FOUR CASES OF DYSPESIA
ACCOMPANIED BY SEVERE EPIGASTRIC
PAIN. - With Notes.

Wm. Lilico, M.B., Ch.B. (2nd Class Hon.) Ed. 1902.
FOUR CASES OF DYSPESIA ACCOMPANIED WITH

EPIGASTRIC PAIN. - With Notes.

I propose first to give notes of certain cases which have come under my care during the last few years, in which the most outstanding symptom has been epigastric pain coming on a certain definite time after eating, but which differed markedly in their course and in their response to treatment. In view of the attention which is being directed at present to such conditions as gastric and duodenal ulcer and hyperchlorhydria these cases have been of great interest to me.

1. J. M. Aet 49, farmer, came to consult me first in the Spring of 1908 complaining of severe pain in the epigastrium which came on regularly about 2 hours after meals.

He gave the following history. At the age of 17, he got a severe wetting which resulted in some dyspepsia for which he was medically treated and from which he made a slow and incomplete recovery. The dyspepsia was accompanied by vomiting and also by pain but the history as regards both was vague.

From this attack he dates the beginning of his trouble. He has since been more or less troubled by pain after food, but this has been more marked in the
Spring and Autumn, though of late years the exacerbations have tended to persist longer. He has been under medical treatment frequently and has used many drugs but only got relief for a time. Certain articles of food such as porridge he has had to give up altogether.

When he came to see me he complained of pain in the epigastrium coming on two hours after eating and persisting till the next meal. The pain was of a severe boring character. He also complained of pain in the back in the region of the 10th dorsal vertebra. He stated that he felt more comfortable - and had less pain - immediately after a meal than before it - that indeed the hour or so immediately after a meal was the time most free from pain. The pain also came on during the night and was relieved by taking milk or other food and he usually took a tumbler of milk to his bedroom at night for the purpose of sipping to relieve the pain.

He had no pyrosis, but had occasional vomiting of food, which relieved the pain.

The patient was a stout, healthy-looking man, looking rather less than his years. He was well built and muscular and in spite of the dyspepsia well nourished with a good layer of superficial fat. The tongue was clean and the teeth good. On superficial
palpation of the abdomen there was tenderness on pressure over the epigastrium to the right of the middle line. Deep palpation and percussion revealed nothing abnormal - there was no dilatation of the stomach and no splashing - nor was there any perceptible thickening in the pyloric region.

The patient was given cachets containing 20 grains of carbonate of bismuth - one to be taken an hour after each meal - and he was limited in diet, the coarser vegetables, broth, fat meat, etc., being forbidden.

When he was seen again after an interval of a week there was marked improvement in regard to the pain and for some weeks all went well. He felt better, slept better, and was nearly free from pain.

In July 1908, I was sent for to attend his wife, and while at the house he complained that his stools were black. I requested to see a specimen, which was semisolid, black and tarry-looking, and slightly but not markedly offensive. He was looking very ill, the conjunctival and buccal mucous membranes were very pale, and his pulse about 120. He said that he was feeling very weak and shaky. He was put to bed, food by the mouth was stopped - only sips of boiled water being allowed - and he was fed per rectum. For a few days when the bowel was washed out previous to the
nutrient enema being given, the stools which came away were tarry, but the colour gradually came back to normal. The pulse also gradually slowed down and the giddiness of which he complained very much at first also gradually disappeared. After the stools were nearly normal the rectal feeding was stopped, and milk, at first peptonised, was given in small quantities by the mouth at frequent intervals. Carbonate of bismuth was also again given and the food gradually increased in amount and variety. Iron in the form of the bipalatinoids of Oppenheimer were also given. He was in bed for a month with a carefully regulated diet. After he was allowed up he still progressed favourably and quickly regained the weight which he had lost during the time he was in bed. Constipation was his worst trouble at this time, but was relieved by a pill containing the extracts of cascara, nux vomica, and belladonna.

I saw him at frequent intervals during the ensuing winter and he had little or no complaint. He was careful in regard to his food, avoiding such things as he knew by experience were apt to disagree with him. His weight kept up, he had little or no pain and was feeling well.

In the beginning of February, 1909, I was again called to see him, and learnt that for a little time
the pain had been troubling him and that that day he had had some malaena. He was again treated by rest in bed, nutrient enemata, etc., but on this occasion the malaena persisted longer and he did not make so good a recovery, the pain, anaemia and constipation being more persistent.

In view of the fact that he had had two haemorrhages, both fairly copious, and that the pain after food was still persisting, operation was advised. He was operated on by Dr. Dalziel of Glasgow in March 1909, who performed a gastrojejunostomy. Previous to the operation the stomach contents were examined chemically and there was a marked decrease of hydrochloric acid. From this fact and also from the anaemia and wasting which by this time was fairly marked, Dr. Dalziel expressed the opinion that there was possibly a malignant growth, even though the loss of weight and anaemia only dated from the last attack of malaena. However no malignant disease was present, but the pylorus was found to be the seat of several small ulcers.

Recovery from the operation was uneventful and good, and since the operation he has enjoyed good health. There has till now (March 1910) been no recurrence of pain or malaena, and he is now able to take any ordinary food.
II. J. W. Aet 60, farm labourer. I was first called to see this man in November, 1908. He had been assaulted by another man and had some slight abrasions on the face. He was a stout, well-built man, slow of speech and movement, and inclined to take the worst view of things. Two nights after the assault he complained of numbness and weakness of the right hand and was seen by Dr. Murray Aynesley of Wigtown and myself. There was no other sign of head injury and the weakness of the arm, which was undoubted, might be explained by the fact that the forearm bore traces of a severe accident which he had sustained some years before in a threshing mill. As there was an assault case pending, and as there were no other signs of head injury it was thought by both of us that he was inclined to make the most of his injuries. The abrasions healed up rapidly. At this time he had no complaint of any injury to the abdomen, but a month later he came complaining of pain in epigastrium coming on about an hour or a little more after meals. A definite statement of his symptoms was very difficult to elicit as he was decidedly under the average in regard to intelligence. He had a furred tongue and stated that he was constipated. The abdomen on examination revealed nothing abnormal by inspection, superficial or deep palpation or percussion. He was
given laxatives, and bismuth carb. in 20 grain doses after meals, but there was very little improvement in the symptoms, though there was no marked wasting and he was able to take a fair amount of food and was able to attend to his work.

On 16th April 1909 I was sent for hurriedly as he had been taken suddenly ill in the fields and had been vomiting blood. When I arrived he had been fetched in home. The pulse was then barely perceptible, he was feeling very faint and ill and complained of very severe pain in the epigastrium.

He was given a small dose of morphia hypodermically which relieved the pain, and was treated subsequently by rest in bed and rectal feeding, succeeded by a carefully increased diet and the administration of carbonate of bismuth. There was very marked malaena, which persisted for several days. Improvement was very slow. The malaena certainly did stop, but on the other hand, the pain persisted and he had a very poor appetite. The pain in the epigastrium was nearly continuous. After the date of the haemorrhage there was also persistent tenderness on pressure in the epigastrium in the middle line. His feet also were swollen and he had great difficulty in getting about after he was allowed up.
As the patient was manifestly making no progress and as the diagnosis especially taking into account the history was rather obscure, he was sent on to the Royal Infirmary, Edinburgh. He died there, and the post mortem report which I received stated that he had a malignant ulcer of the stomach near the pylorus, with secondary liver infection.

III. Miss McQ. Aet 31, came to consult me in November 1908, also suffering from pain which came on about 2 hours after meals. The pain was severe and limited to the epigastric region and was relieved by taking food. She had no history of vomiting but was a good deal troubled by heart-burn. She stated that she had lost a good deal of weight but was not certain how much. Her appetite was good but she was frightened to eat on account of the ensuing pain. The pain came on after any kind of food, fluid as well as solid, so that she was practically starving herself. The conditions had persisted for some months and had been diagnosed previously as a functional nervous dyspepsia but treatment had been of little service. She was also troubled with constipation, having to use laxatives frequently.

There was no history of vomiting of blood, nor of the passage of tarry stools.
The patient was a tall, large-boned woman, very thin and markedly anaemic. She had lost a good many of her teeth and those that remained were most of them carious and quite insufficient for the proper mastication of her food. The tongue was flabby and slightly furred. On palpation and percussion of the abdomen there was nothing abnormal.

She was treated by being ordered a light diet - milk, clear soups, fish, etc. - with 25 grain doses of carbonate of bismuth after meals and was recommended to take cascara segrada at night for the constipation. The improvement in a short time was marked, and she soon could take ordinary food without discomfort. Her general health improved and she began to gain weight. As her teeth were in a very bad state, I extracted them using a local anaesthetic. For the month or two following while waiting for her gums to heal and contract her food was necessarily of a more or less sloppy character and was largely starchy in nature. She began again to complain of pain after food exactly comparable in character and time with that from which she had previously suffered. The bismuth on this occasion proving of no avail and as the food was mainly starchy, a starch diastase (Liq. Taka-diastase. Parke, Davis & Co. in 31 doses) was tried and proved completely successful. Her recovery was uneventful
afterwards and when last seen about a year after this she was keeping well with no dyspeptic symptoms.

IV. J. V., Aet. 39, farm steward, was first seen in February, 1909, complaining of symptoms very similar to the other three patients. His history was that he had suffered from epigastric pain after meals for some years at irregular intervals but that recently the pain was recurring after every meal, that though his appetite was good he was afraid to eat and was consequently getting thinner and was feeling weak and unable for his work.

The pain was severe, was referred to the epigastric region and was felt after any kind of food, liquid or solid. He stated that the pain was least just immediately after a meal. He was also constipated and had to take purgatives frequently.

The patient was a slight, spare man, weather-beaten, but his conjunctival and buccal mucous membranes were pale. He was very thin, and stated he had lost over a stone in weight during the two preceding months.

The tongue was slightly furred and he had some caries in his teeth, particularly among the molars. On abdominal examination there was little subcutaneous fat, there was slight tenderness on superficial palpation in the epigastric region in the middle line and
slight splashing in the stomach, but no dilatation of
the stomach was made out by percussion.

The treatment recommended was again 20 gr. doses
of carbonate of bismuth with laxative doses of cascara
segrada. There was no difficulty about limiting the
diet, the difficulty rather was to get something
which he could take without pain. He was advised to
take milk with plain water added at first. There was
practically no improvement in symptoms following and
the patient began to get very hopeless as to his con-
dition. He stated that he could not get off work to
go to bed and when the question of hospital was mooted,
refused to consider it. Finally as a last resort and
without very much hope of satisfactory result, he was
given pills containing the Pil. Hydrang. and Pil. Colo-
cynth. Co. of the B. P., as his constipation was still
persisting, to be taken at night twice weekly, and he
was in addition recommended to take a saline each morn-
ing and was given a mixture containing Liq. Bismuth and
some Liq. Morph. Mur. To my astonishment improvement
was now very marked. He was soon able to do without
the pills and mixture taking only the saline in the
morning and was also practically free from pain. In
a short time he was able to take ordinary food without
pain. When I last saw him in January 1910 for Lumbago,
he had no stomach trouble, and except for the recent
pain in the back, was well.

The main interest in these cases to me at any rate was the difficulty in deciding whether or not ulcer either of the stomach or duodenum was present. Of course no doubt this difficulty was increased by the fact that one has not at hand in a country practice all the means for the modern laboratory aids to diagnosis and in the majority of cases one has to think twice before adding extra expense to patients who may find it difficult enough to meet the necessary expenses of an illness.

To a great extent the symptom chiefly insisted on by all four patients was the severe epigastric pain coming on at a certain definite time after meals.

Three of the patients were men of middle age and the fourth a woman past the age when chlorotic ulcer of the stomach is commonest and who had moreover no previous history of gastric ulcer or of anaemia.

In Case I the healthy appearance of the patient and the speedy disappearance of all symptoms under fairly simple treatment kept one off one's guard until the melaena revealed the true state of matters.

In Case II the history of the assault and the subsequent complaints regarding the weakness of the
arm combined with the fact that previous to the accident there were no gastric symptoms and at first - when dyspepsia was complained of - no tenderness on palpation or other marked sign made one inclined to pay less attention than was right to the complaints regarding the pain. Had there been at the time of the accident any history of an abdominal injury, one perhaps would have been more inclined to think of gastric ulcer as a possible cause. It is a possibility that there may have been a slight abdominal injury which the man had forgotten about, as the injuries to the face were more likely to keep his attention. Dreschfeld in Allbut & Rolleston's "System of Medicine" - article on Gastric Ulcer - Vol. III, page 448, says it is probable that blows, kicks, falls or continuous mechanical pressure on the epigastrium or abdomen may produce ulceration, sometimes giving epigastric pain for a time - rapidly disappearing under treatment. At other times the condition is more resistant and the clinical manifestations are those of chronic ulcer of the stomach. He adduces cases reported by various authorities Potain, Bouveret, Leube and others as examples.

Whether in the short time this could have in this case gone on to malignant degeneration of the ulcer I cannot say. It may be a case of pure coincidence or it
may be that the malignant disease was there previous to the assault, producing few or no symptoms, but that the shock and lessened resistance consequent on the assault hastened its development.

In Case No. III the treatment by bismuth was completely successful at first and the case corresponded in symptomatology and its reaction to treatment to those described by Hutcheson in the Clinical Journal of August 10th, 1905, as "stenic dyspepsia" or "hyperchlorhydria." No examination of the stomach contents or of a test meal was made, since improvement began with the use of bismuth. The pain after the teeth were extracted was in my opinion due to the starchy nature of the food.

In Case No. IV, I was inclined, especially as he came under my care shortly after No. I to take the view that ulcer was present. I used every means to persuade the man to go to bed. This he absolutely refused. I was much surprised myself to find that his condition depended so much on the constipation, or at any rate that it improved so rapidly when the constipation was adequately treated.

The chief difficulty in the differential diagnosis of such cases as those described lies in deciding which
of them are due to gastric or duodenal ulcer and which to such conditions as hyperchlorhydria if it be admitted that such a condition exists as a purely functional condition. Cohnheim in "Diseases of the Digestive Canal", translated by Fulton states that "epigastralgia occurring at a definite time after eating is the most positive sign of gastric ulcer", (page 111) and defines epigastralgia (page 78) as "pain of a cramp like boring or burning character in the region of the epigastrium occurring \( \frac{1}{3} \) - 4 hours after meals and repeated at the same hour in each case." This was certainly present in all four of the cases which I have referred to. Cohnheim draws a distinction between ulceration and fissures and erosions, which he claims occur in the stomach and pylorus just as they do on the mucous membranes of the mouth and anus. The distinction he draws between ulceration and these fissures and erosions is that in ulceration the pain is chiefly after solid food, in the fissures, etc. after fluid or solid food and more especially after cold drinks and the use of tobacco. ("Diseases of Digestive Canal," page 128.) So that according to Cohnheim any case where there was present severe pain coming on \( \frac{1}{3} \) - 4 hours after meals at a certain definite interval in each case after the meal might be regarded as due to either ulcer or fissure.
C. W. Graham in the Journal of the American Medical Association, August 22nd, 1908, also points out that the pain in gastric and duodenal ulcer is the constant and perhaps most characteristic symptom. He says that the time of occurrence of the pain is its most distinguishing feature and goes so far as to state that unless complications have introduced complexities it is almost if not quite the final evidence for correct diagnosis.

The majority of surgeons seem to take the same view, and say that these symptoms of pain described above, if lasting over a lengthened period are practically diagnostic of ulceration. (See Moynihan's Article in British Medical Journal of March 28th, 1908, page 814.)

On the other hand we find other writers describing similar symptoms in patients similar in age and other conditions as being the result of quite a different condition. Hutcheson in the "Clinical Journal" of August 16th, 1905 and Leonard Williams (ibid May 10th, 1905) describe a form of functional dyspepsia, associated with hyperchlorhydria, in which the pain recurs in the same way after meals and is relieved by food. The condition described by these writers and others is indistinguishable so far as the character and onset of the pain goes from those described by others as gastric ulcer.
It is interesting to compare cases in which there has been a definite history of this kind and where the diagnosis has been eventually cleared up by operation as in the first of my cases. A similar case is described by the sufferer himself, S. T. Irwin, in the British Medical Journal, April 17th, 1909 - page 979, and there is a close correspondence in the two histories.

Dr. Irwin states that from personal experience of a dyspepsia which resulted finally in a perforated duodenal ulcer he is persuaded that there are two stages, a pre-ulcerative stage corresponding to the hyperchlorhydria or acid dyspepsia of Dr. Hutcheson and an ulcerative stage where the symptoms are practically those described by Moynihan in the British Medical Journal of March 28th, 1909 - page 814. The pre-ulcerative stage is characterised by fulness and discomfort after meals, accompanied by pyrosis, but passing away as the stomach gets empty. In the ulcerative stage the pain is more severe - the typical hunger pain - which lasts longer, gets worse towards the end of digestion and is especially apt to be troublesome during the night. He says the two stages agree in regard to the time at which the discomfort begins, are both relieved by taking alkali or alkaline food, but disagree in the character of the pain.
I do not think it possible from the character and onset of the pain alone to altogether affirm the presence of ulcer. For instance in the four cases described there was present pain which came on at a definite time after meals and which in all of them was severe in character. In all of the four cases the duration of the symptoms was prolonged. In two of the cases there was certainly ulcer present but in the other two, in my opinion, it is extremely doubtful if there were - the speedy disappearance of the symptoms and the fact of there being no recurrence in 12 months in one case and 18 months in the other giving one little support for supposing an ulcer present. One has, I think, to rely on other points as well as the character and onset of pain in order to come to a decision. Such symptoms as heartburn and waterbrash are I think of no great importance in distinguishing the cases, as they seem to occur both when ulcer is present and when not.

One important aid to the differential diagnosis is the presence of tenderness on palpation over the epigastrium, which most authorities seem to agree is typical of ulceration, but which Hutcheson (loc. cit.) seems to suggest can be due to spasm of the pylorus secondary to hyperchlorhydria.

As regards the chemical examination of the stomach contents or of a test meal little stress
can be laid upon the estimation of hydrochloric acid in the differentiation of ulcer from conditions similar in symptoms.

It is well known that increase of hydrochloric acid is present in the majority of cases of the chloratic type and is often present in the more chronic forms such as those occurring in middle age. It is disputed and has not been I think definitely settled what precise role the hyper-secretion of acid plays in these cases - some regarding the hyperchlorhydria as secondary to the ulceration, while others maintain that it is an important predisposing cause of ulceration. (See Dreschfeld's Article on Gastric Ulcer in Allbutt & Rolleston's Medicine, Vol. III.)

Dr. Martin publishes in the Clinical Journals of October 1909 statistics as to the chemical examination of test meals - in regard to the estimation of hydrochloric acid, in 25 functional cases, 18 cases of ulcer of the stomach, and 18 cases of carcinoma, and states (Clinical Journal Oct. 27th, 1909, page 39) that in any individual case the percentage of hydrochloric acid present in the stomach contents during digestion does not constitute an absolute diagnostic sign of any particular disease. In fact the only definite conclusion he asserts in regard to the percentage of hydrochloric acid is that a normal or increased percentage is
in favour of ulcer or functional diseases. Hypochlorhydria is in favour of carcinoma.

A more important point is, I think, the examination of stomach contents and faeces for blood either in mass or occult. It is admitted that a copious haemorrhage can proceed from the stomach or intestine without any actual breach of surface, but on the other hand the presence of haematemesis or malaena in a case which presents the symptoms referred to is a strong argument in favour of ulcer - is, in fact, I think, proof positive.

The stomach contents and faeces may be tested for occult blood, i.e. blood occurring in such small quantities as to be only estimated by chemical tests - by Boas's test after the patient has been for 2 or 3 days on a haemoglobin free diet. This test is described in Sahlis' "Diagnostic Methods" (1906) - page 447, and is of great value in those cases where the haemorrhage is very slight.

On the whole there is a good deal to be said for a position in regard to diagnosis midway between the two parties. I do not think it justifiable to make a definite diagnosis of gastric or duodenal ulcer in the absence of both tenderness on palpation and haemorrhage, or at any rate to make such a diagnosis a reason for advocating operation. At the same time there seems to be no very accurate dividing line between the conditions described by Hutcheson and others - and
ulceration and it is as well to remember that cases which seem to correspond to Hutcheson's classification may, if untreated, or if treatment be unsuccessful, go on to exhibit more serious symptoms.

**Treatment.** Where there is a history of epigastric pain coming on some time after eating, and where other conditions such as carcinoma and pyloric stenosis have been excluded, it is advisable and I think absolutely necessary to get the best results to put the patient to bed for a varying time. The recumbent posture does away with some of the risks of a possible haemorrhage, it impresses the patient with a due sense of the care which will be necessary for his recovery and makes the matter of dieting much more easy. A patient who is going about while under treatment is more inclined to take a light view of his condition and he is more liable to temptation in the way of food - and it must be remembered that most of these patients have fairly good appetites. Where the pain is not accompanied by haemorrhage in mass or occult or by any tenderness over the epigastrium, the patient may be let up as soon as the pain is gone,- which will probably be in the course of a week or ten days or less. In the other cases, where there is either a certainty of an ulcer being present or a strong likelihood that there
may be - the period of rest should be prolonged for a month or even more, depending upon the progress of the patient, in the hope of the ulcer healing over. Attention should be paid to the bowels, for there is no doubt that the symptoms are aggravated in most of the cases by constipation, and it would seem that in some - as in Case III - are dependent upon that alone. If the constipation is marked the bowels may be relieved at first by enemata to ensure a thorough evacuation of the lower bowel, and later by the use of laxatives. On the whole, I think, salines taken regularly have the best effect.

The pain in nearly every case is relieved in part or altogether by bismuth, carbonate or subnitrate. I have used the carbonate as a rule in 20 - 30 grain doses, given after meals. To begin with I gave bismuth in these cases with the idea of neutralising the excessive hydrochloric acid, following the recommendation of Hutcheson. With this intention I have given it about an hour or a little more after meals, when regular meals are taken, but if the food is given in small quantities at frequent intervals it may be given three or four times a day. It is fairly successful in relieving the pain in most cases, whatever its precise action may be. It is as well to remember that when bismuth is being given the stools are black, but a greenish
black, distinct from the tarry blackness of malaena.

If the pain be not relieved by the bismuth alone, there may be added a little morphine or belladonna or atropine, but it is as well to do without morphine at any rate in view of its tendency to produce constipation. If given at all, it should be stopped as soon as possible. Hot fomentations or hot poultices in some cases are very efficient in easing pain. The administration of bismuth should be continued especially where ulcer is present, for some time after the pain has gone.

**Diet.** In regard to diet I have made no very definite rules for myself, but have started as a rule with a purely milk diet, giving small quantities frequently. When the patient is free or nearly free from pain clear soups, milk puddings, raw egg and milk, then fish finely powdered, and later eggs lightly poached or boiled were added, and later still chicken and lean mutton, vegetables such as potatoes, etc., being only added after some weeks.

When haemorrhage is present in any quantity, I have been accustomed to cut off all food by the mouth, only allowing sips of cold boiled water. After one considers that the haemorrhage has ceased by the cessation of haematemesis or the disappearance of blood in the stool, and the wearing off of the results of the
bleeding, food may be resumed by the mouth with care.

In 1901 Lenhartz introduced a method of dieting and treatment for gastric and duodenal ulcer which has been well spoken of by several other observers. I have not tried it myself but judging from various results published (e.g. Spriggs in the British Medical Journal, April 3rd, 1909 - page 825) it certainly seems to be worth a trial at any rate - in cases where ulcer is suspected. One great advantage is that it does away with rectal feeding which is distressing to the patient and greatly increases the nursing difficulties. Besides this, in many cases of haemorrhage from ulcer of the stomach, the patient is in a weak and collapsed condition and even if one grant that a certain amount of nutriment is absorbed from enemata the amount is so small that it is of little value, and a mode of feeding which provides material for the restoration of the loss by bleeding is of great value.

The main points in the treatment are:- (1) The giving immediately of sufficient nutriment to improve the general condition of the patient. (2) The giving of these in such a form as to avoid large quantities of fluid and so the distension of the stomach. (3) The neutralisation of the hydrochloric acid usually in excess in these cases by giving proteid food and also bismuth and iron to combine with it.
Feeding is started at once by the mouth at hourly intervals from 7 a.m. to 9 p.m. — a teaspoonful at a time — and the patient is not allowed to feed himself for a fortnight. The food consists essentially of fresh iced milk and raw eggs — the whole egg being beaten up and iced. Granulated sugar is added to the eggs on the third day — later raw scraped beef — boiled rice and soaked rusk are added — and so on. The treatment is described by — amongst others — Langdon Brown in the Clinical Journal, Nov. 25th, 1908 and Sprigg in the British Medical Journal, April 3rd, 1909, page 825.

The question of operative treatment is a difficult one. Some surgeons, e.g. Moynihan in the British Medical Journal of March 28th, 1908, (page 814) advocate gastrojejunostomy in cases which have recurrent symptoms of pain with hyperchlorhydria and epigastric tenderness — in view of the risks of haemorrhage — contraction and perforation.

For myself I think that there are cases which are certainly better to be referred to the surgeon but I should certainly not be inclined to refer all — even where there were present haemorrhage and tenderness on epigastric palpation.

There is no doubt that even still the laity as a whole are not favourably disposed to operative
interference and if given the choice will usually try a possible cure by medical means before resorting to the surgeon and I think there is quite a reasonable hope in the majority of these cases of cure without operation. Apart from the risks and - according to some - the uncertainty of results in these cases of operative interference the question of expense will guide largely the choice of the patient. The operation of gastrojejunostomy is not one for the general practitioner and while for the well-to-do or the poor there is every facility, the middle classes, who do not care to go into hospital, find it difficult enough to meet the expenses of the surgeon, of special nursing and so on.

I think one must have very definite and good reasons for advising operation, and for my own part should advise operation:

(1) In cases with repeated haemorrhages - recurring after treatment, whether these may be in mass or occult - in the one as endangering the life of the patient, and in the other as showing the existence of an unhealed ulcer.

(2) In cases where medical treatment carried out conscientiously is not successful. In all Cases I think medical treatment will produce amelioration but in some the pain recurs at intervals - and these, I
think, are cases for operation since to be of any avail medical treatment necessitates loss of time - which may be a serious consideration for the patient, to say nothing of the risks of contraction of some part of the stomach or of malignant degeneration where an ulcer is present.

(3) In cases where there is persistent hyperchlorhydria as shewing the possibility of the case being one of carcinoma. In these cases the presence of other symptoms such as loss of weight will help in deciding, even in the absence of a definite palpable humour.

(4) In cases where there is evidence of beginning pyloric or other contraction with consequent dilatation of the stomach and perhaps a definitely palpable thickening.

(5) In cases of perforation of a gastric or duodenal ulcer.

The after results of gastrojejunostomy, which is the operation usually performed in this class of case, are not quite agreed upon but it certainly seems in the circumstances detailed above to offer the most certain means of alleviation of the epigastric pain and the avoidance of the dangers of repeated haemorrhage and contraction in cases of ulcer.

In the consideration of these cases there are certain points which it may be well to briefly
summarise.

1. There seems to be a connection between hypersecretion of hydrochloric acid and gastro and duodenal ulcer and it is possible that the ulceration is secondary to a long continued hyperchlorhydria. In cases such as No. 1, and that of Dr. Irwin, there may be a pre-ulcerative stage associated with hyperchlorhydria and an ulcerative stage. Only a careful comparison of the history of a number of such cases could give definite results.

2. In cases where epigastric pain coming on at a definite time after meals is the prominent symptom, the most important points, I think, in deciding whether ulcer is or is not present are:

   (a) Presence or absence of bleeding in small or large quantity.

   (b) Presence or absence of definite epigastric tenderness on palpation.

3. The treatment of the majority of these cases is, at any rate at first, medical - surgical interference being advised only in certain definite circumstances.
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