AN EPITOME OF CURRENT MEDICAL LITERATURE.

MEDICINE.

(391) Amœbic Dysentery.

HARRIS (*Amer. Jour. of Med. Sci.*, April, 1898) has investigated 35 cases, most of which were chronic. In the chronic cases the temperature rarely rises above 101° in the evening. Albumen was only once present, and peptones, albumoses, and globulins were always absent. The stools numbered from 2 to 40 in the 24 hours, and varied in consistency according to the severity of the disease. In 6 analyses of the stools from 2 severe cases large quantities of serum albumen were present. Liver abscess occurred twice, peritonitis twice, piles once, and appendicitis once. Ten were treated with ordinary astringents, and 5 died; and 25 with rectal injections of hydrogen dioxide, of which 8 recovered, 4 improved, 4 remained as before, and 5 died. One case recovered after injections of potassic permanganate. Amœbic dysentery is a disease of the poor, and is almost always associated with filth. The stools should be collected in a perfectly clean and warm vessel; it should contain no water. Urine is particularly damaging to the amœbæ. The amœbæ die in two to six hours after expulsion. They often die as rapidly at body as at room temperature. They did not appear to be killed by saturated solutions of quinine sulphate or boracic acid, but an aqueous solution of quinine 1 in 300 killed them in ten minutes; they were also killed by weak solutions of hydrogen dioxide, potassic permanganate, and toluidine blue. Among the stains used toluidine blue was the best. In staining sections the author has first used eosin or benzopurpurine and then toluidine blue with good results. In 1 of the author's fatal cases the appendix was involved, its walls destroyed, and amœbæ present in the pus in and about the appendix. Two chief lesions are noted: (1) The submucosa shows marked changes, the mucosa being practically healthy, and (2) much less frequently the mucosa is eroded, and there is nothing abnormal beneath it. Thus changes in the submucosa may be traced in advance of surface ulceration. Amœbæ are found everywhere scattered throughout the diseased tissue. Very rarely a single amœba may be found in advance of the pathological changes. The amœbæ penetrate into the deeper layers of the intestine, but usually the peritoneum thickens more rapidly than the necrotic process extends. Hyperplastic tissue found in the disease is more resistant than the normal tissues. The author describes a hepatic abscess in which amœbæ were found. How the amœbæ reach the liver is doubtful, but they are probably brought by the portal vein. Harris then gives the symptoms of amœbic dysentery. The diagnosis can be made by finding the amœbæ. It is a very fatal disease. When it becomes chronic, as it most often does, the chances of recovery, even under the best treatment, are always bad. A severe attack may rapidly get better, or a mild attack get quickly worse at any period of the disease. Relapses are frequent. Liver abscess is a very fatal complication, and perforation and peritonitis always so. In the chronic disease opium checks the number of the discharges, but the author has never seen any permanent good from it. Sulphuric acid has in several cases apparently produced benefit, but never a cure. One patient recovered while taking salol. The author has never obtained any perceptible results from rectal injections of quinine 1 in 5,000, but injections of 100 to 300 watery solution of bisulphate of quinine were somewhat beneficial in one or two cases. He has had good results from hydrogen dioxide injections. The ordinary hydrogen dioxide is diluted four to eight times with water, and about a quart injected twice daily. The diet should be liquid. The author uses milk alone, and occasionally, as a change, egg albumen. He thinks that amœbic dysentery would cease to exist with ordinary attention to sanitary laws.

(392) Beri-Beri.

HIROTA (*Centralbl. f. inn. Med.*, April 23rd, 1898) draws attention to the spread of this disease (kakke) to suckling infants through the milk of nursing mothers suffering from it. He refers to some 52 cases in such infants, of which 42 recovered and 5 died, the result in the remaining 5 cases being unknown. The cases which recovered were treated at first with medicinal agents without much effect, and then the infants were weaned, a wet nurse being used in only a very few cases. Cow's milk or condensed milk was thus mostly substituted for human milk. Improvement occurred almost at once, the vomiting being arrested, diuresis appearing, etc. The aphonia alone remained. The author maintains that the disease is really due to an intoxication brought about by the milk, and that the only sure cure is to withhold the milk, and this before the disease is too advanced. Details are given of 4 severe cases of beri-beri in infants, and the author shows, in a comparative table, that the symptoms presented by the infants resemble those of the acute disease in adults. The beri-beri of these infants thus belongs to the acute pernicious form. The disease must be due to an intoxication, since recovery could not take place so rapidly if it were an infection. Beri-beri in infants thus throws much light on the etiology of the disease. As yet the author has been unable to separate out the disease-producing substance present in the milk.

(393) Diseases of Small Arteries giving Rise to the Symptoms of Dermatomyositis.

W. ROSENBLATH (*Zeit. f. klin. Med.*, vol. xxxiii, Parts 5 and 6) describes the case of a man, aged 37, belonging to a healthy family, who had had no noteworthy illness till the last month of 1895. He then gradually began to suffer from pains, chiefly in the limbs, partly referable to the muscles, partly to the joints. He had enlargement of the heart, œdema of the legs, albuminuria, and tendency to sweating, and to a subfebrile temperature. Occasionally he suffered from vomiting. There was some effusion in the knee-joints, and certain of the finger-joints were at times tender. The clinical features changed somewhat in the course of the disease. On March 10th, 1896, there was much swelling of the skin of both upper arms, less of the forearms; much œdema of the thighs, less of the legs and feet, and none of the scrotum. Active movements of the limbs were then almost impossible; passive movements could be obtained, though in the left wrist they were painful. Owing to the œdema it was difficult to examine the muscles for tenderness on pressure, and the œdema likewise hampered the electrical examination. No special tenderness of the nerve trunks could be made out. Sensation seemed to be unaffected, except that the patient appeared to be very little sensible to strong faradic currents. On March 12th there was a sudden attack of dyspnœa, lasting about two hours, and on March 14th there was a similar attack which lasted longer. The patient died on March 15th, with cyanosis and signs of pulmonary œdema. As to the diagnosis, rheumatism, nervous affections, polymyositis, and trichinosis, were all thought of; polymyositis or dermatomyositis was thought most probable. The *post-mortem* examination showed the following: Œdema of the cutaneous, subcutaneous, and muscular tissues of the body and extremities; fatty degeneration of the heart with dilatation of both ventricles; pleuritic adhesions; chronic catarrh of the stomach; nephritis. Microscopical examination of the muscles and nerve trunks showed that the chief pathological alterations were those of the small arteries in the connective tissue. The following changes were to be noted: degeneration of the vessel walls, exudation of leucocytes and fibroid formation around the vessels and thrombosis. The muscle and nerve fibres themselves were much less affected.

(394) Gastric Form of Epilepsy.

FICHAUX has collected (*Thèse de Lille*, 1897) a certain number of cases showing the existence of a form of epileptic seizure which manifests itself by attacks of gastralgia. This form of the disease has attracted very little notice, Trousseau and Féré being almost the only writers who allude to it. To quote one case in illustration: A girl, aged 22, under the writer's care, apparently in good health, will suddenly cry out with severe pain in the epigastrium, this not being preceded by any other symptom. If standing up, she has time to sit down; she becomes extremely pale, with a slight loss of consciousness lasting for two or three seconds, during which time she is unable to perceive any sensation. On returning to con-

sciousness there is a feeling of fatigue and headache, which lasts an hour or so. Under the influence of bromide these attacks become very much less frequent. In all the cases collected by the author there was this same sudden character in the onset. In the absence of every other symptom the apparently perfect health of the patient between the attacks is strongly suggestive of their epileptic nature.

SURGERY.

(395) Protrusion and Perforation of the Umbilicus in Ascites.

Ehret, of the Strassburg Medical Clinic (*Münch. med. Woch.*, April 12th, 1898) discusses protrusion and perforation of the umbilicus occurring in connection with obstructive ascites. The protrusion may be more or less rounded, or even pear-shaped. Perforation is uncommon. The author gives details of 3 cases, and adds another in which death was due to uncontrollable hæmorrhage from the protruded umbilicus. In one of these cases perforation took place on four or five different occasions, and the patient was still living. In another the patient was alive and free from ascites a year after the perforation. In the remaining case the patient died some three years after the perforation. The rupture took place in all the cases either where tapping was declined or when the patient was not under treatment. In 3 cases there was primary hepatic disease, and in the fourth heart disease. The protrusion may occur where there is no congenital widening of the umbilical ring. If a hernial sac is present the protrusion occurs earlier and more readily, and becomes larger. In 2 cases only fluid was present, and in the third bowel and omentum as well. In cases with previous inguinal hernia the fluid presses back the bowel, if not adherent, from the sac. Thus strangulation occurs in these cases much more readily at the umbilicus than in the inguinal canal. If intestine is present in the protrusion, tapping must be done with caution, the prolapsed bowel being pushed back and held there. In one of the author's cases the protrusion was described as big as a child's head. In two of the cases, after tapping, the whole fist could be introduced through the dilated umbilical ring. The perforation appears to be due to hæmorrhage into the tissues, which then give way. After the rupture complete closing takes place. This rapid closing prevents infection. If the ascites collects anew, rupture may again take place unless prevented by tapping.

(396) Seminal Vesiculitis and Prostatitis in Gonorrhœa.

Swinburne (*Amer. Journ. of Cut. and Genito-Urinary Diseases*, March, 1898) thinks that these complications of gonorrhœa occur oftener than is suspected, and require special treatment. He quotes three cases which, after prolonged and ineffectual treatment for chronic discharge, cleared up when the state of the vesiculæ was found and treated. The author's conclusions are as follows: (1) In chronic urethritis and at the end of prolonged urethritis, or when the posterior urethra is affected, the seminal vesicles and prostate should always be examined. (2) When epididymitis has occurred seminal vesiculitis is very apt to occur also. (3) Tuberculous conditions should be excluded if possible, for the treatment may render the condition worse. (4) The treatment consists in expressing the contents of the vesiculæ by the finger passed above the prostate *per rectum*. (5) Expression of the contents of the vesiculæ is a good test for sterility, to determine whether the ducts between the testis and the seminal vesicles are patent.

(397) Tracheotomy after the Use of Antitoxin.

Noccioli (*Gaz. degli Osped. e delle Clin.*, February 27th, 1898) contributes some statistics as to the results of tracheotomy in diphtheria after the use of serum. His tracheotomies number 15 in all; of these, 7 died and 8 were cured, But for various reasons 4 of the deaths can be excluded, which brings the mortality down to 25 per cent., a great improvement on the statistics of the operation before the use of antitoxin. The author never used an anæsthetic; in all cases except one he performed the high operation. No inconvenience followed the removal of the tracheotomy tube, usually on the eighth or tenth day after the operation.

(398) Sympathetic Papillitis.

Mulder (*Zehender's klin. Monats.*, December, 1897) reports a case of this uncommon affection. E. M., aged 15, a shoemaker, received an injury to the right eye with a piece of a cartridge case while shooting. The injured eye is said to have become blind soon after, and was for a long time very painful. After three months' treatment it quieted down, but the patient has since frequently had headache affecting the left half of the head; at times so badly that he has had to keep his bed for a week or two. Neither eye was painful. On May 4th, 1896, the patient noticed that the sight of the left eye was worse, and soon he was unable to carry on his work. On June 2nd he came under Mulder's care, who noted as follows: The injured eye is of normal size; by focal illumination a small scar is visible in the otherwise clear cornea, probably indicating where the foreign body entered. Anterior chamber of normal depth; iris slightly discoloured, pupil small and bound down by posterior synechiæ; behind the pupil the thickened lens capsule can be seen. No perception of light; tension normal. The globe is only slightly sensitive to pressure, but this occasions some pericorneal injection. The left eye is normal in appearance; no pericorneal injection. Pupil reactions normal. Vision $\frac{6}{24}$ E. The optic disc shows the appearances of a moderate papillitis: veins somewhat enlarged and tortuous, the contour of the papilla being veiled; one small retinal hæmorrhage near the disc. Field of vision normal; slight impairment of colour perception in centre of field. Vitreous and choroid quite normal. No albumen or sugar in urine. The diagnosis was made of sympathetic papillitis, and on June 4th the right eye was enucleated. Examination of it showed total detachment of retina, and in the ciliary region an encapsuled piece of copper. After the operation the headache entirely disappeared. No internal medicines were given, in order to see whether the symptoms of papillitis would spontaneously disappear. June 11th, V. = $\frac{6}{12}$; swelling of papilla and blood vessels less. June 16th, V. = $\frac{6}{9}$; colour vision quite normal. July 4th, V. = $\frac{6}{6}$. The disc has the normal appearance, and only a trace of the small hæmorrhage remains. The patient was dismissed cured; and in November Mulder heard that the eye had remained all right, and that there had been no headache.

MIDWIFERY AND DISEASES OF WOMEN.

(399) Uterine Tetanus with Threatened Rupture.

Brünings (*Cent. f. Gyn.*, April 16th, 1898) saw a 3-para, aged 33, with the following history: On Saturday labour began, and the midwife, an old woman, ruptured the membranes early in the evening. Sunday morning a doctor was called in, and found the uterus firmly contracted and the os nearly dilated. In the evening the condition was unaltered, though pains had been present all day. On Monday afternoon the doctor endeavoured to deliver, both by forceps and by turning, under deep narcosis, but unsuccessfully. On Tuesday at noon Brünings saw the patient; the head had not engaged, but the os was fully dilated. Under narcosis forceps were applied, but no impression could be made; the cervix was greatly thinned out, and there was marked contraction of the uterus round the child's neck. The child's heart beats ceased, and as the mother's condition was becoming grave, craniotomy was performed; but still delivery could by no means be effected, and as it was evident that the mother could not live much longer unless labour could be terminated, Cæsarean section was resorted to. The extraction was easy. The uterus was found to be very livid, and its peritoneal covering markedly œdematous, attaining in parts the thickness of the little finger. The operation lasted half an hour, but shortly afterwards the patient succumbed. The child was unusually well developed; the conjugata vera was just under 4 inches, and the transverse diameter at the brim $4\frac{3}{4}$ inches. The uterine tetanus is to be ascribed to the premature perforation of the membranes in a case where a large child was found in conjunction with a generally contracted pelvis. It is noteworthy that the child remained alive for so long after the onset of the tonic contraction of the uterus.

(400) Hysterectomy for Acute Puerperal Septic Metritis.

VINEBERG (*New York Med. Jour.*, April 2nd, 1898) reports a successful case. Symptoms began on the sixth day after confinement; three days later curetting was done, and was followed by improvement for twenty-four hours. On the twelfth day the patient was taken to hospital, apathetic, delirious, with temperature 103°, and pulse 130. Intrauterine irrigations brought away no *débris*. On the evening of the thirteenth day she seemed sinking, and abdominal total hysterectomy was done. On cutting open the uterus the whole interior above the cervical canal was covered with a dark, tenacious, slimy discharge, emitting a very foul odour. Attached to the left horn was a piece of placenta 2 cm. by 4 cm., and firmly adherent. The patient left hospital in six weeks. The author explains the lateness of the onset in these cases as follows: A piece of retained placenta disintegrates, and the *débris* are at first carried away with the lochia. After a week the cervical canal becomes moderately closed, and at the same time the heavy fundus sinks forward, so that escape of the discharges is interfered with, resulting in absorption and sepsis. This may occur without fœtor of the lochia. The proper treatment is immediate curettage, followed by special precautions to allow of subsequent drainage. If this fail, as shown by rapid weak pulse and loss of ground by the patient, hysterectomy should be done. In a footnote to the paper the author reports a second and later case, where the same treatment was successfully carried out. He gives references to eight other cases reported.

(401) Incarceration of a Pessary.

GALAKTIONOFF (*Centrabl. f. Gynäk.*, No. 5, 1898) states that a country woman, aged 60, suffered for ten years from prolapse. Another peasant introduced an improvised passage made of three stout pieces of iron wire. For four years before treatment the patient suffered from hypogastric pain, fœtid discharge, eczema vulvæ, and escape of pus from a sinus in the perineum. In the sinus one end of the pessary, now broken in half, could be felt. The other end projected from the vaginal mucous membrane, high up to the extent of half an inch; all the remainder lay in the recto-vaginal septum, and could be felt *per anum* immediately under the rectal mucous membrane. The pessary had to be cut out and the perineum required repair by Tait's flap operation. The parts fortunately healed well. Neugebauer relates a case where one end of a broken wire pessary reached the inner extremity of the inguinal fold.

(402) Pregnancy: Suppuration of Hydatid in Liver.

MIKUCKI (*Monatsschrift f. Geburtsh. und Gynäk.*, November, 1897) reports a case illustrating the dangers of hydatid disease of the liver in parous women, even when in abeyance. A woman, aged 33, who had been delivered normally six times, again became pregnant. About the fourth month fever, rigors, and abdominal pain set in, the patient's general condition becoming very bad. Two tumours could be felt in the abdomen in the seventh month, one clearly the uterus, whilst the other, to the right of and above the fundus, was much larger, fixed, fluctuating, and intensely tender. This tumour was diagnosed as either an echinococcus of the liver or an ovarian tumour with twisted pedicle. Von Jordan, of Cracow, operated, and discovered a large hydatid cyst containing about 10 pints of purulent fluid. After the contents had been removed the edge of the cyst was sewn to the parietes and drained, and Mikulicz's gauze drainage applied to the neighbouring peritoneum, as some of the fluid had entered that cavity. Abortion occurred three hours after the operation, and the patient died on the third day.

(403) Fœtus Papyraceus.

LITTAUER (*Centralbl. f. Gynäk.*, No. 2, 1898) exhibited a specimen of fœtus papyraceus at a recent meeting of the Leipzig Obstetrical Society. It was expelled during a twin labour at term, and preceded its brother, which was well developed and delivered spontaneously. There was a common placenta, and infarcts were detected in the segment belonging to the blighted fœtus. The lower part of the fœtus was devoid of all anatomical form, but the upper portion had been subject to lateral compression, and retained its component parts so well that it looked like a profile portrait in a cameo. It seems to have died at about the third month.

THERAPEUTICS.

(404) Periplœin.

LEVASCHOFF (*Vratch*, No. 11, 1898) makes a preliminary communication as to the action of a new cardiac tonic, periplœin. This is a glucoside derived from the bark of periplœa græca, a plant belonging to the order Asclepiadeæ, and growing, among other places, on the south-west coast of the Black Sea. The pharmacology of this substance was first investigated by Burzinski, who found that it at first slows the action of the heart while increasing the blood pressure; if continued and the dose increased, the blood pressure still increases, but there is an increase in the frequency of the heart beats; finally, if still larger doses are given, the pulse becomes irregular, the blood pressure fluctuates, and the heart suddenly stops, the blood pressure rapidly falling to zero. This effect, according to Burzinski, is due to a direct action of the drug on the nerve centres: the slowing of the heart's action in the first instance is dependent on a stimulation of the centres for the pneumogastric nerves, and the increase in the blood pressure is caused by stimulation of the vasomotor centres in the spine and medulla oblongata. The author was induced to investigate this substance, especially in view of its suitability for hypodermic injection, as it is soluble in water, and does not cause any marked inflammation at the seat of injection. The same cannot be said of either digitalin, digitoxin, or Merck's digitoxin. The dose of the substance was determined at first by trials on animals, on healthy subjects (the author and his laboratory assistant), and lastly, with suitable precautions, on patients. The maximum daily dose for hypodermic injection was found to be 0.001 g. The injections were made with sterilised solutions and due antiseptic precautions. The local effects at the seat of injection were slight and unimportant. The rapidity of the effect was first of all studied by its action on the pulse, its frequency, general character, the degree of blood pressure, and its sphygmographic tracing. For greater accuracy the sphygmograph remained on the wrist for two or three hours after the injection. It was found that even one hour after the injection there was a slowing of the heart's action with an increase of blood pressure. In cases with dicrotic pulse, the waves of the pulse became fuller and more regular, and the dicrotism was less marked. The cardiac impulse became more marked under the action of periplœin, but the area of cardiac dulness was not changed except in cases when the remedy was continued for a lengthened period. The heart sounds and murmurs became more distinct. The secretion of urine was markedly increased in cases of heart disease, but no such effect was observed in cases of dropsy of renal or hepatic origin or in healthy subjects. After the second injection there generally appeared a substance in the urine which gave the sugar reaction with Fehling's solution, but did not respond to other saccharine tests (such as phenyl-glycozone).

(405) Electricity in Incontinence of Urine.

CAPRIATI (*Arch. d'Elect. Méd.*, March 15th, 1898) records a case of involuntary enuresis successfully treated by means of the currents introduced into medicine by Morton, of New York. These are known as induced static currents, and are furnished by the oscillatory discharge of Leyden jars connected with an electrical machine. The patient is not insulated, but is connected with one of the jars, while the other is connected with earth. The intensity of the current is regulated by merely altering the distance between the jars. Capriati's patient was a previously healthy man of 35, who was gradually attacked by weakness and wasting in the left leg, with club-foot and exaggerated knee-jerk on that side. There was no reaction of degeneration, but incontinence of urine was very troublesome. The author considered the symptoms to point to a limited lesion of the spinal cord in the lumbar region. At first galvanism was tried with the kathode over the dorso-lumbar spine, and the anode on the perineum; this was continued for 10 minutes daily for more than 20 days without any benefit resulting. Endo-urethral faradisation (Guyon)

was next adopted, but was so painful that it had to be abandoned after two sittings. Finally, Morton's currents were used in conjunction with the spino-perineal galvanisation. Immediate relief followed, and after the treatment had been carried out every other day for two months, cure was complete as regards the incontinence. As galvanisation by itself had proved ineffectual, the credit must be given entirely to the method of static induction. It was extremely well borne when used in the manner laid down by Bordier. A sound, the end of which formed an electrode, was introduced into the urethra as far as the sphincter of the bladder, and its free end was attached by a chain to one of the Leyden jars; the machine was regulated to give 6 to 8 sparks a second, and each sitting lasted 5 minutes.

(406) Treatment of Infantile Paralyses.

EULENBURG (*Deut. med. Woch.*, April 7th, 1898) discusses the value of tendon transplantation in these paralyses, and relates a case of spastic paralysis in which it was successfully performed. In anterior poliomyelitis there is frequently a rapid atrophy of some muscles, followed by contracture in their antagonists, which leads to various deformities of the foot. Electricity and gymnastic treatment are almost useless to overcome these deformities, and hence a mechanical orthopædic treatment has to be adopted. The object of the new procedure of tendon or muscle transplantation is to render the paralysed muscles capable of voluntary movement. The tendon of the muscle to be transplanted is split lengthwise, and is united with the tendon of the paralysed muscle. In paralytic pes equino-varus where the extensor communis digitorum and peronei are affected, transplantation is made from the gastrocnemius, tibialis anticus, and occasionally from the extensor longus pollicis. A portion of the gastrocnemius has thus been united with the peroneus longus and a portion of the tibialis anticus with the extensor communis digitorum. These procedures have been carried out with very good results by several surgeons in the case of the lower extremity, but as yet with very little effect in the case of the arm. In cerebral spastic paralysis definite muscles or groups of muscles with the same function are mostly affected by spasm, whereas the antagonists are by no means devoid of function. Thus Eulenburg adopted tendon transplantation in a case of spastic paraplegia in a child aged 3. A portion of the tendo Achillis with the attached soleus was implanted by Sonnenburg into the united tendons of the peronei, and the foot was put up in plaster. After a fortnight faradic stimulation of the tibial nerve produced pronation with a raising of the outer side of the foot. A month later a similar procedure was carried out on the opposite side. All spasm disappeared, and the child could place its feet on the ground extremely well. In paralytic deformities of the foot this transplantation has been done with success, and Eulenburg thinks that it should be of equal service in spastic deformities. He is also of opinion that it may be of value in partial paralyses left after cerebral apoplexy, in some old paralyses of peripheral origin, etc.

(407) Capillary Puncture of the Heart.

BÉGOUIN (*Sem. Méd.*, January 29th, 1898) refers to the well-known fact that entrance of air into the jugular vein causes rapid death by asphyxia. This asphyxia is due to an accumulation of air in the right ventricle. By experiments on dogs and rabbits he finds that, when air has been insufflated into the jugulars, and asphyxia, which would probably prove fatal, has come on, if the air contained in the right ventricle be aspirated through a capillary puncture, the symptoms of asphyxia disappear gradually as the air is drawn off, and the animals soon recover completely. The author believes capillary puncture of the ventricle would be equally successful in man whenever this accident happens, as in the course of an operation.

PATHOLOGY.

(408) Secondary Infection with Tubercle Bacilli.

D. HANSEMANN (*Berl. klin. Woch.*, March 14th, 1898) says that although the secondary infection of tuberculous lesions with other kinds of microbes has been much discussed, the secondary infection of diseased parts of the body with tubercle bacilli has been less considered. At the Berlin Medical Society he demonstrated specimens illustrating the latter condition. Amongst them was a specimen showing the secondary infection of typhoid ulcers of the small intestine with miliary tubercles. Similar cases have been recorded by F. Ernst, Birch-Hirschfeld, and Heuschert. Hansemann does not think that scrofulous enlargement of lymphatic glands necessarily implies the presence of tubercle bacilli, though such glands are eminently predisposed to invasion by the bacilli. In a child aged $4\frac{3}{4}$ he found scrofulous mesenteric glands, some of which showed simple hyperplastic changes, whilst others showed distinct tuberculous changes. He exhibited a lung with croupous pneumonia; in the hepatised portion were Fraenkel's pneumococci, but there were likewise recent caseous patches containing tubercle bacilli. The patient at first had typical pneumonia with pneumococci in the sputum, but the symptoms changed, and tubercle bacilli appeared in the sputum. He likewise demonstrated specimens from a case of broncho-pneumonia, in which some of the patches of pulmonary consolidation near an old apical tuberculous lesion, had undergone a secondary infection with tubercle bacilli. Fibrous thickening around bronchi, such as occurs in old persons, favours secondary infection with tubercle bacilli, but is not itself necessarily of tuberculous origin. In the chronic fibroid changes sometimes resulting from acute pneumonia secondary tuberculous changes are very apt to develop, and so also in the chronic lymphangitis of the lungs resulting from the inhalation of coal dust, etc. Such cases may, however, be diagnosed as phthisis, without any secondary infection with tubercle bacilli having in reality taken place. There are certain less coarse fibroid changes in the lungs, which are due to chronic lymphangitis of uncertain origin (certainly not caused by ordinary pneumonia, bronchitis, or syphilis), and such lungs are very liable to secondary infection with pyogenic microbes or tubercle bacilli. In another case with a bronchiectatic cavity in each upper lobe Hansemann found only streptococci and putrefactive bacteria in one cavity, whereas a profuse growth of tubercle bacilli was present on the walls of the other cavity; he thinks that in this case the tubercle bacilli lived practically merely as saprophytes, because no tuberculous lesion was found in any other part of the body. He believes that syphilitic lesions in the lungs are generally invaded by tubercle bacilli, and that pulmonary syphilis is thus frequently difficult to recognise; in fact, when completely caseous gummata becomes secondary infected with tubercle bacilli, it is impossible to distinguish them from caseous patches of tuberculous origin. In the discussion which followed Hansemann's paper, Kroenig pointed out the danger of placing patients suffering from pneumonia, or from enteric fever with pulmonary complications, in hospital wards close to consumptive patients.

(409) Hanot's Cirrhosis of the Liver.

E. BOIX (*Presse Méd.*, March 16th, 1898), at the Paris Society of Biology, recorded his observations on the form of hypertrophic cirrhosis with chronic jaundice described by Hanot. (1) The splenic enlargement persists unaltered during the whole course of the illness, although the variations in the size of the liver may be considerable and of frequent occurrence. (2) The splenic enlargement precedes the alterations in the liver, or at least it precedes the outward manifestations of the disease. In one of Boix's patients, who died at about 30 of this form of cirrhosis, a large spleen had been noted during youth. (3) The disease may sometimes occur in different members of the same family. Children of patients may have a large spleen without any other sign of the affection. In one family the children are said to have a very pigmented skin, and this has been observed likewise in some collateral branches of the family. (4) The large spleen may be considered as the essential part of the disease. (5) Although ordinarily malaria has nothing to do with the affection, the cause is probably analogous to that of malaria and dependent on drinking water. (6) As Hanot and Riener admitted, the affection seems to be a specific one, or at least a peculiar infection of the spleen and liver, not a simple infection of the liver.