man who was burned about six months ago. Three months after the burn I operated, and that really is the only case in which I have had a failure, the only case in which there has been marked contraction of the flap following the operation. I attribute that to the fact that I did not wait long enough. If I had waited six months longer, or a year, or two or three, the result would have been better. I usually take the flap from the inside of the left arm in right-handed people. But I have operated on a girl five times. I have restored the upper and lower lids, the area about the nostrils, and have operated also for contraction of the upper lip. I have taken two grafts from each arm and one from the inner surface of the thigh. I only operate on one lid at a time, because in these cases it is necessary to undermine the lid to pull it down and it more than covers the eyeball, whereas if you operate on both lids at one time one lid would overlap the other, which would be objectionable. I always apply a dry dressing first to absorb as much of the moisture, tears and blood as possible. The application of petrolatum, I believe, would prevent this absorption. After the first dressing petrolatum is an ideal dressing.

A CASE OF ACUTE GASTRIC ULCER OF THE ANTERIOR WALL

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Ulcers of the posterior wall and greater curvature of the stomach and duodenum in the region of the pylorus

Fig. 1.—Showing the patient and the location of the subjective pain, the point of tenderness on pressure and the plastic exudate. There was no referred pain or tenderness in the back.

are most common, while those of the anterior wall all the way to the fundic region are distinctly uncommon—

comprising, possibly, not more than 10 per cent. of the areas with which gastric juice comes in contact in the process of gastric digestion. Ulcers in the latter location are but rarely diagnosed medically, diagnosis usually taking place at operation for their perforation. a complication most likely to happen in these cases because of the unprotected anatomy of the anterior area of the stomach. The rapid peritonitis consequent to

Fig. 2.—X-ray plate of the patient, showing the ulcer, the large and prolapsed stomach and the hypermotility. U, ulcer; D, first part of the duodenum; P, pylorus; D.D., lower portion of the duodenum; and F, fundus with the stomach rugae below it.

perforation of these ulcers, also makes the diagnosis of them important, and a case is offered in which this was possible and in which the medical treatment was successful.

Patient.—Miss E. McD., a stenographer, 18 years old, was first seen on Feb. 28, 1911. Her father died at the age of 45; cause unknown. The patient's mother was living and well. The patient had always been fond of sweets (mostly candy) and had indulged intemperately for several years, which at times had brought on an acute distress in the stomach with a day or so of anorexia; other than this the patient had had no illness except measles and scarlet fever in early childhood. In December, 1910, she began to have a constant distress in the stomach, in which the symptoms of excessive gas collection with eructations and pain an hour after meals in the left side of the abdomen were the prominent features. This pain, which was most acute, was relieved to a moderate degree by the taking of food, more so by bicarbonate of soda, and was entirely relieved when the patient lay flat on her back with her corsets off. She stated that by taking milk, eggs and other simple foods in small quantities at a time with the assistance of bicarbonate of soda, she was able to be about at her work. The solid foods she ate evenings and Sundays when she could lie down for three or four hours after taking them. According to her statement, she had lost only 4 pounds since the beginning of her illness.

Physical Examination.—The patient's facial expression was that of intense suffering while sitting and changed to one of complete relief when lying. The lungs were normal, and the heart also, excepting a hemic blow over the body which was transmitted to the vessels of the neck. The skin and mucous membranes were abnormally pale. There was but slight development in the soft body tissues; the long chest and abdomen presented the type of a girl. On palpation the abdomen was held contracted, especially on the left side, and notably the left rectus muscle. An area of exquisite tenderness to pressure was evident about 2 inches above the transverse umbilical line and just at the edge of the rectus. Careful palpation of this area with the knees raised toward the thorax disclosed a mass, thin and soft to the touch, at the exact site of the tenderness, which I am led to believe was a plastic exudate on the gastric peritoneum over the ulcer. The stomach was low and dilated, and gases could be heard passing through the pylorus. The right kidney was palpable to within an inch of the upper pole under deep inspiration. The test-meal (simple) taken the next morning showed a return of 120 c.c., a free hydrochloric acid, 55; combined hydrochloric acid, 28, and a total acidity, 87. A small amount of macroscopic blood was present with one small clot. The feces voided the day before and two days afterward showed the presence of occult blood. Three x-ray plates were then taken. Each showed that the stomach had discharged the greater portion of the ounce of bismuth given into the small intestine (hypermotility), that the organ was large and low (dilatation and prolapse), and that the ulcer-bed was lined with bismuth. When the x-ray plates were held against the patient's body, and the ensiform and umbilical markers on the plates matched to these parts on her body, the location of the ulcer noted on the plate corresponded exactly to the point of tenderness and the plastic exudate.

Course of Disease.—The next morning when the patient went into the hospital, the blood showed erythrocytes 3,700,000, morphology normal, hemoglobin 67 per cent. (Dare), color index 0.6, leukocytes 8,290, and differential count normal. Kept steadily in bed for three weeks, she was fed by the Lenhartz method, the feedings of milk being given at stated times and amounts during the day and night. The administration of finely comminuted foods was begun late in the third week. The stomach was maintained alkaline by a mixture of alkaline powders, without soda bicarbonate, this being given at three-hour intervals. The bowels were moved each day by a castile soap enema (not saline, because this increases the hydrochloric acidity in the stomach). Liquor ferri albuminatis in 2 dram quantities in water t. i. d. was used to combat the anemia, and an ice-bag was employed during the first days to decrease the tenderness at the ulcer site, although this was hardly necessary as the patient was on her back all of the time. She made a perfect recovery, and when she left her bed there was no spasm of the left rectus, no tenderness on pressure over the ulcer site, and no plastic exudate. The blood had come up to 4,100,000 erythrocytes, 87 per cent. and color index 0.85. She was then fitted with a corset which raised the pyloric region over four inches; her feeding was increased to the taking of more solid foods, the alkaline powder kept up, the iron tonic diminished to half quantity each day, and Carlsbad salts used to move the bowels. She went into the hospital weighing 98 pounds, and now at the end of two months thereafter weighs 127 pounds, and is without a symptom of digestive distress. The x-ray plates of to-day do not show the ulcer; the stomach is smaller in capacity, hypermotility is no longer a feature, the test-meals are normal, and the feces free from blood.

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Legal Sentence of Optional Suicide.—In Nevada a condemned first-degree murderer may select one of several methods of self-poisoning in lieu of hanging. Among the poisons he is allowed to select for self-administration is hydrocyanic acid with the information conveyed with the death potion given him, that a drop of this drug put on the tongue will kill instantly.—*Alienist and Neurologist*.

FRACTURE OF THE CERVICAL SPINE*

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History.—H. M., aged 24, a Stanford student, very muscular and athletic, while performing in the gymnasium was tumbling over a horse 2 to 3 feet high. He had taken hold of the saddle, flexed his head and neck, and was in the act of going over when his hands slipped off the saddle. His feet being in the air he fell to the mat on the same side of the horse from which he started. He landed on the left side of the head, with the neck completely flexed and was picked up by the boys in the gymnasium and found to be completely paralyzed from the neck down. He was entirely conscious, and complained of some pain in the neck. He had difficult and asthmatic breathing and a weak pulse. Dr. Mosher, who was near at hand, had him placed on one of the stiff mats and with a student to hold his head in extension sent him to the Peninsula Hospital where I saw him on arrival. He was cyanotic and in a state of considerable shock, but had a normal pulse-rate and was given camphorated oil and strychnin with good effect. The pain in the neck was relieved to some extent by slight extension and pull on the head. This also improved the character of the breathing. If the pull was allowed to relax, the patient became more cyanosed and his breathing more asthmatic and some one had to hold his head in this position until we could get a head harness arranged and fitted to him. On first manipulating the head I obtained crepitus in the lower cervical region and a slight prominence could be felt on the right side of the midcervical region. This extension had to be kept up so long as the patient lived, except when he would ask to have it removed for short intervals. This change gave his neck a rest but he would soon ask to have weights reapplied. At first 15 to 20 pounds was necessary. Later 5 pounds was sufficient.

Examination.—At this time Drs. Josiah Kirk and H. B. Reynolds of Palo Alto saw the case with me. A few hours later Dr. Stanley Stillman and Dr. R. L. Wilbur of San Francisco were called and a complete examination disclosed:

1. Complete paralysis of all muscles below those supplied by the nerves from the fourth cervical segment. Patient could shrug his shoulders or move his head.
2. Complete loss of sensation in all its forms extending up to a line of demarcation extending across the chest $2\frac{1}{2}$ to 3 inches below the clavicle and running out over the upper part of the deltoid and around the back.
3. Loss of knee-jerk, ankle-clonus and cremasteric reflex. Plantar reflex normal. (The patient felt the tapping in the back of the neck when the patellar tendon was struck. This was not felt when tapped at any other point.)
4. Priapism partial. Increased by passage of catheter. Bladder and rectum paralyzed.
5. No profuse or abnormal sweating in paralyzed or other parts of body.
6. No areas of hyperesthesia or pain pointing to irritation.
7. Pupils contracted slightly but reacting to light and accommodation.
8. Temperature 97; pulse 71; respiration 32;
9. Respirations purely diaphragmatic and asthmatic. It is interesting to state here that the boy was a sufferer from asthma, and that the accident brought on an acute asthmatic attack.
10. No interference with swallowing and no hematoma in pharynx.

Dr. Kirk succeeded in getting an x-ray photograph of the neck taken from the side which showed a fracture of the fifth cervical vertebra and a dislocation between the fourth and fifth. Displacement was very slight. The plate also shows very prominent body of axis, which might lead one to believe that there was an anterior displacement of the vertebra.

At this time all those who saw the case, I believe, were agreed that there was no indication for operation but that in

* Read before the California Academy of Medicine, April 24, 1911.