lungs showed at both apices old healed scars. The left base had firm, tough adhesions. The other organs showed nothing abnormal. Histologically the appearance of the lung sections were those of old healed tuberculosis. Sections of the bowel made at the site of stenosis showed thickening of the muscular layers and particularly of the submucosa, with proliferation of fibroblasts. The mucous membrane was in an atrophic condition. Sections from different points stained for tubercle bacilli were all negative.

The points of interest in this case are the length of time lapsing between the primary attack, forty years previously, and the shortness of the period—three months—during which the patient showed symptoms and was extremely ill. This is assuming that the history of "inflammation of the bowels" at the age of 25 was the primary attack of intestinal tuberculosis, and the details he gave of the illness give weight to this assumption, which is further supported by his claim to have enjoyed good health without a break up to the time when his final illness began. Excluding strictures of the rectum, obstruction of the bowel due to cicatricial contraction is a rare condition. A series of 70 cases has been collected (Bernay), and over a period of thirteen years the percentage of cases of cicatricial stenosis causing obstruction was 1.8 out of 669 cases at the London Hospital. According to Nothnagel, the only common causes are tuberculous and stercoral ulcers, but typhoid, dysenteric, duodenal and syphilitic ulceration may be followed by cicatricial stenosis. Tuberculous ulcers usually give rise to multiple stenoses, and in one case described by Nothnagel there were seven stenotic cicatrices.

PYLORIC STENOSIS WITH ACCOMPANYING SPASMODIC DYSPHAGIA.

BY

CAPTAIN E. B. BARTON, M.B., Ch.B., R.A.M.C.,

AND

LIEUT.-COLONEL H. H. C. DENT, M.B., F.R.C.S.,
L.R.C.P., R.A.M.C.(T.F.).

THE following case of pyloric stenosis presented considerable interest on account of an accompanying difficulty and pain in deglutition.

J. W. S., aged 36, previously in excellent health, developed gastric symptoms in August, 1916. He was treated in a military hospital from September 11th to November 10th, 1916, for dilatation of the stomach. At that time he had increasing dysphagia. In December, 1916, on two occasions attempts were made to pass oesophageal bougies. Finally he was informed that he had an oesophageal stricture.

Up to July, 1918, he was in a low category. He had lived on bovril, milk, and slops only, as he was unable to swallow anything solid. He was then admitted to the Clifton Military Hospital in a very debilitated condition. He complained of marked dysphagia, gastric distension and vomiting. The dysphagia had been constantly present since 1916, but was apparently not progressive. There was no regurgitation of food from the oesophagus. Regularly every two or three days he vomited a large quantity of fluid and mucus, sometimes streaked with blood.

A bismuth meal was given and the passage of the bismuth observed with the screen and the x rays. There was a distinct check in the forward peristaltic contraction of the phreno-cardiac portion of the oesophagus. The examination was repeated and the check appeared at a different level. There was very marked gastric delay. Bismuth still remained in the stomach after thirty-six hours. The opinion was formed that the condition was one of duodenal ulcer with pyloric stenosis and a reflex spasmodic stricture of the oesophagus.

On September 4th laparotomy was performed by a para-central incision. The stomach was found very much dilated. The cardiac end was normal. The pylorus was obstructed by a thick fibrous ring which was almost impermeable. Over this ring was a puckered scar suggesting an old duodenal ulcer. Posterior gastro-jejunostomy was performed, an opening being made $2\frac{1}{2}$ in. in length in the stomach and in the jejunum.

He stood the operation well and had hardly any post-operative sickness. He was soon on solid food, and, although the first monthful causes slight difficulty in

swallowing, yet he can eat a full meal with ease. He was up in three weeks. His weight was 8 st. 3 lb. before operation; now (October 10th) it is 8 st. 13 lb. He looks and feels an entirely different man. X-ray examination shows normal swallowing.

INEQUALITY OF THE PUPILS.

BY

T. STEWART BARRIE, M.B., F.R.F.P.S.G.,
GLASGOW.

THE question of the meaning of inequality of the pupils is always being raised for diagnostic purposes, especially in affections of the thorax. According to many authorities, "inequality of the pupils is always pathological";¹ but many observers are not so dogmatic, and admit that the condition occurs in from 1 to 10 per cent. of all cases.²

In order to gain some idea of the frequency of this condition I examined, for this peculiarity, in the course of my work as an ophthalmic surgeon in the Glasgow recruiting area, the eyes of 326 men who had been sent for special examination. Inequality of the pupils was found in 35 cases, a proportion of 10.73 per cent. In none of these cases was there any sign of ocular disease nor manifestation of disease of the central nervous system. The pupils reacted readily to light, and the consensual and convergence reflexes were normal; in each case the inequality persisted in the contracted state.

The inequality in every case was indisputable, the difference between the diameters of the two pupils being from one to two millimetres. This difference is not large, but as pupils are compared by areas it was easier to note differences than to measure them. For example, pupils having diameters of 3 and 2 mm. respectively have areas in the proportion of 9 and 4.

An analysis of these 35 cases gave the following results:

1. The left pupil was the larger in 21 cases, the right in 14.

2. The visual acuity without glasses was the same in 10 cases; the right eye had the higher visual acuity in 8 cases, the right pupil being the larger in 4; the left eye had the higher visual acuity in 17 cases, the left pupil being the larger in 13.

3. The refractive condition of the 35 cases was as follows:

Emmetropia	...	...	...	2
Hypermetropia	...	...	...	2
Hypermetropic astigmatism	...	...	...	2
Myopia	...	...	...	11
Compound myopic astigmatism	...	...	...	1
Mixed astigmatism	...	...	...	3
Anisometropia	...	...	...	9
Not recorded	...	...	...	5

The conclusions which may be drawn from this investigation are as follows:

1. Inequality of the pupils is frequent.
2. It is associated with all refractive conditions, with a tendency to be more frequent in myopic conditions.
3. The visual acuity is not affected adversely by the fact that one pupil is slightly larger than the other.
4. The left pupil is more frequently larger than the right.
5. Inequality of the pupils occurs as a physiological condition.

REFERENCES.

¹ Fuchs, *Textbook of Ophthalmology*, fourth edition. ² Hawthorne, *Clinical Medicine*.

THE Italian Minister of Finance has set up a committee consisting of the deputies Sanarelli, Maggiorino Ferraris, Rava, Landucci, and Belotti, Professors Flora, Vinaj, and others, with the Under Secretary of State as chairman, to investigate and report on the watering places and thermal springs of Italy, and the means of developing their usefulness and increasing their value.

WITH the object of preventing the evils due to the excessively high prices of medicines in Italy, powers have been given to prefects, on the representation of the provincial health council, to fix a maximum price for drugs in most common use. Contravention of this ordinance is punishable by fine up to £40; for a repetition of the offence the penalty is imprisonment up to the term of one year. The shop of the offending pharmacist may be closed temporarily, or in case of repetition permanently, by decree of the prefect.