later in other intestinal parasitic infections. Eosinophiles rapidly disintegrate in the bowel, and although they may be missed in the stools there is often an increased number in the blood. This occurrence of eosinophilia with intestinal parasites is so striking that Lichtenstira has considered them pathognomonic. But later authors have found them to occur in other conditions. Neuhauer and Stäubli report cases of acute diarrhœa with marked constitutional symptoms, finding in the stools of the first Charcot-Leyden crystals, and in the second, eosinophiles. During the height of the attack the eosinophile cells had completely disappeared from the blood, returning with abatement of the symptoms. Analogously, the absence of eosinophiles in the blood has been noted in the acute stage of bronchial asthma, and it has been suggested that the supply is drained by the sudden local demand. Doek has shown that eosinophiles may be present in the stools of patients with amœbic dysentery. In the third case reported by the author, one of acute dysentery, they were likewise found, although amœbæ were absent and no typical dysentery bacilli could be cultivated. In the last three cases reported an interesting affection of the lower bowel is considered, which the authors believe is distinctive enough to be classed as a separate clinical entity. All are remarkably similar, occurring in young adults with symptoms of severe diarrhœa and discharges of blood and mucus. Charcot-Leyden crystals were found in the stools of all and numerous well-preserved eosinophile cells in two. Intestinal parasites as well as specific bacteria (dysentery bacilli, tubercle bacilli, gonococci) were absent. The rectal examination through the proctoscope showed an intensely red, loose, mucous membrane with numerous small, yellowish-white areas of exudate which could be easily scraped off and under the microscope were seen to be made up of eosinophile cells and granules and Charcot-Leyden crystals. After scraping off the exudate a deeply injected bleeding erosion remained. There were no ulcers and no cicatrices. Two of the cases showed a distinct increase of the eosinophiles in the blood. Heiber, in 1905, described a disease similar to this as sigmoiditis chronica granulosa, but as he says nothing about eosinophiles, the two conditions cannot be definitely identified as the same.

SURGERY.

UNDER THE CHARGE OF

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A Contribution to the Study and the Treatment of Impassable Non-cancerous Strictures of the Œsophagus.—Gross and Sencert (*Revue de chir.*, 1907, xxvii, 1) say that when one has failed, after repeated

and careful attempts, to pass through a stricture from above downward, an examination by the œsophagoscope is necessary. Often the stricture will thus be rendered passable, by exposing its upper orifice to the view of the surgeon. Only exceptionally will this method fail. Eccentricity of this orifice is the chief obstacle to blind catheterization. Once the dilatation has been begun it can be carried out without the aid of the œsophagoscope. When a very old and resisting stricture cannot be overcome by progressive dilatation, a metal instrument of the same caliber as the fine dilating bougie should be passed. A thread is tied to its upper end and brought out of the mouth. The instrument is left in place with little or no disturbance to the patient, and is withdrawn by simple traction after twenty-four hours. Ordinary dilatation may then be carried on, or a metal instrument of larger caliber may be introduced by the aid of the œsophagoscope, or this may be continued with instruments of larger caliber until the normal caliber of the œsophagus is obtained.

If the examination by the œsophagoscope reveals a diverticulum or prestrictural pouch, with more or less inflamed and fragile mucosa, threatening postoperative dangers, the method of treating the stricture should be changed. Two varieties of cases present themselves: those in which a gastrotomy has already been performed, and those in which it has not. If a fistula exists, retrograde catheterization may be tried, and if one has the good fortune to pass the cardiac end of the œsophagus, he can practise dilatation immediately, without recourse to the method of von Hacker. Unfortunately this will often be impossible.

When there is no gastric fistula, Delagénière has employed a large gastrotomy in order to pass the cardia and the stricture with a sound. Dilatation by von Hacker's method is then carried out. Gross and Sencert say that this operation exposes the patient to considerable danger from peritonitis and to the possibility of failure to pass the stricture with the dilating instrument. A permanent gastric fistula is then the only salvation of the patient. In such cases the authors propose an operation which they have studied on the cadaver. A median laparotomy above the umbilicus is performed; the stomach is exposed and seized at a point on the anterior surface, about 2 cm. below the cardia. A purse-string suture passed through the external coats of the stomach without going through the mucosa is made to circumscribe here an area 1.5 cm. by 2 cm. in diameter, the ends of the suture being left untied. An opening is made in this area into the stomach and an œsophagoscope introduced, when the purse-string suture is tightened about the tube, preventing the soiling of the peritoneum with stomach contents. The tube being cleansed, the cardia is sought and with care the lower end of the stricture is found. Simple retrograde dilatation is then carried out with the aid of the œsophagoscope. The Gross and Sencert feel certain that this method of retrograde catheterization is a better means of finding the lower end of the stricture than the large gastrotomy of Delagénière. If all these methods fail, then the major operations—external œsophagotomy, œsophagectomy, œsophagogastrotomy—may be considered, but only after repeated failure by all the preceding methods.