Erosive gastritis was consistently observed gastroscopically in dogs given oral aspirin, buffered acetylsalicylic acid, or sodium salicylate. In the case of plain aspirin, the erosions cleared after the fifth day despite continued administration of the drug. However, if the aspirin was stopped for only two days and then restarted, the gastric mucosa remained largely refractory. When aspirin was stopped for longer periods and then readministered, erosions developed. It is suggested that this phenomenon may be explained by development of tolerance to the aspirin by the gastric mucosa. Effervescent buffered acetylsalicylic acid given orally and sodium salicylate given intravenously did not produce gastric erosions in any animal. The appearance of the erosions after giving aspirin in solution would indicate that the size of the particles of salicylate is not the important factor in the production of gastric erosions.

Recapitulating the data of the literature and of our personal works, we can settle a certain hierarchy in the biliary elimination of antibiotics: some, like Streptomycin, Chloramphenicol, Neomycin, Bacitracin have only a poor biliary elimination. Others like the Tetracyclins, Polymyxin and the Penicilins are passing through much better. At last, several antibiotics have a very high, even prevailing biliary elimination, they are: Rovamycin, Erythromycin, Oleandomycin, Novobiocin, the Rifomycins. These antibiotics are eliminated through the liver according to two principal ways which have been studied by the method of clearances. Some like Streptomycin or Chloramphenicol, have a clearance of water or chlorides and are eliminated by simple filtration. Others have a high clearance and are eliminated to elevated concentrations by an active secretion of the liver’s cells (Penicillin for instance).

This study is based on 94 patients followed for a minimum of 8 years to a maximum of 19 years after the operation. Ulcers relapsed only in 5.8% of the cases and these occur ordinarily within two years after the suture. Almost half of the patients then have no further sign of ulcer after suture. It should be noted that 22.8% of perforations are neither preceded nor followed by ulcer symptoms. The outlook for ulcer patients with a suture is not therefore always too gloomy and in a great number of cases, the perforation does not call for a secondary gastrectomy.

The authors report two cases of macroglobulinemia in which the essential clinical manifestation was, in one, intestinal hemorrhages with melena and, in the other,
hematemesis. They draw attention to the need for looking for a macroglobulinemia where there are cryptogenetic digestive hemorrhages. Macroglobulinemia may be represented by symptoms of Waldenström’s disease, but often it is only revealed by the proteinogram. One should therefore use electrophoresis in cases of digestive hemorrhages whose etiology cannot be proved.

Krondl, A.; Vavřínková, H. and Míchalec, C. Effect of cholecystectomy on the role of the gall-bladder in fat absorption. Gut; (J. Brit. Soc. Gastroent.) 5: 607-610 (1964). The role of the gall-bladder in fat absorption was investigated in patients after cholecystectomy and in controls. After ingestion of cream (0.85 g fat/kg body weight) or intraduodenal application of olive oil (0.86 fat/kg body weight) no significant differences in alimentary lipaemia between the two groups were established. The addition of 2.5 dried ox bile to olive oil failed to enhance significantly the alimentary lipaemia in patients after cholecystectomy. However, the administration of 2.0 g. Tween 80 caused a significant increase of alimentary lipaemia in these patients. No difference in faecal elimination of fat between patients after cholecystectomy and controls were found.

It may be assumed that removal of the gall-bladder does not influence the absorption of butter fat and olive oil, and that the evacuation of the gall-bladder is not essential for the absorption of these types of fat in man.


A series of 56 patients with achalasia of the cardia included 16 with reflux after operation of whom seven were symptomless. A radiological technique which facilitated the detection of reflux was employed.

The factors contributing to the development of reflux included duodenal ulceration, previous oesophageal operations, double and strip myotomies, and disruption of the hiatus. Of nine patients with reflux oesophagitis, five required further operative treatment. Careful pre-operative evaluation and the preservation of the hiatal mechanism are considered to be the most important factors in reducing the incidence of reflux. The long myotomy is considered to be necessary to ensure adequate oesophageal drainage. If it is placed on the lesser curve side of the oesophagus and stomach the risk of reflux is likely to be diminished.

The operative technique is discussed on page 84.


A previous study has shown that morphine causes the generation of high intra-sigmoid pressures. In diverticulosis of the colon, this effect is exaggerated in those segments actually bearing diverticula. There is therefore a prima facie case for questioning the wisdom of giving morphine to patients with diverticulosis. In the present investigation, cineradiography was used in conjunction with intraluminal pressure recording to study the behaviour of colonic diverticula after the administration of morphine and other drugs. High intrasigmoid pressures evoked by morphine are shown to be accompanied by distension of neighbouring diverticula, sometimes