blocked with a growth which is very frequently cancerous.

Whatever the cause of the obstruction, the result will be the same, namely, stretching and thinning out of the stomach behind, the symptoms of which will be vomiting some time —usually half an hour or an hour—after each meal, with pain and flatulence.

In the other class we have irritability of the stomach, either from chronic inflammation or from an ulcer, the latter being especially common in young anæmic women. Here we have intense pain coming on immediately after food has been taken; very frequently there will be vomiting, and, where an ulcer is present, there may be hæmorrhage also. A case of this sort occurred recently in my own practice.

A servant girl, aged about 26, consulted my partner for pain after food which had been going on for about seven years. After the manner of her kind she had not bothered very much about it, and had contented herself with taking various patent medicines, and had lived on a diet which consisted mainly of sweets, until vomiting set in after each meal. Some three years previously she had brought up a little blood. Under careful dieting and rest in bed and medicine she improved considerably, but directly she started work again the pain and sickness returned, and I was asked to see her with a view to operation.

When I opened the abdomen I found the stomach reduced to the condition of a crumpled-up leather glove. Its walls were contracted by the scars of numerous ulcers, and the organ itself was tied down tightly by adhesions to the structures beneath, so that a portion large enough to make an opening into was only set free with great difficulty. A posterior gastro-enterostomy was performed, and in a month's time she was able to take light solid food without pain. A month later she went back to her situation, and was able to lead a normal life as regards food.

Gastro-enterostomy has really been one of the most successful operations in surgery in that it has enabled very many people whose existence had previously been a burden to them on account of repeated indigestion to take on a new lease of life and consume ordinary diet, and leave off taking medicines. By affording drainage of food *débris* and irritating gastric juice it has enabled ulcers to heal that have often been the despair both of the patient and of her physician, and it has restored the shattered nerves of dyspeptics, so that they have become useful members of society instead of being, as formerly, a burden to their relatives and to the community.

OUR PRIZE COMPETITION.

NAME SOME DISEASES WHICH MAY CAUSE OBSTRUCTION IN THE ŒSOPHAGUS, AND HOW IS IT USUAL TO FEED SUCH PATIENTS.

We have pleasure in awarding the prize this week to Miss Dora F. Chapman, Norton, Malton, Yorkshire.

PRIZE PAPER.

Cancer of the œsophagus is a serious and most frequent cause of œsophageal stricture. The chief symptoms are, increased difficulty in the passage of food downwards, emaciation and steady decline in strength, together with enlargement of the glands of the neck. Treatment in these cases can only be palliative while life continues. Feeding by nutrient enemata may be resorted to, as supplementary to efforts at liquid feeding in small quantities by the mouth, but, where there is great difficulty in feeding a patient, it is better to have the operation of gastrostomy performed at once, as it gives the greatest relief to the sufferer, and prolongs life.

Gastrostomy entails making a permanent opening into the stomach, through the abdominal wall; a tube is inserted in this opening, and the patient receives liquid nourishment by means of the tube. A funnel is fixed on to the outer end of the tube, and after gently allowing a little warm sterile water down the tube to clear away any clots which may have formed near the opposite end, the food is poured slowly in, and reaches the stomach.

Care must be taken not to introduce air with the fluid. The first few feeds after the operation usually consist of four ounces of diluted milk, but the quantity is afterwards increased two ounces each feed, until the patient is taking 10 ounces of milk and beaten up egg, or other nourishing diet, four-hourly. Six ounces of warm beef tea, to which one ounce of brandy has been added, is very beneficial in diminishing shock after the operation. It is sometimes administered before the patient leaves the operating theatre. During feeding it is important to keep the wound as aseptic as possible. Should the stomach contents escape slightly round the tube, the acid of the gastric juice should be neutralised by powdered potassium bicarbonate, sprinkled over the surface of the skin round the wound. The tube is removed, cleaned, and replaced daily, but during the later stage of convalescence it is taken out altogether, and only introduced for feeding purposes four-hourly. The opening is kept covered by a gauze dressing, and hazeline ointment applied to the skin to avoid excoriation. The patient's mouth must be kept well cleansed, and thirst after operation may be

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