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ROYAL FREE HOSPITAL.

ULCER OF THE STOMACH (?), COMPLICATED WITH AMENORRHOEA, TREATED SUCCESSFULLY.

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CASE. E. S., an unmarried female servant, aged 22 years, was admitted an out-patient of the Royal Free Hospital on the 13th of November, 1855. As a child, her health had been good. She began to menstruate at the usual age, and continued to do so regularly almost up to the above date. The quantity of the flux had, however, gradually become more scanty during the last five or six months; though it was only at the last menstrual period prior to her application at the Hospital that its decrease amounted to complete amenorrhœa.

About two years before the date of her admission she began to suffer from symptoms of severe indigestion:—especially capricious (generally deficient) appetite; pain in the region of the stomach and between the shoulders, usually coming on about an hour after eating; and irregular (mostly sluggish) action of the bowels. After about twenty months of these symptoms, vomiting, which had previously occurred but rarely, gradually became very frequent; and at the end of about four months more it had increased to such a degree, as scarcely to allow any meal to be completely retained by the stomach. This state was accompanied by a great increase in the severity of the pain, as well as by a considerable alteration in its other characters. Latterly, though it came on shortly after meals, as an intense pain, it was almost continuous during the whole day, as a dull burning soreness.

On examination, the pain was distinctly referred to the centre of the epigastrium in front, and to a point corresponding with the spine of the eighth dorsal vertebra posteriorly. In the first of these two situations, it was accompanied by extreme tenderness to pressure; and both pain and tenderness could not only be traced a little distance outwards from this central point in all directions, but could be followed with much more distinctness and intensity towards the cartilage of the seventh rib, forming the anterior edge of the left hypochondrium, behind which point they seem to end abruptly.

The access of this pain, in its severest form, generally occurred about fifteen to twenty minutes after eating. It was provoked by almost all solid food. It was relieved by drinking small quantities of warm tea. But it was especially diminished by the recumbent posture. And as regards the varieties of this posture, although the patient could lie on her back or on either side, yet she found that, during the exacerbations of the pain, it gave her great relief to lean forward, in an almost prone position, at the same time that she shielded the epigastrium from pressure with an arm, or a cushion under the chest. Another fact she had noticed was, that any exertion which at all shook the stomach, such as walking quickly, or coughing, gave rise to a very painful jerking or pulling sensation, in a point corresponding to the centre of the epigastrium. The most careful inquiry failed to elicit any satisfactory evidence of hæmorrhage from the stomach, either in the

matters rejected by vomiting, or in the alvine evacuations. She thought she had once observed a faint streak of bloody mucus in the former, but had not noticed the latter enough to state anything about them.

The aspect of the patient was remarkably pallid and waxy, but not emaciated. The first sound of the heart had a soft blowing character, perceptible enough, but not by any means strongly marked. The pulse was feeble—about eighty per minute. The breathing was not remarkably short on making the slight exertions to which the pain almost limited her. The legs she had occasionally noticed to swell a little at night; but on examination (at 3 P.M., after she had been up all day), there was no positive œdema, although the general relaxation of her flesh almost amounted to puffiness in the subcutaneous areolar tissue.

Being unable to admit her as an in-patient on the day of her first application, I ordered her a tolerably large blister (about five inches by four) to the epigastrium, and a powder composed of trisnitrate of bismuth, ten grains, compound powder of kino, seven grains, thrice daily; and enjoined on her the diet I usually enforce in such cases,—namely, a thin pap made of arrow-root boiled in milk, and allowed to cool, in very small quantities, at intervals of two hours or less, as the stomach would bear it.

About three days after, she again presented herself in the out-patient room. She had lost all vomiting—a result which she attributed chiefly to the blister. But the pain, though slightly diminished, was still exceedingly severe, and almost continuous. And on my explaining my opinion of her state, so far as it seemed advisable to do so, and urging her to come into the hospital as an in-patient, she at once acceded to my request.

On her entering the hospital, I immediately ordered her to bed: and I might almost say that the whole subsequent treatment consisted in the enforcement of perfect rest in this attitude, and of the diet and medicine already alluded to.

After about ten days of this procedure, the pain was so much alleviated that she was allowed to get up for a short time daily, avoiding, however, all pressure of her dress on the epigastrium; the powders were exchanged for a solution of the citrate of iron; and the diet was varied by the introduction of bread instead of arrow-root, ground rice, and sago, into the milk. An occasional aperient of rhubarb pill, and even of castor oil, was now necessary. And finally, after gradually returning to her ordinary food in small quantities, replacing the citrate of iron by the sulphate of quina and iron, and cautiously permitting more exercise from day to day,—her recovery seemed sufficiently complete to allow of her being discharged from the hospital on the 21st of January, 1856. She had menstruated during her stay in the hospital. On leaving it, the only dyspeptic symptom remaining was that she found meat, in large quantity, gave her a slight sensation of discomfort or "weight" in the stomach. Her colour, appearance, pulse, were all normal. In short, I did not hesitate to regard her as cured.

Fortunately, however, there was no necessity for risking the permanence of her amendment by an immediate return to her employment. When ready to leave the hospital, she received a letter of recommendation to the Institution for Convalescents at Walton-on-Thames, where she remained a month. At the end of February she left this invaluable institution, and presented herself again at the hospital, ruddy, comparatively stout, and healthy in every respect.

Her last menstruation had been attended with a symptom too interesting in its relation to these cases generally

not to deserve a passing notice. Two days before this flux, she experienced a sensation of pain exactly in the spot in which the epigastrium had previously been affected. This pain, which was accompanied by the lumbar and abdominal pains frequently felt during menstruation, was relieved by lying down. It was distinguished from the epigastric pain previously felt, not only by its much slighter intensity, but also by its being quite unaccompanied by any tenderness or soreness externally, and by any sensation of nausea or vomiting. It gradually subsided as the flux came on, and had completely disappeared at the end of the first day of menstruation.

REMARKS. The above case is distinguished from all the others hitherto reported by me in this JOURNAL in the important circumstance—that it includes no satisfactory evidence of hæmorrhage, either by vomiting or stool.

Undoubtedly the failure of this symptom renders the diagnosis a less secure one; a proposition which I have hinted at by the note of interrogation in the heading of this article. Still we are bound to remember that, in a considerable percentage of these cases, the hæmorrhage is of so limited an amount as to pass off exclusively by the bowels; and that in a large proportion of these instances, it must depend upon mere accident whether it is, or is not, observed by the patient. In other words, to refuse to diagnose gastric ulcer in all cases in which there is no distinct evidence of hæmorrhage, would be to overlook a large number of the most marked examples of this dangerous and important disease. This statement is confirmed by my *Essay on the Pathology of the Gastric Ulcer*, quoted in preceding Reports.

We are left, then, chiefly to the character and course of the remaining symptoms to determine how far any such case is entitled to this diagnosis: and I think the above instance is a good example of the degree in which a typical character of these symptoms may almost compensate for the absence of evidence of hæmorrhage. The reader who will take the trouble to compare the account of this case with that of a patient of mine, reported in the ASSOCIATION JOURNAL for January 16th (p. 26) of the current year, will probably be struck by the close similarity which the two offer, not only in their age and circumstances, but especially in the leading characters of the pain and sickness, and in their effect on the constitutional health.

As regards the details of the present case, there scarcely seems to be anything that would justify a conclusion as to the site of the ulcer. But if we must hazard a conjecture, it would be as follows. From the extreme tenderness, the lesion might be supposed one of the anterior surface; indeed, its duration, and the dragging effect of bodily movement, entitle us to suspect that it was adherent to the epigastric wall of the belly. But while the site of the pain seems to suggest that the ulcer was on the left of the median line, the date of its access after eating appears to indicate that it was neither near enough to the cardia to be affected by deglutition, nor low enough down in the cardiac pouch to receive the alimentary bolus in its direct descent towards the left end of the greater curvature. If we accept these suggestions, they give us a tolerably definite situation, at or near the centre of that part of the anterior surface which would lie to the left of a vertical line through the middle of the small curvature.

Such a guess (for really it is little more) so far corresponds with the absence of much hæmorrhage, as that it indicates a spot where there is rarely any large vessel that the ulcer can erode.

Nor is it at all contradicted by the peculiar decubitus the patient adopted during the worst paroxysms of pain. That she could often lie in any other attitude with relief to the pain, may be taken as indicating that the ulcer was scarcely on any surface which such postures would place undermost. And I am entitled to conjecture that this special modification of the prone position is almost characteristic of an adherent ulcer of the anterior gastric surface. The relief this attitude affords such an ulcer is probably due to its bringing (and keeping) the delicate adhesions beneath

the lesion in close contact with the apposed epigastrium, the respiratory movements of which it would further limit. Amongst two or three cases of this kind, I may refer especially to one reported in the *Archives Générales de Médecine* (2ème series, vol. viii, p. 215), in which such an adherent ulcer, attended for years by this symptom, ended in a fistula, and was verified by a necropsy.

The relief experienced by warm tea may seem almost a paradox, when contrasted with the remarkable pain this liquid is generally stated to produce in cases of gastric ulcer. But another case which has lately come under my notice seems to afford this paradox an interesting explanation. In the latter, warm tea produced a momentary relief; which, in the course of a few minutes, gave way to a marked aggravation of the pain. Hence I am disposed to think the effect of hot liquids may be thus interpreted. As regards the sore itself, their influence is generally (if not always) an increase of the pain; they act, in short, on the eroded ends of the gastric nerves just as they would on those of any other nerve, in any other part of the body. But when applied to the surface of the ulcerous stomach, without coming into contact with the lesion, they give rise to an afflux of blood, which may ease the pain of the ulcer by the revulsion it can excite.

The moderate degree of amenorrhœa in this case is no doubt partially referrible to the absence of severe hæmorrhage. The relation between the lesion itself, and the disorder of menstruation it often introduces, is too complex to be considered here, further than to state the fact that while amenorrhœa often occurs without being preceded by copious hæmorrhage in the gastric ulcer of early puberty, large or repeated bleedings are pretty sure to be followed by it at any epoch of menstrual life. The reason for this causal relation is obvious.

The curious access of pain noticed during the menstrual crisis is another very interesting point. A very similar attack was noticed in my last report, already referred to. In that case, I did not consider myself justified (from the patient's manner and statements) in assuming that the menstrual pain was identical in situation with the ordinary pain of the gastric malady. But in this, as well as in another case that has since been seen by me, I have been able to assure myself that there was such an identity of site. All three, however, present the differences which I laid down as proving that the menstrual pain was no real relapse of the gastric disorder, but merely a modification (though a very interesting one) of those flying pains so frequent during the menstrual crisis. In all, the attack was during convalescence, when every symptom of the gastric ailment had long disappeared. In all, the pain was unaccompanied by soreness, by nausea or vomiting, and by pain or uneasiness after food. Lastly, in all, the pain was accompanied by pains in the loins and belly; and commencing about forty-eight hours before the flux, ceased from eighteen to thirty-six hours after its complete establishment, without leaving any further symptom behind it. Indeed, I have before me notes of a similar case, in which such pain occurred during the convalescence of a patient who had suffered nearly thirty years from gastric ulcer; and who, when I last saw her, had remained nearly a year perfectly free from this menstrual pain, as well as from every symptom of the malady.

The treatment adopted in the case now reported hardly requires much notice. Considering the chlorotic symptoms present, some would perhaps have thought it scarcely right to enforce a rigid dietary, and protracted lying in bed. But the results seem satisfactory. Indeed, I have a strong impression that in this malady a careful diagnosis of the lesion, and implicit obedience on the part of the patient, will often allow us to effect cures by means which, at first sight appear disproportionately few and simple. But a similar statement might be extended to most other maladies of the digestive canal; in which it is not too much to say that it is the physiologist alone who is the efficient physician.