A man of forty years, a healthy man previously, was taken with what he called "a cold". He next complained of a dull heavy pain in the back, and of a general languor. He had a pulse at 80, and a dry tongue. This condition lasted fourteen or fifteen days; it did not altogether confine the man to his house. Suddenly he became worse. He felt no acute pain; but his countenance was expressive of great anxiety; his breathing was hurried; his pulse was so quick, so irregular, that its time and force could not be estimated; the action of his heart was tumultuous; the secretions remained natural. These signs lasted forty-eight hours; then the lungs began to show evidence of congestion; and this congestion, gradually increasing, was sustained for a succeeding day and a half. The patient had occasion to rise from bed: in returning, he sank on the bed; he was dead.

The *post mortem* examination here revealed the immediate cause of death, in the presence of a large, firm, adherent, fibrinous concretion in the right ventricle, extending into the pulmonary artery. It also revealed more: it explained that there had been long pre-existent inflammatory change; that there had been splenitis, for the spleen was entirely disorganised from purulent exudation.

A lady was seized with cold; she had slight shivering, followed by febrile excitement. The following day there was the merest blush of erysipelas on the ear. The redness progressed a little that day, but was considered too slight to cause alarm. Some fifty hours after the appearance of the local change, this lady felt an uneasiness, oppression, faintness, and dyspnœa, "creeping"—as she expressed it—over her. A stimulant was given, but it was of no avail; from sitting up in her room, she retired to bed, and in six hours she was sinking. She was sinking, according to an explanation which I readily excuse, from suppressed erysipelas; and, indeed, the disappearance of the redness from the ear, as the supply of blood was cut off, favoured so crude a notion strongly. She was sinking, according to fact, from the formation of concretion in the right side of her heart. To relieve the dyspnœa, opium was given, which served truly to soften the agony, but to clench the result. Death occurred within twelve hours from the date of the sinking indications, and the *post mortem* examination revealed the concretion on the right side: a large concretion, filling the auricle, prolonged into the ventricle, and curved upwards into the pulmonary current.

Am I not writing the experience of all practitioners in the above cases? Except that the local mischief commenced on the mucous surface of the air-passages, instead of the skin, the case of the Emperor Nicholas, late czar of all the Russias, was of the kind I have now told. The armies of two great nations, at that crisis, rolled against him harmlessly; so simple a physical act as the deposit of a poor scruple or so of fibrine from his own royal blood dethroned him.

When a fibrinous concretion is deposited on the *left* side of the heart, the ventricle, the infundibulum, and the ascending portion of the aorta, are the most common positions. The general symptoms which characterise the presence of concretion here situated are different in many respects from the preceding. There is suffocative dyspnœa, with expectoration of mucus sometimes mixed with blood; the surface of the body is of a leaden colour, and the body is cold. The muscular perturbation lapses into powerful convulsions, and coma precedes dissolution. These symptoms may extend over many hours; or, as in the preceding class of cases, they may also occur in a sudden manner. The patient, in moving or making a straining effort, may suddenly fall back, may be seized with a violent convulsive fit, and so expire.

I once saw these symptoms and this sudden form of death in an old lady who had previously suffered from no other ailment than a slight attack of cold. In rising from bed, she fell back, and died convulsed, before medical assistance could be obtained. In this case, the concretion had formed as a hollow cylinder in the infundibulum of the left ventricle, had become dislodged, and had been carried into the aorta, which it entirely occluded.

The physical signs of concretion on the left side, in so far as the heart is concerned, are not materially different in reference to the systolic and diastolic sounds from those which attend deposition on the right side. For, if the right side of the heart is free, the two sets of valves on that side are all sufficient to produce the two sounds; so that a mere reduction in the intensity, or rather the fulness, of the normal sounds, is the only probable modification. There is, nevertheless, a distinction in the action of the heart. When the concretion is on the left side, the action of the heart is much more violent, irregular, and tumultuous. There is also a difference in regard to the physical signs of disease in the lungs; the lungs are never emphysematous; they are always congested, the congestion being most decided and extensive. Corresponding with this condition, the dyspnœa is not the syncopic dyspnœa which we observed in the previous cases, but a dyspnœa rather of the pneumonic type, laboured, but free from gasping; the oppression veritably is in the lungs, and is so expressed by the patient.

Death is less easy than in the cases where the concretion lies on the right side, or, at all events, is not so easy to appearance. There is coma, but therewith there is struggling, violent convulsive struggling, to the end. Death takes place often in the convulsion occurring by a mixture of syncope and asphyxia.

There are yet another series of cases in which concretion occurs on *both sides* of the heart at the same time. In these examples, it is to be observed that the signs are, generally speaking, those of concretion on the right side. If there is any distinctive sign of double clot, it is in cases where the valvular mechanism is interfered with by the deposit in the two corresponding sets of valves, the ventricular or aortic. When this is the case, the systolic or the diastolic sound may be lost altogether, according to the sets of valves obstructed in their play by the deposition upon them.

Illustrations of HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

UNIVERSITY COLLEGE HOSPITAL.

SYPHILITIC TUMOUR OF LIP.

Under the care of Richard Quain, Esq.

[*Reported by* W. L. Winterbotham, Esq., *House-Surgeon.*]

Elizabeth M., aged 45, was admitted into University College Hospital, under the care of Mr. Quain, April 29th, 1859.

History. She is a native of Devonshire, but has lived in London six years. She is married, and has three children. The patient enjoyed good health till ten weeks ago, when, for the first time, she perceived a hard swelling in her lower lip, of about the size of a pea, which subsequently turned to a sore. This increased in size; and, in a fortnight afterwards, the glands beneath the chin began to enlarge. She was advised to poultice and foment it, which she did, but without effect. At the same time, her throat became painful, and she experienced difficulty in deglutition. She then applied at the Hospital.

Present State. On the anterior surface of the lower lip projects a tumour, of about the size of half a marble; it extends from the middle line to the left side. The whole of the prolabium is involved, as well as a little of the skin below it. The substance of the lip is engaged in the disease, so much so that only a very thin portion of mucous membrane is free from induration. The outer surface is fissured in one or two parts, and is generally slightly rough. Beneath the symphysis of the chin, and a little behind the anterior part of the curve of the lower maxillary bone, is a tumour, two inches in breadth from side to side, and of about the thickness of the thumb. The skin over it is free from disease; and it is found to be divided into several small masses, evidently consisting of enlarged glands. The glands at the root of the neck above the clavicle are not enlarged; but there is a suspicion of fulness, on touch, of those on the right side. The patient admits that there are at present small sores about the pudenda, but no enlargement of the glands in the groin; that she has had a brown eruption over her whole body, and also small sores about the head. There are at present the remains of a liver-coloured eruption slightly marked, on the forearms, especially the left, evidently maculæ syphiliticæ; also slight remains of papular eruption on the breast. The tonsils on both sides are enlarged, and there is some superficial ulceration; while behind the left mastoid process are two enlarged lymphatic glands. She was ordered to use a gargle of alum and honey, and to take the following:—

℞ Acid. sulph. dil. ʒij; liq. cinchonæ ʒij; mist. camph. ʒvj. M. Sumat ʒss ter die.

May 4th. She is much better. The countenance is less

earthy. The blotching on the forehead is scarcely distinguishable. The tumours are as before. On examination, no sores are discovered on the pudenda; the patient says they have disappeared since her admission into the Hospital.

May 10th. The tumours are apparently diminished in size. The cutaneous eruption is certainly much less perceptible. The throat is better; the tonsils, however, are still enlarged.

May 12th to 20th. The patient's health has been somewhat disturbed. The bowels are relaxed; the appetite is bad; and she has a good deal of sickness. The countenance is flushed. The soreness of the throat is increased; but the swelling of the lip and glands is steadily decreasing, and the eruption fading rapidly away.

℞ Acidi nitrici dil. mx; decocti sarsæ ʒj. M. Fiat haustus ter die sumendus.

May 24th. She feels well again. The tumours are still decreasing; the soreness and ulceration of the throat are gone.

May 30th. Nothing now remains but a thickening of the cutaneous surface of the lip, while the glands under the chin are reduced to their natural size. The eruption has quite disappeared.

She was discharged as out-patient, to continue taking the nitric acid, as during its exhibition the tumours had so rapidly disappeared.

June 30th. All traces of the disease have now completely disappeared. She was ordered to take for a short time four grains of iodide of potassium in an ounce of decoction of sarsaparilla three times a day.

In his clinical lecture on this case, Mr. Quain made the following observations:—

This patient came into the Hospital for the purpose of undergoing an operation for the tumour in her lip; it was supposed to be a cancer. Upon inquiring into her history, I found that the enlarged glands beneath the chin had formed after the lapse of a very short time from the date of disease about it. I found, too, that the tumour of the lip had been very rapid in its growth.

In looking, moreover, carefully at the face of this patient, there was much of an unhealthy aspect—an earthy appearance of skin, with, on close observation, a slightly mottled look; all of which circumstances led me to make inquiries, which soon made it manifest that the disease of the lip was not cancer, but was part of a syphilitic complaint.

The subsequent progress of events fully justified the diagnosis as to the nature of the tumour. The patient improved under the treatment adopted and nutritious diet; the tumour of the lip became soft, and gradually diminished in size; the aspect of the patient was remarkably changed, and she gained flesh. Meanwhile, the slight cutaneous eruption entirely disappeared.

It has happened to me to observe two cases having a strong analogy with the preceding, which it would be as well to advert to briefly: one, a young man occupying the position of a porter in a public establishment, had a lump upon his lip, which was very hard, and covered still, except at the middle, which was slightly depressed, with the epithelium. There was no appearance of other disease. His health was unimpaired; there was no disease about the genital organs; and he denied having had syphilis in any form. The other case was that of a young female in a respectable walk of life. She had a tumour in the lip, indurated and slightly excoriated at the middle. She had no appearance of disease, and stated that her health had been unimpaired for a series of years. After a good deal of examination and consultation upon each of these cases, the tumours were removed. I had an opportunity of observing those cases afterwards, and I believe that in both the tumour was syphilitic; for within six weeks in one case, and a shorter time in the other, both of these persons had on their foreheads and faces, eruptions, easily recognised as belonging to secondary syphilis.

Royal College of Surgeons. The Collegiate Prize subject for 1861 is, "The Anatomy and Physiology of the Suprarenal Bodies." There are two Jacksonian Prize subjects for the present year, viz.: "The Healthy and Morbid Anatomy of the Prostate Gland;" and "A Description of the Diseased Conditions of the Knee-Joint which require Amputation of the Limb, and of those Conditions which are favourable for Excision of the Joint: with an Explanation of the Relative Advantages of both Operations, as far as can be ascertained by Cases properly authenticated."

Original Communications.

MYOSITIS AND MYALGIA: DYSPHAGIA AND PHLEGMASIA DOLENS.

By Thomas Inman, M.D., Physician to the Royal Infirmary, Liverpool.

In a previous communication on this subject, I showed that a process of inflammation, once set up in any muscle from excessive exertion, might extend to the parts in its immediate vicinity; and I gave one instance in which such extension had taken place during scarlatina from the sterno-mastoid to the pharynx. Some friendly critics have objected to this view of the case, thinking that it is more correct to consider that the muscle was affected from extension from the throat.

The following cases enable me distinctly to prove my view of the question to be correct; and they will serve as an introduction to some others, which seem to throw light upon certain cases of *phlegmasia dolens*.

Case i. Miss R., aged 35, a very delicate, but strong minded woman, complained *inter alia* of very severe *dysphagia*, which at times entirely precluded swallowing; and this, by preventing her taking nutriment, aggravated greatly her other symptoms. On making special inquiry into this symptom, I found that it was attended with soreness, pain, and stiffness of every part of the neck. I still farther ascertained that it came on after she had been driving herself about more frequently than usual in her pony carriage, whenever she had been conversing or laughing much, or after she had been bending her head forwards, as in reading a heavy book resting perpendicularly on the abdomen, when lying down. The pain in the muscles of the neck invariably came on *before* the dysphagia, and was attended by hardness of the sterno-mastoids especially. The dysphagia was attended with sore-throat, and invariably continued until she was driven to take absolute rest in bed. It then left her, *pari passu* with the cervical tenderness.

Case ii. Mary C., aged 25, suffering from great debility, after being under my care in the Infirmary for some time, considered herself sufficiently well to attend the chapel. This involved a walk down and up two long flights of stairs, and sitting upright for an hour. Next day she had very severe pain in the neck, especially in the left sterno-mastoid, which was exquisitely tender, very painful, and quite hard to the touch. At that time there was no sore-throat or dysphagia. Next day, however, she complained of sore-throat and difficulty of swallowing; and the junior house-surgeon, who examined it, told me that the fauces and pharynx were very much inflamed, but not ulcerated. By perfect rest and gentle inunction of morphia ointment, the pain, hardness, and tenderness, left the muscle in five days; the throat getting well at the same period.

Case iii occurred many years ago, and until lately was quite inexplicable to me. Miss J., aged 28, very strumous and delicate, was affected by a very peculiar cough, during the paroxysms of which all the anterior cervical muscles were seen to be quite rigid. After this had lasted some days, the whole of the neck swelled greatly, and was acutely tender and painful; and the cough was suppressed as far as possible, from the suffering it produced. The real cause of the cough was never ascertained. After the neck had been in this condition for a day or two, sore-throat and dysphagia came on, with a copious secretion of a dense ropy mucus. From a deformity of the jaw, however, no examination could be made of the fauces. In a week the difficulty of swallowing was so extreme that the patient refused all food. A second physician was now called in, and, under his influence, milk was swallowed in sufficient quantity to sustain life. Change of air was recommended; and by very slow degrees the patient got well. She has, however, been subject to frequent returns of the same class of symptoms; and, on recent occasions, I have been clearly able to trace the following sequence:—Irritable cough, long practice at the harp or piano, with singing, coupled with excessive catamenial flow or other cause of debility, produces an inflammatory condition of the sterno-mastoid; this spreads to the parts around, and ultimately to the muscles of the pharynx and the mucous membrane of the fauces. On hearing this explanation, my patient at once endorsed my views.

These cases, when coupled with the fact that myositis of the solei, gastrocnemii, etc., in patients with sea-scurvy, is always