

tion of fullness and pressure in the epigastrium, pain after eating, nausea and vomiting. These symptoms are very similar to the gastric symptoms in acute appendicitis, which were referred to under spasm of the ileo-cæcal valve. Vomiting of blood may also occur, which feature suggests the presence of ulcer of the stomach. In many cases, however, it is probable that the hemorrhage was from an erosion which, for some unknown reason, is not uncommon in obstruction of the intestine.

The characteristics of the pain in the region of the stomach in ileo-stasis due to organic obstruction are very variable. This is probably dependent partly on the degree of stasis and partly on the nervous state of the patient. In some cases the time of appearing after eating and the intensity and nature resemble similar characters of the pain observed in gastric or duodenal ulcer. This feature often renders it difficult to determine whether the particular case is one of intestinal stasis alone or intestinal stasis associated with peptic ulcer. It has been said by some writers that localized tenderness is not present in the epigastric region in intestinal stasis. This I am satisfied is not correct, for I have frequently observed in patients suffering from the disease unassociated with any lesion in the stomach that they exhibited localized tenderness in the region of the pylorus.

From what has been said it is obvious the symptoms referred to the stomach in ileo-stasis do not form a very characteristic group. It is not surprising, therefore, that the recognition of the disease by the consideration of the symptoms and signs without the aid of radiographic examination is frequently impossible. Some cases simulate chronic dyspepsia due to a gastric neurosis; others peptic ulcer of the stomach or duodenum; others again pyloric obstruction. Indeed, it may be said to simulate the majority of diseases of the stomach, and even gastric cancer. In a case recently under my care the patient, who was a merchant forty-five years of age, had lost thirty pounds weight. An analysis of gastric contents gave a total acidity of 36.5, and free hydrochloric acid of 1.5. The sediment contained Boas-Oppler bacilli in small numbers; no occult blood in faeces or stomach contents. X-ray examination of the stomach showed gastric hypertonus. No X-ray examination of the intestines was made. On account of the presence of Boas-Oppler bacilli I gave an opinion that the case was probably malignant, and advised surgical treatment. An operation revealed a Lane's kink which was corrected; complete recovery followed.