of the state of the viscera within. Few who had seen this preparation for the first time after death, would have thought it possible to verify* the presence and effect of the moderate amount of lymph which bound together the stomach and liver: while the specific signs that I made out were additionally trustworthy, from their having been detected some months before the necropsy revealed their import.

The circumstances calculated to mislead the diagnosis have already been alluded to. But some of them deserve special mention, from the erroneous views which they may serve to refute.

It is generally supposed that ulcer of the stomach interferes but little with nutrition; and hence that the presence of extreme cachexia, in a case otherwise doubtful, would tend to indicate the cancerous character of the lesion. But the clinical study of gastric ulcer quite contradicts this view. During youth, it is true that we often meet with cases in which there is little emaciation or wasting; and sometimes, though more rarely, no very marked loss of colour. But, in middle or advancing life, it is very unusual to find the ulcer present, without the existence of a degree of cachexia and exhaustion, such as it is often quite impossible to distinguish from those seen in cases of cancer. And, since it is during these epochs of life that both† maladies are most liable to occur, it is important that we should not lay any undue stress on a sign which would so often mislead us.

The imminent risk of perforation, that threatened the life of the patient, is another interesting feature of this case. Strictly speaking, perforation had indeed occurred long before. In other words, the wall of the stomach had long been penetrated by the ulcer; and its floor, now formed entirely of new tissue, was the seat of the ulceration. The gradual destruction of the lower half of this mass of organised lymph had excavated a kind of small sac, external to the stomach itself, and communicating with it by the large orifice of the ulcer: and there can be little doubt that, had the patient not died of hæmorrhage and exhaustion, the delicate parietes of this sac would soon have given way, and thus caused an effusion of the gastric contents into the cavity of the omentum behind the stomach. Such a secondary form of perforation is almost the only one by which an ulcer of the posterior surface of the stomach generally opens into the peritoneal cavity.

Lastly, the termination of this case well exemplifies the danger which, in ulcers situated on this aspect of the stomach, more than compensates the diminished risk of perforation. The very adhesion which here opposes penetration of the organ, by binding it down to the apposed pancreas and liver, brings it into close proximity with the large branches of the celiac axis. And any extension of the ulcerative process in the adherent lymph is pretty sure to denude and erode one or other of these vessels, with the result of a dangerous hæmorrhage. In the instance before us, though the ulcer was situated too far to the right to touch the splenic artery, it involved the next most frequent source of such copious hæmorrhage:—namely, one of the primary or secondary gastric branches of the hepatic trunk.

The cavity in the right lung had the size of a walnut; and there was a scanty deposit of crude tubercle scattered throughout the opposite organ. This complication, again, is by no means uncommon in the ulcer of the stomach.

Brook Street, Grosvenor Square, Dec. 11th, 1855.

* Where everything depends on minute accuracy, I may be excused if I allude to some of the means by which I am accustomed to pursue it in such cases as that we are discussing. At the time of making a physical examination, it is my practice to delineate all the suspicious signs on paper, so as to add to my notes of the case, a map of the belly, specifying the site of its different viscera, and the sound, resistance, etc., they afford. And, lastly, in examining a case after death, I read over the written diagnosis before making the necropsy.

† This proposition, which will probably be a novel one to the reader, he will find more fully stated in an article by the author on the "Pathology of the Gastric Ulcer", in the forthcoming January number of the *British and Foreign Medical-Chirurgical Review*.

Peterborough Infirmary.

UMBILICAL HERNIA, WITH RUPTURE OF THE INTESTINE AND SUBSEQUENT CLOSURE OF THE OPENING.

Communicated by Dr. HENRY PORTER, House-Surgeon.

SEPTEMBER 29th, 1855. Sarah Rowell, a stout hearty woman, aged 65 years, had been attended for a fortnight suffering from the ordinary symptoms of dyspepsia, with gastrodynia, but no other complaint; except telling me that yesterday a large quantity of "yellow water" had come away from her body while in bed. To-day, I find her in bed, and am told that more water has come away from her; and she wishes me to make an examination. On doing this, the following case discloses itself; and, in company with Dr. Walker and Mr. T. Walker, is carefully examined.

She states, that fifteen years ago she ceased to menstruate, and then for the first time observed a small tumour at the navel, which disappeared when pressed. This continued to increase for five years, since which time it has remained about the same size. The tumour is now about twice the size of a man's head, much lobulated, and towards the lower part on the left side is a large sloughing ulcer opening into the gut, and giving out a yellow foetid discharge, composed of partially digested food. The whole tumour is tympanitic, and is capable of being diminished by pressure. At the opening in the parietes, which is half the size of the palm of the hand, are apparently two large rounded coils of intestine. On inquiry, she states that about a month ago she fell down with violence, and that the tumour caught the ground; since that time she has felt pain at the part where it has since ulcerated. Nothing was done for this; and on the evening of September 28th, she felt a gush of water, which was found to proceed from a small opening, which has since increased, by the sloughing of the integuments, to its present size. She states that the sore still discharges large quantities of yellow matter. She yesterday took a dose of castor oil, and has since passed a motion *per anum*.

Oct. 2nd. To-day there is no doubt that faecal matter passes through the opening, of a light yellow colour, containing portions of undigested orange, crusts, etc. An opening is now perceptible in the coil of intestine nearest the left side, about the size of a sixpence, and the shape of a leg of mutton. The appearance of the ulcerated surface is rather more healthy, though still extending. A motion was passed *per anum* last night, and her general health continues good. Ordered to dress the ulcer with ceratum cetacei, and to take an effervescing saline mixture, containing a small quantity of sulphate of magnesia.

Oct. 5th. The tongue is very black, and the pulse irregular, but the patient reports herself in good health. A motion is occasionally passed *per vias naturales*, but the discharge from the opening continues.

Oct. 11th. Since last report, ulceration has extended considerably in the superficial textures towards the left side, but no further openings have formed in the bowel; and, indeed, as more of the motion has passed *per anum* and less by the wound, it is possible that the opening which does exist may be contracting. The tongue is cleaner, the appetite good; she takes a pint of beer a day, and makes no complaint.

Oct. 24th. For the last few days, no discharge has proceeded from the part, except a little pus, and the motions have passed naturally. She does not complain of pain in the ulcer, and no extension of the slough has taken place.

Oct. 29th. She has been down stairs the last few days; and the bowels have been constipated; the discharge of faecal matter again coming away from the opening. Ordered to take liquoris sennæ dulcis semijuncium bis die.

Nov. 24th. The bowels are now regular, but some slight faecal discharge continues to escape from the wound. The surrounding ulcer is rapidly healing by healthy granula-

tions; but two or three yellow spots, the size of a pea, are scattered over its surface. She is recommended to keep quiet in bed, and continue the aperient medicine.

Dec. 1st. The old lady has been down stairs in her chair for some days; the ulcer having completely healed, and the evacuations proceeding quite naturally by the aid of gentle aperients; but she complains of pain in the upper regions of the abdomen, with much flatulence and sense of tightness, especially after food. The tumour is well supported by means of a handkerchief, and no topical application is used.

REMARKS. The history of this case appears pretty clear, viz., that an umbilical hernia has existed for at least fifteen years, increasing gradually, until at last it arrived at its present enormous size, gradually distending the abdominal parietes to suit its dimensions. The fall which she received a month before the date of the commencement of the case, in all probability would cause inflammation of the parts; and from such inflammation it is likely that adhesion may have been formed between the sac of peritoneum and the abdominal parietes, these structures at the same time thinning, until at last the rupture took place, and ulceration was established by the irritation of the acrid products which escaped through the opening in the bowel. But when I look at the case as it now stands, I feel incapable of accounting satisfactorily for the process by which the opening has been closed, and the natural course of the excretion established. I must therefore apply to it that ancient and useful term, *vis medicatrix nature*, for the want of a more scientific explanation of the subject; simply adding my conviction, that it has been effected by the edges of the ruptured intestine becoming adherent to the parietes of the abdomen, the continuity of the bowel being kept up by the granulations thrown out from the ulcer.

Although I cannot find an analogous case recorded by any author, either ancient or modern, yet I have received much instruction and gratification from perusing the work of Mr. Travers, entitled *An Inquiry into the Process of Nature in Repairing Injuries of the Intestines*, to which I would refer those who are desirous of prosecuting the study of such like complex points of our profession.

ORIGINAL COMMUNICATIONS.

PARACENTESIS THORACIS: WHEN IS IT JUSTIFIABLE?

By DANIEL H. TUKE, M.D., Visiting Medical Officer to the York Retreat, Physician to the York Dispensary.

[Read before the York Medical Society, Feb. 10th, 1855.]

[Concluded from page 1092.]

HAVING attempted to determine the period of effusion after which expansion of the lung is hopeless, by a reference to *post mortem* examinations, we ought next to inquire what information we can derive from an examination of the living subject suffering from effusion, at various periods of the disease: and here I may state, that it has been extremely difficult to find the records of many cases in which copious effusion had been present for some weeks or months, and in which the return of the lung to its natural size and condition is stated to have occurred.

Of the thirty-eight cases already referred to, reported in the *Medical Times and Gazette*, the great majority of those in which the lung re-expanded, were examples of recent, although very copious effusion. In one case, the lung appeared to have recovered itself after an effusion of three months; but, in the other examples of recovery of the lung, the period was much shorter.

In one case reported very carefully, there can be no doubt that the patient (12 years of age) had been suffering for many weeks from effusion before admission; and as he

was ten weeks under treatment, and there was some contraction of the chest even when first seen, which, however, subsequently disappeared (the lung re-expanding), it cannot be doubted that this is a fair example of a patient having one pleura nearly full of fluid for at least several months, and yet regaining the almost entire use of the affected lung.

In another case, of much shorter duration, under the care of Dr. Burrows, a woman had been ill with pleurisy about a month; and, on admission, the right pleura was found to be full of fluid up to the third rib, and there was even evidence of depression of the right half of the diaphragm. Three weeks afterwards, she was discharged, with the lower fourth of the pleura still full of fluid. Two months afterwards, she was examined, and the process of absorption was found to be complete, and the lung had quite recovered itself.

Dr. Hodgkin has favoured me with the following, in reply to an inquiry:—"In some cases," he says, "in which all the signs of pleuritic effusion had been present long and extensively, and even when marked contraction of the chest has followed, the return to the healthy state has been complete and satisfactory."

"In one of these cases which I now recollect, the patient, a gentleman of middle age, came to me from the country, when the affection was already of some months' duration. His convalescence was slow, his general health having much suffered. There was marked contraction, and little use of the affected side. After some years, I was referred to, in consequence of his desiring to effect an assurance on his life. My reply was such as would deter any office from accepting the proposal; for I believed the side to be so far from being in a condition to sustain life, that, if the other were to be attacked, there would be little probability of his living. The medical examiner of the office, however, found him in so satisfactory a state that, in spite of my report, he was inclined to recommend the life; and it was determined by the directors that I should see and examine my former patient. I did so with great pleasure and satisfaction. My doubts were quite removed, for the affected side had become resonant, and had acquired freedom of motion; the sound of respiration was good, and the full measurement almost restored."

"A similar case is that of a young lady, in whom chronic pleurisy was followed by great retraction. After some years, the recovery was equally satisfactory; and the opposite side having been attacked almost as severely as the first, the recovered lung had its powers put to a severe, but satisfactory test. This lady is still delicate, as she was previously; but both sides of the chest are performing their functions, after the lapse of about twelve years from the first attack."

An essay by the late Dr. Hope contains the record of a large number of cases in which mercury is stated to have effected the removal of the fluid; but there is great doubt as to the nature of many of these cases, how far pneumonic or pleuritic; and, from the contraction of the chest, and the drooping of the shoulder which followed the so-called recovery of many cases, it is clear that in these the lung did not re-expand. The views of Dr. Hope, as expressed in this essay, are characterised by the *British and Foreign Med. Review* as "one-sided and imperfectly established."

Of those cases recorded in the *Medical Times and Gazette* in which paracentesis was performed, the longest period which elapsed between the first attack of pleurisy and the operation, and in which the lung recovered itself, was four months; although here there is no sufficient evidence to prove the precise date of effusion. The patient's age was 18; and, five weeks after the operation, resonance and healthy respiratory murmur were found to have returned.

Of the 24 cases which occurred under the observation of Dr. Roe, the longest period which elapsed between the attack and operation was three months eight days; the pa-

* This was not his own patient. He has already been quoted as mentioning five or six weeks as the longest period he has known compression from effusion, and recovery, in his own practice.