NURSE MU.

Date of Observation.	Sp. Gr. of Urine.	Date of Observation.	Sp. Gr. of Urine.
April 24th ...	1040	August 12th ...	1032
May 12th ...	1032	October 7th ...	1035
June 12th ...	1036	December 10th ...	1028
June 28th ...	1030	February 5th ...	1024
July 28th ...	1035	March 30th ...	1027

NURSE IL.

October 15th ...	1033	February 5th ...	1034
October 30th ...	1020	March 30th ...	1033
December 10th ...	1035		

NURSE MA.

June 12th ...	1035	October 7th ...	1020
July 28th ...	1035	October 30th ...	1024
August 12th ...	1035	December 10th ...	1020

NURSE WA.

June 12th ...	1036	August 12th ...	1035
July 28th ...	1040		

NURSE NE.

June 12th ...	1035	October 7th ...	1024
June 28th ...	1040	October 29th ...	1020
July 28th ...	1034	February 5th ...	1024
August 12th ...	1035		

PARTIAL GASTRECTOMY FOR GASTRIC CARCINOMA: RECOVERY.

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ATTENTION may be drawn to the features presented by the growth in the following case, and by the treatment adopted.

1. The growth was very limited, and the glandular involvement slight. This allowed of removal of both with a fairly wide margin. The tendency of a growth is to spread particularly towards the cardiac orifice, thus it is important to have a wide margin on this side. The section of the stomach corresponded pretty well with the incision used by Mikulicz—that is, from just to the right of the cardiac orifice almost vertically downwards to the great curvature. The glands were quite soft, and did not suggest involvement. The lymph stream from the glands at the great curve passes to glands about the head of the pancreas, and there no enlargement could be detected.

2. An end-to-end junction after Billroth's method was used, as the cut edges could be easily brought into apposition. No after-trouble was experienced from leakage, the occurrence of which has led to the advocacy of other methods.

3. The character of the growth was a colloid carcinoma, and the probably lessened degree of malignancy leads one to hope for a permanent cure.

The patient, a bricklayer's labourer, aged 60, was admitted into hospital under the care of my colleague, Dr. Sharkey, on June 18th, 1908, complaining of pains in the abdomen, sickness, and loss of weight during the preceding twelve months.

He had a fresh complexion and looked healthy; his general nutrition was good with no marked evidence of wasting. There was no history of syphilis, and he was a moderate drinker and smoker; of late, however, smoking seemed to increase his symptoms.

History.

Twelve months before he began to complain of a slight gnawing pain in the upper part of the abdomen, but it was not until four months later that it gave him any serious inconvenience. Then he had pain at different times of the day, which might last from a quarter to two hours at a time, and was relieved on taking food, even if its amount was very small. For the last two months or a little more he had vomited, generally in the evening after his meal; he had brought up a lot of clear, watery fluid at times, which was often followed by vomiting. During the same period he had been very constipated. His appetite had become very poor, and he thought that recently he must have lost about a stone in weight.

Condition on Admission.

Examination gave no evidence of any disease. The abdomen moved well with respiration; there was no distension nor was

there any tumour to be felt. There was some tenderness on deep pressure behind the upper part of the right rectus and a little increased resistance here. His tongue was clean and his urine was normal. The stomach was not dilated, showing absence of pyloric obstruction, and a test meal given on two occasions showed no free hydrochloric and no lactic acid to be present.

Operation.

He was transferred to my ward, and on July 8th I operated. An incision was made to the left of the mid line dividing the rectus sheath and reflecting the muscle. There were no adhesions about the stomach and adjacent structures; the stomach was withdrawn through the wound, and on palpation a lump was felt in the posterior wall. Clamps were placed on the stomach just to the right of the cardiac orifice and on the first part of the duodenum, and this area was packed off with gauze from the rest of the abdomen. An incision in the length of the stomach was made through the anterior wall over the lump, and the posterior wall was extruded through this hole. The lump was a circular flattened growth with hard edges, about the size of a four-shilling piece, and was placed nearer the lesser curvature in the middle of the right third of the stomach; the mucous membrane over it was reddened, but there was no ulceration. There was an enlarged gland felt at the lesser curve about $1\frac{1}{2}$ in. from the pylorus, and another at the same spot at the greater curve; both, however, felt quite soft. No other enlarged glands could be detected. After dividing the gastro-hepatic and gastro-colic omenta wide of the glands and tying off the vessels, the portion of stomach and pyloric region between the clamps was removed. An axial anastomosis was made, the duodenum being joined to the upper part of the stomach wound by a continuous catgut and interrupted silk Lembert stitches; the lower part of the stomach was closed in the same way. There was a little trouble from hæmorrhage into the gastro-colic omentum from a ligature slipping, but otherwise there was no difficulty. The abdominal wall was closed in layers. There was some shock at the end of the operation, but not sufficient to demand infusion; he was given 10 oz. of normal saline with $\frac{1}{2}$ oz. of brandy by rectum, and this was repeated every four hours during the first night.

After-history.

The after-history was quite uneventful, and may be said to have given no anxiety. The next morning he was put on a teaspoonful of water by mouth at intervals and ordered a nutrient enema of dextrose and sanatogen, each 20 grams, in 15 oz. of saline, to be given alternately with the same quantity of saline every six hours. On the 10th the quantity of water by mouth was increased, and on the 11th he was allowed two teaspoonfuls of Brand's essence thrice in the day. Sanatogen in water was added on the 13th, and on the 15th he had whey; on the 17th egg-flip was given. On the 18th all rectal feeding was stopped, and junket, Benger's food, bread-and-milk were allowed, but no feed was to exceed 5 oz. Soft, thin bread-and-butter was added on the 19th, and on the 22nd he was on minced fish. Food now gave him no discomfort. His abdominal wound healed by first intention.

The growth proved to be a colloid carcinoma of the spheroidal-celled type.

The man has been frequently seen by me since the operation, and he has put on weight and remains free from symptoms.

A CASE OF VIPER OR ADDER BITE (VIPERA BERUS).

By R. S. C. EDLESTON, M.R.C.S., L.R.C.P.

BASLOW, DERBYSHIRE.

On Thursday, August 5th, at 5 p.m., I was called to see Dr. H. Peck, Medical Officer of Health of the Chesterfield District of Derbyshire, who, I was informed, had been bitten by an adder near the reservoir on the Duke of Rutland's moor at Ramsley, on the high ground north of Baslow. He had been testing water for peaty acids, and seeing a snake in the grass he picked it up, thinking it was a common grass snake. The snake immediately struck him. I found when I reached Ramsley Lodge at 5.30 p.m. that the bites had been inflicted about 2.30 p.m. The doctor described his experiences as follows:

"I picked up the snake, and he struck me first in the right thumb and hand and then on the left hand. I immediately killed the snake and sucked one of the wounds, probably that of the left thumb first. Almost immediately I began to feel a tightness of the brow, as though a knotted handkerchief had been tied firmly round the head. I removed my hat, but the sensation continued. I became faint, and very soon vomited. The feeling of faintness continued to increase, the lips and tongue and fauces began to swell, and I had great difficulty in getting my breath. I made my way as well as I could, with frequent rests, towards the keeper's lodge, and was finally assisted there by the keeper and his wife."