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ST. GEORGE'S HOSPITAL.

SCIRRHUS OF PYLORUS: EXTENSIVE COLLOID DEPOSIT IN ABDOMEN: DEATH IN BOTH CASES.

Under the care of W. E. PAGE, M.D.: with remarks by G. GODDARD ROGERS, M.D., Medical Registrar to the Hospital.

CASE I. A. H., aged 51, a laundress, of cachectic and emaciated appearance, was admitted on September 17th, 1856. She stated that she had suffered for a very long time from indigestion, which had been worse for three months. Her bowels had not been opened for sixteen days, and she spoke of constant vomiting; but this symptom did not manifest itself after she came under our notice. She slept but little, and had much burning pain at the epigastrium. Her pulse was quiet; tongue clean and moist. In the track of the transverse colon was a hard moveable mass which had not previously attracted her attention.

September 19th. After enemata and purgatives, the bowels acted: the stools being at first scanty and lumpy, but subsequently quite healthy. The epigastric pain was allayed by a mixture of hydrocyanic acid with soda. In two or three days more, the tumour could no longer be felt across the abdomen, but there was a tympanitic condition, and to the left of the median line, and extending into the left hypochondrium, was a large mobile tumour, which was taken at first for enlarged spleen; but on shifting her position from the recumbent into the upright, it fell more into a situation indicating a morbid growth connected with the liver.

She took tonics and brandy with good effect, got up daily, relished all her meals, and went on so well, that I made a note on the 2nd October of her "greatly improved condition".

October 6th. She felt weak and languid, and was glad to be in bed. The tumour appeared to have increased, and she had more tenderness at the pit of the stomach; yet this was only when pressure was made; and there was no vomiting or other urgent symptom. She gradually became exhausted, and sank quietly on the 10th October.

At the *post mortem* examination, beyond slight emphysema of the lungs, there was nothing wrong in the thoracic cavity. On opening the abdomen, the stomach was found dilated, and much lower than usual. Its pyloric end was extensively infiltrated with cancerous deposit, and the disease had extended in front to the under surface of the left lobe of the liver; below to the right extremity of the transverse arch of the colon; behind to the head of the pancreas; all which parts were adherent to the pylorus. On slitting open the stomach, a large ragged orifice of the size of a half-crown was seen leading into an irregular sloughing cavity, walled in by the adherent viscera, and communicating with the duodenum by a very contracted and irregular orifice. The glands of the omentum were extensively diseased. All the other organs were healthy.

CASE II. E. M., aged 40, a delicate and emaciated woman, who had suffered as long as she could recollect from indigestion, was admitted on September 17th, 1856, for violent pain at the pit of the stomach, which had troubled

her for a month. She also said that her abdomen appeared to enlarge on the right side. Bowels open; catamenia regular; tongue dry and brown; pulse small and weak. No oedema of legs; urine clear and free from albumen. Abdomen very tympanitic, with indistinct fluctuation, but no special enlargement on right side. Some calomel and compound jalap powder were given, and then half-drachm doses of liquor potassæ in beer, which, however, induced vomiting, and was discontinued in two days. The pain increased, and henbane was tried, and tincture of opium in repeated small doses with ether. Vomiting now became more frequent; there was considerable dyspnoea, and more distinct fluctuation in the abdomen. It was thought advisable to relieve her by tapping, which was accordingly performed on the 29th. Very little fluid was withdrawn, and no marked benefit was obtained from the operation. She never thoroughly rallied, and died in the course of a week.

After death, a little fluid was found in the pericardium: in other respects the heart and lungs were healthy. The abdomen was very tympanitic, and contained a small amount of transparent yellow fluid. The peritoneum was thickened, and beneath it throughout the length of the intestinal canal and over the abdominal walls were small rounded white patches of malignant deposit, apparently of the colloid variety, which also infiltrated the great omentum and subperitoneal tissue around the pyloric end of the stomach. The muscular coat of this part of the stomach was hypertrophied. The pancreas was much atrophied from pressure by the development of the same morbid structure beneath the peritoneum in front of it; and both ovaries beneath their peritoneal surface partook in the disease. The remaining abdominal organs were healthy.

REMARKS. In commenting on these two very interesting cases, so many instructive points suggest themselves, that it is difficult to bring prominently forward any particular circumstances without overlooking others of perhaps greater importance. The two histories in many respects are not dissimilar, yet an inspection after death finds in each patient a totally different disease. In both we have an account of long existing dyspepsia, followed in the course of time by fixed epigastric pain, but without continued vomiting. In the first, there had been sickness during the sixteen days of constipation; in the second, nausea was brought on by the remedies. Beyond this, both were free from a symptom which is often a great aid to the diagnosis of these obscure complaints. We are also struck by another difficulty. The woman who had scirrhus, where a great ragged ulcerated surface existed, suffered far less pain, and improved much more in health, than the second patient. Then we have the shifting tumour, and all sorts of conjectures hazarded regarding its seat. It was in turn pylorus, liver, spleen, omentum, pancreas. Singularly enough, this last organ, which was a good deal dwelt upon, was found atrophied in the second case; and there seems no reason why atrophy should not have occurred in the first, seeing that a harder and more extensive mass of disease pressed upon, and even slightly infiltrated, the head of the pancreas.

All these little circumstances show how imperfect at present is our knowledge of these tumours, and how frequently the best judgment may be unsound, and the most skilful examiner foiled. Whether the implication of the pancreas in these cases, either by infiltration or compression, has anything specially to do with the rapid failure of the digestive powers, as so frequently witnessed, is a

question which awaits further investigation. One can readily conceive, supposing the theory of this organ rendering fat fit for absorption to be true, that any implication, however slight, interferes with the process, and leads to emaciation. The previous indigestion seems to prove that an atonic condition of the stomach prepares the way for a more serious state of things; and that the first morbid deposit is accompanied with pain differing from the ordinary uncomfortable dyspeptic sensations. After a time, there is an amount of hypertrophy in the muscular fibres surrounding the pyloric end of the stomach, which greatly aids the passage of aliment into the duodenum, and then the former paroxysms of pain after a meal vanish; and should the cancerous deposition be going on but slowly, the health may mend, and the patient for a time indulge the hope of recovery. Such a course probably affords the true explanation of the change for the better in the poor woman whose case is first related. Then came a time when the disease so encroached on the muscular substance, that the slightest quantity of food in its passage caused exquisite pain, and she at last refused all nourishment. In the other woman, there was considerable hypertrophy of the muscular coat at the pylorus, and no infiltration of morbid matter; therefore, one might have expected greater freedom from vomiting, and less pain than in the first patient. The reverse was the case; and we can only attribute her more speedy dissolution to disease occupying such an extensive surface, and keeping up direct irritation throughout the whole cavity of the abdomen: added to which, her general appearance indicated a more delicate constitution, and one far less fitted to bear up against disease than was possessed by the former woman.

CENTRAL LONDON OPHTHALMIC HOSPITAL.

OBSTRUCTED LACHRYMAL DUCT.

Under the care of HAYNES WALTON, Esq., Surgeon to the Hospital.

[Reported by MAURICE DAVIS, M.D.]

[Continued from page 682.]

In our last report, we spoke of the commencement of this affection, and pointed out that constitutional measures, with certain topical applications, may prove sufficient, and effect a cure. We now proceed to consider the later state, in which dilatation by mechanical means is requisite in addition to general treatment, either because the annoyances of the obstruction will not give way to any other method and are unbearable, or because there has arrived that most distressing condition—fistula. Now, it is just the advanced disease that is so common at the hospital; for besides that, in general, persons do not seek advice sufficiently early, there seems to be a large number of cases, the accumulation of years, that are in the habit of going from one medical institution to the other.

An accustomed eye very quickly recognises what may be called the chronic obstruction, for it is truly unmistakable, yet its symptoms must be told. The characteristics, according to Mr. Walton, are weakness of the eye, the eyelashes, especially of the upper eye-lid, are dragged, the inner canthus, and the skin around, to a slight extent, are often wet and soppy. The surface of the eye-ball is unnaturally moist. Over the situation of the sac, there is fullness, pressure on which discharges through one of the puncta, or both of them, tears, mucus, and pus. Sometimes, in addition, there is more or less of ophthalmia tarsi. A habit of winking, with inordinate action of the orbicularis palpebrarum, is common; being, perhaps, a natural effort to empty the duct. A preponderance in the severity of some of these, and an absence of others, must be expected in individual cases.

The actual state of fistula is generally readily detected; that is, when the aperture is single, and is directly over the lachrymal sac; but the abscesses by which it is produced may burst at a long distance from that spot, and sometimes sloughing causes two or more fistulae far apart. Sinuses, too, may at any time proceed from the false passage, and so tend to obscure the diagnosis, especially if the secretions which escape are allowed to incrust. We may state, that the disease for which fistula may be mistaken, is necrosis of some of the bones of the face. Mr. Walton has met with some cases in which the strictured duct, as a cause of the fistula, has been wholly overlooked, and this affection said to exist.

Before we go into the detail of treatment, we take the opportunity to state, if indeed it be requisite, that in these short reports we do not attempt to represent any views or opinions but those of Mr. Walton; and that what we record is strictly his own proceeding, and embodies the principles of his teaching. Further, we think it better in the present instance to depart from the usual routine of Hospital Reports, and not to detail cases, but rather give a summary of his practice.

When it is apparent that there is actual obstruction of the duct, no time is lost in dilating it, except there be such swelling of the parts over as to preclude this; when the tumefaction is first attended to, the abscess, as it may be, evacuated, or the erysipelatous attack subdued by punctures or other treatment, local or general. We will quote Mr. Walton's own words here. "When there is a fistulous opening, the course to be pursued is plain. The channel is completely obstructed, and must be re-established. Prior to that advanced state, there may be differences of opinion as to the stage of disease that imperatively calls for physical measures; but I think it may be laid down as a rule, that when the obstruction involves the necessity of emptying the tube of its accumulations by pressure, the time to employ them has arrived; and to delay their use until from continued morbid action there is material structural change in the tube, must tend very much to lessen their advantage, and to favour the formation of abscess, and its common result, fistula." (*Diseases of the Eye and Operative Ophthalmic Surgery*, page 213.)

After a trial or an examination of the many means used or recommended for the purpose of dilatation, Mr. Walton is convinced that the solid nail-headed style is, according to the state of our knowledge, the most appropriate appliance that we can employ. The points, then, that remain to be considered are, the kinds of style, the method of introducing it, the duration of wear, and the effects.

Mr. Walton's style, as it is called by Messrs. Weiss, the manufacturers of it, is much larger than that generally used, its size corresponding with the duct; that for an adult being the tenth of an inch in diameter, and an inch and a quarter in length. There is a bend or neck to it, in order to sit the better, and to prevent the head, which is round and sufficiently thick to allow the edges to be obtuse, from resting on and irritating the skin. Sometimes, where, for instance, there is a very unhealthy state of the integument, or disease of the bone, it may be advantageous to lengthen the style, so that the extremity should rest on the palatine process of the superior maxillary bone, and altogether prevent the head from touching the surface. There are, too, states in which a globular head is preferable to any other.

It is astonishing how often surgeons fail in introducing the style, and thrust it out of the proper channel, passing it either through the lachrymal bone, or even between the skin of the cheek and the bones of the face. Failure in the ultimate object is frequently due to this. "It requires," writes Mr. Walton (p. 214-15), "some tact to introduce this little instrument readily and neatly. The usual direction to find the spot for insertion, by pulling the lids outwards and making tense the tendo oculi, is not applicable when disease exists. Indeed, with much swelling