neuritis. It is interesting to note that optic neuritis is not mentioned as occurring in enteric fever by either Fagge, Osler, or Strümpell, while Sir William Broadbent, in *Quain's Dictionary*, mentions it only as an almost pathognomonic sign of meningitis. On the other hand, Gowers speaks of it as being not uncommon in both enteric and scarlet fevers; and Taylor records a similar case that has come under his notice.

REFERENCE.
1 *Diseases of the Heart.*

A CASE ILLUSTRATING THE DIFFICULTY OF DIAGNOSIS IN GASTRIC ULCER.

By W. CLARK ALEXANDER, L.R.C.P. and S. EDIN.,
Bowdon.

X. Y., aged 35, had suffered from dyspepsia since boyhood. The pain, seldom acute, occurred two or three hours after meals. He suffered also from flatulence and constipation, seldom vomited, and had had no hæmatemesis. For a fortnight before the present attack he had been very constipated, and the feeling of nausea and discomfort after food had increased. The pain was slight.

On February 23rd I found the patient, who had just returned from a long railway journey, in acute pain over the epigastrium. At night he vomited about a pint of bile and mucus, and felt relieved. Next day the acute pain was better, but there was tenderness over a small area, 2 to 3 inches above the umbilicus. Milk diet was ordered and a purgative prescribed. As it did not act, enemata were ordered, but with no result. On the fourth day small doses of castor oil were given, and the bowels moved twice; the motions soft, with some hard pieces. The feeling of soreness was not relieved, and at times the pain was fairly acute. There was now some distension of the abdomen and epigastrium, and a feeling of resistance on palpation over the latter.

On March 3rd, as the pain was constant, the patient was seen by Dr. Dreschfeld, who diagnosed some slight intestinal obstruction, probably due to adhesions. He advised opium and belladonna pills, and a continuance of fluid diet and enemata. As the latter wholly failed to relieve, I returned to small doses of castor oil. The bowels acted on several occasions, and some quite large hard pieces were passed. After a motion the patient felt that something had moved from the tender area, and the pain got somewhat better, but it gradually came back. I then resorted to large enemata of olive oil (with the foot of the bed raised) which relieved wonderfully for a time, but after some hours the pain returned.

On March 17th, Dr. Dreschfeld again saw the patient, and advised a surgical opinion.

On March 20th, Mr. T. Jones saw the patient, and coincided with the theory of adhesions causing obstruction, and advised laparotomy. After the day I first saw the patient the symptoms, subjective and objective, pointed to some intestinal lesion. There had been no vomiting, no pain referred to the ingestion of food, and the pulse and temperature had been practically normal.

OPERATION.

An incision was made in the middle line 4 inches long, extending upwards from 1 inch above the umbilicus. Colon presented at the lower angle of the wound; it seemed quite healthy and free from adhesions. The liver was much adherent to the abdominal wall, and on careful separation a small escape of gas was noted, having the odour of sulphuretted hydrogen. On further exploration by the probe and sinus forceps about 3j of pus escaped. The peritoneum at the lower angle of the wound was sutured, a large drainage tube inserted into the abscess cavity, the wound in the abdominal wall packed with iodoform gauze, and then left to granulate. The patient had a good night but the wound discharged very freely, and in the morning the dressings, sheets, and nightclothes were saturated. On removal of the dressings a great rush of discharge came through the drainage tube which seemed like stomach contents; this was verified by further examination.

The diagnosis now was gastric ulcer, localised peritonitis, perigastric abscess. This diagnosis Mr. Jones supported on

seeing the patient next day. Nutrient enemata were now given every three hours (3ij peptonised milk with half an egg and a little brandy, alternating with a suppository of peptonised beef). After the first twelve hours the flow of stomach contents ceased, and a viscid bile-stained fluid was freely discharged.

Despite the greatest attention to nursing and feeding, the patient gradually sank, and died five days after the operation, apparently from rapid emaciation through pure lack of nourishment. The temperature rose a little from the time of the operation till death, its greatest height being 100.6° C.

At the necropsy (at which I was assisted by Dr. Gardner, of Manchester) an ulcer, evidently, from the condition of its edges, of long standing and of about the size of a crown piece, was found on the anterior stomach wall in the lesser curvature and close to the pylorus. The site of the ulcer corresponded on the outer side of the stomach with an abscess cavity which would hold about 3iv of fluid, and was in the midst of dense and strong adhesions binding liver and stomach together. The floor of the ulcer had practically been formed by cicatricial tissue and adhesions, and an abscess having formed at the expense of these, the stomach wall had given way at the point of least resistance.

As to the cause of the rapidly fatal issue, even after the establishment of the gastric fistula, there was no evidence of shock; there was no peritonitis or further pus formation; but the fact of the very free exit for the digestive juices externally would lead one to believe that the nutrient enemata could not be prepared for assimilation.

The points of interest in the case are: The occurrence of a gastric ulcer of this size with only the ordinary symptoms of dyspepsia. (The pain had no reference to the ingestion of food, and at no time had there been any hæmatemesis.) The pain being relieved so much by the olive oil injections—a fact which made the diagnosis of ulcer still more difficult. The absence of vomiting during the month he was in bed prior to the operation. The absence of any connection between the ingestion of food and the occurrence of pain in this acute attack, although one would think the ulcer during this period would be easily irritated; and the extreme and rapid emaciation which obtained after commencing the nutritive enemata.

Reasoning from analogy it may be assumed that the correspondence of the pain to the ingestion of food in gastric ulcer must vary greatly according to the position of the ulcer, as in this case the site of the ulcer on the anterior wall and close to lesser curvature would lend itself to escape irritation, either by food passing over it or being deposited in its floor.

A CASE OF ABSCESS OF ABDOMINAL WALL FOLLOWING TYPHOID FEVER: INCISION: RECOVERY.

By GEORGE WESTBY, L.R.C.S.I., M.R.C.P.I.,
Liverpool.

MR. R., aged 21, was under the care of Surgeon-Lieutenant Steel, A.M.D., from February, 1896, to the end of May, 1896, as reported by him in the *BRITISH MEDICAL JOURNAL* of January 2nd, 1897. The particulars of the case prior to coming under my charge, are briefly these: Mr. R., in February, 1896, was found to have developed typhoid fever, complicated with peritonitis, passing on to abscess of the abdominal wall, which was incised; it was not considered advisable to do more at that time, owing to the excessively weak state he was in. This abscess apparently healed, and he returned home to Liverpool at the end of May; he was still weak, but improving, while the aperture in the abdominal wall to the right of and below the level of the umbilicus had apparently closed.

I was summoned to see him at 4.30 A.M. on June 18th, and found that he had had a sharp rigor, followed by pain in the back, and afterwards by pains all over the body, comparable with those from which he had suffered during an attack of influenza. Around the situation of the former wound there was no special pain or tenderness on pressure, but the cicatrix