ostomy. In many cases I have been disappointed to find that when the patients, three or four weeks subsequent to operation, passed from my care, the stomach still remained dilated, but in every case this symptom has disappeared by the end of the sixth month. In no case has hyperacidity persisted beyond five weeks.

In every case but one the bowels, almost always constipated prior to operation, have become normal in action. In all cases the general health has improved marvellously and weight has increased in every instance but one from 20 lb. to 66 lb. In the one exception, a highly neurotic maiden lady with retroverted uterus, only 12 lb. have been gained.

In no case operated upon for gastric ulcer has there been any return of haematemesis except in the one fatal case three hours after operation, that is, before the beneficial effect of the operation had had time to manifest itself.

Such, then, is the record of my cases. Is it sufficient to justify you in recommending your patients, victims of intractable gastric ulcer or pyloric stenosis, to submit themselves to surgical intervention? I have no fear of your answer.

Take then, gentlemen, your courage in both hands; tell your patients candidly of the perils of intractable gastric ulcer and of the hopelessness of the outlook in pyloric stenosis; ask them in no uncertain terms whether or no they are prepared to face the former or to resign themselves to the latter. Decide not rashly nor precipitately upon surgical intervention; but when once you have made up your minds that your treatment by medicinal means—potent and all-sufficient as I admit it to be in many maladies—is powerless in these disorders, then I ask you in the name of justice to hand over your patient to the surgeon, placing reliance upon one of the most beneficent, pain-saving, and life-preserving of operations—gastro-enterostomy—and not delay until the patient is a living wreck and the hour of dissolution is at hand, for such cowardly hesitation is unworthy of your calling, and gives surgery but small chance of demonstrating one of the greatest of its modern achievements—gastro-enterostomy.

HAEMORRHAGE FROM A CHRONIC GASTRIC ULCER: OPERATION: RECOVERY.

By C. FIRMIN CUTHBERT, M.R.C.S.Eng.,
Gloucester.

In a paper read before the Gloucestershire Branch of the British Medical Association in April, 1903, on the surgery of dyspepsia, I dwelt upon the importance of not accepting this term otherwise than as the name of a symptom. I also pointed out how often this symptom depended upon conditions which required surgical treatment. Further, that without a careful examination the real cause of the trouble might be overlooked. Affections of the teeth and of the alimentary canal, together with diseases inside and outside the abdominal cavity, were considered, especially acute and chronic ulcers, and pyloric obstruction due to simple adhesions or malignant disease. Some diseases of the kidney, and in particular movable or "dropped" kidney, accompanied by urgent gastric symptoms (described by Diethl as gastric crises) were alluded to, and in addition biliary colic, ovarian and uterine diseases, and diseases of the appendix. Special stress was laid upon gastric haemorrhage. I said that in no other condition was haemorrhage allowed nowadays to go on to such a narrow margin between life and death as in gastric ulcer, and I advocated that an operation should be undertaken to allay this haemorrhage. I detailed the case of a young man who nearly died of bleeding from the stomach, and upon whom I operated in December, 1901. He made a good recovery, and has been well ever since.

The following is another case of similar urgency:

I have known W.T.H. for about 17 years. When first seen he was 24 years old, and it was probable that he then had a gastric ulcer.

History.

During the past two-and-a-half years he has had four illnesses, with attacks of haematemesis and melaena. On the morning of August 10th, 1903, he vomited blood in his shop, and then walked about half a mile to his home, and I saw him about two hours afterwards. He had vomited a quart of blood. He was blanched, restless, and throwing himself about the bed.

The usual remedies, such as egotine, strychnine, and digitaline hypodermically were used, together with saline solution by the rectum, and turpentine capsules given by the mouth. He was fed by the rectum

with peptonized milk, and saline rectal injections were also given. No bleeding ensued for four days. Feeding by the mouth with 2 oz. of peptonized milk every four hours was then commenced. This was followed in twenty-four hours by another serious haemorrhage.

The hypodermic injections were again resorted to, with the same temporary good result, but were followed in another twenty-four hours by copious haemorrhage, although nourishment by the mouth had been stopped. These recurrences of bleeding took place at intervals of two or three days, and it was very evident that they could not be allowed to go on. He was removed on the evening of August 21st to the Nursing Home about half a mile distant, with a view to operation. He had no haemorrhage that night or on the following morning.

Operation.

On August 22nd, at 3 p.m., the abdomen was opened in the middle line above the umbilicus. The stomach and omentum were adherent to the liver at the pylorus. The adhesions were soft and easily separated. The pylorus itself looked and felt healthy. The stomach was pulled well up into the wound, surrounded with hot sponge cloths, and freely opened by horizontal incision, commencing 1 in. from the pylorus, midway between the lesser and greater curvatures, and extending 4 in. towards the fundus. This gave a good view of the interior of the stomach, which was thoroughly washed out. The pyloric opening felt quite healthy, and the finger passed easily through it. Saline solution at temperature 110° was put into the abdominal cavity, and retained as well as possible for a few minutes. My assistant pushed up the posterior wall of the stomach by passing his finger into the foramen of Winslow. On the posterior surface of the stomach, quite at the upper curvature, close to the pylorus, was a deep-cut ulcer 1 in. in diameter, the edges of the mucous membrane overhanging it, and, as it were, standing out in relief. This ulcer had entirely penetrated the mucous membrane, and had extended well into the muscular wall of the stomach. The mucous membrane around it was swollen, but not much inflamed. The ulcer was situated beneath the adhesions to the liver, and perforation was prevented by the thickening of the peritoneal coats of the stomach. In the centre of the ulcer was a projecting papilla, with a small black point on it, which was evidently a clot plugging a vessel. The whole surface of the ulcer was seared with the actual cautery, and in doing this the suspected artery started bleeding freely. From the size of the vessel it looked as if it was the main branch of the gastro-epiploica dextra, and was obviously the source of the former haemorrhages. The ulcer was pressed well up into the wound, and thereby the bleeding was controlled. A purse-string suture of No. 2 silk was passed round, ½ in. from the centre of the ulcer deep into the tissues, and tied, and the pylorus allowed to fall back. It was then seen that the ligature was effectual, and the bleeding stopped, but in order to make certain, the ulcer was again pushed up into the wound. The mucous membrane was stripped back all round the ulcer, and another purse-string suture put in, half an inch outside the first. The ulcer was by this means completely covered in, so that its seared surfaces came together. The mucous membrane of the stomach was then sewn together with a continuous suture of No. 2 silk, as I am of opinion that it is a great mistake to put in a small silk continuous suture, as it is so liable to break at the time, or afterwards tear out; No. 2 silk does no harm, is reliable, and the continuous suture saves time. The peritoneal surfaces of the stomach wound were then brought together by broad Lembert sutures and the abdominal wound closed with fishing gut.

After-history.

On the next day (August 23rd) I found that the patient had had a comparatively good night, and had vomited only some mucus, which was slightly tinged with blood, as if it had come from the cut edges of the mucous membrane of the stomach. He was fed by the rectum.

On August 29th he was going on well, and feeding by the mouth with peptonized milk and brandy was commenced. Hypodermic injections of digitalin and strychnine had been given periodically after the operation. He had had very occasional vomiting of clear mucus and gastric juice. On September 3rd the wound was quite healed, and all the stitches were removed. On September 11th he was going on well, and had a mutton chop for dinner. On September 24th he sat up in bed a little. Especial care was taken in feeding, so as to give the ulcer a good chance of getting quite sound. On October 6th he got up and sat in a chair, and on October 9th he went back to his own house, feeling very well, but still looking very pale and thin. On January 29th, 1904, he told me that he felt quite well, much better than for years.

The result of this case has been so satisfactory that I venture to publish it in support of the views which I hold, that haemorrhage from the stomach should be brought more often, and sooner, under surgical control. Mr. Mansell Moullin's excellent account of his operations in cases of erosive gastric ulcer, has done much to bring these cases into the hands of the surgeon, and has stimulated us to operate in cases which have hitherto been delayed. Although in ulceration of the strictly erosive character it is said that operation does not prevent the liability to further recurrence of haemorrhages, yet in such a case as the one I quote it gives reasonable hope of preventing such return. The treatment of gastric ulcer by gastro-jejunostomy, so as to ensure physiological rest and thereby healing of the ulcer, has been so strongly advocated, and carried out by Mr. Moynihan and other surgeons so successfully, that there is no doubt that

those hitherto unsatisfactory cases which extend over years, and eventually present themselves with the most alarming and urgent symptoms, will become greatly reduced in number, and when such a case as that which I have described again presents itself, I shall not hesitate to open the stomach and endeavour to find the actual cause of the haemorrhage. If it should prove to be of the "erosive" variety, one can ligature the several bleeding points; and if, as has been described in some cases, no actual bleeding point is discovered, then the mere fact of exposure and manipulation of the inner surface of the stomach, together with hot irrigation, may be expected to do good. With the greatly-improved methods of gastro-jejunostomy and the comparative rapidity with which this can now be done, and with the successes thereby obtained in the treatment of gastric ulcer, there will no doubt arise considerable difficulty in deciding whether gastro-jejunostomy, or attempting to find the bleeding surface, should be preferred, but each case will have to be judged on its own merits. It would be very disappointing after a gastro-jejunostomy had been done to find haemorrhage recurring, and this seems not altogether unlikely if such a large artery has been ulcerated as in the above case.

OZAENA (ATROPHIC FETID RHINITIS), A CAUSE OF GASTRITIS.

By ADOLPH BRONNER, M.D.,

Senior Surgeon, Bradford Eye and Ear Hospital; Laryngologist, Bradford Royal Infirmary.

ONE of the most characteristic symptoms of ozaena, apart from the offensive smell, is the peculiar pale, ashy, complexion of the patient. A bad taste in the mouth in the morning, with vomiting, and no appetite are other common complaints. These symptoms are due to the passing of the offensive nasal discharge full of bacilli into the stomach, and their deleterious action on the mucous membrane and on the contents of the stomach. We know that even the acid contents of a healthy stomach do not kill all the bacilli, as large numbers of them and their spores pass into the intestines unharmed. Bacilli frequently invade the mucous membrane of the stomach and set up extensive inflammation, which causes fatty degeneration of the glands and consequent incurable indigestion. They also act on the stomach contents, decompose them, and produce bodies which are extremely harmful and irritating, and in some cases they also cause putrefaction. We must remember that in cases of ozaena there is a constant trickling down of offensive mucus into the stomach, day and night for years, not only during the periods of digestion, when there is a plentiful supply of hydrochloric acid, but also between meal-times when there is very little HCl. to destroy the bacilli. It is not surprising that under these circumstances the stomach contents are in a very active state of fermentation and decomposition, and that the mucous membrane is in a condition of chronic inflammation. I have washed out the stomach in several cases of ozaena in the morning, and the offensive condition of the contents surpassed even my most vivid expectations.

For some reason or other (possibly due to the contamination of the air by the large number of mills and factories) ozaena is very common in the West Riding of Yorkshire, and yet how often is it overlooked, and even when diagnosed how carelessly is it treated? I recollect extremely well a correspondence I had not very long ago with a well-known physician. He had been treating a lady for some considerable time (and I may say unsuccessfully) for indigestion and vomiting. She consulted me for an offensive nasal discharge. I diagnosed ozaena, and, hearing that she was under treatment elsewhere, wrote to the physician and suggested that perhaps the ozaena might be the cause of the gastric trouble. I was told that it was ridiculous to think that this could be the case, and that specialists should confine themselves to their own specialities. Anyhow, the vomiting soon disappeared when the nasal discharge was cured. In another case a girl complained of offensive breath and vomiting. She had been treated for indigestion for some time, had had most of her apparently sound teeth removed, with no results. She was suffering from ozaena. I could relate numerous similar cases.

The methods of treating ozaena are often most remarkable. Some of the older surgeons seem to think that ozaena is due to caries of the nasal bones (generally syphilitic), and their

treatment consists in scraping away as much of the contents of the nasal cavity as they possibly can.

I do not intend to discuss the various methods of treating ozaena; they are legion. In many cases one or more of the accessory cavities of the nose are affected, and until these are opened up and treated we can naturally not cure the ozaena. I have tried numerous local applications, and find that formalin, used as a spray or douche, is by far the most efficacious. It prevents the formation of crusts, and removes the offensive smell better than any other remedy I know of. I also in bad cases apply trichloroacetic acid or the galvanocautery to the diseased mucous membrane.

AN INSTANCE OF ADIPOSIS DOLOROSA IN TWO SISTERS.

By J. A. HAMMOND, M.B.,
Shanklin.

DR. CHEVERS in the BRITISH MEDICAL JOURNAL for April 2nd, 1904, calls attention to a case of adiposis dolorosa occurring in a male whose father and sister both had the same disease. At the present moment I have under my care a case that also illustrates the fact that this disease may at times be a family one. The patient is a stout woman of 61 years. She has had six children and one miscarriage. There is a fairly strong alcoholic history. The disease started when she was 35 by the deposit of localized fatty swellings in both forearms. At the present moment they are also situated on the thighs and the abdomen. They vary in size from a small orange to that of a walnut. The hands, face, and feet are quite free.

Pain has all along been a marked and persistent feature. Associated with this is considerable tenderness when the swellings are touched. There have been no haemorrhages, but the skin is somewhat more pigmented than usual. There are no mental symptoms and she has never suffered from any form of fit. No change in the thyroid can be made out clinically. The accompanying photograph of the arms may give some idea of their appearance. Although I have not been able to see the patient's sister my partner has examined her. She is a woman of 40 years. She has had seven or eight children and several miscarriages, so there is possibly a specific history in this case. In this latter instance the disease started some years ago, in much the same manner, with local tumours in the arm, and fresh ones are gradually forming elsewhere. Here, again, pain has been a noticeable element.

THE London School of Dental Surgery gave a *conversazione* on June 13th at the Royal Institute Galleries. Prizes were distributed to the successful students by Sir W. J. Collins. The Prince's Orchestra was in attendance, and exhibitions of electrical experiments, abnormal crystals, microscopic objects, and wireless telegraphy were given by Mr. Chisholm Williams, Mr. Charters White, Mr. J. Howard Mummery, and Mr. R. Kerr respectively.

REQUESTS TO HOSPITALS.—Under the will of the late Mr. George Handyside, of Newcastle, £20,000 has been bequeathed to the Newcastle Infirmary, £10,000 each to the Whitley Convalescent Home and the Gateshead Children's Hospital, and £3,000 to the Newcastle Eye Infirmary. The late Miss Elizabeth Esther Gore, of Hove, left £100 to the Sussex County Hospital and £50 to the Brighton and Hove Dispensary. Mr. Samuel Baker Coates, of Stanton Drew, Somerset, bequeathed £200 each to the Bristol Royal Infirmary and the Bristol General Hospital.