Notes of cases
of
Diseases of the Abdomen
by
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Widnes
The constant application necessary to be devoted to any special department of scientific research is liable to interruption in the sphere of general practice, that experiments however carefully planned have invariably to be given up.

During the past three years I have had numerous opportunities of studying and observing various forms of disease connected with the abdominal viscera. It has always been a rule of mine to take notes at the bedside of any patient requiring careful and thoughtful study in diagnosis and treatment, and at time and opportunity afforded, of comparing the same with reports in journals, standard works, and notes of lectures devoted especially to the subject in question. I have not hesitated therefore to refer to my notes and to fall back on my practical work and experience for material from which to write a thesis.
Case I
Perityphlitis
Recovery.

Case II
Obstruction of bowel
Death.

Case III
Obstruction of bowel
Recovery.

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Cancer of liver?
Death.

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Spontaneous Cure.

Remarks on Vomiting.
Case I.
Perityphilitis
Recovery.

R. 13. Aged 35. Draper, residing in Victoria. Was first seen by me on the 21st of July, 1882. He complained of pain in the right iliac region, which had come on gradually, but had now become so severe that he was compelled to assume the horizontal position.

Social History.
He is a sober, steady man, and has always enjoyed good health.

Family History.
Both his parents are alive and well.

Present Condition.
He is a well-developed muscular man, of sanguine temperament, with an anxious expression of countenance. He lies in the recumbent position with the right thigh flexed to relieve abdominal pain. He has been
been sick and vomited twice. His temperature is normal, his pulse is quiet, and there is nothing particular in his general condition to attract attention.

Abdomen.

On examination of his abdomen, there is a distinct fulness in the right iliac region. The skin over the swelling is natural in colour. He can move his lower extremities freely, and can flex his thighs on abdomen without causing him any pain. The abdominal pain is relieved when the right thigh is flexed. There is no curvature of the spine, nor tenderness on percussion.

He has had no dragging pains in the back. The urine is passed readily, is high coloured, acid in reaction, and depositi neither mucous nor pus. It contains no albumen. The pain intermits, and there is no persistent pain except when he moves about or stands. He can lie on the affected side with ease.

Coughing or a deep inspiration causes pain.
pain in the abdomen, owing to the great
tenderness on pressure in the right iliac
region a minute examination would
not be made. The bowels have
acted freely, there are no physical
signs of pulmonary or cardiac disease.
The liver dulness is not increased.
The patient was ordered perfect rest in
bed, liquid nourishment, warm poultices
to be applied locally, and a mixture
containing opium to be taken every four hours.
Feb'y 22d.

The patient passed a very restless
night, pulse 108, temperature 99.2° Fahr.
There is more fulness in the right iliac
region, and greater tenderness on pressure.
So long as he lies in the recumbent
position he feels quite comfortable.
Deep inspiration causes little or no pain,
Occasionally he complains of a sharp
grinding pain which comes on
suddenly, remains for a few moments
and then passes off. There is
considerable tympanitis, and gurgling
sounds are heard at intervals.
The patient is very anxious to be allowed to attend to his business, but after taking the various symptoms and physical signs into consideration, he has received strict injunctions to remain in bed and to continue the local and general treatment.

Feb. 23rd.

The patient got up in the morning and went down stairs to stool. His movements up and down stairs caused him intense suffering. In the morning he dressed with the intention of attending to his work, but was compelled to return to bed again as he felt very ill. On getting into bed he fainted away.

On examination, the right iliac region was observed to be much more prominent than the left. Palpation did not reveal anything as the abdomen was still so tender on pressure that a full examination could not be made. The pain was intense when he coughed or took a deep breath. The right thigh was flexed. The temperature was
was 99.2° Fahr. Rest, hot fomentations, medicinal and dietetic treatment strictly enforced.

Feby: 24th.

Patient passed a very good night. There is little or no pain when he moves about. There is still considerable tenderness on pressure and slight dulness on percussion over the seat of the pain, but nothing definite can be elicited. Lying on his right side gives him great ease. Today he insisted on leaving his bed for the sofa.

When walking across the room he stated he could feel a substance like a marble in his right groin. When he lay down this could not be felt.

Feby: 25th.

The patient passed a most restless night. This morning he had a rigor. The temperature at the time of my visit was normal. He had then a tendency to vomit. His bowels had been moved by a mild aperient given the previous evening. abdomen was
was applied over the seat of the pain, and milk, eggs, and fruit were in repeated doses were ordered to keep up the strength.
Feb'y: 26th

Had another rigor during the night and painted away in the morning. A distinct mass can be felt in the right iliac region. The temperature is 101°2 Fahr. pulse 120. On examining the right iliac region there is found a deeply seated swelling very painful to the touch, dull on percussion above Poupart's ligament, and reaching from the anterior superior spine of the ilium to the spine of the pubis. This condition having in my opinion assumed a serious aspect I suggested a consultation.
Feb'y: 27th

Today Mr. Reymnald Harrison of Liverpool saw the patient with me and made a careful examination of the case. The patient passed a good night and felt much easier but had another painting fit in the morning.

Mr. Harrison.
Mr. Harrison pointed out that the mass had no connection with the spine, ilium, or hip joint, and suggested that the tumour was due to an inflammation of the fascia immediately surrounding the biceps. He was of opinion that we had to deal with a case of peri-arthritis. Although there were indications of pus having formed in the cellular tissue, taking into consideration the history of the development of the mass, the fact that the patient was much easier, the pain not so severe, and the area of dullness lessened, Mr. Harrison did not think it necessary to attempt vigorous active treatment by using the aspirator. He recommended the former treatment to be continued viz.: perfect rest and large poultics locally.

Feb 28th

The patient has passed another good night but complains of gripping. This gripping pain in the abdomen has been constant during the course of the disease.
and is evidently due to peristalsis of the bowel, for I have observed that muscular gurgling noises accompany the pain.

In the right iliac region the fulness previously recorded seems to be less. The temperature is down to 99.4° Fahr. pulse 70.

March 1st.

The griping pain still continues at intervals. In the earlier portion of last night the patient was very restless but slept several hours towards morning. On examining the hardness in the right iliac region there is a considerable decrease both in area and in fulness. I advised his motions to be carefully watched and this morning some streaks of blood and pus were formed intermingled with his stool.

His temperature is normal, and the patient can move about easily in bed. Coughing causes him slight pain.

March 2nd.

On examining the right iliac region a crepitation sound was produced on palpation, but I could not get a repetition.
Repetition of the same. There are occasional purging noises in the gut. He can now be examined without causing him much pain except at one tender spot immediately over the region of the ileo-caecal valve. This spot is hard to the touch. His bowels not having been moved again he was ordered a saline powder.

March 14th.

Bowels moved twice since the 2nd ult. One motion had a streak of blood in it. The other was natural in colour without any indications of blood or pus. The area or dulness is decreasing rapidly. The patient has slept well and has taken some solid food.

March 6th.

Can be examined today without causing any pain except taken heavy pressure is made over one spot. The previously dull portion of the right iliac region has now become highly tympanitic.

March 9th.

The patient was up for...
several hours yesterday and on
examination of him to day elicited nothing
unusual.
From this date the patient became
rapidly convalescent and in a week
afterwards he was able to attend to
his usual duties.

Remarks.
This case has several points of
interest in it:
1st. The obscure history and gradual
commencement. This would seem to
indicate that a latent perityphlitis, or some
chronic disease of the caecum, existed,
before the patient was compelled to fail up
work. And that some error in diet must
lie the exciting cause, although this could
not be distinctly made out.
2nd. The temperature never rose higher than
101° Fahr. in a case where aphlegmonous
inflammation had evidently undergone
depression, as proved by the presence of
pus in the stools.
3rd. The probability of a latent perityphlitis
propagating itself to the iliac fascia and lumbar region.

Iritis is generally associated with chronic disease of the Cecum, or its appendages. The areolar tissue around the Cecum becomes affected and as a rule the diagnosis is not difficult.

Dr. Stephen MacKenzie in his remarks on two cases of periappendicitis reported in the Lancet (21 Sept. 1878) says:—"The disease generally begins more or less abruptly by the patient noticing a fixed pain in the right iliac region." In the Case of T. B. the symptoms came on gradually. Further on Dr. MacKenzie remarks:—"The distinct swelling and inability to extend the thigh which occur so usually and so early in the attack, accord with the result of post mortem examination in leading us to believe that the areolar tissue around the Cecum is almost invariably implicated."

There is a point in the diagnosis between periappendicitis and perinephritic abscess viz. the fixation of the thigh upon the abdomen, which is a constant symptom
in the latter disease, but not necessarily so in the former, unless the inflammatory or suppulsive process affects the sheath of the muscles as well as the circular tissue. Referring to the condition of flexed thigh in perihepatic abscess, Trouseau says: "There then supervened a difficulty and subsequently an impossibility to stretch the thigh which became flexed on the pelvis. Henceforth no diagnostic doubt remained: it was evident that there was an abscess in the renal region and that the psoas muscle was involved in the inflammatory process." In the case of my patient he was quite able to extend his thigh without any pain, thus showing that the muscle was not involved, and when kept flexed it relieved abdominal pain.

Dr. MacCullough Collins in a fatal case from calculus of the cæcal appendix reported in the Lancet (13th Dec. 1849), found on post-mortem examination that: "On removing the intestines the cæcum was found greatly congested and thickened, and the cellular..."
While around in a state of suppuration, but it contained no accumulation within it which he expected to find. In finishing up his report he states: "It is probable that many cases of Peritonitis which recover are due primarily to some irritation or mischief in the appendix, which appears to be more prone to morbid changes than the Cecum is, as in most of the cases which prove fatal the appendix is proved to be affected rather than the Cecum itself."

In a morpopsy performed by Mr. J. Service reported in the Lancet (21st Feb. 50) in a case of fatal peritonitis from perforation of the vermiform appendix he found: "On section a large quantity of pus welled out from the right iliac fossa."

It is therefore evident that in a case of peritonitis when the phlegmonous condition has undergone suppuration it may ritter accumulate and form an abscess, or pus may exist in the cellular tissue without any accumulation. Hence there arises a difficulty in stating definitely when suppuration has taken place.
place. Presuming however that it did so in the case of my patient from the rigor and elevation of temperature, the question arose. How this case assumed a surgical aspect, and is it necessary to carry out some active treatment by using the aspirator or otherwise? But Mr. Harrison although satisfied in his own mind that pus did exist in the right iliac region thought it best to leave the case for a time to the curative powers of nature.

The result has been satisfactory.
Case II.

Obstruction of Bowel (Death).

J. O. aged 45, publican, residing in Widnes was first seen by me on the 23rd of November 1861.

He complained of pain all over the abdomen, of vomiting, and of blood from the bowels not having been relieved during the past fortysix hours, although he has taken one ounce of Castor oil, and two ounces of Epsom Salts.

History of present attack.

The attack came on gradually, soon after taking the Castor oil, and the pain in the bowels was at first supposed to be due to the action of the aperient.

Social history.

Has been accustomed for years to the free use of intoxicating liquors.

Present condition.

The patient is a stout, weary and hollow countenanced looking man, with an intensely agonizing expression of
of constipation. His condition is evidently of a grave character. He is vomiting and suffering from intense pain in the abdomen which is very much swol
His lower extremities are flexed upon the abdomen and is perspiring profusely.
On palpation there was pain caused by pressure over the whole abdomen more intense however in the right iliac region.
On percussion there was a tympanitic sound elicited over the whole abdomen even over the region where the pain was most intense.
His urine was scanty and bright. Colored and he suffered also from severe straining at stool.
There was no external hernia and he never had been ruptured.
His temperature was 98.4°Fahr. His pulse 100.
Taking into consideration the various facts before me viz: the persistent vomiting, the tympanitic, the straining at stool and the fact of his not having had his bowels relieved for several days.
days although such large quantities of aperients had been taken, and indeed all the characteristic symptoms of a strangulated hernia being present. I came to the conclusion I had to deal with a case of internal obstruction of the bowels.

The patient was ordered to have an injection of gruel and olive oil ice to suck, and hot fomentations to the abdomen. He was ordered a mixture containing opium (ten minims of the mixture every three hours).

November 24th

It may be interesting to note that with the exception of the hot applications, the other instructions were ignored, and on cross-questioning the patient's wife, I discovered that she had given her husband a further dose of two ounces of Epsom salts.

The pain was increased in severity, the vomiting was more persistent, and the general condition of the patient was one of the utmost gravity.
I injected per rectum a pint of quill containing two ounces of olive oil which was immediately rejected with considerable force. On repeating this operation later on in the day I observed the bowel to be spasmodically contracted to such a degree that a gum elastic oesophageal bougie would immediately bend on itself and in consequence a stiffer tube had to be used. Small doses of morphia (grain 1/6) were given at intervals hypodermically.

Dr. Starkey Smith of Warrington saw the case with me in the evening and he agreed with my diagnosis of obstruction of the bowels. He suggested the continuance of the morphia in larger doses and the addition of fine-tine castor oil to the injections. This was tried but of no avail as each injection was immediately expelled. The patient gradually and steadily became worse and finally recumbent in a few hours.

The noticeable feature in the case was
was that during the last few hours of the patient's existence he was entirely free from pain. He was perfectly conscious during the whole course of this rapidly fatal illness.

Remarks.

In connection with this case I was forcibly reminded of a Caution quenches us as students in the Class of Clinical Medicine by Professor Younger Stewart. Under the heading Treatment in my class note-boo I find a N.B. to the following effect:

"Be very Cautious with the use of aperients in these cases (I also) especially after the first day. Don't give aperients that produce peristaltic action of the bowels. 1st Because aperients cannot overcome obstruction. 2nd They are apt to increase inflammation in any part. 3rd If you increase action of jut without relief you aggravate symptoms. 4th In some cases the use of aperients favours rupture above obstruction and hasten fatal result.

In
In the case given above the obstruction developed gradually and was certainly aggravated by the free use of aperients, particularly Sulphate of Magnesia, which would increase peristalsis of bowel although at the same time a considerable quantity of the Epson salts would be rejected in the vomit. Another factor contributing to such rapidly fatal result was the constitution of the patient which must have been greatly undermined by his mode of living and the frequent habit for years of drinking ardent spirits.

In the absence of post mortem examination I am unable to arrive at only a proximate conclusion as to the mode of obstruction in this case. From the fact that there was no distinct area of dulness, no special point where the pain was most acute, or to which the symptoms were referable and no evidence of ascites, I incline to the belief that in this case one had to deal
deal with a general obstruction implicating a large portion of the intestinal tract and caused either by a twist of mesentery or by a fibrous band. The result of some previous peritonitis.

My reasons for coming to the above conclusion is based on a short account of a postmortem examination in a somewhat similar case brought up by Dr. Rutherford Macphail of Saltlands Asylum Carlisle. Dr. Macphail made a postmortem examination in a case of intestinal obstruction, in which symptoms lasted only seven hours. "What I found, he says, was that eight feet of small intestine were black and completely strangulated as a result of being twisted or a twist of mesentery. There was some old peritonitis but not recent."

In the case of my patient the probabilities would be that something of a similar nature would have occurred had a postmortem been
made. I am of opinion that I shall never to deal with a case of intussusception nor an ulcer of the intestine.
Case III.

Obstruction of bowel
Recovery.

Mrs. G., aged 35, residing in Wisconsin, was first seen by me on the night of the 31st of December 1881.

The complaints of acute agonising pain in the abdomen

History of present attack

The patient was suddenly taken ill with an acute pain in the abdomen whilst walking across the room. The pain was of such a severe character that she fainted away.

Social history

The patient is the wife of a working man in fairly good circumstances. She is temperate in her habits. The general surroundings are of a satisfactory nature.

Present condition

I saw the patient ten minutes after.
after the seizure, I found her in the following state: She was sitting in an arm chair supported by a friend. Her face was covered with a cold clammy dew, she was excessively pale and with an intensely agonized expression of contortion. She complained of acute pain in the abdomen. On making her assume a horizontal position by placing her on the hearth rug the pain seemed to be very much aggravated. The pulse was weak, slow and almost imperceptible in both wrists. The patient was conscious and perfectly self possessed. On inquiry I found the pain was referred to the right groin and shooting upwards towards the umbilicus. The pain was described as sharp, just as if a knife was cutting her. The groin was examined for a hernia but with a negative result. She was given a few minims of aromatic spirits of ammonia in water and lifted...
into her bed. In about fifteen minutes she began to retch and vomit; and this vomiting and straining continued during the night and for a considerable portion of the following day. Small doses (three minims) of Chlorodyne were given in water at regular intervals. She had also ice to lick, and a spoonful of warm brandy in iced water. The pallor increased. The lips became livid. A large injection of gruel and olive oil was given per rectum. This was retained and gave great relief, but the pain in the side remained. At the beginning of the attack the pulse was feeble, small and hardly perceptible. After the injection was made the pulse began to improve, but the vomiting and retching continued and the pain remained constant. To relieve the pain one grain of a grain of morphine was given hypodermically, and this was continued every three hours.

January 1st, 1882.

This morning the abdomen was
Meas examined and found to be much more swollen. The pain distributed over a greater area and the temperature 102° Fahr. The sickness and vomiting still persisted.

On percussion the whole of the upper portion of the abdomen was highly tympanitic. The lower part of the abdomen immediately above and a little to the right of the pubes elicited a somewhat dull sound.

The injection per rectum of last evening returned. Another injection of gruel and camomile was administered. Anemia in larger doses continued, there was no escape of the lower bowel. Two hours after the last injection the bowels were freely moved. The sickness soon after ceased and the patient fell into a comfortable sleep of three hours duration.

On awakening the pain in the right iliac region and above the pubes was persistent. Hot fomentations were applied over the seat of the pain. Gradually the patient got ease and the bowels acted accord
time (six hours after last injection). She was given teaspoonful doses of beef juice (Johnstines) by mouth and this was not rejected. The pallor gradually disappeared and the patient began to assume her natural appearance.

In the evening I again examined the abdomen. Unexpected tenderness was experienced when percussing slightly immediately over the region of the Cecum. The persistent pain complained of from the commencement of the attack had disappeared, only when pressure was made or during percussion did she complain of pain.

January 2nd

On examination this morning the patient appears to be in perfect health and seems to be rapidly recovering. There is still a certain amount of tenderness on pressure but only slight. The patient was directed to be kept perfectly quiet in bed. Cinchonidine in three grain doses was prescribed every three hours.

January 3rd
January 3rd:
The patient slept well last night. She is free from pain. She has passed a motion natural in appearance. There has been no vomiting, and to all appearances she is doing well.

January 4th:
The patient having got up to have her bed made was suddenly attacked in a manner identical with the attack of the 30th Inst. This time the pain was referred to a point immediately above the pubis two inches below the umbilicus in the middle line. The same phenomena as formerly described were exhibited during the attack. The same extreme pallor was again observed together with an intensely anxious expression. The vomiting was incessant. The stomach rejecting every thing that was given. The pulse was weak, compressible and could hardly be felt. Her lips became livid and she appeared as if about to succumb.
Nor irritations were applied to the stomach. An injection of fruit and elder with some brandy was administered after which the vomitting eased. To allay the vomitting small pieces of ice were given through hydroxyviv acid, biromut, belladonna. were separately administered, each of which seemed to increase the vomitting, I again resorted to the hypodermic injections of morphia which proved of the greatest use in this case "doing yeoman service." (Pptuspie) January 3rd 1212 noon.

Pulse 120, Temperature 99.4
Respirations 24, Complains of no pain, sickness continues at intervals but is not copersistent. Slept on hour this morning, complains of great thirst, feels inclined to have vomits mixed, has passed water twice.
On examination of urine, matox found in abundance but no albumen, Patient is still very pale but
Breathing comfortably. Morphia
from 1/4 grain made 8 a.m.
8.40 a.m.
Pulse 124 Temp. 099.2° Fahr
Respiration: 20.

All pain is seemingly gone and the
patient has lost his/her appetite.
Anxiety observed during the morning
visit. The pain in the bowels has
relieved about one hour after morphine
injection given this morning. Bowels
moved twice during the day. She can
only keep down ice or ice'd water,
boiled juice, soda water and mild
fruit.

On inspecting abdomen it is observed
to be distended rounded and globular.
On palpation it is soft and impervious.
Only above pubis is here any pain elicited.
Percussion: Sym pathetic sound all
over abdomen, only very slight dulness
in right iliac region and above pubes,
but in omphal percussion these parts
are also sym pathetic.

On auscultation intestinal gurgling

Noises
Noises heard, as if under the influence of a narcotic.

Saturday 6th

Pulse 100. Temp. 98.4, Resp. 20

Vomiting occasionally, pain entirely gone. Bowels not moved. Pressure above pubes causes pain.

Sodium citrate again tried in three minims doses every two hours with a view to check vomiting. Milk and lime water also given but each dose causes sickness. Ice is the only thing that can be taken.

3 P.M.


Has been sick twice during the day. Two tablespoonsfuls of milk and lime water given about 2 P.M. were retained. Has vomited bilious looking matter once. The odour of hydrocyanie acid brings on a feeling of sickness. The patient is perspiring freely, feels hot but not uncomfortable.

Another injection of morphia given.

January 7th 10 A.M.
Had a good nights rest, only being down once and took some nourishment. Pain all gone except when strong pressure made above pubes.

Pulse 90. Temp. 98.4

10 p.m.

Was slept three hours this evening. One half pint of milk gruel taken during the day. Vomited once after taking an orange. Bowels moved once. And the patient is in no pain.

January 8. Bowels again moved. Sickness subsided. Convalescent from this date, the patient making a satisfactory rapid and excellent recovery.

Remarks.

The diagnosis in this case points to obstruction of the bowel. The suddenness with which this lesion becomes developed is a recognized fact in cases where the primary cause is due to adhesions or bands of fibrous...
tipul or in colocuus or infaunatio. The spasmodic condition of the lower bowel observed in the case of J. D. pubic anus was not present in this case. In the former the contents were forcibly expelled, in the latter they were retained for a considerable time. The reason for this forcible action of the lower bowel may probably be due to the seat of the structure. If high up in the small intestine or in the region of the cecum the probability is that the lower bowel might not be thrown into a spasmodic condition. Should the structure or obstruction however be lower down say in the sigmoid flexure or between the rectum and the ileo colic valve the lower portion of the bowel might be expected to be found in a state of spasm.
Case IV.

Cancer of Liver?

Mrs JH, aged 53, Widow residing in Widnes.
First examined by me on the 18th July 1980.
Complaints of pain in the epigastrium and loss of appetite and of being jaundiced.

Social history

The patient is in poor circumstances.
Lives in a damp and badly ventilated house.
She has always been temperate in her habits and is the mother of a large family.

Previous health

For some years, the patient has suffered occasionally from attacks of flatulence and indigestion, and also from obstinate constipation.
She has never suffered from any serious illness.

Family history

Father died suddenly from heart disease.
Mother lived to an old age (73) She died from Bronchitis.
The patient had an aunt who had her breast excised for cancer. This is the only case of malignant disease known to have existed in the family.

History of Attack

Three months before consulting me she began to have a dislike for certain articles of diet and afterwards for all kinds of food. Two or three hours after taking food she suffers from pain in the epigastric region. She occasionally vomits a clear viscous fluid, sour and at times extremely bitter. She suffers also from acid fluctuations and her digestive system is generally deranged. For three months these symptoms persisted without any appearance of jaundice. She has also been losing flesh and getting steadily thinner and lately has become deeply jaundiced.

Present Condition

The patient is thin, cachetic, and deeply jaundiced. The temperature is
is normal, pulse 68. The nervous system is affected as is evidenced by the lanugon and constipation and also the general depression of spirits from which she suffers.

Abdomen. Digestive System.
Lips pale and dry. Tongue fissured and covered with patches of white fur. She has a poor appetite. A disagreeable taste in the mouth and suffers from great thirst. She also complains of a drawing pain in the region of the stomach. Her stools are of a clayey colour and the bowels are very much constipated. The urine is diminished in quantity. It is dark, coloured, rich in bile, specific gravity 1026, and contains no albumen.

On inspection the abdomen is flaccid, shrivelled and covered with numerous lines of pregnancy.

Palpation. There is pain caused by pressure in the right hypochondriac at the edge of the liver, immediately below the border of the ribs one inch.
to the left of the mammary line there is felt a well defined indurated nodule about the size of a walnut. It is a dense hard mass & moves upwards and downwards during the respiritory efforts. It is dull on percussion and the dulness is continuous with that of the liver. There is no enlargement of the spleen. The lungs, heart and other organs are apparently normal.

February 21st.

The patient is more emaciated and the jaundice is intensified. The nodule at the edge of liver is much more distinct and has apparently increased in size. This may probably arise due partially to the increased emaciation as well as to the growth of the tumor. There is no abatement of the gastric symptoms, the flatulence, pain on pressure, constipation and discolored stools are all present.

March 1st

The emaciation is steadily
and progressive. There is no
Alatment in all the other symptoms
Jaundice increased urine more
highly coloured and Concentrated, stools
pale and Clayey. Temperature has
risen to 101° Fahr. Tongue dry
Cracked and brown. Breathing
short rapid and difficult.
March 8th

Temperature 103° Fahr. Pulse
120. Respiration 32. Persistent
diabetes and vomiting. The
patient has become delirious
and is very restless
March 7th

Died from exhaustion
Post mortem examination could
not be obtained.

The treatment adopted in
this case was palliative.
To relieve the pain morphia was
given every four hours in quarter
gram doses. Bismuth Hydro-
Amine acid. Atropia and various
other remedies tried to check the vomiting, but they produced no apparent effect. The strength was kept up by giving beef juice, freshly prepared, milk and lime water, champagne and brandy diluted with water given as stimulants.

Remarks

The diagnosis in this case points to carcinoma of the liver. In the absence of a post mortem examination an absolute diagnosis is impossible. The probabilities are that in this case the primary affection was situated in the stomach or the glands in the neighbourhood of the duodenum and that the nodular tumour found at the edge of the liver was a secondary product. In looking over the history of the case the symptomatology points to gastric cancer. Von Zimmer (Cyclopedia of the Practice of Medicine 1876 on page 235) says, "That in about one fourth of the cases of gastric cancer the"
The liver also exhibits Carcinoma degeneration, as also marked by primary cancer of the stomach extending to other organs, it involves most frequently the liver, and in particular cases the disease develops in the latter to a much more marked degree than in the stomach itself.

The evidence upon which the diagnosis is based is the following:

1st. A tumour in the region of the liver, apparently attached, rounded, dense and hard, which steadily increased at time rolled on.

2nd. The progressive emaciation and cachexia. The latter was in this case obscured by the presence of jaundice. In ordinary cachexia there is loss of flesh, and anaemia and loss of vital power. But the presence of a cachectic state is not pathognomonic of cancer as there may be cancer and no cachexia and vice versa.

Temporary improvement in the general health of the patient would
The evidence of the absence of carcinoma

Dr. McCulloch (lecture Diseases of Liver) p. 311

described temporary gain in weight
and strength under treatment is however not incompatible with Cancer of the liver.
In this case there was progressive vacuolation due to absorption of the fatty tissue and whenever present is always an important symptom.

Here are the symptoms often associated with Cancer of the Liver

Big Ascites and the Hydrodrops Paroxysms usually limited to a swelling about the ankles. Also enlargement of the superficial veins of the abdomen. In this case these were absent.
Case V.

Cancer of Stomach

Death.

E. S. Aged 64. Residing in Widnes. First seen by me on the 27th Nov. 81. Complains of sickness and vomiting coming on about two hours after taking food, and of having lost a great deal of flesh.

Social history

The patient is in good circumstances, the mother of 9 children and her general surroundings are of a satisfactory nature.

Previous health.

Has always enjoyed good health until five months ago when she began to lose her appetite, occasionally suffering from attacks of vomiting, always some time after taking food.

Family history.

Both parents lived to an old age.
age. There is no history of malignant disease in the family.

Present Condition

The patient is thin, emaciated, cachectic and hollow-looking with an anxious expression of countenance. Deambulation is difficult. Both thighs flaccid on abdomen.

Abdomen: Digestive System

The tongue is pale, flabby and covered over with a whitish fur. As a rule she vomits two hours after taking food. The bowels are very constipated. The stools natural in color. Urine contains no albumen. Kotaugh, Kisth, Blurred

Physical Signs

On inspection there is a slight fulness observed in the epigastrum. The abdomen is covered over with numerous old scars. The skin wrinkled and dry. The ribs on both sides are seen distinctly protruding. There is considerable emaciation.

On palpation there is a tumor or mass felt in the epigastrum. It is
is hard, painful to touch, lobulated and immovable. The lower border
seems to lie across the ronnel.
The upper border is distinctly indurated.
A furrow or notch can be felt near its center.
The accompanying rough diagram shows the seat and the shape of the
mass as felt and percussed.
Percussion over the tumour gives a
dull sound and on pretty smart
percussion a somewhat sympathetic
sound accompanies the dull.
The liver dulness can be defined
and separated from that of the tumour.
The liver dulness commences in the
anterior axillary line at the upper border
of the fifth rib and extends downwards
for fully five and a half inches.
Here is a distinctly sympathetic note
to be made out between the liver and
tumour on very light percussion.
The splenic dulness is increased and
has no connection with that of the liver.
So the left of the tumour over the
Cardiae
Cardiac region of the stomach a highly tympanitic sound is elicited on percussion.

The other organs are apparently normal.

December 30th

The patient has had several attacks of severe vomiting during the last two days. Each day the vomiting seems to be getting more persistent. The pain over the region of the tumor is more severe. So much so that today a full examination could not be made. Morphine in profound anti acid doses given every four hours, along with some Perlmith and Hydrocyanic acid.

December 6th The pain and tenderness in the abdomen is increased. The features are pinched. The vomiting is incessant, nothing can be kept down. The vomited matter is of a coffee ground colour.

December 10th

The patient died.

Autopsy
Autopsy 26 hours after death.
The body was extremely emaciated, rigor mortis well marked. The usual
incision was made in the middle line
from the manubrium sterni to the
mastilicus. On exposing the stomach
a dark ring around the pylorus
was observed. The pancreas was
studded with cancerous nodules and
adherent to the stomach. The oesophagus
and the duodenum being ligatured the
stomach was removed. It contained
about two ounces of nearly colourless
liquid. There was a cancerous ring
about the pylorus which diminished
the lumen to such a degree that the
tip of the little finger could barely
does pass through it. The whole
posterior surface of the organ was
studded with little cancerous nodules
about the size of peas each being
separate and distinctly circumcised.
The liver was examined in situ
it protruded for about an inch
and a half below the free margin
of
of the ribs. There was observed on its under surface a small circumscribed Cancerous Indurated. The Cancerous mass at the pyloric end of the stomach was ulcerated on its inner surface. Another mass about the size of a wallnut was formed at the cardiac end of the stomach. This portion of the stomach was dilated and its walls thickened.

The other organs were examined in situ and what was seen of these was apparently healthy. Further examination not being allowed.
Case VI

Biliary Colie (Gallstones)
Recovery.

Wm R. Aged 59, residing at Moss Road, Wigan. Examined 20th March 1872.
Complains of pain like knives cutting through her back and sides, and of burning.

Social history.
The patient is a short stout woman. Was 8 of a family. Keeps a small shop. D'only goes out and leads a sedentary life. Was always been temperate.

Family history.
All healthy people living to a good old age. There is no history of organic or Constitutional disease.

History of present attack.
On Sunday night the 19th Oct. about an hour after supper the patient was suddenly seized with acute pain in the abdomen. The pain being so severe that she fainted away.

History of previous health.
The patient has always enjoyed good health previous to the month of October 1889. One evening during that month she suffered from great pain in the abdomen which lasted for about a couple of hours and then suddenly closed. Discoloration of the skin was not observed after this attack. The patient calls it 'Colic'.

On New Year's Eve 1881 the patient had an attack of pain in the abdomen and also of vomiting. This came on about 7 P.M. and lasted 2 hours. Two or three times a week, from this date until March 8th, the patient has suffered from similar attacks. Each attack lasting two or three hours and then passing off.

On the 24th of March 1881 I saw the patient for the first time. At the time of examination, the patient was in bed rolling about from side to side and could not rest in one position, due to intense agonizing pain in the abdomen of a spasmodic character.
One fourth grain of morphine was injected under the skin. In a short time after great ease was obtained the acute pain having suddenly ceased leaving the abdomen very tender. Hot fomentations could not be borne. Next morning the patient was jaundiced. In a few days the jaundice entirely disappeared. Three weeks after this last attack the patient went to Buxton in Derbyshire for a couple of months, while there she enjoyed perfect health.

September 81. The patient again began to suffer from somewhat similar attacks of pain as described above, at irregular intervals. She was not seen by any medical man.

In January 1820 an attack lasting two hours, causing intense suffering and making her quite powerless. Three days after when at stool the patient passed a hard substance dark in colour and not unlike a stone. This unfortunately was
thrown away.
1st March 82. The patient had another attack lasting 8½ hours for a day or two afterwards she was deeply jaundiced.

Present Condition
20th March 82.
The patient lies on her back with thighs flexed on abdomen to ease the pain in her abdomen. She cannot rest for any time in this position and moves from side to side to try and get some relief by change of posture. There is an averse expression of countenance. The skin is cold and bathed in perspiration. Pulse compressible and heart feeble. The pain from which she is at present suffering is intense and somewhat spasmodic in character radiating from region of gall bladder to the oesophagus and visera over the abdomen, through spine and chest. Tongue furred
at Centre, white pale and flabby at edges. Mouth parched. Is very thirsty. Continually itching and inclined to vomit.

Bowel's moved yesterday;

Urine clear and apparently normal

Abdomen.

On inspection full rounded with a few old scars of pregnancy.

Palpation over the whole abdomen very tender. Slight pressure over a spot corresponding to the seat of gall bladder causes great pain.

Percussion. There is a considerable area of dulness over region of liver and gall bladder. My examination has been incomplete due to tenderness and pain caused by palpation and percussion.

A hypodermic injection of morphine.

Since. Not formulated ordered to be applied to abdomen. Ice to back. And an effervescing mixture of bicarbonate of potash and citric acid also ordered.
21st. The morphea has given great ease. The patient passed a somewhat restless night. The skin is deeply jaundiced. Conjunctiva are very yellow. The urine is now thin and muddy. Nitric acid test gives a play of colours evidently due to the presence of bile colouring matter.

The abdomen is very tender to pressure particularly over the region of the full bladder. The inclination to vomit, sickness and pain all gone. The patient feels very weak, and suffers from flatulence.

22nd. Passed a good night.

This morning I found my patient sitting in bed. She feels quite comfortable and does not appear to be so much discoloured as yesterday.

Preserving mixture to be continued. The teaspoonful of Carlsbad salts ordered to be

[Signature]
The patient taken every morning, and was put on a light nutritious diet.

24th My patient was up to take for several hours. The yellow colour has almost disappeared only a faint tinge observed. Appetite improving. Flatulence gone. Urine has become clear.

26th Sunday. The patient left her room to eat and partook of some butchery meat at dinner. Two hours after dinner suddenly taken ill with an acute pain in the right side of the abdomen with aching upwards towards the shoulder, radiating at times from the region of the liver across to the opposite side of the body. It is much more pretious and painful at times, thus having its spasmodic nature.

She has a constant inclination to vomit and suffers severely from retching. Hypodermic injection of morphia grew. In 15 minutes the patient began to experience some
Relief and soon afterwards fell into a drowsy lethargic condition which lasted for 8 hours.

On this morning the vomited matter contains bile, thus showing that the common duct is patent. The patient is deeply jarred and feels quite prostrate. All pain gone. No palpation here to pain and tenderness over region of gall bladder. I have today endeavored to peruse out the liver dulness but failed to accomplish any object due to the patient's restlessness.

As the patient very much better can sit up in bed. Jaundice disappearing. Stools white and Clayey. Urine highly coloured & changes with bile.

30th Patient sitting up, does not complain of any pain. There is still a faint tinge of yellowness.

The bowels have acted and the motions are natural in colour.

From this date up to the present time the patient has had no more

Attatched
Treatment
Treatment.
1st Object was to allay pain by the use of morphine given under skin.
2nd To allay vomiting, retching and thirst. Ice was given to suck, soda water and milk, and effervescent moulds. Not fermentatives tried but cured without more.
Preventive Treatment. 1st Dietetic. Butter oil and fatty substances to be avoided. The patient was therefore restricted to a diet chiefly vegetable.
2nd To regulate the functions of the liver. Gentle exercise ordered, also Carlsbad salts and alkaline remedies with an occasional pil of Calomel and Calomel to be taken at least time and on the following morning a salicylate powder.

Remarks.
The diagnosis in this case points to biliary calculi obstructing and passing through the ductus communis choledochus.
The evidence upon which this
this diagnosis is based on:
1. Sudden attacks of epigastric and acute pain in the region of the liver occurring at irregular intervals after meals, and terminating somewhat suddenly a few hours after commencement.
2. The jaundice supervening on the following morning.
3. The fact that a substance had been passed per rectum dark in colour and like a small stone.

Trouseau (Clin. Med. 4th ed. Soc. Bel. to page 227) says, "The diagnosis of hepatic colic remains imperfect until the time a patient passes a Calculus or a fragment of one. Till then, there are no data except probabilities — probabilities in some cases, it is true exceedingly strong."

The fact of my patient having passed some hard substance like a small stone is I think
this diagnosis is based on:
1st. Sudden attacks of epigastria and acute pain in the region of the liver occurring at irregular intervals after meals, and terminating somewhat suddenly a few hours after commencement.
2nd. The jaundice supervening on the following morning
3rd. The fact that a substance had been passed per rectum dark in color and like a small stone.

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The fact of my patient having passed some hard substance like a small stone is I think
Conclusive evidence of the diagnosis being hepatic colic due to the passage of biliary calculi.
Case VII

Hydatid Cyst of Liver.  Spontaneous Cure.


Complains of pain in his right side, of weakness, and a sinking feeling about the pit of his stomach, with occasional attacks of vomiting.

History of present attack.

Five days previous to date of examination while lying in bed he passed his hand over his abdomen to relieve a spasmodic attack of pain. In doing so he discovered a swelling in his right hypochondrium. This was the reason of his consulting me, more from anxiety to know the cause of the swelling than because he felt pain.

Previous health.

There is nothing definite to relate about his previous health, except that he occasionally suffered from attacks of
of indigestion and constipation.

Social history.

He is a sober, steady, healthy looking man, and has always been so. Both parents living and enjoying good health.

Present Condition.

The patient is a well developed muscular man, of sanguine temperament with rather an anxious expression of countenance. His temperature is normal, skin moist, and limbs of natural size.

Digestive System.

Tongue pale, white and flabby, bowels swallow easily, but eats very fast and is in the habit of bolting his food. Has a sinking feeling in the part of his stomach, is occasionally troubled with flatulence and his bowels are inclined to be constipated.

Abdomen: physical signs.

On inspection there is an bulging or protrusion of the abdominal wall somewhat rounded in form to the upper and outer side of his umbilicus.
On the right side. On palpation this globular swelling is of firm consistence, slightly elastic and smoothly rounded. It does not pulsate but moves upwards and downwards with inspiration and expiration. When the patient is standing the right hypochondrium is observed to be more prominent than the left. On lying down this enlargement becomes more distinct and evident during full inspiration, receding and falling backwards into the abdominal cavity during expiration.

Percussion. The liver dulness commences between the fourth and fifth ribs and extends downwards in the mammary line for fully ten inches. The transverse dulness on a level with the umbilicus is six inches. At its most prominent part of the protrusion the percussion note is dull and continuous with the liver dulness. The percussion note at the flanks is tympanitic.

A tape measurement around the

body
Body over the most prominent portion of the tumour during full inspiration is thirty six inches, and after full expiration thirty five inches.

On grasping this body or mass it can be moved from side to side with very little inconvenience and only slight tenderness. It can be felt to be more or less distinctly connected circumferentially and apparently attached to the liver.

All other systems are healthy.

Diagnosis.

This can only be arrived at by process of exclusion. (I may first of all assume that the tumour is connected with the liver.) From its position and relation to that viscus the diagnosis must necessarily be obscure.

Is it a cancerous tumour? At his age cancer of the liver is not common. There is neither cachexia nor wasting. He nodular character of cancerous tumour is wanting. Cancer of liver is usually a secondary product. And there are no signs of primary
Cancer in the Stomach or elsewhere, although the whole organ is enlarged as is the case in Cancer. There is no evidence of the enlargement being waxy in its nature. The urine is normal both in quantity and quality thus showing that the Kidneys are not affected as is generally the case in Waxy Degeneration. The Spleen is also not enlarged. There is no history of Syphilis, nor any scars on the penis and I may in consequence exclude a tumourous tumour.

If an abscess a high temperature, throbbing local pain, or pulsation would probably be present and the fact of his never having been abroad is further evidence which may be added to show that this swelling is not likely to be an abscess of the liver.

If a dilatation of the gall bladder one might expect more unless jaundice and the form of the tumour would not be quite so globular. There is no
history of gall stones having been passed.

If a lymphatic or lymphoid tumour of the blood would be altered as found in leucocytosis or Hodgkin’s disease, on microscopic examination of blood the number of white blood corpuscles was not in excess, and nothing abnormal could be observed in that fluid.

The differential diagnosis of Cystic tumour of the kidney, ovarian cyst, phantom tumour, Carcinoma of the kidney, Acute Cyst, Anæmia.

Inflammatory meso-renal, mental and pancreatic diseases may be dismissed.

Therefore the Case must be Hydatid Cyst of liver.

Having carefully watched the Case for a fortnight I found that the tumour had increased in size. The patient had not complained of any pain or discomfort since he was last examined and all his functions were natural.

Safe measurements round the body at level of umbilicus that is the point.
prominent part of the tumour during full inspiration thirty six one half inches. When full expiration thirty five one half inches. Transverse dulness three one fourth inches. Liver dulness from above downwards ten one fourth inches.

I resolved at this stage to seek a second opinion and sent the patient to Dr. Cameron of Liverpool who saw the case and kindly sent me the following diagnosis:

"The case of E. H. is an interesting and remarkable one. After a careful examination I was able as it seemed to me to define its limits and I believe it to arise from the under surface of the liver. Although there is a depression immediately below the edge of the ribs the tumour can be traced into the liver, nor could I make out any breach in the surface. The percussion sound was dull over the whole of the surface but became full and resonant to the right and somewhat below the tumour (i.e. in the region of the"
the Cæcum). In regard to its character it does not seem to be solid nor yet absolutely fluctuating but gave to the hand a sense of tension and indistinct fluidity. It was fixed but moved up and down with the act of inspiration and expiration. He told me that it was painless and bore my examination without showing any indication of tenderness by the pressure. Taking all the circumstances into consideration (including the history of its development) I am inclined to the opinion that it is an hydroaædic tumour of the liver.

The treatment adopted was that suggested by Dr. Cameron viz. "placing the maw on a carefully restricted diet, acting freely on the bowels, and giving five grain doses of iodide of potash three times a day." For three weeks subsequent to Dr. Cameron's examination the patient was seen at intervals and carefully examined each time. Having adjusted
to aspirate the tumour and draw off some of the fluid to corroborate my diagnosis, the patient became alarmed and left my care for homoeopathic treatment. But as I had taken great interest in the case I endeavoured to find out the subsequent progress and course of the tumour. Some few weeks after he was last seen by me the patient was one day suddenly taken ill with severe pain in his bowels which was followed by vomiting and purging. I understood he passed a great number of cysts both by his mouth and rectum. He has fully recovered and is now attending to his usual employment. No active treatment was adopted and the liver has returned to its natural size.

Remarks.

The growth of this tumour was remarkable considering that hydatid cysts invariably take a very long time - sometimes years - before they grow to any great size.

Kourenno
Troussseau (Chir. Med. Vol iv. New Ed. 202 Ed. page 274) says, "The Cysts (hydatids) develop very slowly and may take from two to twenty years to be developed.

Murchison (Lectures on diseases of the liver. Lect. iii. page 58) says, 'The growth of a hydatid tumour is slow and imperceptible, and when the tumour is large, it has usually existed for years before the patient has recourse to medical advice.'

In the Case given here there was no obstacle to the development of the tumour except the abdominal parietes, and although I would not lay much stress on my tape measurements around the body, still the fact that the area of dulness increased by one fourth which both transversely and from above downwards within three weeks is strong evidence that the tumour did grow rapidly.

The patient did not suffer from any lung or chest complications nor indeed 26 long as the case was under
My case were there any complications at all.

The chief interest in the case was the diagnosis which was rendered all the more difficult as there were so few opportunities of watching and studying the development and evolution of this tumour of the liver.

The "hydatid vibration" described by Dr. Murelau (page 56 loc. cit.), synonymous I presume with the "hydatid purring" mentioned by Professor Trouvèla (Vol. iv, page 175, loc. cit.), was absent in this case. By the former this is stated to be of considerable value in the diagnosis of hydatids of the liver, while the latter considers it pathognomonic of one hydatid.

In a post note at the commencement of Dr. Murelau's lecture on hydatids of the liver (page 5.5 loc. cit.) it is stated that hydatids are much rarer in Scotland than in England and he asks: "Can this immunity be due to the non-importation of foreign sheep into Ontario?" Or may it be interesting
In reply to this query, that the butcher whose case I described dealt chiefly in foreign meat.

The patient also keeps several dogs and feeds them on the offal of sheep and other animals, and it is not at all improbable that through this source he became affected.
A few remarks on Vomiting.

Here are certain forms of abdominal disease, such as cancer and ulceration of stomach, duodenal and renal colic &c. which are attended by vomiting as one of their most distressing symptoms. This is often so severe as to abandon all other treatment until the sickness is arrested, and I shall now refer to the therapeutic measures which have proved most serviceable in my hands in this emergency. It is clear that as vomiting is a reflex act excited by irritation applied to a sensory nerve and acting through a nerve centre upon the muscles involved in this act, that it may be lessened either by removing the source of irritation or by diminishing the excitability of the nervous mechanism through which it acts. Morphia, sthiocyanic acid and chloroform act as
local sedatives. That is, they have a certain amount of local action upon the peripheral ends of sensory nerves and lessen their excitability to impressions. After absorption into the blood, they are carried to the medulla and there lessen the excitability of the nerve centre through which the reflex action of vomiting is produced. It is obvious that in such cases of persistent vomiting the diet must be of the blandest and simplest nature, consisting principally of milk with either Lime or Soda Water, Conjoined with the decoction of small pieces of Ice. Arnica Mustard poultice may be applied to the Epigastrium. Sometimes a small saliseter and sprinkling over the blistered surface a quarter of a grain of morphia. Medicinally there is found Bismuth the most generally useful remedy, more especially when combined with
With three or four minims doses of dilute hydrochloric acid and given before food. If the disease persists, resort to the use of an effervescing mixture (Potash Bicarbonate and Citric Acid) which always proves grateful, and frequently poisons the irritability of the stomach. Should these measures fail there are several other means or other of which I have often had recourse to with success. These are:

1st. Atropa belladonna or Euphorbium.
2nd. The hypodermic injection of Morphia.
3rd. Bracoate— in 1 or 2 minim doses and preferably in the form of pill.
4th. Champagne.

In cases of Simple Diarrhoea vomiting I know of no better remedy than Salomone, Conjoined with minute doses of Opium.

I shall now refer to two forms of vomiting which are liable more directly under the Construction of medicinal agents than any others. These are...
the morning sickness of pregnancy, of drunkards.

In the sickness of pregnancy there is one remedy which I have often known to act like a charm—that is, the frequent administration of drops of Nux vomica or Atropine. It may be given hourly or three times a day, according to the severity of the case. It sometimes fails and then I have seen benefit from the same dose of Liquor Atropiae or Tincture of Belladonna.

(6) I have found the morning vomiting of drunkards relieved in most instances by Arsenic, given in drop doses of Tonnino solution 3 or 4 times a day.

I see a case reported by Dr. John Wood (Lancet Feb 12/81) in which he operated on a lady for a tumor in the region of the Cecum. The incessant vomiting of greenish vomitus which followed was tried to be stopped by Champagne and Soda Water. The patient had to be fed by enema. Morphiace Hypodermically, drop doses of Opii campestris.
Effervescent draughts of Bismuth and Hydrocyanic Acid and effervescent draughts with Solution of Strychnine all of which failed.

The incessant vomiting in this case lasted three days. Champagne and Soda water being the first thing that would down I notice that the patient had Morphine injected hypodermically three times a day to allay the pain. And it is not at all improbable that this might, some considerable effect in stopping the vomiting.

Von Ziemsen (Cyclopedia Pract. Physiol. Vol. II, p. 254) remarks: "In the treatment of obstinate vomiting, besides the regulation of diet, special remedies may occasionally be required. The most useful are narcotics and cold. Among the narcotics, Opiates, particularly Morphine in connection with Cherry laurin water.

"The Morphine may also be given by hypodermic injection. Belladonna and other narcotics can be given in..."
the same way

"Cold is best employed in the
form of cold compresses applied
to the epigastrium, or by swallowing
small pieces of ice."

In the case of Mrs. P., every thing
described above had been tried but
of no avail. The hypodermic
injections of morphia, and the sucking
of ice seemed to act most beneficially.

But these do not act so quickly and
promptly as is desirable, in the
painful and incessant vomiting due
to Abdominal disease.