later the wound was again allowed to close and the pus in the urine gradually disappeared, and the patient left the hospital September 13th in good condition.

November 29th. Patient reported that she had had no further trouble and was working at type-setting. Urine normal. No albumin.

April 6, 1898. The patient was shown to the Surgical Section. She stated that she was in good health and was working steadily. On examination the right kidney could be felt somewhat enlarged, but there was no sign of a recurrence of the hydronephrosis.

A CASE OF PERFORATING GASTRIC ULCER. OPERATION AT END OF TWENTY-FOUR HOURS. RECOVERY.[1]

BY A. T. CABOT, A.M., M.D., BOSTON,
Surgeon to the Massachusetts General Hospital.

THE following case is unusual, in that recovery followed an operation which was done at least twenty-three hours after perforation of the stomach occurred. Usually operative interference to be successful in these cases must follow closely on the accident; for a rapidly fatal peritonitis is the almost immediate consequence of the escape of the stomach contents into the abdomen. The patient's good fortune in this case was due to the somewhat unusual character of the perforation.

Mrs. G., about thirty years of age, was seen in consultation with Dr. C. C. Odlin, of Melrose, at eleven o'clock on the morning of February 4, 1898. She had for some time been troubled with symptoms of indigestion which were occasionally of sufficient severity to cause vomiting. One week before the vomitus had contained a small amount of blood. An especially troublesome feature of her condition had been the formation of large quantities of gas in the stomach. At one o'clock on the afternoon of the previous day, while at the house of a friend, she had been suddenly seized with violent abdominal pain. A swelling of the abdomen came on rapidly, so that when Dr. Odlin saw her a short time after the seizure it was already tensely distended. He found her in quite a profound condition of collapse. With the use of morphia and of hot fomentations the pain was somewhat controlled and her condition slowly improved.

Our examination showed the abdomen to be tensely distended, somewhat tender everywhere but especially so in the left iliac region and in the epigastrium. No resistance or mass could be felt anywhere. Percussion was tympanitic and especially high pitched in character. The liver dulness had entirely disappeared and a high tympanitic note was obtained over that organ.

A probable diagnosis of perforating gastric ulcer was made and an immediate operation was advised. This was agreed to and at once prepared for. The abdomen was opened just before twelve o'clock. On incising the peritoneum, large quantities of odorless gas escaped. The stomach and intestines were considerably distended and the peritoneal surfaces were moderately injected but no fluid or solid stomach contents were seen although there was a small amount of turbid serum in the dependent parts of the abdomen.

[1] Read before the Surgical Section of the Suffolk District Medical Society, April 6, 1898.

The stomach presented a normal appearance except that just at the edge of the liver was a little fibrinous exudation. Separating the stomach from the liver, more of this exudation was found but not in any quantity. At one point on the lesser curvature of the stomach the fibrin was a little thicker than elsewhere and on wiping it off a yellow, sloughy area about one-quarter of an inch in diameter was brought to view. The centre of this was perforated by a minute opening through which a few bubbles of air escaped. Beneath this the stomach wall was slightly indurated over an area about one inch long by three-quarters of an inch broad.

The above-described opening was closed by folding the stomach wall together over it with Lembert stitches in two rows. These were so taken as to fold in the entire portion of the wall that was occupied by the induration. It was believed that the indurated area accurately marked the base of the ulcer as it existed on the stomach wall and by folding this in, any danger of further enlargement of the perforation in the ulcerated area was guarded against. The accessible portions of the abdomen were then irrigated with a salt solution and carefully wiped out. A small wick of gauze was laid over the lesser curvature of the stomach, reaching beyond the seat of the ulcer and the wound was then closed, leaving a small opening at the upper angle for the emergence of the end of the gauze.

The patient made a steady and uninterrupted recovery. The most troublesome symptom during convalescence was flatulency, which was excessive. Nourishment was provided for by liquid enemata the first few days after the operation, after which food was given in small quantities.

The bowels moved on the third day and the gauze was removed on the fifth day. The wound finally closed at the end of three weeks.

In this case the giving way of the stomach wall in the ulcerated area was undoubtedly due to the extreme distention of the viscus with gas. As far as could be seen, none of the fluid or solid contents had entered the peritoneal cavity. The sloughing condition of the stomach wall just about the point of perforation makes it probable that a much larger opening would presently have been made by the action of the gastric juice on this dead tissue.

The point of greatest diagnostic value in this case was the absolute disappearance of the liver dulness in consequence of the great amount of gas in the peritoneal cavity.

A CASE OF ACTINOMYCOSIS.[1]

BY E. A. CODMAN, M.D., BOSTON.

THE patient entered the Massachusetts General Hospital July 18, 1895, in the service of Dr. F. B. Harrington, by whose kindness I am able to report the case.

He was forty-eight years old and married. The family history was negative, except that his mother and an uncle died of phthisis.

Previous history good until three years before, that is, 1892, when he had a severe attack of the grippe with a very bad cough. His attacks of coughing were so violent that they attracted a great deal of attention

[1] Read before the Surgical Section of the Suffolk District Medical Society, April 6, 1898.

wherever he went, as in a train. This cough lasted with decreasing severity until within a month of entrance. The sputum was sometimes bloody, but usually yellow and foamy. About one year before entrance, that is, summer of 1894, a swelling about the size of a dollar appeared on chest wall near the site of present sinus. In September this swelling burst and a sinus formed. In June, 1895, two other such swellings and sinuses formed.

The cause was supposed to be tubercular necrosis of one of the ribs, and he was recommended to the hospital to have the sinuses cleaned up.

The chest was negative except for cardio-respiratory murmur in region of apex, and harsh breathing with a few râles in left front, in region of sinuses. There were two sinuses and one old scar in cardiac region, low down.

Before entering the hospital the patient had been working for twenty-five years in a straw-hat factory. The straw used was imported from Italy, China and other places.

An operation was done by Dr. F. B. Harrington, and the tract between the two sinuses was dissected out. This tract appeared to be an ordinary tubercular sinus, but Dr. Mallory, who happened to be present at the operation, noticed some yellow granules in the discharge and suspected actinomycosis. He examined these under the microscope and in a few minutes was able to verify this diagnosis. Another tract was then dissected out and the wounds closed except for small drains.

The wounds healed readily except where drained, and on the 25th the patient returned home to West Upton with instructions to take K. I. in increasing doses.

A letter from the patient on January 12, 1896: — "As regards my side, I will say it has healed, as you might say. Since I was in Boston I have taken the medicine you prescribed for me, and shall continue to do so. I expect it will break out in a week or so. There will be a little bunch come about the size of a pea and quite sore. In course of two or three days I tap it with a gold pin, and in two or three days it is healed. A very little matter comes out and then clear blood. These bunches come in the wound. They do not come as often as they did but seem to grow less. As to my health, I have not been so well for five years as I am now."

I saw the patient again in February, 1896. His general health was better than for years. He weighed 144 pounds against 132 for the last fifteen years. He had been taking the iodide up to 110 grains daily.

A fresh abscess which had appeared above median scar, I opened and curetted as far as possible. A week later I endeavored to excise the sinus, but found that it extended over two inches under the sternum. Dr. Mallory was kind enough to examine the specimen again and found the fungus still present.

This wound healed in about six weeks. Since then the K. I. has been continued, and on November 23, 1897, he writes as follows: — "It remained about the same for eight or ten months, and for the last four months it has not troubled me much. It will gather in the same place that you opened when I last saw you. It has been two weeks since I have opened it. Then I got two drops of blood, no matter; it seems to grow less. I think by the feeling it will have to be opened in a week or so. It forms a blood-blister and no larger than a quarter of a small cranberry. There is no pain any more than a sliver under the skin large enough to fester. I call myself better than for years. I have taken the medicine most of the time. I don't think there has been over four weeks in the time I have been without taking it. I skip a day and sometimes a meal or two, that is all. I am working ten hours and feel fine."

The patient has been kind enough to allow me to show him to-night. The sinus has not broken out since six weeks ago. Unfortunately, for the last week he has had a bad cold so that he appears in perhaps worse condition than he really is.

Reports of Societies.

SURGICAL SECTION OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.

PAUL THORNDIKE, M.D., SECRETARY.

REGULAR meeting Wednesday, April 6, 1898, DR. H. L. BURRELL, in the chair.

DR. CODMAN reported

A CASE OF ACTINOMYCOSIS.[1]

DR. A. T. CABOT reported

A CASE OF PERFORATING GASTRIC ULCER.[2]

DR. J. W. ELLIOT read a paper on

INTERMITTENT HYDRONEPHROSIS WITH CURE BY OPERATION.[3]

DR. RICHARDSON: Cases of this kind comprise a field in which the prospect seems to be alluring and brilliant. I was so much impressed by Fenger's paper that I performed the operation on the first case of intermittent hydronephrosis that I saw. This case I reported a year ago, in the *Transactions* of the American Surgical Association. The principle employed by Fenger which Dr. Elliot followed is, I think, the same principle which I used, but I was able to use it, I think, in a more satisfactory way in my case than in those in which it is necessary to open the pelvis of the kidney. I showed my patient at the clinical society of the hospital about a year after the operation and found a perfect cure. The patient was a nurse and had a recurring tumor in the region of the gall-bladder. In fact, I thought the trouble was in the gall-bladder and operated for that. I found that the gall-bladder was normal, but that there was a retro-peritoneal tumor in the region of the kidney which I recognized as hydronephrosis, so that afterwards in my second operation I was guided by the knowledge of the anatomical relations better than if I had not performed the original and more or less unnecessary exploration. In this case the Miculicz operation of pyloroplasty was employed. In Fenger's the valve was removed by an intrapelvic longitudinal incision converted into a transverse one. I used very fine silk and the joint came out very nicely just as pyloroplasties do for strictures of the pylorus. The woman made a good recovery and has been well ever since. It was not a movable kidney. There was no preliminary history in my case, nothing pointing to

[1] See page 134 of the Journal.
[2] Loc. cit.
[3] See page 132 of the Journal.