Apr. 26, 1873.

I hereby declare that the work necessary for my thesis and the composition except those parts marked as quotations has been entirely done by myself.

A.B. Drummond.
Hæmatemesis, with special reference to that form met with in early adult female life.

Hæmatemesis, or vomiting of blood, is said by all writers and observers on the subject to be caused, in the majority of cases, by cancer and ulcer of the stomach, and, less frequently, by cirrhosis of the liver. It also occurs in many general diseases, as scurvy, purpuric hæmorrhagia, yellow fever, acute yellow atrophy of the liver, malignant smallpox, and cholera. It may also be a subordinate symptom of obstructive disease of the heart. It also is said to occur in diseases of the spleen, it may be caused by traumatic injury. Again, the effusion of blood may be vicarious to the menstrual flow.
of hematemesis which, to say
the least, is, is very rare-
and an undoubted case of its
few such seem to have seen.
And there have been a few
cases reported where the hemo-
orrhage was due to the rupture
of aortic aneurisms, as in a
fatal case reported by Welch
in the John Hopkins Hospital
Bulletin 201, caused by a mil-
itary aneurism of a subnecous
branch of the Coronary artery
midway between the Cardia
and Pylorus.
Leaving out of consideration the
rarer causes, and taking the
three main causes, viz., ulcer-
ation and cancer of the Stomach,
and cirrhosis of the Liver, I
shall endeavour to show that
in early adult female life, this
is a form of hematemesis which
clinically and pathologically
can be differentiated from, and
does not bear the same serious import as those due to the cases mentioned. I think it can be shown that those cases are not due to any of the those organic diseases mentioned, but are always preceded by marked anoxemia, and are probably due to changes in the character of the blood and disarrangement of the circulation of the walls and coats of the stomach.

The value of hoesmatinesis as a symptom in organic disease of the stomach has by every writer on the subject been placed as pathognomonic. That is, that given a certain train of dyspeptic symptoms, then plus hoesmatinesis, there is almost certain organic disease present. This almost universal belief has probably prevented the earlier recognition of that form.
of homoeopathics I shall try to describe.

Look at a few of the principal writers on the subject—

Brinton in his work on "Ulcer of the Stomach," p. 104, in discussing the differential diagnosis of ulcer of the stomach, writes, "Unless the pain possesses the character attributed to it; unless this pain is accompanied by vomiting, and unless there be evidence of hemorrhage having occurred in the course of the malady, there is no sufficient basis for a definite diagnosis of the existence of gastric ulcer." And Haberstock, writing later, dwells quite as strongly on this point. In "Diseases of the Abdomen," 2nd Edn., p. 183, he writes "Unless hemorrhage however take place we cannot, with any certainty, diagnose ulceration of the Stomach.

Da Costa, in his work on "Medical
Diagnosis”, p. 576. in discussing hematemesis, writes, “When this is not traceable to a suppression of a natural discharge, and when it does not befall a person who suffers from disease of the heart or liver, or spleen, or esophagus, it acquires great significance. It is the only kind of vomit at all distinctive of a gastric ulcer. Hence its occurrence in a case with the symptoms of chronic gastritis, cancer being excluded, under the presence of an ulcer, probable.” And so on; until as many quotations as there are text-books could be given, all conveying the same impression that, excluding cancer of the stomach and cirrhosis of the liver, and the rarer causes mentioned if hematemesis be present, it is invariably due to ulceration of the stomach. If this always
held good, then the number of cases of gastric ulcer in a dis-
tric such as I live in—must be very great—if we consider
that the relative proportion of females to males who suffer is
about two to one, so that the average frequency of haematem-
isis in ulcer is considerably under 50%; we should there
for far beyond latitude European average of sufferers from gastric
ulcer—namely 5%.

Another point not to be for.

is that this important
sign is frequently absent in cases
where ulceration has been proved
to exist, and it has been
present where ulcer was diag-
nosed—and where afterwards no
organic disease was found.
Dr. Donald Hood, in a paper on
this form of haematemesis, read
before the Medical Society of
London in Feb. 1892, he being the
first to draw the attention of
the profession to this subject,
gives some valuable statements
collected from the clinical and
pathological records of Guy's
Hospital by Dr. Goodall, lately
medical registrar to the Hos-
pi tal. The record examined
extended over twenty years - 1870
to 1890. All the cases referred to
are undoubtedly, that is, that the
haemorrhage occurred while the
patient was under observation,
and in none was the immediate
ment of the patient latter as evidence.
These cases - 155 in number, Dr.
Hood considers under three heads:
1. Cases where the haemorrhage did
not prove fatal, and the patient
was discharged well or relieved.
2. Cases where the haemorrhage
was directly fatal.
3. Cases where, although not
directly fatal, the patient died
later while under observation.
In the first class the number is 118 — 59 males and 59 females. They were diagnosed as follows:

- Simple Gastric Ulcer: 66
- Hematemesis only: 19
- Cirrhosis: 16
- Gastritis: 5
- Carcinoma: 4
- Chronic "Bright": 2
- Injury: 2
- Perforated: 5

In the second class — the number of cases is 19 — 11 men and 8 women.

- Cirrhosis: 9
- Ulceration extending into spleen: 2
- Rupture of Anemia: 3

In the third class — there were 18 patients, 14 men and 4 women.

- Cirrhosis: 7
- Malignant disease: 7
- Granular kidney and ulcer of stone: 1
- Phthisis: 1
- Cardiac disease: 1
- Peritonitis after perforation: 1

The age of the patient is very sim...
portant in estimating the true value of the symptom hematemesis.

In the first class:

Under 30 years: 27 females, 9 males
    Age: 36

Beyond 30 years: 31 females, 51 males
    Age: 82

In the second class, in those fatal cases due to the perforation of a large blood vessel, there were 4 females, aged respectively 33, 35, 37, 53. Three males aged 37, 43, 60.

Nine deaths followed hematemesis from cirrhosis, 6 males, aged 17, 18, 36, 40, 42, 47; 3 females aged 28, 46, 54.

In 18 cases, 14 men and 4 women the hematemesis, although not immediately fatal, was very severe. Three of the men had perforating gastric ulcers, their ages being 23, 37, 62. Six had cirrhosis, ages 20, 30, 32, 42, 44, 54. Five suffered from malignant disease, ages 20, 44, 48, 51, 59. None of the females...
had gastric ulcer, one girl aged 17 had cirrhosis, two malignant disease; both aged 56, and one child; age 10, had cardiac disease.

These statistics therefore go a long way to show that the haemorrhage from the stomach in early adult female life is not usually a symptom of great gravity. They also bring out the fact that in one of the largest London hospitals, during a period of twenty years, there has been no recorded case of fatal haemorrhage in a young female the subject of gastric ulcer. They also show that cirrhosis is a very frequent cause of haemorrhage in early life, and that women are as subject to it as men.

Brünn in his work on "Ulcer of the Stomach," p. 47, discursing hematemesis, records 57 deaths from it, and 233 deaths from
perforation. Of the 57 cases due to haemorrhage, 18 were female, 39 male. The average age of the females was 40.

Hobson found the number of fatal cases occurring at Guy's Hospital during 20 years—the number being 37 males and 27 females. Tabulated as follows:

Hemorrhage Male 12
Female 14

Perforation Male 16
Female 7

Various, excluding males 16
Hemorrhage & perforation males 8.

The ages of the patients dying from hemorrhage are: Males, 28, 43, 53, 53, 58, 60, 60, 63, 63, and females, 20, 50, 50, 53.

In the 155 cases of haemorrhage collected by Dr. Fotherby, 66 were due to pernicious ulcer, 29 of these were under 30 years of age, two only being males, 21 were between 30 and 40 years of age, 11 being females.
Where death was due to hemon- 
age from ulceration into a vessel - there is only one patient under 30 years of age, a male, aged 23, who had Pthisis and pyopneumo- 
thora. All the cases in early adult life were due to hemon- 
age from cirrhosis.

During the twenty years 1870-1890, there were 16 patients admitted to 
Grays Hospital suffering from peritonitis due to perforation of a 
gastric ulcer - 8 males and 8 
females.

Ages: Males: 19, 20, 28, 40, 43, 45, 50, 57, 62
     Females: 14, 15, 21, 22, 23, 34, 40, 67

During the twenty years Labbeau 
& Horbrosh - 18 similar cases 
were admitted - 11 males and 7 
females.

Ages: Males: 20, 31, 34, 35, 42, 47, 62
     Females: 21, 22, 22, 27, 37, 40, 63

Dr. Norman Moore publishes in 
The 31st Volume of the Transactions 
of the Pathological Society.
fatal cases of gastric ulcer occurring at St. Bartholomew's Hospital during thirteen years - 1867-1879. They are 14 - 11 males and 3 females. Two of the deaths were from haemorrhage and were both in males - aged 19 and 57. The ages of the other cases were

Males: 19-36-40-41-46-47-57
Females: 46-47-54.

These statistics have been quoted by the kind permission of J.D. Hood - from his paper.

In the district of North Deon in which I reside anaemia in young adult females is exceedingly common; in fact, with very few exceptions - nearly every girl within a radius of six miles has been treated by me for that disease at one time or another during the last seven years, and I am never without several cases under treatment. I have come to
look on the five complexions for which Devonshire girls are famous, as simply a symptom of dyspepsia. It follows that, as a matter of course, I get a fair share of cases of gastric ulcer and hæmatocolpos. During these seven years I have had only one death from gastric ulcer due to perforation, and I have had no deaths at all from hæmatocolpos, although the cases are, comparatively, numerous. At first I treated all cases of hæmatocolpos with gastric symptoms as being due to ulceration, and used all the rigid precautions commonly used in that dangerous malady. It was gradually forced upon me, however, that these cases of hæmatocolpos with anemia could be divided into two classes; the first, consisting of, as far as I could diagnose,
undoubted cases of organic disease, and the second, consisting of cases when the gastric symptoms were not as a rule of the same severity, not so much pain, etc., and where, in the great majority of cases, these gastric symptoms were ameliorated by the hemorrhage. Perhaps I can best illustrate this by giving the notes of two of these cases. First however mentioning that, when practising in Scotland, I had the opportunity of making a postmortem examination in the case of a young girl aged 19 who died from exhaustion after a long illness, and to whom I was called a week before she died, because of an attack of hematemesis. At the p.m., at which time I was assisted by an experienced pathologist from Edinburgh, the left
Kidney was found to be nothing but a huge abscess cavity. No alteration of any description could be found in the walls of the stomach, although we searched carefully.

Case. Emily Pickard, aged 33, came to us in 1888, suffering from profound anemia, and with a history of having on two occasions, vomited a quantity of blood. She had all the symptoms of anemia, with some tenderness of the epigastrium, frequently pain after food, occasional vomiting and great constipation.

I treated her for gastric ulcer, and her recovery was slow and tedious. A year later she had a slighter attack, and was again treated in the same way. Again, a year later, she came under my care, and I saw her vomit...
about half a teaspoonful of blood.

After keeping her at rest for two or three days, I gave her
on full doses of the perchloride
of iron, with sulphate of baryta
-wine every second morning
in hot water-, and plenty
of good nourishing diet. She
made a very rapid recovery
-most of her gastric symptoms
disappeared after the blood-
and the first dose of salicylic
and she was quite strong
again in three or four weeks,
-a very marked contrast to
the many weeks of tedious
reatment undergone in her
first attack.

Case 11. Mary Baker, aged 19,-
had her first attack from
narcosis during anaemia four
years ago, and was treated
then for ulceration of stomach.
I saw her in 1891-as she
was again "throwing up blood
Whilst I was in the room she vomited a teacupful of blood. She was a tall well made girl, rather stout, but very anxious, with occasional pain and vomiting after food, complaints of great weight in the stomach, and pain on pressure. After rest for two days, with very limited diet, and some astrigents, I began at once to give her ivor, the citrate of ammonia and iron, with sulphate of magnesia very third evening in hot water. She was quite strong again in three or four weeks, the gastric symptoms entirely disappeared. At the time of the hemorrhaxis she was about the fourth month of pregnancy. This was one of the cases I was attending when Dr. Hood wrote to me collecting information for his
Alongside these cases, let me place two from Dr. Hood's paper. The first occurred in the practice of Dr. Barton of Cheshunt Gardens. On Sep. 26, 1890, a young girl suffering from anaemia, aged about 24, a nursemaid, applied at Dr. Barton's house for advice at 10 a.m. She stood there while walking in the park she was seized with vomiting, and threw up about a teacupful of blood. At one p.m. she was summoned to the house where the patient was in service. He found she had had a very severe attack of haematemesis, an immense quantity of blood having been thrown up. The patient was transferred to University College Hospital in an ambulance. While there, a recurrence of haemorrhage took place. A few days later the
patient was seized with "mumps" and died from typhus pyrexia. A most careful and exhaustive examination was made under the supervision of Dr. Ringer, but no source of bleeding could be discovered in oesophagus, stomach, bowel, or lung.

The other case was under the care of Dr. Hood. "M.E.," a female, aged 43, was admitted into the West London Hospital on January 4th, 1872. The patient stated that a few days before admission she was suddenly seized with hoarseness, a large amount of blood being expected. The attack was followed by extreme irritability of the stomach, the matter vomited being coffee ground in character. This coffee ground vomit was noted while the patient was under observation and occurred on several occasions. The epigastria region was very sensitive to pressure. At first-
Light all the symptoms and the physical condition of the patient pointed to a gastric ulcer as being the cause of the illness. But when the past history of the case was inquired into, we ascertained that during the preceding four or five years there had been many similar attacks. During the previous year she had suffered from these attacks. These attacks seemed invariably to have followed a condition of extreme constipation. The patient was suffering much from this cause at the time of her admission, and a pulsatile mass could be easily felt in the abdomen. The treatment was directed solely against this state of the bowel. The patient quickly recovered, losing all pain and digested solid food without difficulty. She was discharged on January 30th, being twenty-six days under observation.
This case is similar to one related by Dr. Stephen Mackenzie in the 9th Volume of the Transactions of the Medical Society. This case however ended fatally, and at the post mortem no obvious sign of disease could be discovered. Of "simple" anaemia, these cases, as far as I have seen them, occur in young adults or females, the subjects of anaemia more or less pronounced. That anaemia is not necessary however is shown by Dr. Hood's case. There has been in all my cases, tenderness of the epigastrium, pain and vomiting, especially after meals and constipation, with either amenorrhoea or scanty white-coloured menses. Many writers maintain that the anaemia is the result of malnutrition; due to the presence of gastric ulcer, causing vomiting of food. Brindley says: "The
Anaemia produced by the hemorrhage is generally associated with a cachexia which seems to be essentially independent of it; being chiefly the result of the malnutrition necessarily implied by frequent vomiting of food, or by the large destruction of the gastric mucous membrane and consequent impairment of its function. This might hold good in those cases with extemely ulcerated surfaces of the stomach where generally vomiting is most severe and the patient may be almost starved to death. But many cases of ulcer, especially the "punched out" variety, remain absolutely latent, and there are no symptoms at all until the occurrence of hemorrhagia or perforation. All my cases have occurred in young women who, though the subjects of
anemia, and with pale, wax-like skin, were yet plump and well conditioned, and not by any means starved looking. In the article on "Gastric Ulcer" in Harris' System of Therapeutics," in discussing the causes of ulcer, the author writes "for, as is well-known, ulcer is most common in the anemic, as a result, rather than as a cause of the impoverished blood; which fact is significant in view of the experiments of Beatson, who found that, when dogs were rendered anemic by frequent bleedings, gastric ulcer developed from much slighter irritants applied to the stomach walls, than when depletion was not practised, and that these ulcers healed more slowly." An additional argument, surely, for
the earlier recognition of cases of "simple" hematemesis, so that no time might be wasted in treating the supposed gastric ulcer. The changes in the character of the blood, anemia and chlorosis, undoubtedly precede the discharge of blood from the stomach; all my cases have been in young women anemic first, with gastric symptoms and hematemesis coming later.

The gastric symptoms—vomiting, pain, and tenderness of the epigastrium—are never so pronounced as in ulceration. The vomiting is not constant; the patient may be days without even feeling sick, and when it does occur, it is not nearly so definite to the taking of food as in ulceration, and the quantity is not so great; frequently also there is no actual vomiting, my
a feeling of sickness. In ulceraion, on the other hand, the act of vomiting is generally a short time after taking food. The food is brought up unchanged, with a little mucus—and frequently a quantity of hyperacid fluid along with it.

Neither is the pain so great in the simple cases. There is no "burning" pain from the front to the back. There is not the acute agony often seen in ulceration—"in fact the pain may be very fleeting all through the case, and is frequently only described as a weight in the stomach.

The tenderness of the epigastrium is, as a rule, much less than that in ulceration—and is more diffused. There is never that definite spot of pain found in ulceration—and by means of which Eswald says one can
define the position of the ulcer
in the stomach. - Brunton says
this area of pain is rarely more
than two inches in diameter.
The constipation is generally
very obstinate, and has, I
think, a very decided influence
on the production of
hernomatoses.
Dr. Hood's case shows this to
a very marked degree. I have
found that those cases can be
much relieved by sulphate
of magnesia alone, but not
by iron alone, if it was
limited to one drug for the
treatment of those cases.
I should certainly choose the
sulphate of magnesia.
A very distinct point in those
cases is the decided amelioration
of the gastric symptoms which
usually takes place after
the hernomatoses; the feeling
of weight disappears from the
stomach, and the tenderness
and pain are much relieved, a marked contrast to the condition of the patient after hemorrhage due to ulcer.

One important fact brought out by the statistics given is that, while there is a liability of the male sex to perforating ulcer in the proportion of one to two of the female sex, postpone hemorrhage except as a result of cirrhosis, is practically extremely rare in young men. Looking at the fatality of gastric ulcer from perforation and peritonitis it would only. I think be natural to find hemorrhage more often followed by false results than it is, if it were always, or even frequently, due to ulceration, and yet, considering the very large number of cases of severe hemorrhage in young females, very few prove fatal.
And why should not the inner membrane of the stomach bleed readily and profusely in wounds without there being a breach of surface? In the cases of haemorrhage admitted into Guy's Hospital 44 of them were considered as being due to cirrhosis. Fifteen of these proved fatal, and in no case was any abrasion or ulcer found to account for the haemorrhage. Dr. Lushington relates two cases as illustrating the difficulty there often is in finding the ulceration, the first, a plethoric woman, aged fifty, the other, a soldier, aged twenty-eight, both with cirrhotic livers. In both of these cases the ulcer was a mere pore-like aperture leading directly into a large branch of the artery. But the post-mortem examination in the fifteen fatal cases of cirrhosis at Guy's Hospital
were all conducted by experienced pathologists, and it is hardly likely that even the "zero-like" aperture could have been missed in each case, especially when they were looking for it.

In cirrhosis then, the bleeding seems to be due to venous congestion, and this is probably the cause also in anaemia, in venous congestion or stasis of the vessels of the mucous membrane of the stomach or oesophagus, the sluggish circulation being due to the nature of the changes in the character of the blood in anaemia.

The effect of treatment in these cases is, in my mind, one of the most powerful arguments in favour of there being no ulcer present. Rest for a day or two with little or no food, expectorating freely, and a little opium till the bleeding cease.
beginning with some of the milder preparations of iron, as citrate of ammonia and iron, with sulphate of magnesia in a copious draught of water every second or third morning as required, and afterwards, some stronger preparation of iron, with plenty easily digested nourishing food, in a few weeks effect such a transformation in the look and strength of the patient, that the idea of the presence of ulceration is quite done away with.

To recapitulate briefly then, in young female adults, there are many cases of haeorrhagia which present the following features— the patients are all more or less anemic. They are anemic some considerable time before the occurrence of haeorrhagia.
They all suffer more or less from constipation and dyspeptic symptoms.

The dyspeptic symptoms are not severe, and are greatly relieved by the bleeding and purgation. They recover quickly under saline purgation, and the administration of iron, with plenty of good nourishing food.

Facial cases are rare. In those facial cases where a post-mortem examination has been held, no ulceration or abrasion of the coats of the Stomach has been discovered.

Of these, it can be shown that even a few of the cases of hemorrhagia, occurring in young adult females, is due, not to ulceration, but to some change in the character and circulation of the blood arising out of the anemic state, then a very decided advance has been made.
Because then a very different form of treatment will be followed. The patient will neither require to undergo that rigorous dietary and general restrictions absolutely necessary in ulceration nor will she be allowed to remain for so long a time, in that anemic state, in the course of which ulceration might occur. Thus much valuable time; and perhaps, many more valuable lives might be saved.