

œdema then subsided. The heart was enlarged in all directions, the apex beat feeble, the first sound at the apex impure, the second sound at the base double, the second pulmonary accentuated. The liver was enlarged; there was ascites; the splenic dulness enlarged. No albuminuria. An exact diagnosis was not made; the heart was looked on as the organ first affected. After two months the ascites had increased so much that some operative treatment was necessary, and laparotomy was performed. An incision was made from umbilicus to symphysis. The peritoneum was perfectly healthy; there were no adhesions. Five litres of yellow fluid were evacuated. The liver was enlarged, extending a hand's-breadth beyond the ribs; the edge was thickened, smooth, hard, and cyanotic. The spleen felt normal. Improvement was only temporary. Puncture was necessary five times, and nine months after operation the patient died. Autopsy showed tuberculosis of the serous membranes; fibrinous pericarditis, with extensive adhesions; cardiac cirrhosis of the liver. Had it not been for the laparotomy it might have been thought the case was one of serous membrane tuberculosis from the beginning, and, in fact, the description of the alterations is not sufficiently clear to enable the reader to exclude a tuberculous origin for the whole case. The author, however, holds a different opinion, although he admits the impossibility of explaining why it is that pericardial adhesions are followed in some cases by the changes found. Still, as Pick pointed out, other diseases of the heart show a great irregularity in the associated changes.

SURGERY.

UNDER THE CHARGE OF

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Surgical Intervention in Hæmatemesis Consecutive to Exulceration of the Stomach.—DIEULAFOY (*La Press Méd.*, January 19, 1898) summarizes his views on this subject as follows :

1. Outside of the simple ulcer, which is a frequent cause of hæmatemesis there is found a superficial loss of substance of quite large extent, which the author proposes to term simple exulceration.

2. This form of ulceration the author believes is capable of producing a more terrible form of hemorrhage than that generally seen in the case of simple ulcers.

3. The loss of substance in simple exulceration does not go deeper than

the mucous layer; it takes in the muscularis mucosæ, however. The great and frequently deadly hemorrhage which results arises from the ulceration of one of the arteries which ramify in the muscularis mucosæ.

4. Clinically, the simple exulceration has the symptomatology of the simple ulcer as described by Cruveilhier, of which it no doubt is the initial stage; but more frequently it commences quietly and at the same time in a latent manner with moderately severe hemorrhages.

5. Surgical intervention is the preferable treatment for hemorrhages consecutive to simple exulceration. The abundance rather than the repetition of the hemorrhage is the indication for intervention.

6. The operator should never forget that the stomach may present an apparently sound appearance and yet be the seat in some part of a simple exulceration. It is therefore essential carefully to examine the entire stomach, if necessary, with a lens, to detect the exulceration, which is frequently accompanied by ecchymotic areas which are points of repair.

7. Suture of the area involved with a small margin of sound tissue usually suffices in these cases. The operative results are generally more successful in this form of ulceration than in the case of simple ulcers, as the limitation of the lesion favors the surgical method of treatment.

A New Typical Form of Acute Intestinal Obstruction.—An interesting series of five cases of intestinal obstruction are reported by HOCHENEGG (*Wiener klin. Wochenschrift*, December 23, 1897) which demonstrate a new typical form of intestinal obstruction which he has named "combination-sileus."

In all the cases it was noted that a stenosis of the colon had existed for some time, producing an hypertrophy of the walls of the gut. Besides this lesion, all the patients suffered from an acute intercurrent obstruction of the small intestine, either by bands, contracting scar-tissue, or herniæ, the acute activity of which was produced by the drawing back of the intestinal contents, in the first place, by the obstruction in the large intestine. The intestine is distended between these points of stenosis and above them, and is marked by increased peristalsis. If the operation is undertaken at this stage only the obstruction in the colon would be detected.

The chronic condition present in the colon would cause an hypertrophy of its walls, and there would be greater force in its peristalsis, which would be more effectual than that of the small intestine, and in consequence the retrograde peristalsis from the colon would finally force all its contents above the seat of stricture in the small intestine.

An operation undertaken at this time would undoubtedly remove only the obstruction in the small intestine, while the primary cause of the trouble would go undetected. This occurred in all the author's cases. At first there was apparent improvement, the patient gaining for a few days, when suddenly the symptoms of obstruction returned, with all their former severity, the subsequent operation alone demonstrating the true condition. Since the former operation and the patient's subsequent condition have so altered the force of the peristaltic movements in the colon that they are scarcely visible, the condition is difficult to differentiate from peritonitis.

Such a condition is a very serious one for an operator to face who believes