

acid and salicylic acid, which thus exert their full effects on the contents of the intestines, and we have the bowel washed out with an antiseptic solution. If we take into consideration that in diarrhœa absorption in the bowel is no doubt less active than in health, and also that the micro-organisms which abound in the intestines aid us in compassing their own destruction by splitting up any of the salol which may have escaped the action of the pancreatic juice, I think we must admit that, theoretically at least, salol is more apt to give good antiseptic results than the other drugs more commonly prescribed. A further advantage is that a larger dose of carbolic acid can be given in the form of salol, owing to its non-absorption in the stomach, than if the drug itself is prescribed.

May not the local action of many other drugs on the interior of the alimentary canal be too much overlooked? Some years ago, in a paper on anemia, the late Sir Andrew Clarke, after suggesting as the cause of the disease absorption of foul gases in the intestines, gives it as his opinion that the value of iron consists, not so much in restoring the red corpuscles, as in forming an astringent lotion to apply to the interior of the bowel, thus preventing the formation of these gases. Do modern therapeutists devote too much research to dilatation and contraction of capillaries and effects on nerve endings, and too little to the immediate action of drugs on the gastro-intestinal mucous membrane?

During an epidemic of summer diarrhœa, of twenty-three cases treated with salol, only one, a child eight months old, proved fatal. In very few cases were more than three or four doses necessary, and rarely were more than one or two loose stools passed after taking the first. Ordinary catarrhal diarrhœa, due to errors of diet, diarrhœa of children, diarrhœa occurring in the course of some other disease, two or three doses seldom fail to arrest, while in the diarrhœa of tuberculosis it can generally be relied upon to give temporary relief. It has been recommended in typhoid fever, but I have no experience of its use in that disease, nor am I aware that it has been given in cholera; but it seems to be well worth a trial, and at least as likely to prove effectual as any drug yet employed.

In all these varieties of diarrhœa the good effects of salol are most probably due entirely to its direct antiseptic action on the bowel contents—destroying bacilli, controlling acid fermentation of food and the putrefactive processes. The sedative action of carbolic acid will also lessen the peristaltic movements, and so relieve pain. The dose of salol for an adult is ten to fifteen grains (best administered in a spoonful of gruel or barley water), which may be repeated every four or six hours; to a child a year old, one or two grains may be given. It is very rarely rejected by the

stomach, and in the above doses does not produce unpleasant after-effects.

RUPTURED GASTRIC ULCER SUCCESSFULLY TREATED BY ABDOMINAL SECTION AND SUTURE.

T. H. Morse (*British Medical Journal*, 1733). The patient, a young lady aged twenty, having had symptoms of gastric ulcer, was suddenly seized with pain, followed by faintness and vomiting. The pain, which was of a burning character, commenced over the region of the stomach, and gradually extended all over the abdomen. Abdominal section was performed nearly five hours after the commencement of symptoms; the contents of the stomach were found in the peritoneal cavity. The stomach was withdrawn, and a perforation found on the anterior surface close to the cardiac orifice. The organ was washed out and the perforation closed with Lembert's sutures; the stomach was returned, the peritoneal cavity washed out, and the wound united. No food was given by the mouth for sixty hours, and at the end of three weeks the patient was quite well. The author had not up to the present time seen a record of any other successful case of this kind in this country, though cases had been reported by Drs. Penrose and Dickinson, also by Mr. Gilord and Mr. Barling, and by Mr. Warrington Haward, references to which were to be found in the *British Medical Journal* of the past year.

Mr. Barwell, in the discussion, said that he had been able to find twenty-five cases on record of closing a rupture in the stomach wall, and there were at least four others. In one of the twenty-five cases there was a localized abscess close to the small curvature; this abscess was opened, and that was all that was found to be necessary. He then described Kriege's case. Mr. Barwell suggested the following points, which he thought might point the way to success: First, to operate as soon as possible; secondly, that the incision through the abdominal wall should be to the left of the middle line; thirdly, to search very thoroughly the front wall of the stomach, as in these cases the opening was for various reasons liable to be hidden by lymph, puckering, etc. He suggested that it might be advisable to introduce into the patient's stomach some colored fluid, such as coffee, for this purpose. He could not agree with Mr. Haward that it was necessary to cut away the margin of the ulcer before suturing the stomach. He thought that Mr. Morse had done very wisely in washing out the stomach, and also in eschewing antiseptics in washing out the peritoneum. Mr. Barwell had seen very good results in washing out the peritoneum with warm distilled water in restoring patients from collapse during abdominal operations.