showing signs of returning consciousness. Hot-water bottles were then applied all round his body and he was covered with blankets. I ordered him a mixture of ammonia with digitalis and at 2.30 P.M. I left him apparently comfortable. At 4 P.M. I again visited him and found a different state of things. He then presented all the symptoms of a man suffering from hydrophobia. Frequent violent spasms recurred about every five minutes and were preceded by most painful symptoms of fear. The patient foamed from the closed mouth. The trismus was continuous all through, even during the intervals between the spasms. He thumped his sides and body violently with his hands. The sight of water or sound of it was the cause of instant spasms. Also blowing over him had the same effect. I now inquired if he had any wound or cut about him. "Oh, no, sir," said his friend, "only he has a small bite on the calf of the left leg which he received about eight days since from his own dog." This made me fear a regular attack of rabies. He continued to get worse at every attack and it required three strong men to hold him in bed. Opisthotonos was now manifest and he had seminal emissions. He could take nothing by the mouth and his case seemed to me to be very hopeless unless I could control the terrible fits. Accordingly I ordered an enema containing six grammes (one and a half drachms) of chloral hydrate with six grammes of bromide of potassium in infusion of valerian to be administered and to be repeated every hour until the patient became easy. Suffice it to say that the first enema sent him to sleep at 7 P.M. and he slept until seven o'clock the next morning, and when he awoke he demanded his coffee and was quite himself. Since then he has remained quite well. The dog has shown no signs of rabies.

I do not consider that this man was poisoned with rabies, but his symptoms exactly resembled those of that disease. I have very lately had two fatal cases of rabies under my care and the symptoms in all three cases were exactly similar. Convulsions and spasms I have often seen after carbonic oxide poisoning, but not those dreadful fits accompanied with the fear of water and wind. The trismus in this case was the first symptom and it was continuous during the whole time of his attack. This sign has been especially noticed by some writers as occurring in coal-gas poisoning.

Constanta, Roumania.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

KING'S COLLEGE HOSPITAL.

A CASE OF HOUR-GLASS CONTRACTION OF THE STOMACH; OPERATION; RECOVERY.

(Under the care of Mr. WATSON CHEYNE.)

WE must congratulate Dr. Burney Yeo and Mr. Watson Cheyne on the accuracy with which they diagnosed the hour-glass condition of the stomach. It is not very unusual to met with it at a necropsy,[1] but it is certainly rarely that it can be diagnosed clinically. We agree with Mr. Cheyne that the Heineke-Mikulicz operation which he performed was without doubt the most suitable under the circumstances. As more than three and a half months have elapsed since the operation the hope that the patient is permanently relieved seems fully justified.

A married woman, aged forty-six years, was admitted to King's College Hospital on Nov. 8th, 1897. The family history was unimportant. In December, 1881, the patient began to suffer with great pain in the hypochondriac region and in the right shoulder and, in fact, with all the symptoms of ulcer of the stomach with the exception that she had at that time no hæmorrhage. She was treated for this condition by diet and in various other ways and had suffered from symptoms off and on since that time. Sometimes she would be pretty well for some months and then without any apparent cause the whole trouble would return again with all the characteristic symptoms. She had been abroad and consulted medical men in various countries. Lately the symptoms had been those of obstruction rather than ulceration and the diagnosis of pyloric obstruction had been made by several physicians. The patient was very considerably emaciated and was in a feeble state of health. She did not so much complain of pain in the hypochondriac region as of what she termed "an uncomfortable feeling," a feeling of distension and flatulence, and frequent vomiting. She did not vomit every day (the vomiting occurred about every second or third day), nor did she bring up anything like the whole quantity which she took. She had of late been living entirely on fluid diet and only a portion of the fluid taken was brought back again after one or two days. The amount that she would bring back after a couple of days was from 16 oz. to 30 oz; the longest time that she had gone lately without vomiting was three days. Her weight on admission was 7 st. 4½ lb. On examination the stomach was not very markedly dilated and the dilatation was not uniform; it seemed to be specially marked about the cardiac end and to a less extent towards the pyloric end, but there was not the greatly distended stomach which is usual in cases of pyloric obstruction. On listening with a stethoscope over the middle of the stomach region a gurgling could be heard from time to time as if fluid were running through a narrow orifice and Dr. Burney Yeo, who saw the patient in consultation, stated that in his opinion the case was one of hour-glass contraction of the stomach, resulting no doubt from an old ulcer. On Dec. 1st a vertical incision was made over the stomach, in the middle line about four inches in length, and when the peritoneal cavity was opened the stomach was drawn out of the wound; it was then found, as had been expected, that just about the centre of the stomach there was an hour-glass contraction. The stomach, especially towards the cardiac end, was very considerably dilated and there was also some dilatation towards the pyloric end. The contraction was very marked and when it was laid open it was found that the communication between the two portions of the stomach was extremely small; as a matter of fact, a crow quill could hardly have passed through. There was a good deal of scarring and cicatricial tissue in the neighbourhood and at the actual point of the contraction there was no mucous membrane at all. An incision was made through this contracted portion in the line of the stomach so that the ring of cicatricial tissue was divided transversely; this incision was extended into the healthy parts of the stomach for about one and a half inches on each side, and then the angles of the incision were brought together and the rest of the part was sewn up—first with a few stitches which went through the whole coats of the stomach and then with a row of Lembert's sutures; in fact, the operation performed was identical with that employed in cases of contracted pylorus under the name of pyloroplasty. After the operation was concluded an opening was left between the two portions of the stomach which could readily take a couple of fingers. The wound was then stitched up and the patient was put back to bed; she was not very collapsed after the operation. The wound healed by first intention and the patient went on very well. There was no sickness after the chloroform, she took food by the mouth, milk and beef-tea, &c., but for several days the chief feeding was rectal. On the fifth day she was fed entirely by the mouth; no sickness occurred until twenty-eight days after the operation, when she had one attack of vomiting apparently associated with eating an orange. As regards her diet, after about a fortnight she was allowed to have solid food. On Dec. 14th, for example, her dinner consisted of fish and bread, her tea of a cup of tea and bread and butter; on the following day she had fish; on the 17th she had chicken, and so on. The patient was discharged on Jan. 7th, having gained 8 lb. since her admission, and she stated that she felt better than she had felt for many years; this improvement still continues; she has been sick once since she left the hospital and that also she attributed to an error in diet. She is still somewhat troubled with flatulence, but beyond that her condition is practically normal. She still continues to gain weight.

Remarks by Mr. WATSON CHEYNE.—The interest of the case lies first in the diagnosis—viz., that instead of being a pyloric obstruction as had been supposed by other physicians

[1] La Médicine Moderne, Jan. 16t , 1895.

it turned out to be a typical hour-glass contraction of the stomach. The diagnosis chiefly depended on the absence of the marked dilatation of the stomach which would occur in pyloric constriction and in the bubbling of the fluid through a narrow orifice which was heard, not in the situation of the pylorus, but about the centre of the stomach. The further point of interest is in the treatment. One was very much tempted to excise the contracted portion of the stomach altogether and to stitch the walls together on each side and no doubt that would have been followed by complete recovery without any risk of recurrence of the contraction, for of course it must be admitted that there may possibly be an increased contraction still and some recurrence of the symptoms, but the patient was in an extremely feeble condition and it did not seem justifiable to subject her to the prolonged operation which would have been involved in this procedure, nor was I quite sure that the circulation in the stomach after complete bisection would have been quite satisfactory. On the other hand, the operation performed answered all expectations and the fact that the symptoms have now been absent for several months and that she is able to take solid food without any trouble leads me to hope that the result will be a permanent success.

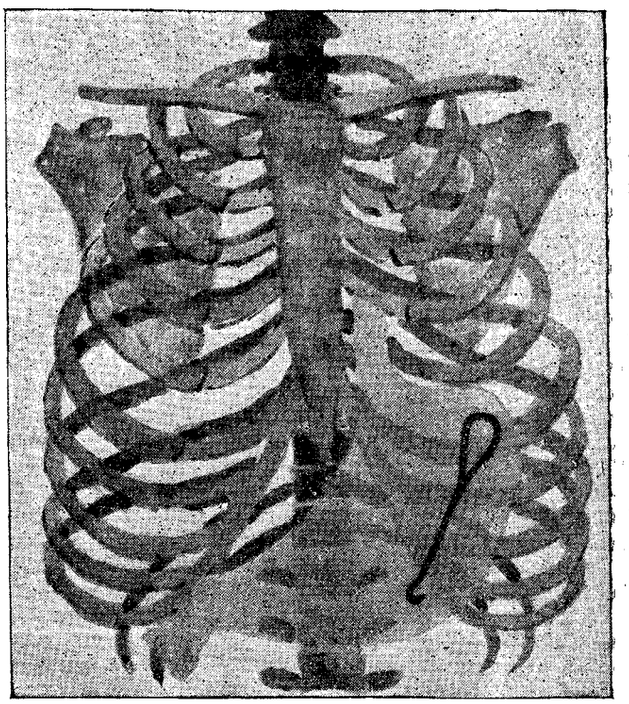
KENSINGTON INFIRMARY.

A CASE OF GASTROTOMY FOR REMOVAL OF A FOREIGN BODY.

(Under the care of Dr. H. PERCY POTTER.)

THE necessity for gastrotomy for the removal of a foreign body from the stomach can only arise in cases in which the body is unable or unlikely to pass through the pylorus. Probably the most frequent foreign body is a coin and in the majority of instances it has no difficulty in leaving the stomach; but in the case of a long thin body the chance of getting through the pylorus is very small and the object is either retained indefinitely in the stomach or finds its way, after causing ulceration, through the walls of the stomach, as in a case we have recorded lately which was under the care of Mr. Morgan at Charing-cross Hospital.[1] In the case of such a body it is very necessary that an operation should be performed as early as possible. In all these cases, however, the evidence of the presence of the foreign body is not very satisfactory and until the introduction of the Roentgen rays no method existed by which the surgeon could assure himself that a foreign body was really present, so that he often hesitated to operate when an operation was very desirable.

A well-nourished woman, aged thirty years, was admitted to the Kensington Infirmary on Jan. 13th stating that she had intentionally forced a button-hook about four inches long down her throat. She was quiet and reserved and gave every detail of the act in a rational manner, so her statement was believed. The hook could neither be seen nor felt. A bougie was without difficulty passed into the stomach. She was kept under observation till 8 P.M. and then taken to Dr. Low, who produced by the Roentgen rays three unmistakeable negatives of the foreign body *in situ*. It lay in the epigastrium on the left of the middle line, the hook portion pointing downwards and inwards about an inch outside the first lumbar vertebra. On the morning of the 14th a median vertical incision three and a half inches long was made between the xiphoid cartilage and umbilicus, opening the peritoneal cavity. Upon introducing two fingers to the left the loop of the button-hook was found deeply situated; the hook portion was manipulated towards the plane of the abdominal incision, steadied between the thumb and finger, cut down upon, and removed.[2] The mucous membrane was united by a continuous silk suture, the mucous and serous coats by Lembert's suture, and the parietal incision by interrupted silk and silkworm-gut stitches. The wound was then dressed with blue gauze steeped in perchloride and was covered with a many-tailed (or domett) bandage. The operation was practically bloodless and no sponges were introduced into the abdomen. An hour after the operation the patient vomited blood-stained fluid; in the afternoon, during the intervals of sleep, she complained of pain which was relieved by an injection of morphia. A nutrient enema of peptonised milk was given in the evening and repeated every four hours. Ten drops of laudanum in hot water were given by the mouth at 9 P.M. On the 16th the wound was dressed; the epigastrium was slightly distended; there was no pain. A lemon was sucked to allay thirst. Two teaspoonfuls of peptonised milk were taken every hour; this quantity was gradually increased till the 24th when the



patient had an egg with bread and butter and enjoyed some "beef-cacao." On the 25th the sutures were removed and she was allowed fish on the 27th. The wound was completely healed on the 29th and the patient got up on Feb. 4th convalescent. There was absence of fever and complication of any kind throughout the case.

Remarks by Dr. POTTER.—The operation of gastrotomy has frequently been performed for the removal of a foreign body from the stomach and provided these cases are taken in hand early the results are favourable. It must be difficult in most cases to determine with accuracy by external manipulation the site or even the presence of a foreign body which has been swallowed, but by the use of the Roentgen rays there is a new light thrown upon these cases and a decisive verdict given in respect of the necessity for an operation. The difficulty of obtaining good photographic results consists in the thickness of the abdominal walls and contents and the movements of respiration and likewise of the stomach itself. The accompanying illustration is reproduced from a drawing of the skiagram, which is somewhat indistinct and blurred; but sufficiently definite to determine the presence of something which ought not to be there. My thanks are due to Mr. Osborn and Mr. Lloyd for their valuable assistance.

[1] THE LANCET, Feb. 5th, 1898, p. 385.

[2] The button-hook was of the cheap steel variety, shaped out of a piece of soft steel wire, and measured four and a half inches in length and one inch in breadth at the loop.

THE PRINCE OF WALES'S HOSPITAL FUND FOR LONDON.—We have received a copy of the "Subscription Book and Stamp Album," issued in connexion with, and in support of, the Fund, together with an autograph letter from H.R.H. the Princess of Wales in which she makes a heart-touching appeal to the children of the United Kingdom to assist the Fund by contributing their donations however small.

CORNWALL COUNTY ASYLUM.—The annual report of the Cornwall County Asylum at Bodmin showed that during 1897 the average number of patients had been 770, the highest yet recorded. The temporary accommodation provided near the asylum for 18 male patients is occupied and there are 22 patients boarded out at the Plymouth Borough Asylum. The report adds that the isolation hospital is to be commenced immediately. The committee refer in terms of regret to the resignation of the medical superintendent, Mr. Richard Adams, M.R.C.S. Eng., L.R.C.P. Edin., after forty years of valued service.