

was noticed that his abdomen was gradually swelling. During the whole of this period there was no pain attending either the jaundice or the swelling. Three weeks before admission he first felt pain in the epigastrium, and this had a distinct relation to the ingestion of food, following and remaining for about three hours after eating. The bowels have always been costive. No history of hepatic colic. Previously to the onset of the present illness he had always been a healthy man, except occasionally suffering from "bile in the stomach." Has always been temperate, only taking an occasional glass of beer to meals. No history of syphilis. Family history good.

On admission, the skin and ocular conjunctivæ were intensely yellow, and there was great discomfort from itchiness of the skin. Pulse regular and fairly strong, 64 per minute. Temperature normal. Abdomen ascitic, measuring at the level of the umbilicus thirty-two inches. Liver dulness in right mammary line five inches and a quarter. Palpation of the abdomen was impossible on account of the ascites. No pain or tenderness on pressing over the region of the liver. Heart sounds normal. No abnormal physical signs in chest. The stools clayey, almost white. Urine of a dark reddish-brown colour; sp. gr. 1020; of an acid reaction; no albumen, but giving a well-marked reaction with nitric acid for bile pigments. Calomel and colocynth were ordered as pills to be taken twice a day, and to have a low diet of milk and beef-tea.

Sept. 25th.—Feels better. Pain in epigastrium after food not nearly so frequent or well marked. Abdomen still tense, and the patient complains of considerable amount of flatus after food. Ascites increasing.

Oct. 3rd.—On account of the great increase of the ascitic fluid, which had begun to impede respiration, paracentesis abdominis was performed, about seven pints and a half of deeply stained fluid being withdrawn. On palpating the abdomen almost immediately after the withdrawal of the fluid, the thinned-out border of the left lobe of the liver could be easily felt, but the edge of the right lobe could not be detected beneath the costal margin. On deeply palpating the abdomen in the umbilical and lumbar regions a few indistinct nodular masses could be felt.

Oct. 4th.—Has been much relieved and feels much more comfortable since the tapping. Slept soundly during the night.

5th.—Vomited freely during the night, the vomit being of a darkish-brown colour, with a characteristic "coffee-grounds" appearance. Has also suffered greatly from hiccough, which comes on about ten minutes before the vomiting, after which it disappears. Does not complain of any pain or tenderness. Turpentine capsules were ordered by the mouth, and nutrient enemata every four hours.

6th. The vomiting still continues, preceded by the hiccough, which has become very distressing. Ergotine, hypodermically and as pills, had no effect. Ice was ordered to be constantly sucked, and ice-bags applied to the epigastrium, but without diminution in the vomiting. The vomit examined microscopically was found to be composed of mucus and broken-down and partially digested blood corpuscles, but no sarcine.

The patient gradually got weaker from the constant loss of blood and exhaustion from hiccough and vomiting. He died at 7 o'clock next morning.

At the necropsy, made twenty-eight hours after death, a considerable quantity of bile-stained fluid was found in the peritoneal cavity, and scattered freely over the surface of the parietal peritoneum and mesentery were a number of nodular growths about the size of horse-beans. The ascending colon was firmly adherent to the parietes, and underneath the upper part of the duodenum, pylorus, liver, right kidney, and head of the pancreas were all firmly matted together. The gall bladder, owing to this matted condition, could not be made out at all, but, on section of the whole mass, a cavity, which represented the gall bladder, was found, filled with twenty-six small irregular gall stones, varying in size from a lentil to a split pea. There was also contained in this cavity a considerable quantity of thick pale mucus. In the duct beyond was found a much larger gall stone, tightly impacted, and surrounding this a mass of new growth, binding down all the surrounding organs. The liver tissue was apparently healthy, but deeply discoloured, all the bile ducts being much dilated. Scattered throughout the substance of the liver were a number of small nodular growths, especially on its upper surface, and the diaphragmatic peritoneum was also freely studded

with similar growths. The kidneys were considerably disorganised, the cortex being much thickened, and the Malpighian pyramids contracted. The new growth had involved the fat at the back of the right kidney, which was adherent to the capsule. The body of the pancreas was healthy, but the head was involved in the growth. The stomach and duodenum were congested, but no ulceration or ruptured vessel could be discovered. The pylorus was very little, if at all, constricted although surrounded by the growth. Other organs healthy. Portions of the above growths were sectioned, and found, under the microscope, to be carcinoma of a scirrhus nature. The liver in the neighbourhood of the gall bladder was gradually becoming invaded, as also the capsule of the right kidney.

Remarks.—Primary carcinoma of the gall ducts and gall bladder is sometimes met with, but the point of interest in this case is the probable determining cause of the growth. The impaction of the large gall stone in the commencement of the common bile duct most likely in the first place set up a simple inflammatory process, which afterwards took on a cancerous action, rapidly growing and involving the neighbouring organs. Other points of interest are the absence during life of any symptoms of impaction, there being no hepatic colic, and the rapidity of the case to a fatal termination from the onset of the symptoms.

KASHMIR MISSION HOSPITAL.

ABDOMINAL CASES.

(Under the care of Mr. A. NEVE and Dr. E. F. NEVE.)

CASE 1. *Ovarian cyst; ovariectomy; recovery.*—R—, aged about thirty-five, with typical ovarian tumour physiognomy. The swelling was first observed ten months previously to admission. The abdomen was very large, measuring thirty-eight inches in circumference, and was entirely filled by a regular, fluctuating tumour, not movable. Diagnosis: a cyst, chiefly unilocular, of left ovary.

Operation.—Chloroform having been administered, a four-inch incision was made, the omental adhesions were separated and ligatured, and the cyst was tapped. No more adhesions being found, the tumour was drawn out. The pedicle, which was long and not thick, was ligatured after transfexion, and each half tied, with one encircling knot added. The abdomen was then irrigated with warm water which had been previously boiled. A little oozing took place apparently from the omentum. The pelvis was sponged till dry, a glass drainage tube inserted, and stitched with silk in the usual manner. Examination of the tumour showed it to be a multilocular cyst with very varied contents. The evening temperature was 101.3°; after this convalescence was afebrile.

The discharge was for two days blood stained; on the third day it was clear, and only a teaspoonful in amount. On the fourth evening the tube was removed. The first dressing was on the seventh day, when the wound was found healed and the stitches were removed. For several days there were a few drops of discharge from the sinus left after the removal of the drainage tube. At the end of the third week she sat up, and was out. She went home on the twenty-sixth day, looking years younger than before the operation.

Remarks by Mr. A. NEVE.—The preparations for the operation were those of strict Listerism, the operation itself being aseptic rather than antiseptic. The drainage tube did no harm, and may have been useful. I was much indebted to Miss L. Butler, who superintended the nursing, and assisted in the operation.

CASE 2. *Suppurating ovarian cyst; tapping; injection; cure.*—The patient, a well-to-do woman, had a tumour filling the left side of the pelvis, projecting to the level of the umbilicus. It was noticed three months previously; latterly it had been painful, and she was getting weak. Diagnosis: probably an ovarian cyst.

Treatment.—An exploratory incision or any attempt to excise was refused by the friends. On aspirating, some very fetid pus was withdrawn, but the tumour was only reduced by one-half. At intervals of a fortnight four aspirations were performed; after each it rapidly refilled. A small incision was made, and the peritoneal surface at the seat of the punctures exposed and allowed to granulate for a week; the cyst was again aspirated and one drachm of pure carbolic iodine injected. There was pain for a few days. The tumour then began to diminish, and the patient six months later was quite well.