In January, 1927, he still had flatulent dyspepsia, and cholecystography on two occasions failed to show the gall-bladder. The report on a barium meal was that the first, second, and half the third part of the duodenum were enormously dilated, possibly by obstruction by the superior mesenteric artery. On my advice an exploratory laparotomy was done. The gall-bladder was removed, but was found to contain no calculus and did not seem to be unhealthy. From this time flatulent dyspepsia had persisted more or less continuously with bouts of vomiting. Barium meals on several occasions showed no abnormality of stomach or duodenum. In March, 1946, he had jaundice with relapse, presumably due to infective hepatitis, which was epidemic at the time. During the summer of 1947, while on holiday in England, he was very ill, vomiting frequently and losing a great deal of weight. He was admitted to hospital, and after barium and fractional test meals was told he was suffering from "cramp of the stomach," which in the light of recent events presumably meant pylorospasm.

I saw him in October, 1947. He was then extremely thin, but stool culture revealed nothing abnormal. By the middle of January, 1948, he had been free of symptoms for three months, had been eating less carefully than for a long time, and had gained some 18 lb. (8.2 kg.). This ruled out any possibility of carcinoma. It was quite evident that his symptoms were closely related to worry, of which he had been free during these three months. On Jan. 20 he relapsed. He now restricted his food, but had vomited several times daily for a week. His subsequent history is as follows:

Jan. 22.—Still vomiting; mental confusion and delusions. Admitted to hospital. Urine: a few granular and hyaline casts; traces of albumin; sp. gr. 1014. Blood urea 172 mg., plasma chlorides 415 mg. per 100 ml.

Jan. 23.—No more vomiting. Urine 14 oz. (400 ml.). Rational at times. B.P. normal. Glucose-saline, 500 ml. b.d. subcutaneously; orange juice, etc.

Jan. 24.—No vomiting. Great mental confusion.

Jan. 25.—No vomiting. Urine, 70 oz. (2 litres). Blood urea, 200 mg. per 100 ml. No noteworthy change occurred for five days.

Jan. 30.—Urine, 70 oz. Blood urea, 72 mg. per 100 ml.

Feb. 1.—Urine, 30 oz. (850 ml.). Vomited copious green fluid several times.

Feb. 2.—Urine, 34 oz. (965 ml.). Copious vomiting.

Feb. 3.—Copious vomiting of green liquid. On inspection very strong peristaltic waves visible in epigastrium, with a swelling as large as a tangerine orange progressing towards the pylorus, as seen in congenital pyloric stenosis of infants. Barium meal: on screening, very strong peristalsis of stomach with antiperistaltic wave after it had reached the pylorus. Two-and-three-quarter hours later no barium had passed the pylorus. Atropine 1/100 gr. (0.65 mg.) subcutaneously; "bellafoline" 10 minims (0.6 ml.) t.d.s.; phenobarbitone $\frac{1}{4}$ gr. (50 mg.) t.d.s.; glucose-saline 500 ml. b.d.

Feb. 4.—No vomiting. Urine, 20 oz. (570 ml.).

Feb. 5.—No vomiting. Atropine, 1/200 gr. (0.32 mg.) b.d.

Feb. 6.—Copious vomiting. Atropine and bellafoline discontinued. "Antal" 10 ml. I.V. daily for 18 days. (Antal is a French preparation containing 1 mg. of atropine and some sodium bromide.) It was noticed that the very violent peristalsis of the stomach which occurred after the ingestion of any food ceased in a few minutes after the injection of antal; the patient then announced that the spasm had relaxed, and food was passing the pylorus.

On Feb. 20 he was eating cold chicken and ham without inconvenience and had returned to work in his office.

Nov. 10.—For four months past he has been free of all symptoms, eating normally, and feels better than he has done for 25 years.

I believe the "cure" to be due to his realization that the gastric trouble was due to psychological causes.

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Sternal Swelling as a Presenting Sign of Hodgkin's Disease

The association between sternal swellings and Hodgkin's disease has been noted by Goldman and Victor (1945) and by Sicher (1948). The latter describes an unusual case in which Hodgkin's disease manifested itself by a sternal swelling of two weeks' duration. The following case is of interest in that a swelling had been present on the sternum for five years before the diagnosis of lymphadenoma was made, and because the patient had been successfully treated for pulmonary tuberculosis.

CASE HISTORY

The patient, a woman aged 36, with a considerable medical history, was notified to this department in July, 1947, as a case of tuberculosis, and was admitted on Aug. 11 to sanatorium for further investigation.

She had had measles and scarlet fever, injuries due to a fall of 30 ft. (9.14 m.) at the age of 13, and pulmonary tuberculosis at 22. She was in sanatorium from July, 1933, to January, 1934, and was treated by left A.P., which was continued privately thereafter; last refill January, 1946. Menstrual disorders for years; had D. and C. in 1943 and again in January, 1947. Chronic dermatitis of both hands.

A small swelling on the upper sternum first noticed about 1942 had remained static. After the uterine operation in January, 1947, the swelling had enlarged noticeably and progressively. In June, 1947, the condition was diagnosed as tuberculosis, and the case was notified to the public health department.

When I first saw her in July, 1947, her general condition was fair. She was febrile, toxic, and anaemic, but, apart from the swelling and some weakness, had no complaint. The lungs showed signs of fibrosis but none of any active disease. The cardiovascular, digestive, and nervous systems were clinically normal. The dermatitis of both hands was in a quiescent phase, but there was slight dry eczema of the webs of the fingers.

The swelling was a rounded painless protuberance on the upper sternum about the level of the second costal cartilages. It was exactly in the midline and occupied almost the breadth of the sternum. There was no tenderness or sign of pointing, but the overlying skin was reddened and fluctuation was present. No parasternal lymph nodes were detected. Aspiration was completely unsuccessful. Radiography of lungs and thorax revealed very slight old fibrosis in the right mid-zone, denser fibrosis in the left mid-zone with pleural thickening, but no sign of active disease or of hilar enlargement. The radiologist also reported a large round swelling of the soft tissues of the sternum both anteriorly and posteriorly about the second rib level; no erosion of the sternum was observed, but the anterior end of the second left rib was ill-defined. Other clinical findings were enlarged glands in both axillae but no adenopathy elsewhere; red cells, 3,730,000; Hb, 53%; white cells, 15,400; B.S.R., 51 mm./hour.

When she was admitted for sanatorium observation on Aug. 11 no definite diagnosis had been made. While various possibilities were recognized, tuberculosis was considered the most probable cause, especially in view of her previous history. On Sept. 4, however, biopsy of glands from the right axilla revealed changes typical of lymphadenoma. The patient was thereafter transferred to a general hospital where she received deep x-ray therapy, and was discharged on Nov. 21. Since then she has gone to live in the country and has not been examined, but is known to be fairly well (November, 1948).

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