OUR PRIZE COMPETITION.

STATE GENERALLY THE SYMPTOMS OF GASTRIC ULCER, AND THE DANGERS ARISING THEREFROM. HOW WOULD YOU FEED A PATIENT SUFFERING FROM THIS DISEASE?

We have pleasure in awarding the prize this week to Miss E. A. Noblett, 2nd Northern General Hospital, Headingley, Leeds.

PRIZE PAPER.

Perforating or peptic ulcer is a lesion peculiar to the stomach, the first part of the duodenum, and the lower end of the œsophagus, *i.e.*, to parts exposed to the gastric juice. The ulcer is usually single, but there may be more than one.

Symptoms.—No disease or condition may have on the one hand more characteristic, or on the other hand more ill-defined symptoms, than gastric ulcer. Taking a typical case, we may expect:—

1. Pain and tenderness over the gastric region. The pain is severe, and shoots through to the back, and is rendered worse by eating or by firm pressure.

2. Vomiting after meals. This may occur soon after food has been swallowed, but more frequently after an hour or longer. It usually gives temporary relief.

3. Hæmatemesis (vomiting of blood) may be very copious, and occurs in probably more than half the cases. It may be directly fatal or comparatively slight. Melæna (passage of blood by the bowel) is present in about 10 per cent. of the cases.

4. The appetite remains good, but the patient is afraid to eat, lest pain is set up.

5. The tongue is clean, and may be pale and flabby. There is little wasting.

These symptoms, in combination with the history, anæmia, and the absence of a tumour, point strongly to the presence of an ulcer. Often, indeed, the symptoms are very slight, and a copious or even fatal hæmorrhage, or the occurrence of perforation, may be the first indication of such a condition.

Perforation is indicated by the sudden occurrence, after a meal or severe exertion, or during vomiting, of intense pain in the upper part of the abdomen, with rigidity of its walls, faintness, rapid wiry pulse, pinched and anxious face. The abdomen is much distended, and fatal peritonitis may result.

On the other hand, it is not uncommon for adhesions to form between the walls of the stomach and neighbouring organs, and the ulcer, after perforating the gastric walls, burrows into the pancreas, spleen, or liver. Large vessels may be eaten into in a similar manner, and bring about a fatal issue from hæmorrhage. Even small erosions may sometimes prove fatal in this manner. Other complications through the ulcerating process are:—

Perforation into the pleura; gastro-duodenal fistula; perforating into the lesser peritoneum, giving rise to sub-phrenic abscess.

At times the ulcer in its healing causes so much contraction and puckering of the stomach near the pylorus that an obstruction is offered to the escape of food from the stomach.

Surgical measures are called for in the event of perforation, subphrenic abscess, repeated or very severe hæmorrhage, and in cases attended with pyloric stenosis.

Diet in post-operative cases or after hæmatemesis.—Nothing is given by mouth for the first thirty-six to forty-eight hours except water in small quantities, lest vomiting appear. On the second or third day albumen in teaspoonful doses is administered, and, if borne well, broths and milk are rapidly added. When full diet is resumed after operation, a liberal diet is allowed. The important rule should be not what is eaten so much as the method of eating. The food should be eaten dry, and each mouthful should be chewed till it is fluid. The quantity will then regulate itself; too much will not be eaten. Also, saline by proctoclysis is given every five hours for the first twenty-four hours, after which time nutrient enemas are alternated with the salt solution. A mild soap and water cleansing enema should be given two hours before the morning nutritive. Nutritive enemas are usually given for more than a few days, perhaps a week or two or longer. The nutrient should not be given until all the wash water has come away, otherwise the enema may be immediately rejected.

Some surgeons substitute suppositories for nutrient enemas, and five are given per day, preceded in the morning and followed late at night by a pint of salt solution by the drop method, to supply the necessary fluid.

Rectal feeding is at best a poor substitute for feeding by mouth, and in the most favourable cases the patient is being subjected to partial starvation, and food is now given sooner and with much less hesitation than formerly. The patient is allowed tea, red wine, broths, chopped chicken, beef, lamb, potato, soup, eggs, four or five days after the onset of hæmorrhage or after an operation, and ordinary diet is gradually resumed, made up of things easy to digest.

HONOURABLE MENTION.

The following competitors receive honourable mention:—Miss A. B. Owen, Miss S. Simpson, Miss Dora Vine, Miss Henrietta Ballard, Miss H. M. Springbett, Miss E. Mackenzie.

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