That appears to be morally certain concerning the precocious hemorrhages of the Schnitzler type; the arterial ischemia alters the arterioles, which burst when the inflow of blood succeeds in removing the strangulation.

The occurrence of venous thrombosis does not rest on any practical observation, and is contrary to physiological facts generally conceded. The lesions found at autopsy upon which its occurrence is based do not exclude hemorrhage of arterial cause; they only reinforce it the more strongly.

LUKSCH reported 210 operations for strangulated hernia performed at the Clinique de Nicoladoni during six years, among which he found 2 hernial intestinal hemorrhages.

A Case of Myositis Ossificans.—JOSSEMAN and HORAND (*Revue d'orthopédie*, May 1, 1905, p. 235) report the case of a girl, aged seven and one-half years, who was well until May, 1904, when she contracted whooping-cough. At this time she had a violent fright and some days later fell on her forehead from a height, sustaining only a superficial wound in the right frontal region. This healed without incident. Three weeks later there was noticed a swelling of the back, which increased rapidly in size without pain, and without any other symptom than some disturbance of the general health, repeated epistaxis, and some degree of somnolence. The swelling of the back extended over the right side from the neck to the lumbar region and as far forward as the axillary region. The skin was adherent over it. In the upper part the swelling was diffused and poorly defined; on the contrary, below it was well defined and showed the character of a large bony plate, which seemed to be attached to the corresponding part of the pelvis. Some of the muscles are also involved.

The literature shows that, as in this case, the affection begins in the muscles of the neck, scapular region, and the back. It then extends to the superior extremities, and only later reaches the lower extremities.

Only the muscles of the glottis, the heart, and the tongue never become involved. The affection comes in successive attacks, with variable intervals. It appears to be always fatal in from ten to twelve years, either by pulmonary complications, rendered very grave by involvement of the respiratory muscles, or by the progressive extension of the lesion until the muscles of mastication are involved.

Berthier and Stempel have shown that the disease involves the connective tissue of the muscles, and that it is developed in three periods: first by embryonal infiltration, second by fibrous induration, and third by ossification of this tissue.

Surgical Treatment of Ulcers of the Stomach and of its Complications.—MOYNIHAN (*British Medical Journal*, April 8, 1905, p. 753) distinguishes between acute, subacute, and chronic ulcers. Acute perforation is sudden and complete, the stomach contents being free to escape at once into the peritoneal cavity. In the subacute form the ulcer gives way almost as quickly, but, owing to its small size, or the emptiness of the stomach, or to instant plugging of the opening by an omental graft, or to speedy formation of lymph, the escape of fluid is small in quantity and considerably less damage is done. Moynihan found that there was always a complaint of greater discomfort for several days preceding the

rupture. These premonitory symptoms are important, and may, if recognized, lead to prevention of the perforation.

In chronic perforation the ulcer eats slowly through the stomach wall, and a protective peritonitis has time to develop. Escape of stomach contents is local, leading to a barrier of lymph and a perigastric abscess. It occurs most frequently on the posterior wall of the stomach, and is thereby "subphrenic."

Operative experience shows that recovery from all these forms of perforation is possible, although the acute is probably almost invariably fatal. Recovery does not mean return to health, but the changing of an acute and desperate illness to a prolonged and painful invalidism, escape from which can only be effected by surgical means. Moynihan has treated 22 cases of perforation of ulcers of the stomach or duodenum, of which 14 recovered and 8 died. In all except 1, and in that no inquiry had been made, previous symptoms had been observed. In the majority of the patients there had been no increase in the severity of the symptoms during the few days preceding perforation. In 3 of the 22 cases a distinct and notable exacerbation is recorded.

The perforation was found on the anterior surface of the stomach in 13 cases, on the posterior surface in 2 cases. As a rule, it was near the lesser curvature and nearer the cardiac end. In 1 case two perforations were found, both on the anterior surface about one and a half inches apart. In 1 case the perforation occurred in the centre of an hour-glass stomach, and gastropasty had to be performed. In 7 duodenal cases the perforation was found in the first portion six times; in the beginning of the second portion once.

Hemorrhage may occur from an acute or a chronic ulcer. The characteristics of an acute gastric ulcer are spontaneity, abruptness of onset, the rapid loss of a large quantity of blood, the marked tendency to spontaneous cessation, the infrequency of repetition of the hemorrhages in anything but trivial quantity, and the transience of the resulting anemia.

The bleeding from a chronic ulcer may vary within the widest limits, both of frequency and quantity. He divided them into four groups:

1. The hemorrhage is latent or concealed, is always trivial, and often inconspicuous.

2. The hemorrhage is intermittent, but in moderate quantity, occurring spontaneously and with apparent caprice at infrequent intervals. The life of the patient is never in jeopardy from loss of blood, though anemia is a persisting symptom.

3. The hemorrhage occurs generally, but not always, after a warning exacerbation of chronic symptoms. It is rapidly repeated, is always abundant; its persistence and excess cause grave peril, and if unchecked, will be the determining cause of the patient's death.

4. The hemorrhage is instant, overwhelming, and lethal.

The one character that the hemorrhage should possess to warrant operation is recurrence. Operation is, therefore, very rarely necessary in acute ulceration.

In chronic ulceration two plans may be followed: The surgeon may search for the ulcer or ulcers and deal with them directly by excision, ligation, cauterization, or otherwise; by the second plan he deals with the hemorrhage indirectly by performing gastroenterostomy as speedily as possible. Wherever it is possible the former is desirable. The most

deliberate search, however, may fail to find it. It may be inaccessible, multiple ulcers may be present, or it may be impossible to locate any single point as the source of the hemorrhage, the whole surface seeming to weep with blood. Gastroenterostomy in all of Moynihan's cases led to instant cessation of the bleeding and to the speedy and complete healing of the ulcer.

Hour-glass stomach is far commoner than was at one time supposed, and its existence was formerly attributed to a congenital fault in development. Moynihan has shown that it is always acquired and the result of chronic ulceration. There may be great difficulty in dealing with this deformity, owing to the fact that there are two pouches in the stomach, both of which must be drained, and the fact that in a certain number of cases a constriction in the body of the stomach is associated with one at the pylorus.

THERAPEUTICS.

UNDER THE CHARGE OF

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The Chloride-free Diet in Dropsy.—DR. R. MASSALONGE and DR. G. ZAMBELLI believe that sodium chloride plays a considerable part in the origin of oedematous conditions, and as a logical consequence considers that in such disorders a chloride-free diet may be instituted with benefit. This conclusion is the result of observations upon patients suffering from nephritis, with oedema and ascites, from whom the chlorides were withheld, resulting in a diminution of the dropsy and of the albuminuria and the production of diuresis. In the oedema of cardiac conditions the institution of a chloride-free diet lessened the intensity of this symptom, regulated the heart's action, and seemed to act upon the organ as a tonic. In the ascites of cirrhosis of the liver this diet, in connection with the administration of theocin, caused a greater diminution of the fluid than even paracentesis. Likewise, in the ascites of tuberculous abdominal lesions, the treatment by diet and diuretics achieved good results. A febrile movement seems to contraindicate the prescription of a chloride-free diet, but to afebrile cases of pleuritic effusion the treatment should be applicable.—*Wiener klinisch-therapeutische Wochenschrift*, 1904, No. 50, p. 1336.

The Antipyretic Action of Antipyrin.—DR. ALFRED MARTINET believes this is due: 1. To a slowing of the process of nutrition, especially of the process of oxidation, which causes a diminution of the production of body heat. This interference with oxidation, in the minds