The patient should be moved as little as possible on his return to bed. He should be placed in the right lateral position, and be allowed to recover in peace, a careful watch being kept to prevent any obstruction of the airway. Apart from any other consideration, anoxaemia seems to be a pronounced predisposing factor in the causation of vomiting. Post-operative sedation should be applied, and the use of suppositories—e.g., nembutal—should not be forgotten.

Vomiting which is actually occurring may be treated by a variety of remedies. Drinks of hot water, to which 10 to 15 grains of sodium bicarbonate may be added, strong hot black coffee, Lugol's iodine, and sips of champagne all have their measure of success. Lenevitch (1892) advised washing out the stomach with warm alkaline solution (sodium bicarbonate). Though suggested at such a relatively early date, this line of treatment has proved most efficacious, especially in cases of persistent vomiting.

Summary

The incidence of post-anaesthetic vomiting in 1,000 consecutive cases is compared with that in four series, each of 100 cases, in which a different anaesthetic sequence was used.

The effect of sex and of certain surgical procedures on the incidence of post-anaesthetic vomiting is shown, particular reference being made to oro-nasal and minor gynaecological operations.

Lines of treatment for this condition are suggested.

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Medical Memoranda

Leiomyoma of the Stomach with Ulceration

Although cases of leiomyoma of the stomach have not infrequently been reported in the literature, the following case is considered worth while recording in view of the fact that the nature of the tumour was diagnosed pre-operatively, and because some light may be shed on the kind of ulceration occurring in conjunction with these tumours.

CASE REPORT

A lighterman aged 65 was admitted as an emergency, having had a severe haematemesis. Shortly after admission he vomited more bright red blood. His haemoglobin was found to be 30%. He had a history of intermittent indigestion for fifteen years, each attack lasting for from two to three months, and the periods of freedom from pain lasting for as long as two years. There had been no vomiting or loss of weight, and the pain had never been severe. Three weeks before admission there had been a small haematemesis, but since then, until admission, no abdominal pain.

On examination there were slight tenderness in the epigastrium and extreme pallor of the skin and mucous membranes, but otherwise no abnormal physical signs were seen. A transfusion of three pints of blood was given, and the patient improved considerably. X-ray examination performed a month after admission, when the haemoglobin was 68%, revealed a large filling defect high up on the anterior walls of the stomach. Rugae were obliterated over the filling defect, which was circumscribed and well defined. No niche, crater, or spasm was seen.

In view of the x-ray findings a diagnosis of a benign tumour of the stomach was made, and partial gastrectomy was performed on March 18, 1941. In order to section the stomach

above the tumour it was necessary to remove about three-quarters of that organ. The gastrectomy was of the modified Polya type. No glandular enlargement was found in the abdomen, and tissues surrounding the stomach were healthy and free from adhesions. There was no indication on the peritoneal surface of the nature of the tumour, but its mobility within the stomach suggested that it was benign. After an uneventful recovery the patient was discharged on April 8, with a haemoglobin of 105%.

The pathological report on the specimen (see Fig.) was as follows:

Macroscopic Examination.—The stomach is enlarged, the rugae on the body being well marked. There is a firm growth at the cardiac end in the anterior wall near the lesser curve. The growth is oval, measures $2\frac{1}{2}$ by $1\frac{1}{2}$ inches, and appears to be insinuated between the mucous and serous layers. Its borders are sharply defined, and the mucous membrane over it is stretched and rugae free. There is an ulcer measuring half an inch in diameter, the margins of the ulcer being sloping and its floor necrotic. The cut surface shows a definitely lobulated structure, many of the lobules showing marked congestion, and giving rise to the effect of a coloured pattern.

Microscopic Examination.—The growth consists essentially of muscular fibres with a whorl-like arrangement. There is, in addition, a fair amount of fibrous tissue derived from areas of resolving haemorrhage. The growth in parts is oedematous and throughout is richly cellular; no significant changes are present in the mucosa beyond congestion and some polymorph infiltration. There is no particular cellular infiltration around the ulcer on the summit. Its walls are sloping, and it appears to be a simple pressure atrophy of the mucosa.

Diagnosis.—Leiomyoma of the stomach.

DISCUSSION

Edwards and Lewis (1940) describe a case of leiomyoma that gave rise to haematemesis, which left the patient with only 30% of haemoglobin. Apart from this case, it would seem that the degree of bleeding in our case was unusually severe. They quote Starr Judd as saying that true peptic ulceration may occur on the surface. The microscopical and macroscopic appearances of our case, together with obliteration of rugae over the tumour, strongly support the view that ulceration was due to pressure atrophy. In view of this it is rather surprising that the haematemesis that ensued was so severe. The cause of the gastric symptoms, which had persisted for fifteen years, remains in doubt. The rest of the stomach mucosa showed no signs of gastritis, nor was it apparent how such a gastritis could result from the presence of the tumour. However, the proximity of the tumour to the cardia could, in view of the size of the tumour, undoubtedly have given rise to the considerable disturbance of the mechanics of gastric digestion, and this might be the explanation.

The recommendation of Edwards and Lewis that local resection is all that is required in these cases is undoubtedly a wise one, except that it is difficult to be quite certain of the nature of the tumour. Moreover, the technical difficulties involved in performing a sleeve resection with the tumour so highly situated would be very considerable.

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