Meeting of Medical Societies.

PATHOLOGICAL SOCIETY OF TORONTO.

January 30th, 1892.

The society met in the Biological Department, the president, Dr. J. E. Graham, in the chair.

Dr. J. E. Graham presented a specimen, and read the following history:

A CASE OF SUB-DIAPHRAGMATIC ABSCESS ACCOMPANIED BY EXTREME DILATATION OF THE STOMACH.

Notes taken December 30th, 1891.

G. W., aged thirty-five, a builder, has never been strong, suffered for the last six or eight years from dyspepsia, which was at times so aggravated that he could only take limited amounts of the simplest kinds of food. During the past summer he suffered from a pain, more or less continuous, in the right side, and was treated for liver trouble. In the autumn he spent some weeks in Muskoka, but returned very little benefited in health. He was pale and emaciated, and the dyspeptic symptoms were worse than usual. In November he was much startled by a fire which occurred in his house; he exerted himself more than he had done for months in putting out the fire, and immediately afterwards was seized with a severe pain in the right hypochondriac region, accompanied by very great weakness. He was seen by a physician, who found him in a partial state of collapse. Under treatment the pain was relieved, and he rallied considerably. He was, however, much troubled by severe vomiting of a blackish liquid. This vomiting occurred both after taking food and in the intervals. It was not accompanied by pain, and was at times so severe that the fluid would be discharged with considerable force.

Three weeks after the first, he was seized with a second attack of severe pain and collapse. This occurred on a Sunday, and on the following Monday evening Dr. Cameron and I were called to see him in consultation with his attending physician, Dr. Shaw. We found the patient sitting up in bed, pale and much emaciated. He could speak clearly, but his voice was weak. His pulse was 140, and temperature 101°. Upon physical examination, the stomach was found to be enormously distended. The greater curvature was half way between the umbilicus and the pubes. A large solid mass was found in front of the stomach, which we diagnosed to be liver; stomach tympanites was found both above and below the mass. The lower margin of the mass extended down to the umbilicus. At the same time we noticed that the pulmonary resonance on the right side behind did not extend lower than normal. The heart and lungs were found healthy. The diagnosis made was stenosis of the pylorus and dilatation of the stomach. We did not attempt to account for the peculiar position of the liver, except that it was probably much enlarged.

The patient died suddenly the following morning. A *post mortem* was made eight hours after death. Upon opening the abdomen we found extreme dilatation of the stomach, and the liver, normal in size, lying in front of it. The greater curvature passed in a line rather below midway between the umbilicus and and pubes. The liver appeared to be somewhat rotated and pushed downwards, so that the left lobe was in front and below. In trying to separate the liver from the diaphragm, a large abscess was opened, which was found to contain two pints and a half of pus. The abscess cavity extended backwards and upwards, pushing up the diaphragm. Its upper margin corresponded with the fifth rib on anterior border of axilla, sixth rib at post border, and eighth behind. The cavity was not connected with the liver. The sac was thick and strong. It covered a portion of the upper surface of the liver and lower surface of the diaphragm. In the region of the pylorus and abdomen inflammatory adhesions existed, matting the intestines together in a confused mass. Upon examination of the pylorus a contraction was found produced by inflammatory adhesions, but no hardness or ulceration was discovered in the wall itself. The abscess could have been easily reached between the ribs, and could have been thoroughly drained. It is probable that the patient had for months a dilated stomach, the result of dyspepsia, but the extreme dilatation may have been of later origin.

These cases of sub-diaphragmatic abscesses unconnected with the liver are somewhat rare. I have seen two cases, in one of which a diag-