In the museum of St. Thomas's Hospital there is a specimen (1676A) of a clean transverse rupture of the inner coats of the upper part of the descending thoracic aorta leading to diffuse and extensive haemorrhage into the surrounding connective tissue. There is no macroscopic disease of the vessel, but microscopic examination revealed the presence of marked fatty degeneration of the intima. The patient, a lad aged 18, experienced acute pain in the abdomen for three days, but complained of nothing until the day of his death. When seen, four hours before death, there was nothing in the symptoms to suggest that he was seriously ill. Death was sudden and unexpected. No history of strain or injury was elicited; at the *post-mortem* examination the mediastinum was found full of extravasated blood and the left pleura contained three pints of it. That the rupture occurred in two stages is clear from the fact that, microscopically, the termination of the rent in the inner tunics is seen to be undergoing repair.

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THREE CASES OF GASTRIC CARCINOMA PRESENTING UNUSUAL FEATURES.

BY

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THE following cases of carcinoma of the stomach appear to be worthy of record in view of the anomalous symptoms they presented.

1. Simulating Chronic Intestinal Stasis.

A man, aged 54, was sent to me for suggestions as to treatment for chronic constipation. He was a thin but muscular man, who gave a history of very severe constipation of twelve months' duration, and of failing vision for the same length of time. His appetite was good and he had only vomited twice—once three weeks before and once seven days before my examination. He had had no pain after food, no vomiting of blood, nor melaena.

On examination of his abdomen I found no distension nor tumour, nor was there any tenderness to be detected, but there was a suspicion of visible gastric peristalsis, and this was confirmed at a later examination. All further examination was negative. I referred him to an oculist, who reported early atrophy of both optic discs, and after exclusion of pituitary tumour he suggested that the condition might be due to the absorption of toxins from his stomach. A neurologist, however, put down the condition of the optic discs to early tabes dorsalis. A test meal showed the absence of free hydrochloric acid. X rays showed that there was marked dilatation and hypertrophy of the stomach, which was not completely emptied for twenty-four hours after ingestion of the bismuth meal. A diagnosis of pyloric obstruction, probably due to a healed ulcer, was made. At operation a tumour was found, involving the greater curvature near the pylorus (microscopical examination later proved it to be columnar carcinoma). The pylorus admitted the tip of the little finger easily. There were no enlarged glands to be felt, nor was there any other evidence that the growth had extended beyond the stomach. Partial gastrectomy was performed by the posterior Polya method, and the patient left hospital on the twenty-first day. His constipation immediately disappeared, he put on weight, and ten months after the operation he informs me that his vision has improved and that his condition is in all respects satisfactory.

2. Simulating Gall Stones.

A man, aged 52, with the diagnosis of gall stones. He gave a history of discomfort after food for several years, but had had no real pain after food and had never vomited until six weeks before I saw him, when he was seized with agonizing pain in the right hypochondrium, with vomiting. This pain subsided, and twenty-four hours later he became slightly jaundiced. He had had two other almost exactly similar attacks before seeing me, and in every instance these attacks occurred in the evening.

On examination I found him to be a well nourished man of healthy appearance. The abdomen moved well on respiration; no tumour was felt, but there was marked tenderness over the tip of the ninth costal cartilage, and this tenderness was accentuated at the end of inspiration. At operation a well marked carcinoma of the pylorus was found. This was adherent to the neck of the gall bladder and was separated from it with some difficulty. The gall bladder contained no stones, and its wall showed no gross pathological change. Partial gastrectomy was performed by the anterior Polya method. As there was considerable oozing from the region of the neck of the gall bladder a small drain was left in for twenty-

four hours. The patient developed a slight duodenal fistula on the ninth day, which healed within a few days, and the man was discharged in a satisfactory condition on the thirty-seventh day. He has put on weight since operation, his paroxysmal attacks have disappeared, but he complains of pain in the left hypochondrium, particularly if he becomes constipated. Presumably this pain is due to pressure upon the transverse colon by the anastomosis.

3. Simulating Acute Intestinal Obstruction.

A woman, aged 68, came under my care with the following history. The day before admission to hospital she suddenly became ill with acute abdominal pain, vomiting, and distension. Her doctor ordered enemata without effect, and an immediate operation was advised, but this was refused. He therefore administered morphine and next day she came under my care. She was a thin anaemic woman and looked acutely ill. She informed me that her previous health had been good, but that for the last year she had been losing weight and her appetite had become poor. She complained of intense abdominal pain, chiefly in the right hypochondrium, and she vomited half a pint of dark material during my examination. Her pulse was 100 and of fair quality. The abdomen showed extreme distension, especially in its lower half, the upper abdomen being comparatively flat. Rigidity was present in the right hypochondrium, and on deep palpation a tender tumour could be felt. This did not move on respiration, but on account of its rigidity its outline could not be felt. The stomach appeared not to be markedly dilated, but splashing was easily elicited. No gastric nor intestinal peristalsis was seen. A turpentine enema produced a large passage of flatus, the distension completely disappeared, and in twenty-four hours the patient's condition had greatly improved, and all vomiting had ceased. Forty-eight hours after admission she suddenly collapsed and died. At the *post-mortem* examination a huge carcinoma of the pyloric end of the stomach was found. The stomach was markedly dilated and was full of fresh blood, which came from the splenic artery, into which the growth had ulcerated. There was no stricture nor other lesion of the intestinal tract.

These cases illustrate the difficulty of diagnosis in many cases of gastric carcinoma, and demonstrate the importance of radiological examination of the alimentary tract in obscure cases of abdominal disease. Early diagnosis of gastric carcinoma is of paramount importance. In its early stages it is very amenable to surgical treatment, while the last stages of the condition when left without operation are, alas! often terrible to the patients and very distressing to those around them, while recurrence after gastrectomy in many cases causes death from asthenia with slight or no suffering. Carcinoma of the stomach appears to be on the increase. It is a very protean disease, and from the point of view of diagnosis the cases may be divided into three classes:

1. Those with symptoms of gastric disorder—often labelled dyspepsia or gastritis until too late.
2. Those with signs of malignant disease in which the site is not discoverable—for example, cases which are at first diagnosed as pernicious anaemia, Addison's disease, etc.
3. Anomalous cases, three of which are described above.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

ANTISTREPTOCOCCUS SERUM IN ERYTHEMA NODOSUM.

ERYTHEMA NODOSUM is most commonly described as a rheumatic affection, and the treatment in the many and various books I have consulted is invariably some preparation of salicylic acid. The prognosis as regards recovery is of course good, but the usual duration is about five or six weeks and appears to be almost uninfluenced by the usual treatment; recovery is followed by prolonged convalescence in which a rather intractable anaemia is conspicuous.

About three years ago I had two cases. The first was a woman, aged 48, who had a quinsy; about a week or ten days after its commencement, and when the throat was practically well, typical erythema nodosum developed; this lasted about five or six weeks; recovery was slow and more or less uninfluenced by the usual treatment. The second was a man of 28 who had follicular tonsillitis, followed in about ten days by a typical attack of erythema nodosum. He was treated in the usual way, and recovered in about five or six weeks. In neither case was there any history of rheumatism, and in both cases convalescence was prolonged. These two cases occurred about the same time,