NOTE ON THE PROVINCE OF COUNTERIRRITATION IN DISEASES OF THE EYE.

By FURNEAUX JORDAN, F.R.C.S.,
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MANY diseases of the eye are of a specific character, and require specific remedies; many are of a degenerative character; many are successfully treated only by operative interference. My experience teaches me that counterirritation is the great remedy for inflammatory diseases. In proportion as the inflammatory element predominates over specific and diathetic elements, so is the utility of a second, not too near and not too distant, inflammation. The more acute and destructive the inflammation, the more striking and rapid the effects of counterirritation.

Gonorrhœal ophthalmia, purulent ophthalmia, purulent ophthalmia of infants, are frequently destructive to sight; gonorrhœal ophthalmia very frequently so. As a rule, all these inflammations may be checked instaneously by a broad horse-shoe of smart counterirritation to the forehead, temple, and cheek. Acetum lyttæ, nitrate of silver, or iodine, may be used. The effect may be maintained by fresh applications within or without the first circle.

A young farmer was recently sent to me with gonorrhœal ophthalmia. The chemosed conjunctiva projected beyond the lids half an inch; the cornea was wholly opaque, and in patches yellow. I applied acetum lyttæ (glacial) freely over the forehead, temple, and cheek. In forty-eight hours the chemosis and copious discharge had almost disappeared, and the cornea had regained sufficient transparency for the vision of large objects.

An infant with purulent ophthalmia, and completely opaque cornea, was brought to me. A narrow zone of counterirritation restored transparency in twenty-four hours.

The treatment just described is much more certain and rapid than any nitrate of silver treatment, however assiduously conducted. In the more chronic inflammations of the ocular surfaces, the chronic counterirritation (if I may so call it), in the form of a seton or a mild horse-shoe, if appearance be not very important, is certainly more efficient than any other treatment. More than this; every strictly inflammatory disease to which the human frame is liable is more quickly subdued by counterirritation, if the locality and the agent be judiciously selected, than by any other remedy—rest being, of course, the necessary attendant of all remedies. I have spoken of counterirritation as the best remedy; other remedies need not be excluded, whenever the surgeon considers them necessary.

OBSTETRIC MEMORANDA.

LABOUR INDUCED BY UTERINE INJECTION.

By EDWARD GARRAWAY, Esq., Faversham.

A LADY, aged 27, with some narrowing of the antero-posterior pelvic diameter, who had aborted twelve times, went on with her thirteenth pregnancy. It being considered expedient to induce labour at seven months and a half, a silver catheter attached to a flexible tube was passed well up and swayed to and fro between the cervix uteri and the membranes, so as to separate them rather freely. A pint and a half of warm water was injected, producing no pain, only a feeling of distension. On withdrawing the catheter, not a drop escaped. In an hour afterwards there was a rigor, with vomiting, pain, and an escape of water. The os was dilating, but very rigid. Twenty minims of Battley's solution were given and repeated; in six hours the head was on the perinæum, and in another hour delivery was accomplished.

The interesting features in this case are the large amount of water that was thrown into the uterus, the absence of any discomfort occasioned thereby, and the prompt and powerful action it induced. So far as I could judge, the patient would have borne another pint or two. My injection clearly went to the fundus uteri and remained there.

In a discussion held some since at the Obstetrical Society, upon a paper by Professor Lazarewitch of Charkoff in Russia, advocating the injection of the fundus uteri, Dr. Greenhalgh characterised the proceeding as dangerous. He had injected the uterus once only, and alarming symptoms followed; and he had been informed by a former President of the Society of another case in which the death of the patient ensued, a lady in whose case he had twice before brought on premature labour by rupturing the membranes. Professor Lazarewitch quoted twelve cases, in all but one of which pains began immediately, and, with one exception, resulted favourably. In the exceptional case, however, he stated that death was in no way due to the operation. The largest quantity of water which the Professor injected was six ounces. In my own case, I intended to have injected till the patient felt uncomfortable; but, after throwing up thirty ounces, I considered it would be indiscreet to tax her toleration further. The child survived, and the mother convalesced remarkably well.

REPORTS
OF
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

GUY'S HOSPITAL.

DISLOCATIONS OF THE HIP-JOINT.

(Under the care of Mr. BIRKETT.)

CASE I.—A small, but healthy man, 36 years old, was admitted 5th January, 1870, on account of the following injuries, reported by Mr. R. W. Murphy. He was engaged in clearing manure from a doorway, when the door, which was supported by props, falling, knocked him down and lay across both his thighs. He was also struck from behind by a weight of falling manure. On admission, soon after the accident, a dislocation of the head of the right femur into the thyroid foramen was detected by the house-surgeon. He was much contused on the back and loins also. The house-surgeon reduced the dislocation by manipulation when the man was fully under the influence of chloroform. The limbs were maintained in the extended posture. The next day, the man complained only of pain about the hips, loins, and back, which was much aggravated by a troublesome cough. Of the injured hip-joint, he made no complaint, and even pressure over the articulation did not hurt him. Slight flexion could also be performed without pain. In three weeks, he walked well.

CASE II.—A muscular, healthy man, was admitted in November 1869, having fallen from a height of sixty feet to the ground. In the fall, he struck upon the roof of an outhouse. The left side of the chest was severely injured. The right hip-joint was dislocated, the head of the right femur being lodged in the ischiatic notch. The bone was easily replaced in the acetabulum by the house-surgeon, *without* chloroform. The man survived the injury but a brief period.

Next day, an examination after death showed fracture of all the ribs on the left side, except the first and last, and laceration of the lung. When the glutæus maximus of the right side was reflected, a large quantity of blood was seen clotted beneath it; both the gemelli and quadratus femoris muscles were lacerated. The superior and posterior part of the cotyloid ligament, together with a long piece of the bony brim of the acetabulum, were detached, and the torn capsular ligament was lying loose. This ligament was torn through all round the joint, with the exception of the strong anterior part called ilio-femoral. The ligamentum teres was torn away from its attachment to the fossa in the acetabulum.

LONDON HOSPITAL.

ORANGE-PIP IN TRACHEA: REMOVAL.

MR. COUPER lately operated on a somewhat unusual and interesting case of foreign body in the trachea. Elizabeth W., aged 2½ years, was brought to the hospital suffering from considerable dyspnœa, and with the history that she had had a cough for some days. On questioning the mother more closely, it appeared that urgent dyspnœa had come on suddenly while the mother was carrying the child upstairs. The child at the same time was sucking an orange. The difficulty of breathing continued for about twenty-four hours before the child was brought to the hospital. While in the receiving-room, the child vomited, bringing up the remains of an orange. When the finger was placed over the trachea, some small hard body could be felt to hit against the larynx during expiration. Under these circumstances, Mr. Couper performed tracheotomy. The pip of an orange at once presented, and was easily removed. A stitch was inserted into the trachea, and the external wound closed. The child breathed through the mouth. The child has had no bad symptoms since. The stitch broke away on the following day.

LOCUST-BEAN IN TRACHEA: REMOVAL.

In another case, three years ago, Mr. Couper removed a locust-bean from the trachea of a child about four years old. The child was brought to the hospital suffering from great dyspnœa, which had come on suddenly while the child was sucking a bean. In his case, too, a

hard body could be felt in the trachea by the finger. It was propelled against the larynx at each expiration. As soon as the trachea was opened, the bean could be seen to be carried up with each expiration, but would not come out. The edges of the trachea were held open; and the bean was transfixed with the point of the knife, and thus extracted. The child unfortunately died of pneumonia.

The important practical point in both the above cases is the confirmation of the diagnosis by the surgeon being able to feel the foreign body moving within the trachea. The object of stitching the edges of the tracheal wound together was to prevent the direct access of cold air to the lungs. In a former case, Mr. Couper stitched the edges of an incision in the thyroid cartilage together, with great success. The patient was an old lady; and Mr. Couper operated for the removal of warty growths of the inferior vocal cords. Three stitches were inserted into the thyroid cartilage, and the union was remarkably rapid.

MIDDLESEX HOSPITAL.

Operation Day, January 26th, 1870.

Mr. De Morgan amputated at the hip-joint for a Tumour in the Thigh in a young man of 23. The tumour was of four months' growth, and extended from above the knee to a couple of inches below the trochanter minor. It had latterly given great pain. The operation was performed by making two semilunar incisions from above the trochanter —the one towards the inner, the other to the outer, side of the thigh. The capsule being cut through, the head of the bone was readily dislocated; and, the knife being passed behind the bone, the remaining tissues on the inside of the thigh were divided. The aorta had been compressed by a Lister's tourniquet, and not more than six or seven ounces of blood were lost. The vessels, including the large veins, were tied with silk ligatures previously steeped in carbolic acid. The wound was sponged with the strong sulphurous acid solution. A deep quilled suture was passed through the flaps, which were then brought together at the edges by ordinary suture; and lint soaked in sulphurous acid solution, one part to eight, was applied over the stump. In a high amputation performed last year on a young woman for tumour of the thigh, the deep suture was used, and the stump dressed in the same way. Although ligatures were used, no suppuration took place; and the patient was up, with the wound quite healed, in three weeks. The present case promises equally well. Since the operation, the wound has mostly healed; and there has been only a trifling amount of suppuration from the point at which the main ligature was brought out, and from one other small point. The whole amount has not been more than a large teaspoonful a day. The skin has shown no trace of inflammatory action, preserving a natural colour up to the very edge of the wound; and there has been no swelling of the tissues of the stump. Constitutionally, the patient has not had a single symptom indicative of a great operation. This immunity from inflammatory action appears to attend generally the continued use of sulphurous acid. Nothing more is required than that cloths dipped in the solution should be kept to the wound, just as would be done with ordinary water-dressing. The tumour, on examination, proved to be a sarcoma, containing at parts large spaces filled with blood, and bloody serum. The central part was hard from deposit of calcareous matter; it had not formed true bone. The origin was clearly from the inner layer of the periosteum towards the lower fourth of the femur.

Mr. Moore extirpated the Eyeball of a man aged 50, for destructive inflammation of the organ, which commenced in May last, from the admission of lime. The upper eyelid was adherent to the anterior part of the eyeball, which again was inflamed, disorganised, and shrunken. The patient had continued to suffer most severe pain from the state of the eye; and, symptoms of serious sympathetic irritation of the other eye supervening, Mr. Moore determined to remove the eyeball. This was done by dissecting off the adherent conjunctiva from the eyeball, and enucleating the ball; the optic nerve being severed from the outside.

Mr. Moore also operated on a man forty-five years old, for Epithelioma of the Scrotum of ten months' standing; it involved the left part of the scrotum, and extended inwards to the tunica vaginalis, to which it was adherent for about an inch. The part was enclosed and lifted up in a hæmorrhoid-clamp, and removed.

Mr. Moore operated for Strangulated Inguinal Hernia in a woman about forty-five years old, who was brought into the hospital during operations. The symptoms of strangulation had lasted a week, but they had not been of a very severe character. Taxis was attempted; and, finding this of no avail, Mr. Moore operated in the usual manner. A thin sac of peritoneum was exposed, and in it was found a small portion of omentum very tightly constricted.

A child a year old was shown, with a Congenital Opening between the vagina and bladder, which formed the Urethra. It was simply the urethra without a sphincter. Mr. Moore considered it advisable to postpone any operative interference until the child was somewhat older.

Mr. Nunn operated on a case of Stricture of the Rectum by dilatation with metallic and with flexible bougies. This was the *third occasion* on which the patient had been fully subjected to the influence of chloroform for the purpose. In the first instance, a very tight stricture with sharp edge was encountered within easy reach of the finger, and beyond it a contraction of the gut of quite an opposite characrer—gristly, unyielding, irregular, and impermeable to the finger, from implication of other than the mucous and submucous coats of the rectum.

Mr. Nunn, during his clinique, made the following remarks. "I have long had the conviction that strictures of the rectum, not cancerous, are for the most part syphilitic, although I have not been able to show you indisputable signs of constitutional syphilis on the surface in every case that we have had in these wards; nevertheless, the patient has been always open to the charge of having suffered from syphilis, whenever palpable signs of that disease have not been demonstrable. For example, there is this case; the patient is of florid complexion; to all outward appearance, healthy; but we have the history of her past life to show that she has run the risk of syphilis; and there is, besides, a condition of the margin of the anus justifying the suspicion of the existence of mucous tubercles and fissures at a former period. On the other hand, we have had in some patients syphilodermatous phenomena that render denial of previous chancre superfluous; cases where we can point to palmar psoriasis, loss of hair, spots in the scalp, and cracks at the angles of the mouth. I confess, however, gentlemen, that I was at a loss to picture in my own mind the chain of events. Constitutional syphilis, presenting palmar psoriasis, loss of hair, etc., is only too common, whereas stricture of the rectum is but occasionally, so to speak, met with. I, however, in a private case, believe I have met with the 'missing link' belonging to this chain of events; it is the initial link. It consisted essentially in this: a lady, during her first pregnancy by her husband, who was, at the date of his marriage, in the early stage of constitutional syphilis, had some very indefinite symptoms of syphilitic infection. She miscarried at the seventh month; afterwards she consulted me for catarrh of the rectum, with fissure of the anus and vaginitis; suffice it to say, that the symptoms of secondary syphilis were very indefinite. Without my further particularising now, why should not this catarrh of the rectum be followed by stricture just as a gleet is frequently followed by stricture of the urethra? I trust that the measures I have employed may obviate such a distressing result; but in how many cases would not catarrh of the rectum be considered as a mere irritation of the lower bowel, and be disregarded by a patient in the poorer classes as one of the inevitable ills connected with child-bearing, or rather with miscarriage? Further, I would especially draw your attention to the circumstance that all our patients with non-cancerous stricture of the rectum have been females. In the case of the private patient just spoken of, you will mark also that I specified vaginitis as one of her troubles. I cannot help imagining that the close anatomical relationship of the vagina and rectum has an important bearing in the disease with which we are dealing. If there be no continuity of inflammation in the tissues of the two canals, there may be a somewhat analogous tendency to metastasis, as we see in gonorrhœa, where urethritis is replaced by orchitis, or by inflammation of the prostate and neck of the bladder. You will remember last year I drew your attention repeatedly to a case of syphilitic stricture of the rectum, sent to the Hospital by Mr. Edward Tyler of High Street, Marylebone. In that case the stricture was accompanied by the formation of an abscess external to the gut, which burst into it and the ischio-rectal region; and also to another case some months previous, sent to the Hospital by Mr. Firman of Gravesend. Now, you must not conclude that the diagnosis of the nature of a stricture of the rectum is an easy matter; it is quite the contrary in some instances; and you must form your diagnosis by giving more importance to the history of the case than to the sensations conveyed by the touch. I met with a case, in private, in conjunction with Mr. Aikin of Clifton Place, Hyde Park, in which a disregard of the history—namely, that a miscarriage at an early month was followed by smart inflammation along the track of the round ligament and other perimetric tissues—would unquestionably lead any practitioner examining the rectum to declare that there was cancerous thickening of the rectum: in fact, two physician-accoucheurs, who were consulted, did declare that such a hopeless state of matters existed. Sufficient years have now elapsed to refute their opinion, seeing that the lady is now enjoying excellent health, and has added to her family without inconvenience. I may tell you that some years since I admitted into the cancer-wards a female patient, believing her to be suffering from cancer of the rectum. I made my diagnosis by the touch. Some weeks afterwards I observed a very marked eruption on the palms,

which led me to suspect I had fallen into an error, as had really occurred. The subsequent progress of the case proved that the strictured condition was not cancerous."

Mr. NUNN operated on a girl aged 10, for Disease of the Hip-joint. The disease of the bone had been present for ten months, and had been treated by the extension-pulley and weight; but, although she had been considerably relieved by this means and by leeching, the characteristic symptoms of hip-joint disease became prominent. Mr. Nunn made an incision over the trochanter three inches in length, through the fascia of the gluteus maximus, which was crossed transversely by a second incision at its middle in the fibrous structures only, so as to do away with pressure over the trochanter by the gluteus maximus through its insertion into the fascia lata. Perforation was made into the diseased trochanter, and a small piece of potassa fusa inserted, with the view of obtaining free discharge from the bone and anchylosis of the joint.

BIRMINGHAM GENERAL HOSPITAL.

OLD SYPHILIS: EPILEPTIC FITS: CEPHALALGIA: LOSS OF SPEECH: THICKENING AND ADHESION OF THE CEREBRAL MEMBRANES: OBSTRUCTION OF THE LEFT MIDDLE CEREBRAL ARTERY.

(Under the care of Dr. RUSSELL.)

THE subject of the case was an out-patient during most of the time. He was aged 37, had lived a dissipated life in youth, and had had syphilis, but the nature of the disease and the period were uncertain. At present, however, his throat bears evidence of extensive mischief, and his upper teeth have all fallen out. He became an out-patient in March 1869.

Two years previously, he had an epileptic fit, a second in a month, and a third five weeks before his application at the Hospital, in which, from the report, the convulsive action was unilateral, on the right, the two previous ones having been probably of bilateral character. During these two years, he had also been subject to severe pain, chiefly occipital, in violent paroxysms of long duration, apparently very severe at night, and accompanied by vertigo; the pain was also seated elsewhere, especially in the region of the parietal eminences.

Such were his chief complaints when I first saw him. He gained great benefit from large doses of iodide, none from bromide of potassium. In August, he had a fit, in which he lost speech for half an hour; the former fits were replaced by paroxysms of vertigo, of severity, attended by some confusion ("mithering"). The pain had not ceased. Intellect had hitherto remained entire. Late in December, he suffered from constantly recurring fits of loss of power to articulate; "he tried to bring out his words, but could not"; "he sat up all day without speaking"; "he asked for contrary things to what he wanted". He was taken as an in-patient on December 20th. He would then speak most of a sentence correctly, but invariably came to some word which he miscalled or replaced by gibberish. The defect was greater in reading, many words in a sentence being changed, or quite unintelligible; he was sensible of the imperfection, and tried to correct it.

By January 11th, he had become much worse. Whole sentences were unintelligible; some of the wrong words, however, had a relation to the subject, as "pills" for mixture; and I detected the word "fares" very often, he being a cabman. Desiring to speak of something wrong in his eyes (an idea suggested solely by our having just examined them), he expressed himself thus: "It says things that I shown such different tones"; "they are chiefly the thing that there is anything about". And in reply to "how are you?" "I feel lost and very low the last two years". He misstated the time constantly; indeed, blundered more in this respect than in most others. The following articles were held up to him in quick succession, and in the order now stated. A pen, "ken"; keys, "kemp, inches"; knife, "knife, penknife, sir". Again, a pen, "knife". Again, keys, "penknives, sir"; a shilling, "some money, sir; its sixpence; sixpence". A watch, "watch, sir"; but could not name the hour. He could write his name correctly; but, in writing from dictation, there was hardly an English word in the sentence, and much of the writing, like the gibberish spoken, was unreadable. Smell was lost, probably from the state of the throat. Taste remained perfect, and so was hearing. Vision was good with the right eye; he even read No. 1 Jäger with difficulty; but with the left eye it was very imperfect; he could not read below 16. The other cerebral nerves seemed perfect in their action, except slight left ptosis and sluggishness of the left pupil. The optic disc was found by Mr. Arthur Bracey to be very indistinct in the right eye, and the origin of the vessels obscure; in the left eye, the disc was grey and anæmic, and its outline indistinct. At a later period, Dr. Welch entirely failed in procuring the compliance necessary for making an examination; this was in the aphasic period of the case, and accorded with the loss of control over his speech. He declined rapidly, and died at the end of January.

On *post mortem* examination, we found universal adhesion of the brain to the dura mater, and much thickening of the membranes. At the base, dissection was needed to clear the different parts; all of which, including the nerves, were connected with the thickened arachnoid. The arteries of the base, like the other parts, were closely attached to the thickened membrane, but all were perfectly pervious except the left middle cerebral, which was thickened in its coats, and surrounded, just above its origin, by a dense yellow mass about the size of a horse bean. A similar mass adhered closely to the surface of the insula; the structure of both was granular matter, minute irregular nuclei, and small fat groups. The left middle cerebral artery was filled at its origin with a colourless unadherent plug of fibrin, which did not extend into the carotid; all its branches were empty. No marked softening was discovered on the surface of the brain, which, however, was somewhat damaged in the process of removal; but a small softened cavity lay just outside the anterior extremity of the left corpus striatum; and the exterior of that body, with the connected white matter, was softened. The spinal cord, its membranes, and the other organs of the body were healthy.

MEATH HOSPITAL.

CHRONIC OTORRHŒA: SUPPURATION OF THE MIDDLE EAR: THROMBOSIS OF THE LATERAL PETROSAL, AND CAVERNOUS SINUSES OF THE RIGHT SIDE.*

(Under the care of Dr. STOKES.)

JAMES BYRNE, aged 49, a fisherman, was admitted into the Meath Hospital on the 12th of January, 1870. He stated that, on the 1st of the month, he had caught cold; that he had struggled against his illness for some days, but in vain; that, finally, on the setting in of severe headache, he had sought admission to hospital. He was a man of powerful build, had lived a temperate life, though necessarily one of hard and unremitting toil; and had enjoyed good health, excepting that for many years he was subject to severe attacks of cold, and, during them, to a *fœtid discharge from the right ear*, the hearing in which was much impaired. Physical examination revealed the existence of general bronchitis without any special symptoms of fever; the heart being normal and the pulse but 65. The only other point in the case that attracted attention was the discharge from the right ear of a purulent fluid of very fœtid odour. After the lapse of twenty-four hours, the head-symptoms became more pronounced, pain having increased, and a low delirium having set in at night. Profuse perspirations occurred during this and the following days. On the 17th, a new and remarkable sign appeared; this was *sudden and extreme œdema of both eyelids*, with great chemosis. Under the use of local applications, poulticing and fomentations, this œdema almost subsided in the course of two or three days. A trace of it, however, remained in the right eyelid. On the 20th, subsultus and floccitatio were noticed, and he passed urine under him. The delirium now became more or less constant. Two days subsequently, a slight puffiness above the mastoid process of the right temporal bone appeared. No pus escaped on making an incision. From this time, the patient continued to sink until 9 p.m. of the 25th, when he expired, a discharge of purulent matter and blood having just before taken place from the nose and mouth. Up to the last, but very slight febrile disturbance had shown itself.

On *post mortem* examination, made fourteen hours after death, purulent meningitis of the base of the brain was discovered, involving the region of the pons Varolii, and extending along the right crus cerebri. There was also superficial softening of the antero-inferior portion of the right side of the cerebellum. No morbid appearances were marked in connection with the abdominal viscera, and the lungs were free from any purulent deposits. Numerous bands of adhesion, apparently of old formation, existed in the right pleura. Subsequently, a minute examination of the right temporal bone and sinuses of the brain was made by Dr. A. W. Foot, when the following pathological conditions were noticed. The lining membrane of the external ear was thickened, whitish, and sodden from long contact with purulent matter. The membrana tympani was destroyed, with the exception of a narrow rim of its attached border; and the malleus was, in consequence, set free. The mucous membrane of the middle ear was pulpy, vascular, and bathed in pus; more particularly that portion of it which lines the minor wall. The mastoid cells opening into the tympanum had their lining membrane in the same condition as that of the middle ear. The latera sinus was completely obstructed by softening coagula, and purulen matter lay between the outer wall of the sinus and the bone on which it

* A case remarkably similar to the present one is recorded in Dusch's monograph on *Thrombosis of Cerebral Sinuses*. (New Sydenham Society, vol. xi, p. 97.)

rested. The superior and inferior petrosal sinuses were occupied by similar clots, and the cavernous sinus was likewise the seat of a suppurative phlebitis. The parts of the dura mater related to the petrous portion of the temporal bone, were thickened, easily detached, and, in places, actually separated by lymph from the bone beneath. It appeared, from the absence of fœtor, and of discoloration or softening of the bone, that the lesion which caused death was essentially, not a caries, but a suppurative phlebitis of the sinuses of the skull, propagated through the cells of the mastoid bone from the inflamed mucous membrane of the middle ear. It would further seem that the peculiar ocular phenomena, which suddenly appeared a few days before death, were due to the obstruction of the right cavernous sinus, which interfered, directly, with the venous circulation of the right eye, and, indirectly, with that of the left.

CLINICAL LECTURE ON SEVERAL CASES.

By MR. PAGET, F.R.S.

MR. PAGET (on Wednesday last) alluded briefly to the case of erysipelas following burn, which he mentioned in last week's lecture, and in which he considered that erysipelatous inflammation of the membranes of the brain had been succeeded by erysipelas of the scalp. The child in a few days showed signs of pneumonia, and quickly died. At the *post mortem* examination, small pyæmic abscesses and deposits were found in the lungs. The membranes of the brain were quite healthy; and this fact, in Mr. Paget's opinion, strengthened the accuracy of his diagnosis, for recent erysipelas of the skin is known to leave little, if any, *post mortem* evidence of its presence; and the same may, therefore, be justly surmised with respect to the cerebral meninges.

Mr. Paget made a few remarks in connection with this case, on the *causes of death from burn*, which he arranged under the headings of Shock, Secondary Inflammations of various Internal Organs, and Perforating Ulcer of the Duodenum. Mr. Paget considers that death from shock is often accelerated by the previous inhalation of very hot air, which must act injuriously on the lungs. The "secondary inflammations" were, the lecturer suggested, often of the same erysipelatous type as we commonly see in the cutaneous structures.

Mr. Paget next referred to a case (in Sitwell Ward) of a large *Cyst in the Neck*. The patient is a girl, 18 years of age. She had no nævus or tumour in the neck until about twenty months before admission, when she noticed a small lump on the right side of her neck; it steadily increased until her admission, when a tumour larger than a man's fist was discovered under the sterno-mastoid muscle. It contained fluid; and, after consultation, Mr. Paget tapped it with a very small trocar. A small quantity of sero-purulent matter escaped, which was found to contain broken-down pus, crystals of cholesterine, and large epithelial cells—the latter structure pointing to its real nature, as that of a cutaneous cyst. Mr. Paget remarked on the apparently trivial nature of deep-seated cysts in the neck, but insisted that they are really of considerable importance for the following reasons. They are large, and increase steadily; they sometimes contain blood, and refill with that fluid after they have been punctured, so that even fatal hæmorrhage has followed an operation apparently harmless; they are often deep-seated, and connected with important structures such as the spine and the sheaths of the blood-vessels; when they are tapped they often refill, and require to be emptied repeatedly; lastly, if they be laid open and made to suppurate, it is often very difficult to make them heal from the bottom, while, if suppuration continue, it may involve important deep-seated structures.

Syphilitic Disease of the Rectum.—The patient whose case illustrated Mr. Paget's remarks on this condition, was a woman who was admitted in a state of great misery and exhaustion, suffering from acute syphilitic ulceration of the rectum and syphilitic cutaneous growths about the anus. She had involuntary passage of fæces, and much foul mucous discharge from the ulcerated intestine. The history of syphilis was imperfect; but there were scars, like those of tertiary ulcers, on her lip, and scars about the vagina; she had some old tubercular mischief at the apex of one lung, but this was evidently not progressing. But little could be done to alleviate such an extreme condition of general weakness and local disease, and the patient gradually sank and died. After death, very extensive ulceration was found, involving the rectum and extending upwards into the sigmoid flexure, colon, and about the lower six inches of the ileum. Mr. Paget described the ulcers as presenting just the characters of tertiary syphilitic ulcers on the skin, circular or oval, the edges well defined, smooth, not indented, not raised, not overhanging, the base resting on the submucous tissue, and nearly smooth. These characters, as the lecturer pointed out, could be well seen in the upper part of the ulcerated tract; but lower down, in the sigmoid flexure and rectum, the ulceration was described by Mr. Paget as "confused", having resulted from the coalescence of numerous small regular ulcers.

Mr. Paget alluded to the rarity of death from syphilis, except when it affects internal organs; remarking, at the same time, that syphilitic lesions of internal structures are much commoner than until lately was supposed. In describing the chief features of syphilitic disease of the rectum, Mr. Paget first noticed the cutaneous growths about the anus which, he considers, almost always accompany that condition; and mentioned the points in which they differed from warts and from condylomata. They were described as growths from the skin, smooth, and flattened from side to side by mutual apposition. Mr. Paget stated that, in chronic syphilitic disease of the rectum, the symptoms are less severe than they were in the case under consideration, but that they produce great discomfort and inconvenience. The chief characters of this condition were stated to be a thickened and indurated condition of the lower part of the rectum, with ulceration of its mucous membrane, and the existence of a sharply defined and often narrow stricture at about an inch and a half from the anus.

The points of distinction between cancerous and syphilitic disease of the lower bowel were pointed out as follows. In cancer (except in the latest stages) the anus is free from disease; while in syphilis the above mentioned cutaneous growths are always present. In cancer, from one to three inches of the rectum are usually quite healthy; in syphilis, the ulceration comes quite down to the anus.

Between tuberculous and syphilitic disease of the intestines, Mr. Paget drew the following distinctions. In tuberculous disease, the seat of greatest action is the lower end of the ileum; in syphilis, it is the rectum (even the colon being but seldom extensively affected). In tuberculous disease, there would be deposits of tubercle in the bases of the ulcers, and in the subperitoneal tissue or the mesenteric glands; and there would be also *progressing* tuberculous disease of the lungs.

Treatment.—Mr. Paget said that iodide of potassium has very little effect on syphilitic ulceration of the rectum, but that mercury, given with great caution and due consideration for the state of the patient's health, often produces marked improvement. Locally, Mr. Paget advocated removal of the leaf-like cutaneous growths around the anus (taking care not to remove them all at once in cases where they completely surround the orifice, for fear of contraction), *incision* of the stricture, and subsequent diligent use of bougies. Mr. Paget, however, cautioned his hearers against employing bougies whilst active disease is going on, as the intestinal walls are then so weak that perforation has been known to follow the too zealous use of the instrument. Local cleanliness and the use of astringent applications were mentioned as matters of course.

REVIEWS AND NOTICES.

A TEXT-BOOK OF PRACTICAL MEDICINE, WITH PARTICULAR REFERENCE TO PHYSIOLOGY AND PATHOLOGICAL ANATOMY. By Dr. FELIX VON NIEMEYER, Professor of Pathology and Therapeutics; Director of the Medical Clinic of the University of Tübingen. Translated from the Seventh German Edition by G. A. HUMPHRY, M.D., and CHARLES E. HACKLEY, M.D. New York: 1869.

THE appearance of a German text-book on the practice of Medicine, in an English form, should at least raise our curiosity. It can scarcely be said that text-books on medicine in the English language are wanting. Since the publication of the last edition of Sir Thomas Watson's work, nearly a dozen treatises—all more or less ably written, and fairly on a level with the most recent observations on medicine and therapeutics—have appeared in Great Britain and America. The translators of Professor NIEMEYER'S work, however, consider that still another is required. Following the example of all modest authors, they usher themselves and their goods into notice by a preface to the effect that all previous works are excellent—most excellent, indeed, except in one particular; and it is to supply this want that they venture "to suppose that an English edition of the work might be acceptable to the medical profession in *America*"; but why an *English* edition of the work might not be acceptable to the profession in *England* also, we are at a loss to see. Be this as it may, the translators have, we think, ample excuse for their venture. It is on account of the vast strides in the sciences of pathology and therapeutics which have been made in Germany of late years, and which are partially recorded in the work before us, that we have the opportunity of reviewing the present edition: and