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Hon. Vice-President of West London Medico-Chirurgical Society;
Ex-President of the Incorporated Medical Practitioners'
Association.

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With the Author's Compliments

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I esteem it a privilege to have the opportunity of taking part in so important and interesting a subject for debate as gastric ulcer, the existence of which is often unsuspected, the symptoms frequently being obscure, and *ergo*, the disease is in consequence concealed or unrecognised.

This was the case in the history of the two pathological specimens that I have the honour of showing the Society this evening. In the smaller specimen, kindly lent me by Dr. Donald Hood, the senior physician of this hospital, the symptoms were, at least during the life and illness of the patient, entirely latent. I have taken great interest in the subject of gastric ulceration, and thinking the disease is very frequent and often unrecognised, I obtained the permission of Dr. Collier, the medical officer of health for this district (containing over 100,000 inhabitants), to examine the mortality tables for the last five years, and I find out of 8305 deaths, in only ten (six males and four females) is gastric ulcer given as a cause of death. Five of these were from perforation, and four out of the five deaths were females; in two others perforation is mentioned as the immediate cause of death, but one of these was certified as arising from cancer of the pylorus, and the other, a male, aged 72, was certified as the sequel to pernicious anæmia, the result, no doubt, of malignant disease. I have not included either in the ten registered deaths from gastric ulcer, but I think it quite probable, as no *post-mortem* was made, that the perforation in both cases was due to gastric ulcer. A death was also registered of a man, aged 81, from *senile* gastric disease: this, too, may mean gastric ulcer.

On October 29th, 1894, the sister of a medical friend, aged 60, had been feeling very unwell with painful dyspeptic symptoms, for which she consulted a well known hospital physician and a recognised authority on gastric ulcer (Dr. Habershon). After careful examination of the patient, he was able to allay anxiety by the assurance that her illness

[1] Read before the West London Medico-Chirurgical Society, November 1st.

was not due to ulcer. The very next day she was seized with alarming and sudden hæmorrhage. Dr. Habershon again saw the patient and at once diagnosed gastric ulcer. This lady, a few years ago, was thought to have had typhoid fever, but there were never any spots, and from the description of her illness that her brother gave me, I thought then that it was very doubtful if it was typhoid, and I believe it was afterwards considered that her illness was then, as in last October, owing to gastric ulcer. She has since quite recovered.

I have been induced to direct my attention to the subject of unrecognised ulcers, more especially of the stomach, to which I must necessarily limit my remarks, because I have reasons for believing that gastric ulceration when unaccompanied by hæmorrhage or vomiting is very frequently overlooked, and this is the result of over 30 years' experience and observation in what was formerly a large general practice.

At the annual meeting of the British Medical Association in 1894, a very important discussion took place on the operative treatment of perforated gastric ulcer, and in the debate that followed Mr. Pearce Gould's able introductory remarks, Mr. Haslam, F.R.C.S., surgeon to the Birmingham General Hospital, said : It was therefore incumbent on all having cases of perforation under their treatment to note carefully what were the symptoms in the early stage.

S. H. T——, whose case I shall more particularly ask your kind attention, was under my intermittent but yet rather frequent observation for the long period of ten years.

As a member of the Hammersmith Sanitary Committee, I have the privilege, which I regularly avail myself, of examining the weekly mortality returns of the registrar of this district, and I have more than once remarked to the medical officer of health how seldom gastric ulcer with or without perforation is recorded as a cause of death. This opinion led me to examine the mortality tables of the district for the last five years, with the discovery that gastric ulcer is seldom given as the cause of death. Therefore, I think the apparent infrequency of recognised gastric ulcer or the mortality due to this disease, can be judged by the statistics of the Registrar General, but the death certificates, I think, on the contrary, have rather a tendency to prove

that the disease is not infrequently overlooked and perhaps ascribed to some other cause, such as collapse, syncope, anæmia, typhoid, tubal pregnancy, gall stones, &c. For ulcer of the stomach is overlooked, as Fagge writes, "Not because the patient has shown no signs of gastric disorder, for such signs may have been observed for several years (at least by the patient) but being of so slight a description that the case has been regarded as one of mere dyspepsia." And the absence of both hæmorrhage and vomiting is particularly likely, as in the case of S. H. T——, to cause its non-recognition.

In the important discussion last year at the annual meeting, at Bristol, of the British Medical Association, Mr. Pearce Gould mentioned seven recoveries by operation from the dire effects of gastric perforation, and I have noticed since, at least two or three other recoveries after operation from this fatal disease recorded in the medical journals.

It was the decided and deliberate opinion of the eminent medical gentlemen who took part in the debate, that the operation of gastrotomy will become more and more frequent —and successfully frequent, too—as soon as we are able to diagnose the locality of the gastric-ulcer; and when we can map out the exact situation of the ulcer with the same precision as eminent physicians now map out the lesions of the brain, there can be no reason why it should not be, alike to the saving of many lives and the prevention of much acute suffering and agony. I am led to hope that the publishing of such cases, with details, before such a society as this, of the two pathological specimens before you, may tend to this much to be desired result, especially where the ulceration is on the anterior wall, as in this case,[2] and these are by far the most frequent and the most serious (85 per cent. according to Brinton, going on to perforation), and yet by far the easiest because more accessible for operation. Of ulcers on the posterior surface of the stomach as few as 2 per cent perforate, and 85 per cent of recoveries. The ulcers, according to the authority of Welch, cicatrise; but with diffidence I would perhaps like to add it is my conviction that many cases of gastric ulcer occur and recover

[2] The small posterior ulcer was of much later development.

without recognition, and the patient being perhaps little aware of impending danger from which he or she, particularly if a young girl, has happily escaped. The converse too is also true, that probably many cases *diagnosed as ulcer* on account of attacks of hæmorrhage, which may have been merely attacks of hæmatemesis purely of a functional nature.

Perhaps the present opinion of the profession is to-day hardly that of Cruveilhier's, that simple ulcer of the stomach tends essentially to a cure, yet this is an encouraging opinion and is supported by many statistics, and one that ought to be remembered, and emanating from so great an authority should guard us against hasty operative interference, and tend to quicken the intelligence of the profession for the early recognition of the disease, for it is doubtless in the early stages that we may hope by rest and carefully regulated, easily assimilated regimen, and appropriate treatment, promote or even cause recovery.[3]

Case 1.—S. H. T——, æt. forty-six, a merchant's clerk, had been under my care more or less since 1885. Obit. October 27th, 1894. I certified his death as due to gastric-ulcer; duration uncertain. Perforation 20 hours. Pleurisy left c. effusion.

History.—S. H. T—— was a neurotic, taciturn, somewhat phlegmatic man, of anxious temperament, and of straitened means. Father, who was an artist of some merit, and fairly successful, committed suicide after killing his wife in a fit of temporary insanity. Children strumous and phthisical. I attended a son, aged twelve, in 1892, who died from tubercle and cavity of right lung, with copious effusion, for which my son aspirated with temporary relief, but chest quickly refilled. Dr. Herbert Alderson also removed several tuberculous cervical glands from his daughter in 1894, who later on developed tuberculous glands in wrist, which were removed in this hospital. I have lately attended another daughter with a slight hæmoptysis.

In 1876 S. H. T—— suffered very much from dyspepsia. Said "in 1884 he had two years of it; frequent vomiting and pain, which was both relieved and increased by food. No

[3] This tendency to cicatrise is well shown in the smaller specimen of Dr. Hood's, the small perforation being in the centre of the cicatrix.

nausea, but appetite. Is almost always troubled with dyspepsia and acidity."

In 1888 I attended him for an exceedingly severe attack of lumbago, for which it was necessary to keep him in bed ten days. He had no vomiting, nor nausea or sickness of any kind, but was exceedingly anxious about himself, and had a fear of impending death totally uncalled for by symptoms. I even remember calling on one occasion during this illness and finding the knocker of his front door muffled, and as I entered his wife telling me he did not think he would last long, but he was rather better now since the clergymen had been (he had three). Now, looking backwards since his death, I have thought, was not this exceedingly neurotic condition, this dread of impending dissolution, and an hypersensitiveness to *any noise*, due to the existence, *even then*, of this large anterior ulcer which you have now the opportunity of examining?

In 1891 S. H. T—— again suffered much from dsypeptic symptoms, and during this year he had he said "three weeks of fermentation," his food never seeming to digest. In consequence of these symptoms, and by an extremely rigid diet and a fear of eating, he reduced himself to a state of considerable emaciation. On a more liberal diet and careful attention to a sluggish liver he greatly improved and gained much in weight; so greatly did the patient improve in appearance that I contemplated publishing his case as a recovery, from that interesting disease, described by Sir William Gull as "anorexia nervosa," for at one time he well depicted the extreme emaciation, the ghastly look, the cold, clammy skin, the eye without lustre, and such similar signs as were comparatively lately described by that deceased physician as diagnostic of this disease, but the sharp lines of the anæmic countenance causing this peculiar physiognomy were owing, I can but now think, to gastric ulceration, which the late Dr. Brinton mentions that he has often "recognised gastric ulcer in a patient at a glance by these symptoms, even in a crowded-out patients' room."

I also attended S. H. T—— for a brief illness in Aug., 1894, from 14th to 23rd. On the 18th I was sent for, and found him in the w.c., where he had been for at least half an hour; he was almost pulseless, and in a cold, clammy perspiration, countenance exceedingly pale and anxious. I attributed

symptoms to cardiac syncope, or even possibly an attack of angina, for the heart's action was very feeble; by the aid of warmth and restoratives he quickly recovered, and very soon appeared in his usual health and resumed business; but the duration was but brief before the commencement of his fatal illness, and even during this interval he applied to my son (I being away on my holiday) for relief from his dyspepsia, whom I desire to thank for the brief, practical, and suggestive notes that I have just read, and which I did not see until after his death.

On Monday evening, October 8th, 1894, feeling well, he went to the city to witness a chess tournament of blindfold simultaneous play by Mr. Blackburn, when he was taken suddenly violently ill, and only able to return to Hammersmith with great difficulty and in acute pain; his fellow passenger by rail who accompanied him almost lifted him out of the cab and aided him to walk into my consulting room, and told me he quite expected his death in the railway carriage; he was ghastly pale, and his countenance was pinched, his eyes staring and sunken, and his physiognomy was that indicative of acute abdominal pain. He said he was in the greatest agony, but I admit and with regret that I did not ascribe as much importance to his subjective symptoms as I ought, for he frequently appeared to me to exaggerate his feelings, although less so latterly. It was a cold and foggy autumnal evening, and I thought he had taken cold and was suffering from another acute attack of colic or abdominal spasm, for he had no fever, no sickness or even nausea; his respiration normal; his pulse 90 and regular. He complained of pain all over abdomen, but particularly in the right hypochondrium; the abdomen was not tender, nor the pain increased by percussing, but there was evidence of much flatulence, although not much distension. He said he could not lie down even for examination, and was easiest in the prone position; his posture as he entered my room was as I see it now illuminated by the light of subsequent events strikingly significant, *with his body bent*, his stooping gait, his hand pressed on his epigastrium as if his abdomen needed supporting.

I gave him a strong anodyne draught containing sp. cajuputi and sp. am. co., and ordered him hot poppy fomentations. His friend accompanied him home in the

cab, and feeling anxious about him on reflection, I followed him shortly afterwards. I found him in bed, but in acute pain; he now pointed to the left hypochondrium as the seat of the greatest agony, and I injected over this spot two discs of morphia, gr. $\frac{1}{8}$, in each, and being still unrelieved I repeated injection of one disc, and I thought with some abatement of the acute pain.

On my visit next morning he was calmer, and had had a little, although disturbed, sleep towards early morning, but none in the night. My son accompanied me, and I had the advantage of his keen, careful, and painstaking observations. We were unable to discover any physical signs of disease; his lungs, heart, liver, and kidneys appeared healthy; pulse 90; temperature 100; respiration 80; decubitus dorsal; legs not drawn up, nor abdomen tender. We thought, and I think not without reason, that his symptoms were due to abdominal colic, or neuralgia from catarrh. Dr. Herbert Alderson aptly suggested the passing of a gall-stone, but as he had no jaundice, and having seen him in these attacks before, I diagnosed nothing more serious than abdominal spasm of the neuralgic type, occurring in a hypersensitive and somewhat hysterical subject. Yet how often do we see "the symptoms of true disease," as Weir Mitchell observes, "painted on an hysterical background," but unwisely forgetting this, and in the absence of both nausea and vomiting, we relieved his evident anxiety by falsely judging by his past recoveries from similar, although less aggravated symptoms, and cheered him by predicting again an early recovery.

On the 10th T. had risen to 103°, urine loaded with lithates acid; sp. gr. 1030. Soda salicylic was now prescribed in gr. x. doses, and this speedily reduced temperature, and indeed the temperature on the 12th was subnormal 87°. I changed the salicylic for iodide and bicarb of potash c. sp. am. co. and bromide and nepenthe. Anodynes, in fact, in some form or other, were given at frequent intervals during illness, according to pain and symptoms. The pain was of a paroxysmal character, although he said it never left him, and was much worse at night.

On the evening of the 18th I was suddenly sent for, with a very urgent message that S. H. T—— was very much worse, and would I go directly. I responded to the call at once,

and thought the patient not as decidedly worse as the messenger implied, and thus again did the *intermittency* of the symptoms tend to the non-recognition of the disease.

On October 22nd I discovered slight friction on the left side, and the usual signs of pleurisy gradually developed; he never had a rigor, nor to the last any bulging of the intercostal spaces, or other sign of copious effusion. The pain in his side, which he with emphasis affirmed had never left him, was now ascribed to the attack of acute pleurisy, although the seat of it, according to the patient, varied, sometimes being most acute at the back, and possibly due to the decubitus dorsal posture I thought that he invariably maintained, only occasionally did it appear in his stomach, but was now evidently greatest at his side, for which he particularly requested a belladonna plaster.

On the 25th, after an aperient, he had very copious action of the bowels, which had previously been confined, and not acted for two or three days he said, that he was and appeared much better, and I had still great hope of his recovery. He had had an excellent night after a nepenthe draught, but the improvement was not lasting, and on Tuesday evening I was again summoned by an alarming message. The patient had experienced a day of intense suffering, and felt sure he could not recover. On my arrival I at once noticed a great and decided change: the whole character of the illness seemed gravely altered since my last visit; his face was ashy pale; pulse small, 120; respiration 30, but not difficult; skin cold and clammy, and his agony evidently great. The case was hopeless.

On my visit next morning he was evidently dying, but perfectly conscious and sensible of his danger. He longed and prayed for death to release him from his acute suffering, and died at 3 p.m., about twenty hours from the symptoms of sudden collapse, and when I think perforation may have occurred. From this case I entirely confirm the observation of Dr. Donald Hood as to the intensity of the pain of death from gastric ulcer. The agony this patient suffered was far more distressing and alarming to both patient and friends than any case of angina pectoris that I have seen, nor do I remember ever having been so helpless to afford relief.

Post-mortem was made by my qualified assistant, Mr. Bucknill, in the presence of Dr. Herbert Alderson and

myself, about twenty hours after death. No *post-mortem* rigidity, no emaciation, body fairly nourished. About a quart or rather more of fluid was removed from left plural cavity, the first part of which was comparatively thin and clear serum, the latter foul smelling and purulent, while the fluid nearest the spinal column was almost pure pus, greenish and vile smelling. Traces of miliary tubercle at apex of right lung, both lungs buoyant on water, left collapsed and had evidently been compressed by the fluid against the vertebræ. The stomach large and somewhat dilated, and was in parts firmly adherent, and was removed *from the body with great difficulty*, and was especially firmly attached to the diaphragm, and slightly also to the liver and omentum. The cardiac and pyloric ends were tied, but as soon as the organ was removed from the body, on being tilted, fluid food escaped from a large perforated ovoid ulcer with roughened and ragged edges on the anterior surface of the cardiac end and near the lesser curvature, and also near the lesser curvature a much smaller perforation was afterwards discovered of a round punched out ulcer near the pyloric orifice and on posterior surface. Heart healthy, valves normal and competent; liver appeared fatty, but not amyloid. A large abscess existed over and around the cellular tissue of right kidney full of thick greenish pus. There was no fluid in the peritoneum, nor *any evidence of peritonitis*. The intestines were perfectly healthy. The stomach contained about Oss. of egg and milk; the mucous membrane of the posterior wall and about the cardiac end was much pigmented.

For the following pathological notes I am indebted to Dr. Abraham, pathologist to the West London Hospital, who kindly undertook the minute examination of organs for me.

Report on a Stomach and Fragments of Liver, Kidney, and Lung, from Dr. Alderson's Case (examined in May, 1895, by Dr. Abraham).

Stomach.—The organ was already opened, and had apparently been removed from the body with some difficulty. The walls were in parts much lacerated, the mucous membrane rubbed and thinned in places, possibly from *post-mortem* digestion, and the general condition by no means

good for examination. The mucous membrane, particularly of the posterior wall and about the cardiac end, was curiously mottled with an almost black pigmentation, and in some places anteriorly and along the lesser curvature there were areas of roughness and localised induration of the inner coat without pigmentation. Not far from the cardiac orifice and on the anterior wall an irregular ovoid aperture was seen, *with thickened rough edges*, and another much smaller and more rounded perforation was also present posteriorly and near to the pyloric end of the stomach. This was a distinct punched out perforation, with a well-marked thickened border like the other, and probably the result of a gastric ulcer. On the serous surface of the organ, near the perforations and elsewhere there was much evidence of inflammatory adhesions. Microscopical sections were taken of one of the localised indurations of the mucous membrane through the edge of the larger ulcer, and from the more pigmented part. In all cases the sections exhibited much destruction of the glandular epithelium, and an extensive infiltration of the mucosa and submucosa with an irregular-celled growth, much of it apparently inflammatory. The section of the discoloured part showed abundant presence of masses of black pigment, scattered and in cells, principally congregated in the submucosa. The condition of the tissues at the time of examination was such that satisfactory preparations could not be made.

Liver.—The spirit specimen showed no change to the naked eye, but under the microscope there was evident an extensive interstitial hepatitis, the connective tissue framework being impregnated with collections of small cells.

Kidney.—No very obvious pathological changes were observed in this organ.

Lung.—The piece of lung was thickly studded with dark patches of discolouration; the fibrous septa seemed to be exaggerated, and thickened foci could be felt and seen at intervals. A section through one of the latter shows the structure of tubercle, a collection of irregular cells with some central caseation, and occasionally a giant cell. In the connective tissue there is much pigment, chiefly in irregular scattered cells, which resemble those seen in a melanotic sarcoma. No bacilli were found, but the tissue was not in a proper condition for their detection.

It is unfortunate that the *post-mortem* examination was not more thorough, and that the specimens were not at once presented for examination.—P. S. A.

I would like to direct attention to the pathological appearance of the stomach, more especially to the size, situation, and appearance of the ulcers, their growth and probable duration, and to the peculiar pigmentation of the organ. The large ulcer at the cardiac end I think probably may have existed even in 1884. There is a significant note of my son's, written in August, 1894, shortly before his fatal illness, that leads to this opinion. It may, in fact, if it existed then it did heal; and these ulcers are well known to heal and then relapse. The stomach was firmly adherent to adjacent organs and tissue, and thus formed a floor around which it perhaps cicatrised and healed; at any rate some such cause must have prevented the escape of the contents of the stomach into the serous cavity of the abdomen.

These ulcers are both located, as is usual, near the lesser curvature, though not opposite each other, one near the cardiac and the other at the pyloric extremity. Sir William Gull has thought this was owing to the fact that this part of the organ is more fixed than the rest. If this large ulcer had existed in any form in 1884 it, of course, must have healed, relapsing *pari passu* with his illnesses, and the symptoms, as well as the *post-mortem* examination of the stomach, render this perhaps probable, for the edges of the ulcer are rough, although the ulcer has a smooth border; and Fagge mentions in vol. ii of his work on medicine, page 186, when an ulcer has existed a very long time it has smooth rounded edges.

The successful case of gastrotomy recorded last year at the British Medical Association Meeting by Mr. Pearce Gould has caused me to contemplate whether this case would have been one for operative treatment at any period of his illness, but the fact of two ulcers existing would seem to negative the suggestion, to say nothing of the phthisical history of the patient. I would, too, call your close observation to the pigmentation so beautifully shown in this specimen, and remind you of the valuable pathological notes of Dr. Abraham, who writes: "Sections were taken of one of the localised indurations of the mucous membrane

through the edges of the larger ulcer, and from the more pigmented part. In all cases the sections exhibited much destruction of the glandular epithelium, and an extensive infiltration of the mucosa and submucosa with an irregular-celled growth."

It has been a question of thought with me: if this patient had recovered and lived two or three years, whether this ulcer might not have become malignant? Fagge says, page 187, vol. ii: It is an interesting question whether cancer ever develops itself secondarily in the floor or on the edge of a simple ulcer. Trosseau speaks of them as antagonistic. Brinton, on the contrary, is disposed to think one may gravitate into the other. Of course, extensive development of malignant disease would obliterate all traces of the ulcers, but my patient suffered very much from gastric acidity. Now the converse to this is the case in cancers, and as free HCl_3 is absent in cancer of the stomach a chemical test has been proposed to differentiate the two diseases.

It has, I fear, probably occurred to many of you who have honoured me with your presence to-night to ask: Why were not these ulcers, which had evidently existed for so long a time, recognised in life? Because gastric ulcer in a comparatively healthy man is not common, and the usual symptoms of this disease were absent—*i.e.*, hæmorrhage and vomiting. Brinton and Habershon, both distinguished physicians and renowned authors, state that the diagnosis of gastric ulcer can be made only in a very few instances unless the symptom of hæmorrhage be present. Dr. Donald Hood writes: "With many, I might almost say with all, it—*i.e.*, hæmorrhage, has been the symptom which is looked upon as conclusive in the differential diagnosis of organic and functional disease of the stomach; between the various forms of dyspepsia and ulceration."

On account of his excessively neurotic hysterical temperament, and to the occasional vomiting that he did sometimes have latterly I did not attach its proper significance, but thought it due, if not to the ordinary pyrosis that often accompanies chronic dyspepsia, to that form of hysteria not infrequently occurring in women when the stomach is emptied by vomiting as soon as digestion commences, and chiefly, perhaps, because his illnesses were of very brief duration,

or rather, the period for which he applied for medical aid, and also because he was a most temperate man and an unlikely subject for such a disease.

The importance of recognising this disease, and, too, if possible, in the early—*i.e.*, the pre-ulcerative stage, is very great if we are, as we ought to attempt, to cure the disease; and if it prove fatal it may be still more important, for death by perforation is apt to occur with alarming suddenness, and, too, in an apparently healthy subject; and its non-recognition, cause the suspicion of poisoning that the symptoms might not unnaturally give rise to, and cause untold agony to the possibly suspected relative, and also much mental suffering to the family. Gastric ulcer with perforation has not infrequently been mistaken for a case of wilful poisoning. The Duchess of Orleans, who died from the disease in 1670, was thought to have been poisoned by her husband, until "Littre, in a masterly clinical and historical commentary, proved her death to have been caused by perforation from a gastric ulcer." Successful results from operative treatment in large numbers will be delayed until our diagnosis of gastric ulcer is more certain, and the symptoms cease to be, with advancing clinical knowledge, so frequently latent; and Billroth's promising operation, with its gratifying and almost miraculous results, deferred until our diagnosis becomes more perfect, and this desirable hopeful object we general practitioners, who more frequently see the disease in its early stages, can do much to promote.

Having told you why these ulcers in this most interesting specimen of S. H. T—— remained unrecognised until after death, or rather why I failed to interpret the symptoms aright, there are still a few points in the history of his illness that I think may be interesting to recall to your remembrance. First, as to his severe attack of lumbago, from which he suffered so very severely in 1888 and had also a brief attack in 1891. The pain was severe enough for him to keep in bed for ten days, and I afterwards remembered that the pain was not only in the lumbar muscles, but also in the spine, or, as he said, in his back. The vertebræ were not tender, but the pain was deeply seated, and would correspond to the usual seat of gastric ulcer—*i.e.*, between the eighth and ninth lumbar vertebræ. And here is another symptom: he had a great fear of impending death, so foreign to patients,

even when suffering from acute lumbago; and he was also very susceptible to noise, which caused him to have his street door muffled. Now both these symptoms are consistent and, indeed, symptomatic of gastric ulceration. There is, too, one other symptom that I have already mentioned that appears to me worthy of special note—*i.e.*, he was easiest with his body bent; and I have since learnt from his fellow-clerks that he latterly often, when suffering from spasms at his business, would go into the office and lie down on his face, by which means he procured ease.

I cannot close the history of this case without reminding the members of this Society, who are mostly, I think, general practitioners, that S. H. T—— sought relief at St. Thomas's Hospital. I know that he went at least once only a few months before his death, and at my suggestion, but he was very silent about this visit. I could obtain no information from him, and could only infer that he had obtained no relief and no further knowledge as to the disease he was suffering from, beyond that of chronic dyspepsia.

Since writing this paper I have asked his wife if she could give me any information as to this visit to the Hospital, and she replied she would give me his book, which would tell me what they prescribed for him, for they kept him waiting so long, several hours altogether, that he could not wait for his medicine, and he never, in consequence, went again. Unfortunately, his daughter, thinking it of no value now, had burnt the book only a few days before I called, or it would have been interesting to have seen the name of the physician who examined him, and to have read his remarks on the case. And this illustrates forcibly the too-crowded state of the out-patient departments of our hospitals. No doubt but for this lamentable fact that Sir Andrew Clarke failed to recognise, he would not only have waited for his medicine, but have gone again, and probably, after more close observation, would have been recommended to have become an in-patient, and his physician communicated with me, and operative treatment suggested or undertaken, supposing after further observation his disease had been diagnosed; for although his children have developed phthisis, and traces of tubercle were found in his right lung, it could only have been of very recent origin, for he had no cough, no expectoration, no physical signs of lung disease;

and if his ulcers could have been cured and more liberal regimen allowed, I think it is perhaps probably S. H. T—— might have become a comparatively healthy man !

In concluding the history of this case, I would wish to add a few words as to the cause of gastric ulcer. In the case of S. H. T——, it was, I believe, produced by long-continued mental anxiety. I have a letter from him written on May 3rd, 1894, that in almost pathetic language mentions his straitened means and the difficulties of his position, which leaves to my mind no doubt as to the cause of the disease; in fact, my experiences of over thirty years of practice leads me to the conviction that gastric ulceration—when not the result of syphilis or alcohol, and the patient over *forty*—is almost invariably due to mental cause (unless occasioned by local injury), and especially in those cases where there is no hæmorrhage and the symptoms obscure or latent and of tardy development. In young patients the subjects are almost always females, and arises most frequently from uterine causes, such as acute suppression of the menses, which is well proved in the case of Dr. Donald Hood, the pathological specimen which I have also the privilege of shewing.

Dr. William Williams, of Liverpool, physician to the Royal Southern Hospital, has written a pamphlet tending to prove that chlorosis and gastric ulcer are synonymous, and in these patients the symptoms are peculiarly latent and obscure, and in the opinion of Dr. Williams are caused by tight lacing.

For the following notes of Case 2, the specimens in the smaller jar, I am indebted to the kindness and courtesy of Dr. Donald Hood.

Case of Perforating Gastric Ulcer.—M. M——, a healthy-looking, well-nourished girl, aged eighteen, came into West London Hospital on February 15th, 1895, suffering from catamenial pain and pyrexia. Illness commenced suddenly on the previous day with severe pain, and spread to the lower part of the abdomen. Catamenia appeared on February 12, and ceased suddenly on the following day. Supposed chill. On admission patient complained of intense pain situated on lower portion of abdomen. The abdomen was swollen and acutely tender near the hypogastric area.

Liver dulness distinct. There was evidence of pleurisy and fluid in left chest. Temp. 101-102 ; resp. 40 ; pulse 120.

First seen by Dr. Hood on the evening of February 16th. Patient was then most comfortable. The possibility of a perforating gastric ulcer was discussed,[4] but the balance of clinical evidence, added to the then known history of the case (previous dyspeptic symptoms being denied) seemed to negative this cause, for the peritonitis which from the physical and general symptoms appeared more likely to have followed some uterine trouble (acute suppression of menses).

On February 17th, symptoms much intensified, and patient died at 3 p.m.

Post-mortem.—The upper and posterior wall of stomach much thickened (cicatrised tissue) and adherent to under surface of diaphragm. In this region a small punctured ulcer was found communicating with the abdominal cavity. There was purulent pleuritis, but although no direct channel existed between the pleura and stomach from the presence of old cicatrised tissue, it was evident that an ulcer had previously perforated into the pleural cavity.

[4] The friends of the patient stated after her death that she had suffered very much from dyspepsia.