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THE OPERATIVE TREATMENT OF ULCER OF THE STOMACH.

A very complete report on this interesting subject was presented by Mr. Pearce Gould, at the Bristol meeting of the British Medical Association. He premised by stating that the pathogenesis of the disease is still obscure, being met with frequently in anæmic young girls, particularly maid-servants, as well as in middle-aged men. As a rule, only a single ulcer is found, situated, most frequently, on the smaller curvature, more rarely, on the larger curvature of the stomach. In size, it is about as large as a quarter of a dollar, and its depth is variable. The clinical signs of this disease, pain, hematemesis, and melæna, are sometimes not well marked, and may be absent; in the latter case, a diagnosis of the disease is, of course, impossible. In some cases, also, the pain may be severe, and may be accompanied with frequent vomiting. There may also be intervals of shorter or longer duration, during which the patients do not complain of pain, or any other morbid symptom. Perforation occurs in 25 per cent. of the cases. Most frequently, and this is particularly observed in maidservants, the perforating ulcers are situated on the anterior wall of the stomach. Perforation of the posterior wall is much more rare.

Billroth had recommended laparotomy, followed by excision of the ulcer and suturing of the wound in the stomach as a prophylactic measure. The mortality from this operation, however, is large, and besides, there is no sign, by which one can exactly tell, whether the ulcer is located near the cardia, or the pylorus, on the anterior, or posterior wall of the stomach.

In 85 per cent. of cases, a cure may be obtained by purely medical treatment. Perforation into the peritoneal cavity is, almost invariably, fatal. Death is, in such cases, due to shock, or it may result from peritonitis. The acute symptoms of perforation, in cases in which the patient does not die from shock, last for twenty-four hours. The shock is of variable intensity, and may, sometimes, be confounded with the collapse, which precedes dissolution. Shock is best treated by hypodermic injections of morphine, and local applications of heat.

The operative treatment of the perforation consists, in stitching the wound (with silk), and in carefully cleansing the peritoneum. The latter is of the greatest importance, so much so, that, upon its careful performance, the success of the operation especially depends. The operation should not be performed, during the first period of shock, neither should it be delayed, until peritonitis has had time to become general.

As the localization of pain gives no exact information about the real site of the ulcer, the abdomen should be opened in the median line—this form of incision allowing the operator to explore, easily, all parts of the peritoneal cavity. For washing out the peritoneum, Mr. Gould recommends the physiological solution of chloride of sodium, or plain boiled water; antiseptics he rejects, as he considers that they are toxic in such cases. The ulcer,