

peristaltic action to be seen; no swelling to be detected anywhere over stomach or duodenal area; gurgling constantly audible with a stethoscope. Liver not enlarged. The vomited matters are acid in reaction, and, on standing, separate into a superficial, floating, frothy portion, which contains sarcinæ and torulæ under the microscope, but no blood, and a lower greyer portion of semi-digested chyme. The other organs are perfectly healthy. Urine normal in colour; acid reaction; no albumen; no sugar; no excess of indican; sp. gr. 1019. The patient weighs 142½ lb.

On July 19th the patient was sent into a private hospital, and was seen by Drs. Gardner, Giles, and Todd, and Professor Watson. On the 21st the stomach was washed out, and he was given an ounce of senna mixture every four hours and a soap enema at night. On the 22nd the stomach was washed out at 7 A.M., no food being allowed by mouth. An ounce of brandy in warm water was injected into the bowel at 8.30 A.M. An operation was performed at 9 A.M., Professor Watson, Drs. Gardner, Giles, Todd, and Swift being present, Dr. Todd giving ether, Dr. Giles helping me, with the assistance of Drs. Gardner and Swift, to all of whom I have to offer my best thanks, especially to Dr. Gardner, who gave me most valuable advice all through from his great practical experience, both in gastric and abdominal surgery in general.

Operation.—The abdomen having undergone the usual clearing and washing with carbolic lotion, an incision five inches long, extending from one inch below and to the left of the xiphoid cartilage to an inch below the cartilage of the ninth rib, was made, dividing the left rectus abdominis. All vessels having been ligatured, the peritoneum was opened, when the transverse colon with the mesentery presented. This was kept out of the way with a sponge, and the stomach brought up into the wound. This appeared very vascular, and of a bluish-red colour. Sponges having been placed around, an incision about two inches in length and in the long axis of the stomach was made with scissors, beginning one inch from the pylorus. The finger was inserted, and passed quite readily through the pylorus and down the duodenum for some distance without feeling any evident stricture, and the largest size Macnaughton Jones's dilator readily slipped to the left of the spine without meeting any resistance. The pylorus was dilated so as to admit two fingers without much trouble or resistance. The walls of the stomach were thickened and very vascular, and the surface of the nervous membrane studded with small granular-looking bodies. The mucous membrane was sewn up with a continuous silk suture, and then thirty Gussenbauer's sutures of fine silk inserted into the wound of the stomach, which, when tied, brought the serous surface well together, with an extra plain suture at either end. The peritoneal cavity was washed out with a warm boracic solution, and the abdominal wound treated in the ordinary way. The wound was dressed with iodoform and salicylic wool. The operation lasted an hour and twenty minutes. There was very little shock. The patient vomited twice after the ether, bringing up two ounces of bloody, frothy slime.

From this time the patient made an uninterrupted recovery, having nothing by the mouth but ice to suck, and being fed by nutrient enemata every four hours from the operation till the fifth day (July 27th), when he was allowed some jelly by the mouth, which caused no ill effects. Next day (July 28th) he had some bread-and-milk. On Aug. 1st (the ninth day from the operation) he was allowed fish, an egg, and bread-and-butter, with no ill results. On the 4th all stitches were taken out. He got up on the 5th (fourteen days from the operation), and had a chop for dinner, without any inconvenience. His weight on Aug. 12th was 140 lb., being a loss of 2½ lb. since the operation. He was able to take ordinary full diet. There was no pain, but sometimes a little flatulence. The bowels acted every day with the help of cascara jujubes. After this he left for the country.

On Sept. 18th the patient returned to town. He looked and felt exceedingly well and strong. Was able to eat anything except pork, pastry, and cheese. Now and then he suffered from flatulence. He had never been sick since the ether vomiting. His weight was 154½ lb., a gain of 14½ lb. in thirty-nine days. On Oct. 19th the patient came complaining of a little weakness at the cicatrix; otherwise he continued to eat well, and had no pain to speak of, no flatulence, and no nausea or vomiting. He was following his usual employment as a railway permanent-way man. He was weighing 158½ lb., a gain of 18½ lb. since Aug. 5th.

From the history and the symptoms this patient presented, I feel pretty sure that it was a case of cicatricial contraction of the pylorus, and in this view the medical men who saw the case with me concurred, and strongly recommended Loreta's operation, which I had commenced to do when I came upon a fairly patent pylorus, which certainly ought to have allowed all ordinary food to pass through it, and only shows how easy it is to go astray in a diagnosis. The late Professor Loreta points out that the diagnosis has to be made between cancer, fibrous stricture, and idiopathic gastritis. Cancer could be excluded in my case by the nineteen years' history and the absence of any tumour. The difficulty was between stricture and idiopathic gastritis, and Loreta gives rules as to deciding which of the two is present. He says that if the vomited matters be carefully examined in stricture, the lower layers will consist of acid chyme well digested, as it did in my case, whereas in gastritis it is undigested food and little chyme, and in the former case a longing for food, in the latter a loathing. Everything seemed to point to a stricture, but this could not be when the finger so easily slipped through the pylorus; and the peculiar granular appearance of the inside of the stomach pointed more to idiopathic gastritis. The question is, How did the operation cure the patient? as it certainly seems to have done. The only way I can see of explaining it is that the incision acted as a strong counter-irritant to the walls of the stomach, which evidently from their appearance were suffering from a chronic gastritis, and, together with the rest the stomach had for five days when nothing was given by the mouth, brought about a healthier condition of the mucous membrane, and so allowed the food to digest properly. I think giving solid food early and pushing it, instead of giving slops, goes a long way towards improving the stomach. Another reason for such marked improvement is that a sort of spasmodic contraction occurred at the pylorus similar to what we know occurs at the anus, and which was cured by the stretching.

Adelaide, South Australia.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON THE VALUE OF THE INJECTION TEST IN DOUBTFUL CASES OF RUPTURED BLADDER.

By W. J. WALSHAM, F.R.C.S.,

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THE value of this test was well illustrated by a case recently under my care at the Metropolitan Hospital. The patient, an elderly woman, had been knocked down and run over by a van, one of the wheels passing over the lower part of her abdomen. On admission she was found to have a fracture of the pelvis, involving the sacro-iliac joint, with considerable separation of the pubic symphysis. She was quite unconscious and in an extremely collapsed condition. The skin was cold and clammy, the pulse small and weak, and the respiration feeble and sighing. When I saw her shortly after her admission, she was still deeply collapsed, but had slightly recovered consciousness and complained of great pain in the lower part of her abdomen. It was doubtful how much urine she had in her bladder at the time of the accident, since, having only partially regained consciousness, she could not answer this question satisfactorily. I passed a silver male catheter, but only a small quantity of blood-stained fluid escaped, and on depressing the handle the points seemed to be felt more easily than normal by the hand above the pubes. The history of the accident, the collapsed condition of the patient, the fracture of the pelvis, the separation of the pubic symphysis, the pain in the hypogastrium, the escape of only a small quantity of bloody fluid on the passage of the catheter, and the apparent abnormal projection of the point of the catheter above the pubes when the handle was depressed, led me to suspect a rupture of the bladder. Seeing the importance of early

recognising this injury if treatment by suture of the ruptured viscus is to have a fair chance of success, I determined to explore the bladder by an incision above the pubes. Before doing so, however, I thought it as well to try the injection test. I therefore forcibly injected a measured quantity of water into the bladder through a full-sized catheter tightly fitting the urethra, and then after a few minutes drew it off, taking care to prevent any loss. The same amount, within a drachm or so, as that injected was returned. In the face of this test, therefore, I resolved to wait a few hours before undertaking any active measures. Suffice it to say that in the course of the evening the patient passed urine naturally. After this she had no further bladder trouble, and made an uninterrupted recovery.

Weymouth-street, W.

A CASE OF SCARLET FEVER, MEASLES, AND DIPHThERIA RUNNING TOGETHER IN THE SAME INDIVIDUAL.

BY CHARLES H. TAYLOR, M.B. LOND.,

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E. W—, aged four years and a half, was admitted into the Derbyshire General Infirmary under Dr. Greaves on March 29th, 1890, suffering from scarlet fever. She had a typical rash, with sore throat and tongue. Temperature 103° 2'. The fever ran an ordinary course, and on April 9th she was peeling generally, the throat being still somewhat swollen, and the glands of the neck enlarged. On April 10th, twelve days after admission, the child began to sicken again, and complained of headache; the temperature began to rise, and there was marked coryza. On the 11th she had a rigor (temperature 105° 4'), and the following morning presented a well-marked measly eruption over the face, neck, and wrists.—April 13th: Rash disappearing; temperature falling; child seems better; throat still inflamed.—14th: Temperature 104°; patches of membrane seen on both tonsils.—15th: Membrane on soft palate, removal of which causes bleeding; much difficulty in deglutition, and also in respiration; symptoms of laryngitis appearing.—17th: Respiration still difficult; quantity of muco-purulent discharge from nose; throat less inflamed.—23rd: Child seems better; takes nourishment well; tongue cleaner; ulcers on tonsils, but no membrane to be seen; respiration much easier; pulse fairly good.—24th: Has had two slight attacks of syncope while sitting up to be fed; seems unable to swallow in the recumbent position.—25th: The child, after awaking from a short sleep, was rather restless, had another fainting attack, and died.

Remarks.—When the membrane first appeared on the tonsils we were doubtful as to its nature, and inclined to look upon it as merely an aphthous condition arising in the course of a specific fever; but from the way in which it spread to the larynx and nasal cavities, and the subsequent development of the general symptoms, we were induced to look upon it as a case of diphtheria, and to treat it accordingly. It is not uncommon for measles to supervene during an attack of scarlet fever, or for diphtheria to attack a patient suffering from either measles or scarlet fever, but the occurrence of the three together is, I think, of such rarity as to be worthy of recording.

Derby.

CASE OF HYOIDEAN DISLOCATION IN PULMONARY PHthisIS.

BY HENRY S. WOOD, M.B., C.M.

I THINK the following case (which was under the care of Mr. M. W. Roe), owing to its rarity, is worthy of record.

A hurried message was sent to say "that the patient, H. L—, had displaced a bone in his neck, and that he was choking." On arriving, the patient, aged about twenty-seven, was sitting up in bed with his arms crossed over the upper part of the thorax, one hand grasping the upper portion of his neck as if to steady the hyoid bone, and the other steadying the larynx. His face was much emaciated, and wore an aspect of distress; there was slight cyanosis; but the symptom most complained of was a feeling of impending suffocation. The head was thrown slightly forwards on the chest in order to relax the muscles. The patient at first

could not be persuaded to let go his hold on the neck, but after a little while he did so, and then we saw clearly the exact state of affairs. There was a certain degree of prominence on the left side of the neck, in the region of the submaxillary triangle; on feeling for the hyoid body, it was found to have deviated from the mesial plane of the neck. On running the finger along the greater cornu, the tip of the horn was found to be displaced upwards and to the left, so as to be on a level with the angle of the inferior maxilla. It was evidently a dislocated hyoid. No crepitus could be detected. Reduction was effected by making the patient swallow; and while fixing the thyroid cartilage with one hand, the bone was pushed in the opposite direction to the displacement, and went in with a perceptible click and a slip, much to the patient's relief, the dyspnoea improving directly. The bone was kept in position by means of two pads, one on each side of the body of the hyoid, and a bandage round the neck. The bone has since been dislocated in a slight degree, but reduction was effected in the same way. According to the patient's statement, the bone was displaced during a violent paroxysm of coughing, with the head bent laterally to the right side. Physical examination revealed extensive tubercular disease of both lungs, an empyema on the right side, and extensive disease of the larynx, epiglottis, and neighbouring parts; the voice was very feeble, and almost reduced to a whisper. On referring to the subject in Holmes' "System of Surgery," I find a case of Dr. Gibbs quoted; and in the above case the only cause which appears feasible to my mind is that, owing to the degenerative and ulcerative changes in the neighbourhood of the hyoid bone and laryngeal cartilages, the ligaments must have been relaxed, or may have undergone a certain degree of softening; at the same time the muscles arising in and inserted into the hyoid must have lost their normal tone, partaking in the general debility, and so predisposing to the dislocation, which was actually brought about by a paroxysm of coughing. The method of reduction is somewhat different from that described in Holmes' "System of Surgery," but, owing to the urgency of the case, there was no opportunity left to inquire as to the exact method of reduction.

Wincanton.

ICE IN STRANGULATED HERNIA.

BY J. HOWARD WILKINSON, L.R.C.P. LOND., M.R.C.S.

A CASE which, I think, well illustrates the occasional value of ice in strangulated hernia occurred recently in the West Bromwich District Hospital.

T. F—, a labourer, aged thirty-five, came to the hospital on July 15th at 8.30 P.M., and was admitted under the care of Mr. Langley Browne. The history he gave was that while at work that morning, at about 10.30 A.M., he had a sharp pain in the groin, and "felt something slip." He then found that there was a lump in the right groin, and went home and remained in bed. He was sick about five times during the day, and was seen by a medical man in the evening, who ordered him to go at once to the hospital. On admission there was found a rounded swelling the size of a tangerine orange occupying the right groin, immediately over the situation of the external abdominal ring, which was tender on pressure, quite devoid of impulse, and irreducible. He immediately vomited on taking anything by the mouth, and had passed no flatus since the accident occurred. The patient was at once placed in a warm bath and reduction attempted while he was in the bath. This failing, he was put to bed, and the parts were shaved ready for an operation. However, as the symptoms were not very urgent, he was given one grain of opium, and an icebag was applied to the groin. He vomited four times during the night. At 10.30 A.M. on the following morning the taxis was again tried, with the result that the hernia was easily reduced.

Now Mr. Heath, in his letter to THE LANCET of July 6th, says that he deprecates the application of ice to a *bond fide* strangulated hernia. This, however, appears to me to have been certainly a strangulated hernia. It was irreducible, there was obstruction to the passage of faeces along the bowel, and there must have been obstruction to the circulation of blood in the wall of the bowel, as it was so tightly nipped that there was no impulse whatever on coughing. I think this case shows that the use of ice in an early case of true strangulated hernia is good treatment, and should generally be tried before submitting the patient to operation;