# REPORTS OF SOCIETIES.

## MEDICAL SOCIETY OF LONDON.

NOVEMBER 26TH, 1853.

FORBES WINSLOW, M.D., D.C.L., President, in the Chair.

### FIBRINOUS PLUGS IN VEINS. BY HENRY LEE, ESQ.

Mr. LEE exhibited the preparation of a case in which the profunda femoris vein, with its branches, was plugged with a mass of fibrin. This had resulted from the introduction of purulent matter into the blood from an abscess on the inner side of the thigh. He detailed certain experiments performed by M. Gaspard, who injected into the right jugular vein of a dog two and a half ounces of thick fœtid fluid, derived from the maceration of cabbage leaves in water. Death occurred during the following night.

On *post mortem* examination, the lungs were found of a dark colour, with some black patches, but still crepitant. The left ventricle of the heart presented brown stains; its internal surface was of the colour of lees of wine. The right ventricle contained a hard fibrinous concretion, two drachms and a half in weight, of a light yellow colour, and having the external appearance of grease. It was of the same consistence throughout, and was free at all points, except a small portion which was attached to an inflamed spot on the inner surface of the ventricle. No appearance of the injected fluid could be detected in the clot; it was prolonged into the pulmonary artery, vena cava, vena azygos, axillary vein, and even into the right jugular vein.

Dr. ROUTH remarked, that putrid pus had been injected into rabbits without injury, and that wounds from dissection are usually innocuous. The results mentioned by Mr. Lee must arise from other circumstances, as those of epidemic influences and bodily weakness. Hectic fever does not usually follow the introduction of pus within the system.

Dr. MACKENZIE agreed with Mr. Henry Lee on the question of the obstruction of veins by fibrinous deposition from a vitiated condition of the blood. He did not speak specifically of a vitiated condition of the blood from pus, because this, being a fluid which varied very greatly in its properties, would give rise to very different results in different cases. Speaking, however, of vitiation of the blood generally, he could affirm that, from this cause alone, arrest, stagnation, and coagulation of the blood might take place in the veins, without any primary inflammation of their coats. That some alteration of their lining membrane was induced by the vitiating matter, he had no doubt, although it was difficult to define its precise nature; and he believed that, in consequence of this alteration, the blood, instead of flowing onwards, was arrested and coagulated in the veins. Upon this arrest and coagulation the general phenomena of phlebitis ensued.

### INTERNAL METRITIS AND UTERINE CATARRH. BY E. J. TILT, M.D.

Dr. TILT contended, that to subacute inflammation of the mucous membrane of the neck of the womb the term uterine catarrh should alone be applied; by giving it to acute inflammation of the neck, French pathologists had been led to use dangerous injections into the cavity of the womb. Subacute inflammation of the mucous membrane lining the womb was characterised by the usual uterine pains and hysterical phenomena, and by inconsiderable swelling, if any, of the cervix, which was sometimes only painful on lateral pressure, the discharge being rarely muco-purulent, generally mucous, and sometimes sanious. In addition to the known means of treatment, Dr. Tilt advocated the topical application of tincture of iodine to the inner and outer surface of the womb, to be repeated every four or five days. Acute inflammation of the mucous membrane of the body of the womb could not be distinguished from the inflammatory affections of the whole organ; but, in some cases of menorrhagia, this mucous membrane was alone affected, and threw off a false membrane, different from the decidual membranes which have been hitherto described. Dr. Tilt exhibited a morbid specimen, taken from a young woman who died of menorrhagia under Dr. Watson. He thought that future researches would show that there was a chronic inflammation of the body of the womb, in most cases of dismenorrhœa accompanied by exfoliation of the mucous membrane. He then described a form of internal metritis, to which he gave the name of hæmorrhagic, to mark the symptom by which it was habitually accompanied. He illustrated it by a case in which astringent injections, cauterisation of the neck of the womb with the nitrate of silver, as well as internal remedies, were without avail; whereas, when large doses of morphine, two grains *per diem*, were given to allay pain and calm hysterical symptoms, the sanguineous and semi-purulent discharges were checked, and the patient recovered. Another variety of internal metritis was characterised by the growth of fibro-plastic vegetations on the surface of the womb; these vegetations giving rise to sanguineous discharges and severe uterine symptoms. Dr. Tilt deprecated the use of uterine injections, on account of the uncertainty of their action, either in a similar set of cases, or even in the same patient—admitting, however, that they might, perhaps, be useful in some cases of the fibro-plastic variety. In that disease he recommended the careful introduction of Recamier's curette, a uterine sound a little larger than Dr. Simpson's, somewhat curved at its extremity, and hollowed out under its curvature, so as to remove the vegetations by gentle abrasion. Dr. Tilt had also found this instrument very useful in removing portions of retained placenta, the presence of which were indicated long after parturition, by flooding, by an enlarged body of the womb, and by uterine symptoms. He also showed another large instrument, which had been used by Recamier for the same purpose as the smaller, when the internal neck of the womb was widely dilated by inflammatory action—a circumstance of rare occurrence. He had found another plan of treatment successful in one case of the fibro-plastic variety; viz., after the application of the speculum, to introduce into the cavity of the body of the womb Dr. Simpson's uterine sound carefully surrounded by cotton-wool, saturated with tincture of iodine. The vegetations came away with a sero-purulent discharge after a few days; the operation was repeated, and the patient was in a short time relieved of a sero-sanguinolent discharge, which had lasted for years. Dr. Tilt inferred that tincture of iodine and iodide of iron were the topical applications from which practitioners would derive the greatest assistance in the treatment of uterine diseases.

Mr. STREETER (holding up the large curette invented by Recamier, and exhibited by Dr. Tilt) asked if it was really intended to be introduced into the uterus? It was a most dangerous instrument; and he did not think that it could be introduced, a few days after delivery, for the removal of retained portions of placenta.

Dr. HENRY BENNET did not understand why the mucous membrane of the neck of the uterus was more prone to inflammation than that of the body of that organ. He had rarely met with the latter disease, but believed that it would be indicated by exalted sensibility of the organ, enlargement of the cavity, a patulous os uteri, a sero-purulent or bloody discharge, and a marked reaction on the health. The mere presence of hæmorrhage, or of fibrinous casts, would not prove its existence. The treatment of inflammation of the mucous membrane of the canal of the cervix is simple and effective, while that of the body is beset with difficulty and some danger. He had known the introduction of a bougie to dilate the canal not only give intense pain, but induce abscess of the broad ligaments. He had employed the nitrate of silver and the acid nitrate of mercury.

Dr. GREENHALGH believed that uterine catarrh is due to inflammation of the mucous membrane both of the body and of the canal. In the acute forms of the disease, he would employ the hot-bath, with mercury and Dover's powder; and in the chronic states he would direct change of air and improvement of the general health. He would not affirm that the application of potassa fusa and other local remedies was always improper, but he believed it to be rarely called for. As a rule, he objected to much local interference.

Dr. MACKENZIE was persuaded that the anatomical seat of uterine catarrh was exclusively the cervical canal, and the numerous mucous follicles with which it was studded, rather than the mucous membrane of the body of the uterus. So confident was he on this point, that he would venture to assert that all mucous discharges proceeding from the uterus had their origin in the cervix, and all sanguineous or sero-sanguinolent discharges in the lining membrane of the body of the uterus. Some time ago, he had the opportunity of making several observations upon this membrane in a case in which the uterus was inverted; and he had observed that, whilst it was constantly covered with a sanguineous fluid, no mucus was ever exuded from it; and that, under the influence of mechanical irritation, blood and not mucus was thrown out from it. With regard to internal metritis, and the dependence of uterine catarrh upon inflammation of the cervix uteri, he had great doubt as to the accuracy of some of the opinions which had been expressed by Dr. Tilt.

Internal metritis, in the ordinary sense of the word, he regarded as very rare; and he thought that the immunity of the lining membrane of the uterus from inflammation might be explained by a reference to its anatomical and physiological characters. On the one hand, it was extremely vascular; and on the other, its function being that of separating periodically a certain amount of blood from the system, or something very analogous, we could understand how, under the influence of irritation or causes which, in other organs, would give rise to inflammation, and free transudation of blood would take place, and so remove that congestion which was a primary and essential condition of the inflammatory process. The preparations shown as instances of false membrane exuded from the lining membrane of the uterus, as a consequence of inflammation, did not, in his opinion, support this view of their origin. The supposed false membranes appeared rather to be derived from blood which had been poured out into the uterine cavity, and which, having lost its fluid and coloured portions, had become moulded into the shape of the body and neck of the uterus—changes which had no more connexion with uterine inflammation than had the fibrinous concretions often found in the heart and great vessels with inflammation of these organs. Uterine catarrh, also, in his opinion, had no necessary connexion with inflammation of the uterine neck. It was essentially hypersecretion of the mucous follicles of the cervix; and, as such, might have its origin in any of those deranged states of the constitution and of the nervous and vascular systems by which the nutritive and secretory functions generally were liable to be modified or affected. Some time ago, he had a case which illustrated these views, as well as the relative value of constitutional and local treatment; and which clearly indicated that profuse uterine catarrh might occur without any inflammatory lesion of the cervix; whilst the inefficacy of local, as compared with constitutional treatment, was forcibly shown.

SATURDAY, DECEMBER 3RD, 1853.

FORBES WINSLOW, M.D., D.C.L., President, in the Chair.

EXOSTOSIS ON THE CRANIUM OF AN EPILEPTIC PATIENT. BY DR. GIBB.

Dr. GIBB exhibited a portion of a parietal bone which had a small exostosis on the inner surface. It had been taken from a woman, aged 40, who had been epileptic from the age of 15. She died in the hospital at Montreal, four days after being admitted labouring under delirium tremens. The symptoms of the latter disease were strongly marked; and she also had epileptic attacks three times on each day of her stay in the hospital. The dura mater appeared quite healthy throughout.

PATHOLOGY AND TREATMENT OF SWELLED TESTICLE. BY J. L. MILTON, ESQ.

The author had not found neuralgia, tubercle, or carcinoma, as the result of orchitis; all he had found were the common proceeds of inflammation, and he believed that neglected orchitis very often impairs the functions of the testicle. A long time after a so-called cure, the epididymis had been found hard, and, after death, examinations of the testicle, where a similar hardness could be felt through the scrotum, showed induration of the epididymis, contraction, etc. Mr. Holmes Coote had also found the vas deferens contracted, and its walls softened. The author then examined the various theories of the origin of orchitis from gonorrhœa, and rejecting those of metastasis and an erratic disposition of the gonorrhœa towards its decline, he observed that there were no proofs of the doctrine of sympathy; speaking of a case, in which the extremities only of mucous canals became inflamed, Mr. Milton thought that extension of the inflammation took place in every case. The absence of pain in the intervening parts might be owing to their lower organisation; Sir A. Cooper had shown that the inflammation was milder in the lower part of the urethra. Orchitis does not arise when the gonorrhœa is most intense, but when the inflammation has had time to spread backwards. He doubted whether orchitis arose from injecting stimulating medicines.

Mr. Milton suggested treatment by means of preparations of potass and graduated injections. In upwards of six hundred cases of gonorrhœa treated thus, three only had been attacked with orchitis, and in these the treatment had not had a fair trial; he thought antiphlogistic treatment useless, and preferred half-grain doses of morphia and acetate of ammonia, with blistering on the second or third day. He applied hot water to the scrotum, and allowed nutritious diet and stimulants in moderation.

A discussion followed, in which Dr. de Meric, Mr. Hancock, Mr. Dendy, Mr. Weedon Cooke, Mr. Acton, and other gentlemen took part. In the course of the discussion,

Dr. GIBB said that he had seen orchitis treated in the hospital at Montreal by an ointment containing one grain of biniodide of mercury in ten grains of lard. The time required for cure was from twenty-four hours to three days. He had himself employed this plan in two cases with success.

SATURDAY, DECEMBER 10TH, 1853.

FORBES WINSLOW, M.D., D.C.L., President, in the Chair.

FIBRINOUS CONCRETIONS IN THE HEART OF A MAN WHO HAD ATTEMPTED SUICIDE BY HANGING. BY B. W. RICHARDSON, ESQ.

Mr. RICHARDSON exhibited some specimens of fibrinous concretions, taken from the heart of a man who had attempted suicide by hanging. The patient was a tall man, a resident in Mortlake, who on Wednesday, November 30th, suspended himself in a narrow passage, in such a position that the cord did not press on the trachea. He remained suspended for, it was believed, at least a quarter of an hour. When cut down, life was not extinct. After some time, respiration and circulation returned; but there was complete anæsthesia. After some hours, the circulation and respiration were much above the healthy standard; and on the following Friday he died, with "typhoid" symptoms. On examining the body, along with Dr. Willis, Dr. Cormack, and Mr. Brown, Mr. Richardson found firm coagula of fibrin in both the right and the left cavities of the heart, and stretching into the vessels. The brain was much congested; and there was considerable effusion in the arachnoid.

NEW FORCEPS FOR APPLYING LIGATURE TO ARTERIES. BY DR. DE MÉRIC.

Dr. DE MÉRIC exhibited a forceps which had been referred to him by the Council. It was the invention of M. Apostolides, a Greek medical student in Paris. There was an apparatus by which, a noose having been first formed and placed on the forceps, the ligature was pushed down over the artery, and then tied.

MODERN PHILOSOPHY OF CANCER. BY ROBERT DRUITT, M.D.

[This paper will be published as an original communication in this JOURNAL.]

In the discussion, Messrs. Richardson, W. Adams, Pilcher, Weedon Cooke, H. Smith, and Drs. Semple and Snow, took part. Several of the speakers agreed as to the propriety of rejecting the term malignant.

MONDAY, NOVEMBER 12TH, 1853. [PHYSIOLOGICAL SECTION.]

W. TYLER SMITH, M.D., Vice-President, in the Chair.

ON THE COLOURING MATTER OF THE BILE. BY EDWARDS CRISP, M.D.

Dr. CRISP exhibited numerous specimens of dried bile, taken from various classes of vertebrate animals. His object had been to examine the correctness of the doctrine advanced by Kölliker, that the colouring matter of the bile is formed from the *débris* of blood-corpuscles, which had been destroyed by the spleen. He had found that this view was negatived, by the fact that removal of the spleen did not affect the colour of the bile in the manner which would be expected from this theory. In fact, the bile was of a deeper colour in a dog from which the spleen had been removed, than in another in which that organ had been allowed to remain.

NEW COPPER TEST FOR SUGAR IN ANIMAL FLUIDS. BY C. D. GIBB, M.D.

Dr. GIBB was accustomed to test for grape sugar in animal fluids, by adding from half a grain to two grains of black protoxide of copper, then pouring in liquor potassæ, and boiling for two or three minutes. The liquid turned of a more or less cherry colour, with evolution of oxygen, and the red suboxide of copper was precipitated. The test is very delicate.

MODUS OPERANDI OF NARCOTICO-IRRITANTS. BY JOHN SNOW, M.D.

Dr. SNOW said that all narcotics were more or less irritants, causing redness and heat in most cases when applied to the skin, and general excitement when absorbed in the blood. It was the opinion of many physiologists that these agents acted as stimulants in the first instance, and produced their narcotic effects by exhausting the sensibility; but this view was untenable, first, because the stimulant effects were often absent altogether, and when present they bore no relation to the amount of stupor which might follow; secondly, because excitement often appeared again in the process of recovery, when the insensibility passed off; and lastly because, in the use of volatile narcotics, the coma could be continued or allowed to subside at pleasure, by merely keeping up or leaving off the inhalation, which proved that the excitability was merely suspended, and not exhausted. The connexion between the irritant and the narcotic effects of medicines was of a very close nature, although it was not one

of cause and effect. He considered that both the irritation and the narcotism were caused by one power in the agent applied, namely, the power of diminishing oxidation in the living body. A number of reasons were given to show that narcotics have the power of diminishing and preventing the process of oxidation, on which sensibility, contractility, and the other animal functions, depend. The following are some of them. The amount of carbonic acid gas produced in respiration has been found to be diminished by certain narcotics, as alcohol, ether, and chloroform. The colour of the venous blood is lighter than usual in patients under the influence of the two latter agents, showing a diminution in the changes which take place in the systemic capillaries. When animals are killed in the space of about five minutes by narcotic vapours, the chief symptoms and phenomena are the same as in asphyxia by privation of air. The greater number of narcotics have the effect of preventing combustion, putrefaction, and other forms of oxidation out of the body; their power as antiseptic, etc., bearing a direct relation to their power as narcotics, when they resemble each other in their chemical constitution.

Whilst the diminution of oxidation in the system produced narcotism directly, it indirectly caused irritation, by inducing congestion in the capillaries and small arteries, where sufficient vascularity existed. Dr. Alison, Dr. John Reid, and various others, had shown, by facts which he enumerated, that the circulation through the capillary blood-vessels is assisted by the various changes of composition, etc., taking place in the neighbourhood of these vessels, the chief of which consisted in a process of oxidation. When this process was diminished, the flow of blood through the capillaries was impeded, and these vessels and the smaller arteries become congested, causing the redness and other phenomena of irritation. It was in the most vascular organs, and in persons having most blood, that irritation and excitement were most frequent. Microscopic observations had shown that the circulation through the capillaries was impeded or stopped by the action of opium, carbonic acid gas, and some other narcotics. Narcotico-irritants did not increase either the mental or bodily powers of persons in perfect health, in whatever doses they might be administered; but a small quantity of wine or opium often gave temporary energy to those who were in a state of debility. In such persons, what blood they had loitered chiefly in the large veins, and a slight obstruction to the capillary circulation caused the blood to accumulate a little in the arteries, and the heart was impelled to increased action to overcome the resistance. Under such circumstances, the better supply of blood to the various organs more than compensated for the true narcotic action of the agent employed. From the continued presence of certain narcotico-irritants in the blood for a long period, as in Bright's disease of the kidneys, the left ventricle of the heart often became hypertrophied by its efforts to overcome the resistance to the circulation through the capillaries. It had been lately stated, that the poison which sometimes caused coma and convulsions in this disease was carbonate of ammonia, arising from the decomposition of urea in the blood; and some experiments he had performed on gold fishes showed that carbonate of ammonia was a much more powerful poison than urea.

In the discussion which followed, Mr. Richardson, Drs. Cogswell and Sibson, and other members, took part.

## EPIDEMIOLOGICAL SOCIETY.

B. G. Babington, M.D., President, in the Chair.

Monday, December 5th, 1853.

### THE INDIAN PLAGUE AND THE BLACK DEATH. (COMMUNICATED BY J. O. M'WILLIAM, M.D.) BY AUGUST HIRSCH, M.D., OF DANTZIC.

The author stated that in the whole history of epidemics, there are few epochs more interesting than that of the fourth decennium of our century; for then, within a few years, we find many most important diseases spread epidemically over the globe. These were preceded by agues, which prevailed at the close of the third decennium, and by the influenzas of the years 1831-33. Cholera, which in 1823 had stopped short on reaching the frontier of Europe, overspread with the force of a torrent the Russian empire, and in 1831 entered Germany, where, in the southern parts of the kingdom, it was soon followed by typhoid fever and dysentery. At the same period "sweat fever" appeared in France and Italy, and, for the first time "typhus cerebralis" was propagated epidemically. In North America cholera, typhus and yellow fever, ra[illegible]. Turkey, Western Asia, Egypt, and the greater part of North Africa, were ravaged by typhoid fever and Oriental plague.

It was just at that period that a disease of a new and most malignant character broke out in the north-west part of Hindostan. Research among the archives of the Medical Board, however, made it evident that the same disease prevailed some years before in those regions; but the attention given to it had subsided soon after the epidemic ceased. The author considers the disease in question to have been a very decided plague, specifically modified; and that, in order to distinguish it from the Oriental plague, it may justly be denominated the "Indian Plague." The first historical report of the outbreak of the Indian plague dates from the year 1815, in the provinces of Kutch and Guzerat, which in the previous year had suffered from terrible famine. Neither the origin nor the course of the epidemic could be distinctly traced, but there is no doubt that the disease already, in May, 1815, had spread over some parts of Kutch, and the district of Wagoor; that it raged in these territories until the following year, and made great havoc among the inhabitants. At the same time the epidemic appeared in Kattywar, whence it spread to Scinde, and in November it reached Hyderabad, where from 60 to 70 persons daily fell victims to the plague. The epidemic entered the north-eastern district of Guzerat in the beginning of 1817, and abated in the fall of the year. With the rainy season of 1819 it burst forth with new vigour, and overspreading the territory which had suffered during the previous year, reached the northern part of Guzerat, and in the east the Zillah of Ahmedabad. With the close of 1821 the epidemic everywhere disappeared; and except the remark of Dr. Rankine, that the plague had been observed in 1823 in the mountainous territory of Kamoon, we have no information of its re-appearance until 1836, when it broke out with great malignity in a country far removed from that above-mentioned. It was then that the disease for the first time attracted general attention, and gave rise to scientific inquiries, and the adoption of sanitary measures. The Radjpootana States were the scene of the ravages of this epidemic; and as the first Report of the disease came from Pali in the province of Marwar, it has obtained the name of the Pali plague, although it is anything but certain that the epidemic originated in that place, for it also raged at the same time (July, 1836) in other districts of that province. After having traversed the greater part of Marwar, the disease passed the chain of hills separating the eastern borders of this province from Meiwar, overspread that country, and afterwards the district of Adjmer. Early in 1837, when the epidemic in Marwar had nearly ceased, it appeared in Misserabad, and declined with the rainy season. At the close of 1837, it again invaded Marwar, especially the town of Pali, and continued till the spring of the following year. Since that time, up to 1850, there is no further report of the prevalence of the malady. It was in this year that a fresh outburst occurred at Ghurevhal and Kamorn, in the Himalayan territory. Dr. Hirsch gives a very minute and graphic description of the mode of invasion, and of the general symptoms of the disease. The disease, although a bubonic plague, was distinguishable from the Oriental plague by an attendant pulmonary affection, with haemoptoë. The mortality was dreadful; the supposition that it was from 75 to 80 per cent. of those attacked being by no means exaggerated. In the town of Pali alone, in a population of 20,000 inhabitants, 4,000 persons fell a sacrifice to the plague in the period of seven months. The disease did not appear to be contagious, nor was it at all influenced by season.

The author adduced strong evidence as to the identity of the Indian plague with the black death of the fourteenth century, which Hecker and other writers had shewn to be a buboine plague, combined with an affection of the lungs.

Dr. James Bird had not actually seen the disease; but after a careful examination and comparison of the various accounts to be found in the reports of the Bombay and Calcutta Medical and Physical Societies, and from information derived from other sources, he was satisfied that this Indian disease is a form of sporadic plague, propagated by pulmonary imbibition in the high-walled, crowded towns of India, and not communicated like the ordinary epidemic plague of the Levant, which required malarious influences for its propagation. Dr. Bird had seen cases of plague occurring sporadically in Upper Egypt, when the disease was not epidemic. The natives did not consider this form of the disease infectious; they handled the dead and sick with impunity, and they confidently asserted that it would not spread.

Dr. M'William wished to ask Dr. Bird whether attention had been drawn to the conditions under which the disease spread in

India. In Egypt the plague was annihilated both by high and low temperatures, and only spread when the heat was moderate. Did a similar law prevail in India?

Dr. Milroy considered that this paper clearly showed that true plague of the Levant had appeared in India, and that *spontaneously*; for its appearance in an island instead of a maritime district seemed to exclude the possibility of its having been conveyed from the Levant. It was very important to bear this fact in mind, as it shows that this and similar diseases may develop themselves in different countries spontaneously. The fact of the occurrence or absence of hæmoptysis was not a sufficient ground for a distinction between the two diseases. It arises from the same cause as the black vomit of yellow fever, viz., congestion of the capillaries, in the one case of the stomach, in the other of the lungs. Nor is the absence or presence of infection any ground for a distinction. Plague was not nearly so contagious as is generally supposed, and the sporadic cases could easily be explained by the crowded and filthy houses in which the natives live. Attention should be drawn to the simultaneous appearance of plague, cholera, typhus, etc., in different parts. Probably, at certain times, a malarious influence spreads over the whole globe, and causes different forms of disease in different parts of the world.

Dr. J. Bird, in answer to Dr. M'William, observed, that in Egypt the plague disappeared after St. John's day, when the weather became dryer; but he was not aware that any similar law was known to hold in India. He concurred with Dr. Milroy in thinking these different epidemics essentially the same, and varying only in the circumstances in which they occur.

Dr. Snow observed, that the plague was most prevalent at Gourlah when the temperature was moderate—between 60° and 70° Fahr.; but that cases were also known in cold and in hot weather, as was occasionally the case in Egypt.

## MEDICO-CHIRURGICAL SOCIETY OF EDINBURGH.

SESSION XXXIII. SECOND MEETING.

WEDNESDAY, DECEMBER 7TH, 1853.

JAMES Y. SIMPSON, M.D., President, in the Chair.

The following officers were elected; *President:* James Y. Simpson, M.D., Professor of Midwifery in the University of Edinburgh. *Vice-Presidents:* T. S. Combe, M.D., John Taylor, M.D., Samuel A. Pagan, M.D. *Ordinary Councillors:* John Gairdner, M.D., Richard J. Mackenzie, M.D., Benjamin Bell, F.R.C.S.E., James Struthers, M.D., Alexander Ziegler, M.D., James D. Gillespie, M.D., J. Matthews Duncan, M.D., Andrew Wood, M.D. *Treasurer:* Robert Omond, M.D. *Secretaries:* W. T. Gairdner, M.D., 18, Hill Street; J. Warburton Begbie, M.D., 21, Alva Street.

### PRACTICAL REMARKS ON THE MINERAL WATERS OF HOMBURG. BY W. SCOTT, M.D.

Dr. Scott referred to the comparative ignorance that prevailed in this country as to the waters of Homburg; and he mentioned that Dr. James Johnston had omitted mention of them in his work on the spas of Germany. He would plead these facts as an excuse for bringing under the notice of the Society a few remarks on a German watering place, in which he had resided for some time.

Dr. Scott gave a brief detail of the situation of Homburg, and noted its rapid increase in population. In 1841, it contained only 1071 inhabitants, while in 1852, they had increased to 6000 or 7000. The chief springs were the Elizabethen-brunnen, the Kaiser-brunnen, the Stahl-brunnen, the Sauer-brunnen, and the Bad brunnen. Their chief ingredients were muriate of soda, muriate of lime, and carbonate of iron; which in their varying proportions constituted the peculiarities of the different springs. Thus the Kaiser-brunnen contained half as much more of muriate of soda than the Elizabethen-brunnen, and double the quantity of muriate of lime; and consequently was a stronger water. Again, the Stahl-brunnen contained double the quantity of carbonate of iron found in the first mentioned spring. The Sauer brunnen was a milder aperient, and less chalybeate, for a similar reason.

Generally speaking, these springs were employed in chronic affections of the skin, scrofula, and syphilitic diseases. Occasionally, however, they were found to be too irritating in certain cases of skin affection. Again, in scrofula, benefit was obtained from adding the lees of salt, which, from the iodine contained in it, appeared to have a good effect. It was chiefly, however, in conjunction with other springs that most benefit accrued from their use.

The season extended from the middle of May to September; and during this period, from the sheltered situation, the temperature was remarkably regular. The time for taking the waters was from 6 to 9 A.M. The baths were generally taken three hours after breakfast. In the dietary, which Dr. Scott gave at length, he recommended the avoidance of vegetables, as potatoes and fruits.

Occasionally disastrous effects were found to follow the use of the waters. He referred at length to the case of the late member for Peterborough, whose death had occurred in July last. This gentleman had long been suffering from a disturbed state of the bowels, and a variety of treatment was had recourse to in vain. He tried the waters; but they produced a spasmodic affection of the bowels, which led to a fatal issue. The case too of the late Duke of Nassau might also be mentioned, where death suddenly took place after using the bath. As to the so called *Bad-krisis*, with its disagreeable train of symptoms, he thought it might be entirely obviated by giving some mild alterative, or suspending for a time the use of the waters.

In his own experience, he had found the waters of Homburg especially useful in all forms of biliary derangement, and particularly in the dyspepsia resulting from too close attention to business; although, no doubt, a good deal of the benefit obtained was due to the change of scene and mode of living, etc. Also in rheumatism and gout: in hepatic diseases, although perhaps here Homburg was surpassed by some of the thermal springs of Bohemia; in female complaints, in which, next to dyspepsia, the most benefit was obtained: and finally, in chronic catarrhal diseases, and in glandular and hæmorrhoidal affections. As to the affections of the skin; the various forms of herpes and impetigo were found especially tractable. Generally speaking, the waters were contra-indicated in all acute and febrile diseases, in organic diseases of the heart and lungs, and in cases with tendency to congestion of the head. He cautioned against the use of the waters in cases of irritability of the stomach, where it depended on disease of the kidney. In conclusion, Dr. Scott mentioned that Artesian wells were being bored, which would add greatly to the present supply; and recommended to the notice of the Society the late work of Frederic Müller, on the waters of Homburg. The waters of Homburg contained no bromine, and thus differed from those of Kreuznach.

Professor Syme had found that the use of mineral waters generally aggravated hæmorrhoidal affections. As to the case of sudden death mentioned by Dr. Scott, he attached little importance to its having occurred after taking the bath; as patients at these mineral springs were so continually going in and out of the baths, it was no wonder that death should overtake them in one or other of these processes, just as it did other people in their beds.

Professor Simpson, in inquiring of Dr. Scott as to the differences subsisting between our own Scotch mineral waters and those of Homburg, stated that in this country the chief ingredient was muriate of lime. He had latterly seen good reason to adopt Sir Robert Carswell's views with regard to fibrous tumours of the uterus; viz., that they were merely a nodose collection of the ordinary tissue of the uterus, and liable to go backwards, or undergo a species of involution, just as took place in the normal uterus after delivery. If this were the case, the beneficial effects of the waters of Kreuznach were easily explained. Cases, however, he had seen which had returned to this country without the slightest benefit; and in such the sustained use of bromide of potassium was followed by marked diminution in the size of the tumours; in one case, fully one half. This salt is more potent than the iodide of potassium; and seems to be useful as a tonic, as well as a deobstruant. In two cases in his practice it produced salivation. Dr. Locock had stated to him that several of his cases had been much bettered by the Kreuznach waters. But in a case which had occurred lately in Dr. Simpson's practice, no good had followed the use of the waters, though the medical attendant at the place thought otherwise.

### CONTAGIOUS NATURE OF CHOLERA. BY DR. TRAILL, OF ARBROATH.

This paper consisted of a succinct and remarkably accurate investigation into the history of all the cases of cholera which had occurred in Arbroath, during the very recent visitation of the epidemic. The cases in all amounted to twenty-six, of which fifteen died, eight recovered, and three were still under treatment. Of the twenty-six, four cases were ascertained to have been imported; in thirteen, no communication with infected individuals could be traced; and in nine, the information was faulty. In five of the cases, cholera was only fully deve-

loped after removal to the House of Refuge; but all the cases were affected with diarrhœa. Of the nurses, one died; but all suffered from diarrhœa. Five of the patients were of dissipated habits; two remarkably so: the remainder consisted of children and of persons reputed sober. In the town itself there is a general want of good dwelling places for the labouring classes. The water, which is obtained from wells, is abundant, and the soil rests on dry gravel. The sanitary condition of the town, which is above par, does not explain the occurrence of the disease.

The statement was tested by reference to a neighbouring locality in the town, in nearly precisely similar circumstances as regards sanitary condition, and containing a hundred and thirty inhabitants. Of these, not one took the disease. And a more striking instance was cited in the case of the row of six cottages, where the disease first made its appearance. In all, the drainage was imperfect; but the cottages to the west were more favourably placed than the others. In the four centre cottages, there were twenty-seven persons. In the two end ones, twelve lived. Of the twenty-seven, all but one escaped, and that was an infant. Whereas, of the twelve inhabiting the end cottages, six took cholera, four choleraic diarrhœa, and two suffered from diarrhœa. Dr. Traill did not undervalue the importance of sanitary reform; but he confessed to being convinced, by his late experience, of the contagious nature of cholera.

Professor SIMPSON called on Dr. Tait, of Dunse, to favour the Society with an account of the recent epidemic in that town.

Dr. TAIT stated, that of the ten cases which had occurred, he had only seen eight. Between the first and second cases, no communication could be traced; but the houses were contiguous. The drainage was bad. Case No. 3, lived about one hundred yards from No. 2; he was a railway-guard, and had communication with Newcastle in the discharge of his duties, he suffered from diarrhœa for a day or so, and was drunk the day previous to his seizure. No. 4 was the wife of No. 3. Nos. 5 and 6, the Knoxes, father and daughter, lived in the middle floor of the same house as Nos. 3 and 4, who were waited on by the daughter, and had some clothes washed by her. One old woman who resided on the same floor with Nos. 5 and 6 had no communication with persons labouring under cholera, and escaped—the same is true of three people who occupied the ground floor. No. 7 lived several hundred yards away from the last cases. He was the sexton, and had, on several occasions, assisted the nurse in waiting on those affected. No. 8 was the late Dr. Drysdale, who attended all the cases; but on the day of his seizure was more than usually exposed, as for three hours he had to officiate as nurse, and from the extreme jactitation of the patients, was brought into closer contact with them. No. 9 was a woman who came to attend upon the Knoxes, and was of drunken habits. No. 10 was the wife of No. 7, she assisted occasionally in nursing, she died of the consecutive fever. Case No. 1 was of a delicate frame of body; while case No. 2 was of intemperate habits. The drainage in the neighbourhood of both their houses was very imperfect. Such facts no doubt gave a strong predisposition. He had remarked the immense number of midges which loaded the atmosphere during the prevalence of the epidemic. In Dunse, the average duration of the disease was from twenty-four to twenty-eight hours. The whole duration of the epidemic was seventeen days, and the number of cases of diarrhœa was twenty.

Dr. LOWE of Saughton Asylum, stated that the midges made their appearance before the cholera; but that when it appeared, they were replaced by the aphides, perfectly distinct from the midges, and widely different in habits.

Dr. W. T. GAIRDNER, during the cholera visitation of 1848, had issued circulars to various surgeons throughout the country, requesting reports of the progress of cholera in the affected districts. At first he was inclined to regard the disease as non-contagious; but before many reports had reached him, the evidence as to its contagious properties became to his mind irresistible. No doubt cholera was less contagious than typhus; but the evidence of its contagious properties was precisely similar.

First:—cholera followed the track of Typhus in any given locality; the same houses were attacked, and in the same order; it might be said, however, that the only similarity was, that in both instances dirty places, under bad sanitary conditions, were attacked. But cholera sometimes attacked places by no means the dirtiest and worst in a locality; and even then, the same houses or streets were the seat of both diseases; proving that their mode of propagation is not very different. This was well illustrated at Mauchline, where the affected locality was limited in extent, and by no means the worst in the town.

Second:—In a large proportion of cases, an importation of the disease could be made out in towns or villages, if not in the first cases, at least before the disease had become epidemic. Even where, as in the case of Stirling, importation was not made out, there was every reason to believe it might have been discovered, had all the facts been known. In this instance, the epidemic was observed gradually to close in on every side, till within a mile or so of the town, and there was no doubt that the first cases that occurred in Stirling, were precisely at that part of the town which had most communication with the nearest affected village in the neighbourhood.

What had we in these reports that was adverse to the doctrine? From Selkirk we had the vague statement, that the communication with the surrounding districts was very limited; in other cases the disease appeared to arise in isolated localities within the town; but it was difficult to construct a strong argument out of these merely negative facts. In Dumfries, in the epidemic of 1832, the medical men opposed the idea of contagion, and in 1848, there were some of them very strong non-contagionists. The first report that was received from Dumfries declared that the patients in their general hospital had remained quite exempt from cholera, although exposed, without any precautions against infection, to the presence of cholera patients, and stated that the attendants upon the sick had remained likewise free from the disease. These statements did not satisfy the medical man who had treated most of the cases in hospital, and who had therefore the best opportunity of knowing the facts. From his report, and from a correspondence in the *Medical Times*, it appeared, that in 1832 no cholera patients were admitted into the hospital; in 1848, however, cholera cases were admitted, and there were separate wards provided; but notwithstanding the utmost care to avoid infection, of five nurses, one took cholera and died, while many of the patients had attacks of diarrhœa. Of the nine medical men of Dumfries, one died, and more than a half of their number were confined with diarrhœa. Two of the twelve special assistant medical men were attacked, and one died. The report from Falkirk by Dr. Hamilton, that from Kilmarnock by Dr. Hood, and the one from Kilwinning by Dr. Craig, were all strong in their evidence in favour of contagion. The small proportion of victims among the general population in the last-mentioned locality, gave strong evidence of the contagious character of the disorder. The first person attacked was the grave-digger, who had attended thirty cholera funerals before his seizure: the second was his father, living in a separate house: the third was his sister-in-law, also in a separate house, and at some distance: the next were her two children; then two married sisters of the first victim; and lastly, the husband of one of these, and the son of the other. This was only one specimen out of many facts which had reached him, similar to those so clearly narrated by Dr. Traill.

Professor SYME drew attention to the facts connected with the removal of the smack *Trusty* from Leith, to the Hope at Queensferry, where one fatal case had occurred among the officers of quarantine.

Professor SIMPSON said, that on the arrival of the smack at Leith, a boat went out to her with a pilot, and brought two individuals on shore; these were the first cases that occurred in Leith. The vessel was now sent to the Hope. The captain having mentioned his fears that cholera-subjects had formed a part of his cargo from London, his cargo was put on one of the Lazarets; the sick and the healthy were removed to the other Lazaret. Two or three of those on board, and among the sailor-nurses took ill. Round about, there were many ships stationed, and some of their crews were affected. Dr. Simpson could only regard the crew of the *Trusty* as so many ton of contagion. Dr. Simpson of York, had mentioned to him that the very reverse of what had taken place at Stirling, had occurred in that city. The cholera was found to radiate from York into all the surrounding villages, as an imported disease. At Knaresborough, however, the medical man had searched in vain for evidence of its importation, but in a cursory visit which Dr. Simpson of York, had paid to the town, he found that the two first patients had lived at the opposite ends of the town, and no communication could at first be traced between them; but it was ascertained that the two had met at an inn where a traveller had died of cholera, and that they had assisted at the secret removal of the body.

Dr. BEGBIE had never been impressed with the idea that the ordinary mode of propagation of cholera was by contagion; and the cases in Arbroath related by Dr. Traill, in no measure altered that opinion. No doubt the importation of the first and

second cases from Dundee, where the disease was prevalent, and the occurrence of the third and some of the subsequent cases after communication with the two first, was calculated to lead to the impression that the spread of the disease was by such communication; but when we considered that out of twenty-six cases, comprehending the whole of the epidemic, there were no fewer than nine who had no communication with those first affected, or, so far as he understood, with each other, the evidence failed to satisfy his mind that there was anything more than a coincidence between the occurrence of the disease in Abroath, and the return of the first and second cases from Dundee. Its subsequent spread appeared to him to be from epidemic influence, connected with atmospheric and telluric causes at that time set in operation in the former place, and not to importation. He had long been satisfied that cholera was not contagious in the ordinary acceptation of the term, from his own experience during the first epidemic of the disease in this city in 1832. On that occasion, he had been appointed along with Dr. Hamilton Bell, to the charge of the first hospital for the reception of cholera-patients, and during the six months he had officiated there, no instance occurred of the disease having been communicated to any of the medical men in attendance, or to any one of the establishment of servants, nurses, porters, or to any visitor, of whom there were many. During the whole course of the epidemic in Edinburgh, only one practitioner died of the disease; and he had not attended any cholera-patient, having from the first entertained a great dread and apprehension of its effects on his own person. The occurrence of the disease in Dumfries had been referred to. The invasion of the disease there, was a strong proof of its non-contagious nature; for how could the well known circumstance of forty or fifty cases occurring at the same time, in the course of one night, on the first out-burst of the disease there, be accounted for by importation; or the sudden termination of the epidemic without spreading to other immediately contiguous places?

Dr. Myrtle gave the result of his experience in the City Quarantine House during the epidemic of 1848, where only two or three cases occurred among many hundred persons drafted from the most wretched quarters of the town, many of them suffering from diarrhœa.

Professor Bennett thought, from the tenor of the discussion, that the Society was coming to the conclusion, that if cholera was not contagious in masses, it might be so in detail. Now, if a small village were attacked, there appeared to be little difficulty in obtaining evidences of contagion. But in a large town, such as London, the doctrine was not believed in: and the same was the case with regard to India. The strongest argument against the contagious nature of cholera, was the fact that the disease progresses from east to west. Now what is contagion? It is usually regarded as the propagation of disease by touch or contact; while infection includes propagation by means of particles in the air. If the cholera progresses from east to west, it can be by neither of these two ways. Russia has again and again, with its armies of quarantine, attempted to check its advance; and yet the disease has progressed in its usual direction. This has been done three times, and the same result has followed. It never progressed in directions running north and south, or west and east. Cholera cannot therefore be contagious. If studied where it attacks masses, it cannot be proved to progress by contagion; but it is from little villages, where all the inhabitants are known to each other, and where the field of observation is very contracted, that the only arguments of the contagionists are drawn.

Dr. Scott agreed with the remarks of Dr. Bennett, and instanced the case of a ship in Bombay Harbour suddenly struck by a land-squall, and in which, in a few hours, eighteen died of a crew of a hundred and forty: on the removal of the infected crew to an island, the disease had as suddenly disappeared.

Professor Simpson, in answer to Dr. Bennett, begged to remind him that, as far as mere progress was concerned, the contagious exanthemata, small-pox and measles, had, in their first arrivals from the east, the same history as cholera. Again, cases of cholera had occurred in ships crossing to America; but there was no instance on record of one occurring on the voyage from America to Britain. Again, in no ship starting from England for India, and of course not touching at any infected port by the way, has the cholera ever broken out; although, on Dr. Bennett's showing, it ought to have done so.

Dr. W. T. Gairdner objected to the statements of Dr. Bennett, as to the progress of cholera in the mass. If cholera was contagious in detail, then he thought that evidence ten times as strong existed to its contagion in the mass. From India the cholera radiated in all directions; and the law of its progression was apparently that of human intercourse. It passed from India indifferently to Siam, China, Ceylon, the Punjaub, and to Persia. From the latter it proceeded further; and why? because this was one of the great lines of human intercourse. It was conveyed to the island of Bourbon by a ship; and, wherever it crossed the ocean, it followed the track of ships, and landed at sea-port towns, which were always the foci from which islands and isolated countries and continents became infected. If this did not constitute a strong probability that cholera was contagious in the mass, he did not know what could do so.

Dr. Alexander Wood granted that cholera was not propagated by contagion only; but he was greatly surprised to hear of no contagion. The statements in the paper of Dr. Traill, and the admirable remarks of Dr. Gairdner, contained to his mind irresistible evidence to show that cholera is contagious. It was very strange that Dr. Bennett should try to set this evidence aside. India was the great focus of the disease, and, as every one knew, lay to the eastward of Europe; and of course any disease starting from India, naturally reached us from the east. There was no doubt that cholera was more contagious here than in India. An Indian officer had lately informed him that a body of troops lay encamped, with a river running through the encampment, and separating the infantry from the cavalry. The cavalry hospital was on the same side as the infantry: the disease raged among the cavalry, while the troops on the opposite bank escaped. But the cavalry sentinels stationed round the hospital were seized with the disease; and in the previously healthy villages, where the clothes of the soldiers were sent to be washed, nearly all the inhabitants were seized. How could this be explained, except on the admission that cholera is contagious? The American reports bear similar evidence. Why is contagion so easily proved in villages? Because the communication with the sick can be more easily traced. With regard to cholera, we must come to the same conclusion as we do with regard to other diseases, such as small-pox, etc., etc.: that, though not necessarily contagious, yet they may be so. Dr. Begbie had stated that no attendant, etc., had been attacked in the Cholera Hospital on the Castle Hill during the first six months of the epidemic of 1832; yet cases occurred to show its contagious nature, and the disease spread from the hospital. In Surgeons' Square Hospital, the cholera attacked the nurses, in the proportion of one in five. A short visit of a medical man to a well appointed hospital proved nothing; but friends calling upon the sick in ill-ventilated and small apartments, gave a different result. He was clearly of opinion that, in the Arbroath epidemic, the existence of any telluric influence was to a great extent disproved.

## LIVERPOOL MEDICAL AND PATHOLOGICAL SOCIETY.

Thursday, October 20th, 1853.

John Cameron, M.D., in the Chair.

### DROPSY OF THE UPPER HALF OF THE BODY, FROM A TUMOUR ENCIRCLING AND COMPLETELY CLOSING THE SUPERIOR VENA CAVA. BY JAMES TURNBULL, M.D.

On the 3rd of Sept. 1853, Mr. Blower requested Dr. Turnbull to see in consultation a remarkable case of dropsy of the upper half of the body, which had been under his care for about ten weeks, and had also been seen by various other medical men. The gentleman was twenty-six years of age, of fair complexion, and did not appear of unhealthy constitution. His breath had become rather short about the end of May; and when he first consulted Mr. Blower, it was on account of dyspeptic symptoms and headache. Soon afterwards, however, he had several attacks of severe spasmodic pain at the stomach, which were relieved by the use of hot applications. It was observed that on stooping his face became swollen and livid. The patient also found that he could not button his shirt collar. It was then discovered that the neck and chest were œdematous, and the veins of the chest enlarged and tortuous. All these symptoms had much increased when Dr. Turnbull saw the patient; the difficulty of breathing was so great, that he could not lie down; the face was much swollen; the lips somewhat livid; and the neck, the front of the chest, and the arms, pitted on pressure. There was a distinct line about the margin of the ribs, separating the œdematous from the non-œdematous part. Over the whole front of the chest there was a tortuous network of enlarged veins of deep blue colour, which emptied themselves into the two epigastric veins, which were also much enlarged. Two enlarged veins were also seen along the back

of the chest, where, however, there was scarcely any perceptible œdema.

*Physical Signs.* Over the centre of the sternum there was very decided dulness on percussion; and there was also more than the ordinary amount of dulness in the region of the heart. This dulness was partly attributed to the œdematous state of the parts. There was dulness over the whole of the lower parts of the left side of the chest; and behind the dulness reached as high as the centre of the scapula. There was also absence of respiration inferiorly, and other signs of effusion. At this period, there were no signs of any considerable effusion on the right side; but a subsequent examination showed that fluid had accumulated here also. The sounds of the heart were natural, but dull and distant; and no impulse could be felt. In the course of the aorta, no pulsation or murmur could be perceived.

*Diagnosis.* The condition of the veins and the œdema of the upper parts of the body, showed clearly that there was obstruction to the return of the venous blood through the superior vena cava; but the cause of this obstruction was less obvious. The following were considered to be the possible causes:—1. Closure of the veins from the effects of inflammation of the coats. 2. The pressure of an aneurism. 3. Pressure of a cancerous tumour of the lung upon the vein. 4. Pressure of a tuberculous gland upon the vein. There was nothing in the history of the case to lead the obstruction to be attributed to any one of these causes more than to another. There had never been any pain, except when the patient had the temporary spasmodic attacks; and there was no special reason for thinking that it had arisen from inflammation of the vein itself, which would have been the least injurious of the causes of obstruction, seeing that the circulation might have ultimately accommodated itself to it. Aneurism was considered to be one of the most common causes of pressure upon the vena cava; but the course of the aorta had been carefully examined, without any murmur or pulsation being detected. There were no well marked symptoms of pulmonary disease; and the age and appearance did not seem to indicate the probable existence of cancerous disease of the lung or other parts. It did, however, appear not improbable, especially as there was so much dulness over the sternum, that there might be tubercular enlargement of the bronchial glands.

The *treatment* was directed with the view of promoting absorption of any glandular enlargement or effusion of lymph or serum resulting from inflammatory action. He had, before being seen by Dr. Turnbull, been treated with hydragogue cathartics; the left side had been blistered; and his mouth was slightly affected with calomel. A diuretic pill, containing squill, digitalis, and blue pill, was given twice a day, with the view of maintaining the mercurial action for a short time; and a mixture, containing iodide of potassium and liquor potassæ, was prescribed. These and other means failed in producing any impression on the disease; the quantity of fluid in the left side of the chest increased, and it accumulated in the right side also, producing most urgent dyspnœa. He also complained of a feeling of fulness and pressure at the stomach. On the 25th of September, he died.

Examination of the Body. On endeavouring to raise the sternum, it was found to be adhering at every part to a large tumour, which occupied the whole of the anterior and extended into the posterior mediastinum. It spread on each side beyond the cartilages of the ribs, covering and adhering to the corresponding portions of both lungs. A very dense portion of the tumour covered the heart; and the tumour and pericardium were inseparably united. It had grown along the large vessels, and the superior vena cava was completely encircled and obliterated by the pressure of a portion of the tumour. A soft fibrinous looking clot appeared to have completed the closure of the vessel. The vena azygos, which entered the cava above the obstruction, was much enlarged. The tumour rested inferiorly upon the diaphragm, and laterally and posteriorly, in which directions it was extending itself, it had a nodulated appearance. It was firm in structure, and could not be broken down with the fingers. Internally it had a variegated aspect, like some kinds of marble, the greater part being of a grayish white colour, with nodules of a more yellow colour. Under the microscope, numerous nucleated cells were visible, but none of the tailed cells so common in most cancerous structures. There could not, however, be any doubt that the tumour was of malignant nature, and growing rapidly.

Remarks. The most prominent symptoms in this singular case were the varicose enlargement of the veins of the chest, and the dropsy of the upper half of the body, to which part it was confined until the circulation became generally obstructed by the effusion into the chest and the great dyspnœa. The late Dr. James Carson, jun., brought before this society several years ago two cases of a similar kind, and Dr. Turnbull had the opportunity of repeatedly seeing one of them in the Northern Hospital. The patient had the same varicose enlargement of the veins and œdema of the chest and face as was observed in this case, but he recovered, and was afterwards able to pursue a laborious occupation. The enlargement of the veins, however, continued; showing that the obstruction to the venous circulation must have been permanent. In the other case, the obstruction was produced by pressure from a scirrhous tumour of the lung resting upon the superior cava. Dr. Watson related a case similar to the one now detailed, where the obstruction arose from a large aneurism of the arteria innominata pressing upon the vena cava, at the point where the two great trunks unite to form the cava. Dr. Peacock, in a paper in the *Medico-Chirurgical Transactions*, states that complete obstruction of this vessel is extremely rare, having been so in only three out of nine cases he had been able to collect.

With respect to the nature of the tumour in this instance, it would seem, from its firm structure and nodulated appearance, to have been cancerous, and the abundance of nucleated cells would likewise appear to indicate rapid growth. It may be more difficult to decide in what structure it originated. Its complete incorporation with the pericardium, and the way in which it had extended along the vessels, might seem to show that it had originated in this serous membrane; but it had also extended in a similar way along the pleura pulmonalis and costalis. It was in close contact with the whole of the posterior surface of the sternum, occupying the situation of the thymus gland, no trace of which was observable. It is therefore probable that it may have begun in this body; and Dr. Walshe states that, though no case of cancer of the thymus gland had come under his notice, there could be no reason to doubt that carcinomatous disease of this organ does occur.

# ASSOCIATION INTELLIGENCE.

## METROPOLITAN COUNTIES BRANCH:—SPECIAL GENERAL MEETING.

A special general meeting of the Metropolitan Counties Branch was held on Tuesday, 13th December, at 37, Soho Square. The President, Sir John Forbes, M.D., occupied the chair. The following members were present:—Henry Ancell, Esq. (London); John Bowling, Esq. (Hammersmith); John Rose Cormack, M.D. (Putney); R. P. Cotton, M.D. (London); Benjamin Davies, M.D. (London); Alexander Henry, M.D. (London); C. F. J. Lord, Esq. (Hampstead); John Propert, Esq. (London); B. W. Richardson, Esq. (Mortlake); R. H. Semple, M.D. (London); Edward Waddington, Esq. (London); George Webster, M.D. (Dulwich); Robert Willis, M.D. (Barnes), etc.

The President said, that the meeting had been convened by the Council for two objects; First—To consider what steps ought to be taken with reference to the Vaccination Act; and Secondly, to receive and consider the Report of the Medical Reform Committee. In the absence of Dr. Webster, who was to have introduced the first subject, he would suggest that Dr. Semple, chairman of the Medical Reform Committee, should favour the meeting with their Report.

### MEDICAL REFORM.

Dr. Semple said, that there was not much of a Report, inasmuch as there had been nothing to do; the Medical Reform Bill not having gone into the House of Commons. The Medical Reform Committee had held one meeting, in accordance with the instructions received from the General Meeting, at which were present a great many veteran reformers. Upon that occasion, the resolutions passed were of a general character, which did not pledge the meeting to support the Bill, and at the same time did not object to it. Dr. Semple then read the following Resolutions adopted at the Meeting of the Committee:

"That this Committee think that it is the duty of the Metropolitan Counties Branch of the Provincial Medical and Surgical Association, to support a Medical Reform Bill, so far as it shall give effect to the great principles of uniformity of edu-