvature, where it was in part obviously due to an effusion of lymph beneath the peritoneal coat. The mucous membrane of the stomach appeared to be swollen, and was of an opaque yellowish-white colour, with here and there a few patches and streaks of injected venules. The surface was nowhere eroded or ulcerated, except at the margin of the wound, where it appeared to have undergone some slight digestion or softening. The thickening of the walls gradually shaded off towards the pyloric and cardiac ends, where it ceased almost abruptly. The coats of the first portion of the duodenum, however, were in some measure thickened. The cut surfaces of the stomach everywhere exuded a creamy purulent fluid, which seemed to flow from the submucous and muscular coats, to the swelling and infiltration of which the thickening was mainly due.

¹ Clinical Lectures on Diseases of the Nervous System, by Thomas Buzzard, M.D., p. 152. Churchill, 1882.

² THE LANCET, vol. i., 1882, p. 728.