derness, some muscular rigidity, and dullness on percussion; but on deep palpation the outline of the distended and thickened caecum could be distinctly felt. With this attack there was no haemorrhage and little mucus in the stools, but there was at one time aphthous stomatitis, an occasional concomitant of colitis. There were no signs of appendicitis, and it was evident that the condition was one of pericolicitis dextra; this slowly improved under treatment, though the walls of the caecum and ascending colon are still abnormally thick, and the whole colon is dilated.

Apart from its direct importance, pericolicitis has a significant bearing on the differential diagnosis of obscure abdominal lesions; if on the right side it may produce symptoms and local signs difficult to distinguish from periappendicular lesions in the more acute cases, or from malignant disease of the caecum in its more chronic form; if on the left side, the pericolicitis may be overlooked, the case being regarded as one of "chronic constipation" until some more formidable complication develops, or if there is much distension of the bowel with inflammatory induration malignant disease of the sigmoid may be erroneously diagnosed.

ULCERATIVE COLITIS.

In its most severe and characteristic form, tropical dysentery, the symptomatology of ulcerative colitis is well known, and of recent years much attention has been given to cases coming under Subgroups 2 and 3—that is, to epidemic outbreaks of "asylum dysentery" such as that so ably described by Gemmel,¹ and to more limited outbreaks, such as that described by Dr. Carver in his communication on acute infective colitis to the Medical Society of London last session. Of the sporadic forms, "simple" or "idiopathic" ulcerative colitis has obtained general recognition since Dr. Hale White published his series of cases in *Guy's Hospital Reports* for 1888. Recent pathological and bacteriological investigations have tended to bridge over the differences between the several forms of ulcerative colitis and to approximate them to dysentery proper.

As to the clinical characteristics of ulcerative colitis, all that can be said here is that in typical cases the diagnosis is clear owing to the coexistence of: (1) Symptoms of intensely acute colitis with pain, diarrhoea, tenesmus, characteristic brownish-red stools of viscid mucus and blood; (2) severe constitutional symptoms, usually high fever, and always marked prostration and wasting; (3) a third characteristic feature is the frequency of serious local complications—perforation, peritonitis, local or general, severe haemorrhage, and uncontrollable diarrhoea. The diagnosis is, however, not always so easy, the characteristic complex of symptoms may not be present until quite late in the disease, the onset may be insidious and misleading; indeed, chronic diarrhoea without the characteristic stools may be the only definite symptom. In this, as in the other and less severe types of colitis, great variations will be found, and in atypical cases the true nature of the disease may only be discoverable by critical scrutiny of the symptoms, systematic investigation of the dejecta, and careful physical examination of the colon.

REFERENCES.

¹ BRITISH MEDICAL JOURNAL, 1905, i, p. 466. ² Arbuthnot Lane, *Lancet*, 1903, i, p. 152. ³ M. de Langenhagen, *Muco-membranous Enterocolitis*. ⁴ BRITISH MEDICAL JOURNAL, January 13th, 1906, p. 1898.

TWO CASES OF RUPTURED DUODENAL ULCER.

WITH A NOTE ON THE EFFECT OF POSTURE ON THE LOSS OF LIVER DULLNESS.

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THE two following cases are good examples of perforation of the duodenum without either vomiting or abdominal distension.

CASE I.

E. S., aged 32, a painter, was admitted on October 9th, 1905, at 8.30 p.m., suffering from an acute attack of pain in the abdomen.

History.

He gave the following history: For the past nine years he had suffered from severe pain in the epigastric region, coming on sometimes immediately and sometimes an hour and a half

after food. The pain was accompanied by abdominal distension and palpitation of the heart.

At 4 p.m. on the day before admission, the pain was more severe than usual, but he continued to work.

At 11.30 a.m. on the next day, while working, the pain came on so severely he was obliged to go home. He attempted to walk, but was obliged to lie down by the roadside. There was no vomiting, the bowels did not act, and no flatus was passed. At 2.30 p.m. $\frac{1}{2}$ gr. morphine was given previously to sending him to hospital.

Condition on Admission.

He was quite warm and not collapsed. The pulse was 120 and the temperature 101° F., with the tongue moist and only slightly coated. The abdomen was uniformly painful, retracted, and very rigid. It was extremely tender, but no mass or dull area could be made out. The liver dullness was present.

Operation.

At 9 p.m. a median incision was made from ensiform cartilage to umbilicus. On dividing the peritoneum gas escaped at once. The ulcer was found in the duodenum 1 in. from the pylorus. The ulcer was closed by one suture of thick catgut through all the coats of the bowel. This was buried with Lembert sutures of fine catgut. The peritoneal cavity was washed out with hot saline solution, and drained from both flanks and from above the pubes. Rubber tubes only were used. The incision in the epigastric region was completely closed.

The drainage tubes were removed twelve hours after the operation, and recovery was uneventful.

CASE II.

P. P., aged 58, a cartman, was admitted on January 27th, 1906, at 3.30 a.m., suffering from acute pain in the abdomen.

History.

At 10 a.m. on January 26th he felt sudden severe pain at the lower part of the abdomen. The pain increased in severity, and two hours later he was found lying on the ground doubled up with pain. At this time the pain, it was stated, shot into the right testicle. Since the commencement of the attack the bowels had not acted and no flatus had been passed, yet he had never vomited. A week previously he had consulted a chemist for what he called a "kidney attack."

Condition on Admission.

He looked very ill, and was collapsed. The pulse was irregular and small, 135; the temperature 99° F. The abdomen was retracted, immovable, and extremely rigid. It was tender all over. The left flank was dull, but the right was resonant. The liver dullness was absent in the nipple line and in the mid-axillary line. The urine contained albumen, but no pus or blood.

Operation.

The operation was similar to that in the first case, the ulcer being similarly situated. The peritoneal cavity contained a large quantity of bile-stained fluid. It was washed out and drained from both flanks and above the pubes. His condition never improved, and he died twenty-four hours after operation.

Necropsy.

A post-mortem examination was made. There were two ulcers close together in the duodenum. One of them had perforated, the aortic valves were very calcareous; two of the cusps appeared to have fused together.

It will be observed that the liver dullness was absent in one of the cases. I have noticed in connexion with this loss of liver dullness that the dullness can be made to return by getting the patient to roll on to his right side; but that when the patient is turned on to the left side the dullness is not at once again lost, but only after some jerky movements, such as coughing or retching, have been made.

The explanation appears to be that, when these cases are turned on to the right side, the liver returns to its accustomed place, and there sticks until some sudden movement of the diaphragm shakes it off. It is, therefore, of value to bear in mind how this diagnostic sign of pneumocoele is altered by change of position.

MR. JAMES CANTLIE, speaking at the Commemoration Day proceedings at Livingstone College last week, said that in tropical countries disease struck down its victims with terrible suddenness, and it was necessary that ordinary missionaries should know how to deal with the more common diseases. People said that a little knowledge was a dangerous thing, but the course at Livingstone College gave to missionaries exactly the teaching they required. He regretted that the chief missionary societies had not dealt with the matter adequately by sending missionaries to uncivilized lands without proper equipment in the way of medical knowledge. They were juggling with men's lives.