FOUR CONSECUTIVE CASES OF PERFORATED GASTRIC ULCER SUCCESSFULLY OPERATED ON.

By R. F. TOBIN, F.R.C.S.; Surgeon to St. Vincent's Hospital, Dublin; Examiner in Surgery in the Royal College of Surgeons, Ireland.

[Read in the Section of Medicine, April 11, 1902.]

Perforated gastric ulcer is such a growing subject, and one of so much interest to both physician and surgeon, that I shall make no apology for venturing to introduce it for discussion, by laying before you some particulars of, and remarks upon, the four cases referred to in the agenda paper. The rate at which the subject is growing I would indicate by quoting the concluding remarks of a remarkable paper read by Dr. Parsons before this Section in 1892. In it he says—"If I have persuaded any of my audience to add acute peritonitis to the generally admitted four great surgical emergencies requiring immediate operative interference, my object in writing this paper is gained." These remarks were very fitting then. Surely there is no one here to-day to whom he could address them. His object has been completely gained.

The four cases I am about to refer to were all in St. Vincent's together at the beginning of this academic year, and I opened the session with a clinical lecture on them. Three of them had been operated on by me, the fourth by my colleague, Dr. Alfred Smith, at whose request I have incorporated it with mine—first, because it has much in common; secondly, because he refuses to have anything to do with it. "I never," says he, "travel beyond my own area, except on compulsion."

The following are points of resemblance in these cases. All were women between the ages of twenty and thirty, and of that weak texture that marks anaemic girls. All had
previously complained of gastric trouble; three of the four were domestic servants. In all the situation of the ulcer was the same; in all the method of operation was, excepting one or two details, identical; in all there was not only recovery but a more rapid return to good condition than would probably have been the case had they been admitted to hospital just before the perforation had occurred and had that catastrophe been averted by rest and medical treatment. The symptoms in the four cases at the time of operation also showed much uniformity—there was pain in the left epigastric region and pain above the left clavicle, scanty vomiting and retching, rigid abdomen, absence of abdominal respiration, absence or diminution of liver dulness, and shock.

Let me refer in detail to some of these points.

1. The position of the ulcer: They were all situated as in the specimens I show you from the Museum, R.C.S.I., at a point an inch or two in front of the cesophageal opening. This, as far as I can judge from my own observations, records of cases, verbal communications and specimens in museums, seems to be far and away the most common site for the operating surgeon to find a perforation. Granted that this is so, the interesting question arises, Why is it? My explanation, not of the ulceration but of the perforation that accompanies ulceration in this locality, is as follows:—The perforation, as I have just said, occurs in the area of the stomach that extends forward from the cesophagus underneath the liver, an area that would be pressed upon by the liver were that organ unduly depressed or the stomach unduly drawn up. Now, owing to the laxity of tissue in the usual sufferers from this disease, and to the fact that they are on their legs all day long, the liver is not well braced up. Moreover, the stomach, owing to its fixity to the diaphragm, is being continually drawn through a long range of movement as the anemic sufferer goes about her work. Now, thinking