their size and shape are concerned, to the capacity of the strictured passage, and to the normal or abnormal course of the urethra in its entire length, most strictures can be overcome, and the urethra restored to its original condition, with as much security against relapse as by any other plan of treatment that has hitherto been devised, and with less risk of injury to the patient; and that the call for the knife is exceedingly exceptional.

Finsbury Place South, May 1861.

DOES THE PERICARDIUM INVARIABLY BECOME ADHERENT TO THE HEART AFTER ACUTE PERICARDITIS AND RECOVERY?

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THE BRITISH MEDICAL JOURNAL, for March 16th, contains some remarks by Dr. Hinds, of Birmingham, on this very interesting question. The author thinks it should be answered in the negative. He admits the difficulty of "dealing with it very positively and conclusively," owing chiefly to the rarity of opportunities of examining the bodies of persons who have made recoveries from acute pericarditis. He assumes, correctly I believe, that most pathologists hold with Dr. Watson, that the cessation of the to-and-fro sound is owing, not to absorption of the effused lymph, but to adhesion of the opposed surfaces of inflamed pericardium, and that "in this catalogue of apparent but unreal recoveries many of Bouillaud's cases of 'pericarditis terminating in health' ought to be included." He then relates two cases, occurring in his own practice, with the results of which he thinks "the principle above laid down is not consistent."

The first is the case of a gentleman, aged 27, who exhibited all the symptoms of pericarditis. He was treated by local bleeding, calomel and opium, and diuretics, and in eleven days the friction sound, together with "a little bruit with the first sound of the heart" had completely disappeared. This was three years ago, and the patient "shews not the slightest departure from robust and perfect health."

The second case is that of a child, aged about two years, who died after a few days illness, no heart symptoms having been detected during life. At the autopsy "the heart was found glued to the pericardium throughout its whole surface by a thick toughish layer of recent lymph."

Now, cases such as these are, comparatively speaking, common enough. Every practitioner who has seen much of acute disease must have met with instances of pericarditis in which all the symptoms, general and auscultatory, have disappeared, and apparent recovery has taken place; and others, which have terminated fatally, and in which obliteration of the pericardial cavity from recently effused lymph has been found after death. But what bearing they have upon the question with which Dr. Hinds heads his paper I am at a loss to understand. If his patient who had pericarditis three years ago were to die, and his pericardium were found to be free from adhesions, we should then have something like evidence before us. The grounds, however, upon which Dr. Hinds claims the cure as "complete and real", and arrives at the general conclusion that "pericarditis, with exudation of lymph on the surfaces, is a curable disease, and that in a strict and just sense of the term", appear to be:—

1. That he cannot reconcile the fact that his patient, a young man, appears in perfect health three years after an attack of pericarditis, with the idea that adhesion took place at the time of the attack. "If the heart," he

asks, "had been glued to the pericardium, could such complete and lasting recovery have occurred? Surely not."

2. That he has never seen, and doubts the existence of, cases of adherent pericardium, "if we except those from recent disease." "Do they ever occur?" he asks. "Has any practitioner seen many, or any, such cases in which the patients, well of the cardiac, have died of some other disease, or even 'apparently' well of the cardiac disease, living in apparent health for any considerable period afterwards?" "I have never myself met with any case of adherent pericardium, except from recent disease."

I must confess that I read these remarks, especially the last sentence, with amazement. How long it has been an established fact that old pericardial adhesion is occasionally met with at *post mortem* examinations, usually quite unexpectedly, I do not know. But many readers of this JOURNAL must remember the discussion which took place some twenty years ago between Drs. Barlow and Chevers as to whether such a pathological condition led to hypertrophy, or to atrophy, of the muscular tissue of the heart. It has been thought by many physicians, by Dr. Munk among them, that it may be detected with tolerable accuracy during life. Specimens of it are to be found in almost every museum. Dr. Wilks observes (*Pathological Anatomy*, p. 65), "more frequently than this" (partial adhesion) "the heart is found universally adherent to its serous covering; thus, at the beginning of this year we found it three times in one week, and quite unconnected with the disease of which the patient died, one indeed being an accident, and another a surgical case." Besides numerous instances in the *Pathological Theatre* at Guy's Hospital, I have met with two or three in private practice; in one of these, a child aged 9 years, the pericardial adhesion, which was universal and evidently of long standing, was quite a minor feature, death having been caused by the suppurative mass of enlarged bronchial glands, which had opened into the œsophagus, and penetrated the pulmonary veins, giving rise to immense and rapidly fatal hæmorrhage.

Chronic adhesion of the pericardium, then, is a condition by no means unfrequently met with, and is compatible with the continuance for a very considerable period, not merely of life, but of tolerable health, with an absence of cardiac symptoms, provided it be not complicated with endocardial disease; in short, "simple" pericardial adhesion produces no appreciable untoward consequences." (Wilks, *op. cit.*)

As regards the second of the two propositions, already alluded to, with which Dr. Hinds sums up his paper, viz., that pericarditis is a "curable" disease, I will only say that, without denying the possibility of the absorption of the effused lymph, I think the evidence he brings forward wholly inadequate. The circumstance that slight and partial adhesions only are sometimes found seems to render it probable that a portion of the exudation, at all events, may be absorbed (supposing that the inflammation in these cases originally involved the whole of the membrane—which is not certain). But we ought, it seems to me, to suspend our judgment on this point till we are in possession of well authenticated cases of patients who have had unequivocal symptoms of pericarditis, who have recovered, have subsequently died, and have been found on inspection, free from pericardial adhesion.

CASTOR-OIL BREAD. The difficulty of taking castor oil, when but a mild effect of it is wanted on the bowels may be removed by kneading, etc., bread with it, instead of butter or lard. Bread made with it will be found quite as good to the taste, if made with fine castor-oil or finer than with butter, etc. (*Med. Times.*)