Large Mononuclear Leucocytes, 1% (Normal 1-2). Transitional Forms, 1% (Normal 1-2).
Polymorphonuclear Neutrophiles, 76% (Normal 70-72) Eosinophiles, 2% (Normal 2-4).

GASTRIC ANALYSIS—
Gastric Extract. Meal given, toast and tea. Quantity Removed, 3 ozs. Food Remnants, slight. Blood, none. Tissue Bits, none.

Chemical Examination—
Reaction, acid. Total Acidity, 50. Free H.C.L., present. Combined H.C.L. ..... Total H.C.L. ..... Lactic Acid, absent. Altered Blood, none. Bile, none.

Microscopical Examination—
Micro-Organisms. B. Oppler Boas, none. Yeasts, none. Sarcines, none.

X-RAY (FLUOROSCOPIC EXAMINATION).

HEART—Normal.
LUNGS—Normal.
STOMACH—Position, Normal. Visible Peristalsis, marked. Filling Defects, none. Incisura, none. Hypersecretion, not visible. Mobility: (a) Stomach, greatly dilated and slightly fixed; (b) Pylorus, fixed; (c) Duodenum, slightly fixed. Tender Point, in epigastrium and over McBurney's point. Residue after six hours, marked. Empty in 14 hours.
SMALL INTESTINE—
Duodenum, empty in 18 hours. Ileum, empty in 28 hours.
LARGE INTESTINE—
Colon, empty in 42 hours.
COLON—Fluoroscopical Examination by Opaque Enema, normal.

Discussion.—My first impression of this illness being of a nervous origin was dispelled immediately I saw her in an attack. Her pain was indeed intense. Her facial expression was of one who was suffering real agony. The epigastrium alone appeared rigid ,throughout the remainder of the abdomen the muscles were soft; there was no rigidity. It would appear that the seat of the pathological lesion, whatever it may be, would be found in the immediate epigastric region.

Now, what lesion would likely be responsible for the symptoms here produced? Is it intestinal, is it pancreatic, is it stomach ,is it gall-bladder? Is this an enterospasm due to periodical contraction of some portion of intestine in the upper abdomen? Should this be the case, it is likely to be secondary to a chronic intestinal obstruction, one in which the lumen of the gut is not completely occluded from an anatomic point of view, yet sufficiently contracted to chronically interfere with the passage of feces. Should such a condition become acute, the clinical picture presented would be one such as has been described here.

In chronic intestinal obstruction we have most obstinate constipation which may have existed for a long period. A purgative may frequently have to be given, the patient discovering that a bowel movemet is very difficult to obtain without. It is frequently the case that this severe constipation will alternate with diarrhœa. If the stenosis is situated in the large intestine, constipation is an early symptom, if in the small, it is usually quite late in appearing.

This girl has never had any constipation, she has never had any diarrhœa. Her bowel movements have always been quite normal.

One of the earliest symptoms of stenosis in the bowel is vague indefinite colic. These spasms gradually become more severe and definite in location, and almost invariably are accompanied by vomiting, which