Remarks ON THE CAUSES AND TREATMENT OF FUNCTIONAL DYSPEPSIA.*

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I wish to make it quite clear at the outset that the subject we have in hand is the treatment of purely functional cases of indigestion, involving reference to their causation. This naturally excludes all cases of gastric and duodenal ulcer, dilatation from pyloric obstruction, and malignant disease of the stomach; in fact, all those organic cases which have been swept of late into the surgical net of ever-increasing dimensions, which net must now be stretched wide enough to include even certain cases of chronic and latent appendicitis.

This is not the moment at which to discuss the question lately brought forward by Mr. Moynihan of Leeds, which has for some time past more or less occupied the minds of abdominal surgeons and all physicians interested in gastric cases, namely, May not distant lesions, and especially lesions of the appendix, be responsible for symptoms referable to the stomach and commonly ascribed to gastric and duodenal ulcer? But I may say that my own experience would support Mr. Moynihan's contention, as I have met with several cases in which the clinical picture was that of gastric ulcer, whereas the only structural abdominal change found on exploration was in the appendix.

I feel, however, with Mr. Bowlby, and my colleague and co-worker, Mr. Rutherford Morison, that the experience of practical physicians and surgeons does not warrant the conclusion that cases in which the symptoms of gastric ulcer are the result of chronic appendicitis are of common occurrence, and that it is incumbent upon us to approach with still greater caution the question of an operation in cases in which the symptoms point to chronic functional dyspepsia. Before long no doubt we shall view the whole matter in its proper perspective, and be in the position to distinguish on ascertained diagnostic grounds the cases that are suitable for medical from those that are suitable for surgical treatment.

Meantime there still remains to us the vast majority of dyspeptic conditions which form a very large proportion of the cases that engage the attention of the general practitioner. Assuming that organic disease is excluded, I pass on to consider functional gastric disease and its treatment.

First, as to the character of the functional disturbance, I fully recognize the importance of distinguishing between the various forms of dyspepsia from the physiological point of view of disturbance of the various gastric functions, but I think if we are to treat our patients' cases with success we must also recognize that each dyspeptic individual is liable in a peculiar way to some one form of indigestion by virtue of some special inherent weakness or anomaly. In one there is a tendency to excess of hydrochloric acid and so-called "acid dyspepsia" is the trouble. In another the secretion is deficient and his case is one of "atonic dyspepsia." In yet another carbohydrate digestion is imperfect, so starches come to be the bugbear; whilst in a fourth everything is ascribed to disordered hepatic function; or, again, another class may be labelled "defective motility." I do not quarrel with this attempt to lay a finger upon the special part of the digestive system at fault, but what I want to point out is that we do not help our patients a great deal by thus classifying their complaints, and that it is more to the point to recognize that whatever the special form of indigestion to which they are liable may be, the attacks can nearly always be traced to a definite cause which in the individual acts with unerring certainty in producing their own special form of indigestion. In other words, it is clear that whilst it is a matter of scientific interest to diagnose accurately the special form of indigestion with which we have to deal, it is of much greater practical importance to discover the cause and point to the direction in which relief may be obtained.

EXCESS OR DEFICIENCY OF HYDROCHLORIC ACID.

When confronted with a case of functional indigestion, it is a common practice to attempt first to ascertain whether the symptoms suggest an *excess* or a *deficiency* of hydrochloric acid—in other words, whether the case belongs to the sthenic or asthenic type of dyspepsia; but to determine this point is often by no means easy.

The former is associated with a more robust and more energetic type of person than the latter, and the subject of excess of acid has usually a fair appetite, which may be excessive, and suffers from epigastric fullness and at times heartburn, pyrosis, etc., which symptoms are generally postponed some hours after food. As a rule, the subject of asthenic dyspepsia is, on the other hand, a weakling with predominating nervous symptoms, lack of appetite, pain or discomfort soon after food, flatulency, etc., which symptoms go on throughout the whole time of digestion. Such patients are afraid of food, which aggravates their trouble, whilst the patient with sthenic dyspepsia is often materially relieved after eating a good meal.

Assuming it is possible to determine the part played in production of the symptoms by an excess of hydrochloric acid, or the want of it, we proceed to make a careful selection of the remedy to be employed. In atonic cases, so often met with amongst poor overworked and nervously prostrate women, we may prescribe an acid and nuxvomica mixture with advantage, though it is well to bear in mind the fact that such patients may be suffering at the moment they seek advice from an active catarrhal condition of the gastric mucous membrane—gastritis—when it is advisable to commence treatment by a soothing antacid remedy (bismuth, for example) with very simple soft food. It will not be long before we may resort to a more substantial diet and acid tonic after meals, though the success of our treatment will turn largely upon the management of the diet at the commencement, and of the constipation so often a noticeable feature in cases of the kind.

The sthenic cases—hyperchlorhydria—should of course be treated by antacids. The success of these remedies depends so much upon how they are employed, that we cannot, in instructing our patients, give too much attention to the details. Dispensing chemists will tell you how common it is for the instructions upon a prescription to be incomplete, whilst nearly every doctor has had the experience of receiving a request from the patient, either in person or by letter, for instructions how the medicine is to be taken—before or after meals? It is above all things essential at the outset to secure the patient's whole-hearted co-operation, and it is important that he should understand that a second visit, if possible in a few days or a week, is necessary in order to adjust matters; and this is where the consultant is at a disadvantage, for as a rule he only has one chance, one visit at which to give all particulars.

A judicious combination of soda and bismuth an hour or two after meals, and careful diet, will work wonders, provided our diagnosis is correct, but so great are the difficulties in some cases, that it may be impossible to be quite certain whether we are dealing with a case of excessive secretory activity or one of achylia. I may illustrate by the case of a lady aged 38 the subject of constipation with frequent attacks of indigestion, characterized by pain two or three hours after food, heartburn, retching, pyrosis, etc. An active, clever woman, with a strong gouty history, a highly suggestive type, and presenting the symptoms of excessive acid, yet nothing did her so much good as a strong acid and pepsin mixture after food, whilst antacids, prescribed as I have suggested, did not suit her at all.

The treatment of constipation, very often the fundamental and often a subsidiary cause of the dyspepsia, may also present great difficulties. I do not propose here to enter into these, nor to give detailed attention to the medicinal remedies, because I wish to point out that however successfully the character of the dyspepsia may be diagnosed, and however soundly the remedies may be prescribed, it often happens that we still fail to effect a cure, and for this failure I think both an explanation and another line of treatment may be suggested. Unless we can find out and correct what has brought on the dyspepsia—whatever its character may be—our efforts to relieve the condition itself may be persistently thrown away.

For the patient's benefit, the question of first importance is, What is the cause of the condition? What is it that

* Condensed and recast from a lecture delivered at the Post-Graduate College and Polyclinic.

has led to indigestion? To discover the cause of the ailment is, as you know, often a very difficult matter. Here the personal factor comes in, and unfortunately it is given to comparatively few to be able to elicit from the patient a clear and truthful story, including statements of a highly personal character, which often are admissions made with great reluctance, but without which the doctor is helpless to aid or relieve his patient. Some men naturally invite confidences, whilst others repel them, but, though the capacity to win confidence is very largely a natural gift, it can in a measure be acquired, and any effort on our part in this direction will be found to be amply repaid.

The other day a lady patient had two small skin growths which needed removal. I got a surgical friend to perform the operation, which he did under local anaesthesia. He was a man whose manner is at times a little abrupt, and whose skill with the knife is not to be measured by his suavity. The novocain employed was not very successful, and the patient called out lustily. "Keep still," said the surgeon. I was sitting by the patient and doing my best to assist my friend by encouraging her to remain quiet, and with a view of attracting her attention, and perhaps also to apologize for his manner, I remarked, "You see, he is a surgeon. I don't think he would make a very good physician"; to which she replied, "No, he wouldn't, and he certainly wouldn't get any of our secrets out of us." This illustrates what I mean, and I would repeat, if we are to treat indigestion with success, we must learn the art of getting our patients' secrets out of them.

The great majority of our functional dyspeptic cases are due to certain obvious causes which I may enumerate as follows: Errors of diet, the bolting of food, dental deficiency and imperfect mastication, irregularity of meals, chronic bacterial intoxication, the abuse of alcohol or tobacco, constipation; or, on the other hand, they may be secondary to Bright's disease, phthisis, or other chronic debilitating disease. Or, again, the cause may be remote; for example, it is not infrequently the case that indigestion forms one of the earliest symptoms of prostatic retention with residual urine, the gastric symptoms disappearing with removal of the cause; or a scarcely recognizable anaemia may stand between us and the successful treatment of our patient. But besides all these, another large class of cases exists in which the cause is to be found in some functional nervous disturbance, and I feel we cannot lay too much stress upon the connexion existing between mental states and the digestive function. So much is this the case that I think it would be well within the mark to say that digestion is carried on at a high state of excellence only so long as mental equanimity is maintained. I will return to this later.

We begin, then, the treatment of a case of indigestion by a very careful inquiry into the cause of the condition; and I wish it to be fully understood that by cause I do not mean the essential pathology of the case, though this also has to be taken into consideration, and an accurate diagnosis should include it; but I refer here to the reason why the patient's symptoms have arisen at this particular time, the act of omission or commission on the patient's part which has determined the incidence of the attack. We have seen that as a rule each patient has his own particular brand of indigestion, the symptoms of each attack varying but slightly from previous ones. One person complains of water-brash and heartburn, another of pain or sense of weight which is always in the chest; another has flatulency in the early morning with distension and depression; in another the pain is referred to the epigastrium and between the shoulders; in another, again, all the discomfort is at night, and insomnia is a prominent symptom. As you know, the symptoms are grouped in endless variety, though repeating themselves in individual cases with wonderful consistency, and my aim is to show that often cases can only be treated successfully when the particular fault or habit upon which they depend has been discovered and corrected. From this point of view cases of indigestion may be arranged in groups, which would have a certain practical utility. Thus we have a series of cases in which dyspepsia invariably follows a lowered state of health from whatever cause, such as overwork and the need of rest and holiday, a severe cold, an attack of influenza, etc. In another, certain articles of diet—a hard-boiled egg, for example—and even certain

methods of cooking food stand in a causal relationship to the attack; others fall naturally into the group depending upon faulty mastication; others can be ascribed to constipation, and this is probably one of the largest groups. In others the pernicious habit responsible is overeating, or, again, excessive smoking, particularly cigarettes and cigars; in another group we may place the cases which depend upon the time of meals, and here irregularity comes in; and finally we have the important group of nervous or mental cases. The causes are very numerous and have to be worked out carefully in each case.

SOME ELUSIVE CAUSES OF INDIGESTION.

Let me now refer to a few of the causes of indigestion which are especially apt to be elusive, as patients systematically withhold the information of which we are in search, and upon which the success of our efforts so largely depends. We are, then, placed on the horns of a dilemma—either to remain in ignorance or to risk giving offence by pressing home our inquiry.

The subject of excessive or indiscreet eating and drinking opens a wide field for inquiry, but it is one upon which people are sensitive, and the true state of the case is seldom laid before us. The inquiry has to be approached with the utmost discretion and great care taken to avoid the impression that we have taken upon ourselves the rôle of detective (which we are often forced to do) and are inquiring into our patient's bad habits. I cannot illustrate my meaning better than by reminding you of the difficulty we all experience in eliciting a history of alcoholic excess, especially in women. As I have elsewhere observed, we all know how futile it is to ask some people, especially when the patient is a woman, if they have been accustomed to take stimulants too freely. The habit will be denied indignantly, and it may be our relations with the patient and friends compromised. We are, therefore, obliged to approach the subject very cautiously, adjusting the inquiry to the intellect and temperament of the patient; for example, instead of asking the questions directly, we may, perhaps, begin by a cautious inquiry into former illnesses, and refer to the opinion of medical men under whose care the patient has been, and then ask in a guileless way what stimulant Dr. So-and-so ordered. Then possibly the patient may be induced to discuss the uses and effects of the different varieties of alcohol—brandy, port wine, gin, whisky, beer, etc.—and in this way evince a comprehensive knowledge of the whole series; then we may make a gentle inquiry as to the form that suits her complaint, at which stage it is, perhaps, just as well to desist from further investigation. Here, of course, there is ample room for the judicious exercise of the detective faculty; but common sense, that supreme guide, will keep us right, and may warn us in certain cases that we must do without a history and content ourselves with the knowledge that for all practical purposes a certain group of symptoms are always due to alcohol.

The habit of indulging in excessive meals is a common cause of dyspepsia. The patient is often a highly strung and vigorous person, who exhausts himself by his work, and feels stimulated and sustained by food, and eats more than he can digest, though he often obtains temporary relief by eating. Or he is very fond of the pleasures of the table, and having a good appetite, between his attacks he is led to indulge it whenever any dish to which he is specially partial is before him. Many of these people are not really gluttons, and therefore respond truthfully enough according to their light, when questioned, that they do not eat a large amount, for, in fact, they may not be aware that they are eating more than is good for them. One difficulty is that the generality of people do not know what is enough and what too much food; the ordinary estimate of the necessary amount is far too high. Another is that very few realize the fact that the process of digestion uses up nervous power; most imagine that the more they eat the more strength they will have, whereas the truth is that beyond the amount needed by each individual to repair waste in proportion to his expenditure in muscular or mental work, the rest is superfluous, and consumes in disposing of it nervous energy that might otherwise be utilized in more valuable ways.

Indigestion from a plethora of food may reveal itself by unpleasant taste in the mouth, with dry, parched tongue during the night, a congested feeling about the nose,

a sense of fullness in the epigastrium, a flabby tongue marked by the teeth; or in some cases the tongue becomes sore and blistered; and later, should the cause and symptoms persist, there is loss of appetite, nausea, flatulence with disagreeable breath. No cases of functional dyspepsia are more amenable to treatment if taken early, for they usually respond at once to a suitable diet and a gentle saline purgative with some carminative; but it is essential to discover the cause, for the patient, though eating less on account of loss of appetite, continues because of habit to eat too much; and, to be really effective, treatment should be on starvation lines, so as to secure to the over-taxed digestive organs that full measure of rest of which they stand so much in need. Excess of food is also a common cause of a form of chronic indigestion, which may show itself by symptoms that may scarcely be thought worthy of attention—flatulence, distension after food, drowsiness, a loss of the wonted energy, etc.; and these symptoms, if the cause be persisted in, may become very chronic indeed, and difficult to treat, for the habit of eating too much is perhaps as difficult to control as the habit of taking stimulant to excess or smoking too much, and there are few who will carry out faithfully the doctor's instructions. The truth is, in a chronic case weeks and weeks of care are necessary, and the very best resolutions are broken by the little extra food incidental to a dinner party; or the patient is induced to "seek other advice," for all chronic dyspeptics discuss their symptoms with their friends, and none have the courage to impart the doctor's opinion that they eat too much, but welcome the suggestion that they should see some one else. I have often been struck by the fact that a chronic dyspeptic patient can never be induced to tell you the particulars of the advice he has received, but contents himself with the assertion that the doctor under whose care he has been for some weeks did not understand his case. *Disobedience to law* may be said to stand out prominently as the cause of nearly all dyspepsias, though in none more than in the case of patients who suffer from excess of food.

It must not be forgotten that a patient may be indiscreet in the quality of his diet as well as the quantity, and though not indulging to excess, may continually eat food that disagrees with him. It is a very difficult question how far we can rely upon a patient's statement under this head, for there is nothing which blinds the intellect more than a preconceived idea, and there are very few accurate observers amongst our patients. They will tell you that milk disagrees, that they cannot eat fried fish, that they suffer when the smallest flavouring of onion has been introduced into a dish, that they can always tell by the after-effects when meat, say in the form of a stew, has been cooked more than once; the fads are endless, and though no doubt some of the statements of this kind we hear are correct enough, the majority are baseless and are advanced to explain a dislike which should really be regarded as a matter of taste. These cases are usually examples of nervous dyspepsia, and should be treated as such, or else they are patients who deliberately fall back upon their idiosyncrasies in order to explain symptoms that are really due to some bad habit which it is desired to conceal. But there are many ways in which patients may be indiscreet in the quality as well as quantity of their food. For example, quite a number take too much salt with their food, and in this way aggravate the tendency to an excess of hydrochloric acid; others are too fond of highly-seasoned food or of pastry or sweet things; or, again, the quantity of liquid imbibed at a meal may be too large. In such cases a very careful revision of the diet is absolutely necessary.

DIET.

To this question of diet I can only here refer very briefly. I may of course assume that the mouth has been examined and the teeth and gums attended to, and instructions given as to careful mastication and the necessity of avoiding work or exercise soon after a meal. For the rest, the diet must depend upon the nature of the case, though the majority of chronic dyspeptics do better on a little soft and easily digested food, such as tender white fish, chicken, or tripe, and a little well boiled rice with milk, than on slops; and we need scarcely be reminded that tea, coffee, sweet stuffs, alcohol, and all indigestible foods, including, amongst vegetables, turnips, carrots, parsnips, cabbage, etc., should be avoided. We are often

asked to prescribe a special diet, and no doubt there is a great temptation to skate on the thin ice of quackery in directing our patients how they should diet themselves, for they will insist upon minute details, and many doctors indulge their patients' whims to the fullest extent; and unfortunately it is, I fear, well within the mark to say that some of our most distinguished physicians have lowered both themselves and the profession by undue exactitude in the matter of dietetic details, a practice—I had almost said a trick—upon which many reputations have been established. It is of course our duty to advise in favour of a nitrogenous, or a starchy, or, it may be, a mixed diet, and to offer some hints in the shape of warning against indigestible articles of food, and here there is ample room for skill, as some people can digest certain articles when they cannot digest others of very similar nature—for example, potato may disagree whilst rice may not; or hard-boiled egg may be suitable, whilst a soft-boiled egg may cause nausea; indeed, there is no end to the idiosyncrasies met with amongst dyspeptics. It may be useful in some cases to insist upon all animal and most vegetable food being finely minced or put through a sieve or one of the useful modern nut-mills, so as to eliminate all hard pieces and reduce to a uniform pulp. This is a very useful expedient, and certainly does not savour of quackery. I should like to add that it is most undesirable to encourage any patient to dwell anxiously on details of diet. With dyspeptic neurotics, of course, the very opposite should be our aim; but in all ordinary cases of indigestion it is best to keep as far as possible to broad lines of information and advice, which can easily be applied in detail by the exercise of a little common sense.

THE MENTAL ELEMENT IN DYSPESIA.

Now let me return to the part played by mental disturbance in the production of dyspepsia. The class of patients I now have in mind when tracing the nervous or mental origin of their dyspepsia must be distinguished from those commonly recognized as dyspeptic neurotics. With the neurotic the dyspepsia is an abiding trouble; he is obsessed by his gastric symptoms, dwells upon them continually, sits in judgement upon every article of food presented to him, yet it is obvious to every one that if it were not the stomach it would be some other organ; that it happens to be indigestion is really an accident in the case; and, further, the particular symptoms as described by the patient usually bear very little resemblance to the account furnished by the patient suffering from the ordinary forms of functional dyspepsia due to the causes I have already referred to. Let us not, however, forget that the subject of neurasthenia does fail to digest his food and suffers in consequence, a vicious circle being established.

But apart from these victims of neurasthenia there is frequently another connexion between mental disturbance and dyspepsia—a connexion that is almost never recognized by the patient, and is unfortunately seldom observed by the doctor, for it is common for both doctor and patient to attribute depression to the dyspepsia when the dyspepsia is really induced by a depressed state of mind brought about by other conditions. A few cases will illustrate the point. A gentleman whose child met with a serious accident sustained a severe nervous shock when the news was taken to him, and this was followed by months of anxiety, with persistent dyspepsia as the outcome. In another instance a young man had failed to pass an examination, considerable importance being attached to the matter at home. A lady dyspeptic had, it was ascertained, been much worried by servants leaving and the difficulty in finding others. A young lady whose life was spent in the most depressing religious environment was victimized by dyspepsia. A gentleman with literary tastes compelled by force of circumstances to devote his energies to a depressing commercial life had dyspepsia without other cause. In another case a young lady had experienced a matrimonial disappointment; in another a lady was compelled to live under great domestic distress, she and her husband leading solitary lives in the same house; in another a young lady had the unenviable duty of acting as go-between for her father and mother, who were continually quarrelling; in another a trained nurse was greatly disappointed of the promotion she expected; in another a lady's home life was made

wretched by the continual grumbling of a very irritable husband.

Cases of this kind might be multiplied indefinitely, but I only desire to illustrate the type. These patients come to the doctor complaining simply of indigestion, and a careful and tactful search has to be made to discover the cause in the shape of some depressing circumstance of environment. Their cases stubbornly resist the ordinary medicinal and dietetic treatment, but respond to a well-directed attempt to remove the cause. If the environment can be modified—that is, if the circumstances themselves can be reached and altered (in some cases, perhaps, by plain speaking to relatives)—well and good; if not, the patient can perhaps be removed from them for a time, or, better still, may by a strong and encouraging effort be induced to take a different attitude towards them and gain a brighter view of life. A difficult undertaking this may be in some conditions, but the result will often repay the attempt, and sometimes has an effect that appears to be almost miraculous. At any rate, neither drugs nor diet, but a change in some life-circumstance, gives the clue to the successful treatment of very many cases of dyspepsia.

As further illustrating the success attending the discovery of the cause of an attack of dyspepsia and its removal, I may mention a few examples. A gentleman whose dyspeptic symptoms had lasted two or three months, and were apparently the outcome of a long period of anxiety on account of his wife's illness, went to see a surgeon, who, taking the case to be probably malignant and suitable for exploration, hedged over the diagnosis and yet left a very unfavourable impression upon the patient's mind, with the consequence that the symptoms grew worse. A consultation was held and a definite decision arrived at against organic disease and against operation, with the most happy results. A very similar case was that of a medical man who suffered occasionally for years from indigestion. He consulted a brother practitioner, telling him he thought he had a pyloric or a duodenal ulcer, and asked him to advise him on the question of operation, as he felt that a posterior gastro-enterostomy might cure him. They decided to come to me, and I felt justified in regarding the case as functional, dismissed the question of operation, and spoke very encouragingly. Within ten days or a fortnight I had letters from both my friends, the doctor and his patient (for they lived at some distance) conveying the intelligence that the symptoms had quite passed off and ordinary food could be taken.

Another phase of the nervous side of indigestion is to be met with in people who exhaust their nervous energy; and the result is the same whether the exertion be physical or mental, whilst not infrequently the candle is burnt at both ends. Practice amongst all classes of society furnishes many examples which belong to this group, and the fact will at once occur to your mind that one of the most useful of therapeutic measures in stomach cases is *rest in bed*. To this we ascribe the great majority of cures in cases of chronic functional dyspepsia in our hospital patients. That physical exertion, if excessive, will derange the digestive functions to the extent of producing a trying illness cannot be denied; here are some instances. A lady entertaining in her country house a party of friends fatigued herself by a long walk, and in consequence suffered, as she had often suffered before, from indigestion. She was unable to rest, and sought relief in careful diet and stomachic mixtures without success, but the attack soon yielded to rest after the departure of her guests. The wife of a member of Parliament, who was most energetic in furthering her husband's interests at the time of the election, developed a group of symptoms referable to her stomach. These she neglected, as she had suffered from indigestion before, and declined to forego any of her engagements, but sought relief in mixtures and diet, so far as she could exercise care, but with little result. I induced her to diet herself very carefully, and to lie in bed for three weeks, which she did with complete success; the symptoms, which had lasted twelve months, entirely disappeared.

Another example of nervous indigestion cured by rest in bed is the case of a lady who experienced a severe shock when travelling with her husband in an express train. The dress of a fellow passenger, a lady sitting

beside the door, was found to be caught in the door. The train was travelling at a high rate of speed, and my patient's husband attempted to release the dress by opening the door. It at once swung open, and could not be closed on account of the wind. He struggled with it for upwards of half an hour, until the next stop, and seemed all the time in imminent danger of falling out of the carriage. Weeks of indigestion followed the fright—flatulence with discomfort after food, depression, giddiness, etc.—and there was little or no improvement until she was induced to rest. And it is not alone cases that have an obvious nervous origin that are benefited by rest, for many chronic cases, the cause of which is not easy to determine, that prove most obstinate under dietetic and medicinal treatment, will yield to rest, and it must not be forgotten that a large number of the neurasthenic cases will respond only to rest with isolation from home influences, as treated by Weir Mitchell.

The limits of my paper prevent more than a very sketchy dealing with the subject, but my desire is to put a familiar subject in a somewhat novel light that may help to explain why we so often fail to effect a cure. I am myself so convinced of the practical importance of hunting out the inducing cause in each case of indigestion with a view to its removal, that I regard investigation of the secretory activity of the stomach, followed by prescription of appropriate diet and acid or antacid remedies, as being valuable, no doubt, for giving relief, but only too often insufficient for a cure; and foremost amongst these perplexing and often highly elusive causes stands mental and nervous disturbance.

An Address

ON

REFLEX PAIN IN DISEASES OF THE ABDOMINAL VISCERA.

DELIVERED BEFORE THE GREENOCK AND DISTRICT
FACULTY OF MEDICINE.

BY

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THERE is nothing actually new in the symptom of reflex visceral pain; what is really of importance in connexion with it is that we have come to know more definitely about its origin, and much more clearly about its clinical significance. This has arisen largely from the enormous strides which surgery has made within recent years. Previously, it was only through the accidental light thrown upon the subject by a necropsy that a certain symptom during life received its correct explanation after death. So that much depended upon the ever doubtful possibility of a necropsy whether or no a particular symptom would receive its right interpretation. Since, however, the surgeon has found it possible to operate with such impunity upon almost every region of the body, any obscure or persistent symptom is never allowed to pursue an uninterrupted course without an effort to afford relief by direct inspection. Thus, then, many a pain which hitherto had been recognized only as a probable indication of a particular disease, has, as the result of operation, come to receive a degree of certainty which renders it a valuable and positive factor in the chain of symptoms that collectively contribute to a correct diagnosis. I shall limit my remarks to reflex pains as they are manifested in affections of the viscera within the abdomen.

In order properly to appreciate the significance of a pain and the reason for its occurrence, I must outline briefly the normal anatomical and physiological factors which necessarily enter into all considerations of the subject. Pain in itself we must regard as Nature's peculiar and special way of indicating that her normal functions are being prejudicially or injuriously disturbed. That, at least, is its significance; but whether we are to look upon it as a separate and distinct manifestation of a newly awakened sense evoked through a special system