LONDON
JOURNAL OF MEDICINE,

A MONTHLY

Record of the Medical Sciences.

FEBRUARY 1852.—No. XXXVIII.

## ORIGINAL COMMUNICATIONS.

# A CASE OF TUBERCULOUS DISEASE OF THE UTERUS AND OVARIA; AND A CASE OF POLYPUS OF THE UTERUS.

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DIFFICULTIES in the Diagnosis of Uterine Disease Complicated with Tumours, are constantly met with in practice; and no better method of diminishing these difficulties at present exists, than the comparison of the symptoms and physical signs in cases similar in their nature, and their contrast in cases of dissimilar character. In the two following cases, entirely dissimilar in their nature and terminations, it will be seen that some of the symptoms were most unlike; while there were others which resembled each other sufficiently to show the great care required in the examination and diagnosis of this class of maladies.

The first case is interesting, inasmuch as it presents an instance of the rare localisation of tubercle in the uterus, and the still more rare example of its deposition in the ovaria. Rokitansky even states that he has never seen an instance of ovarian tubercle. The account of this case, and the autopsy, are chiefly taken from the notes of Mr. J. W. Trotter, one of the resident medical officers of St. Mary's Hospital.

### I. CASE OF TUBERCULOUS DISEASE OF THE UTERUS AND OVARIA.

Lydia O., aged 35, was admitted June 13th, 1851, into the Victoria Ward of St. Mary's Hospital. The subject of the present case had been a domestic servant for the last three years. Previously to this, she had travelled three years as the companion to a lady. For the last nine years she had been a widow, her husband having died of phthisis two years after marriage. Until within the last five months, her place of residence had been the country, and her cicrumstances, as regards air, food, etc., had been most favourable to health. Her parents were both dead; they died of phthisis, and her father had suffered from fistula in ano. Out of a numerous family of brothers and sisters, only

the patient herself and a married sister survive: all the rest have been carried off by phthisis. These particulars were, however, only ascertained from the surviving sister, when the patient herself became dangerously ill.

Three months before her admission into the hospital, she suffered unusual pain at the catamenial period. The discharge was very profuse, black, and offensive, continuing for a fortnight. To arrest the flow, ice was applied to the abdomen, and astringents were given internally. From this attack she slowly recovered to a considerable extent. A fortnight ago, she had what she called a bilious attack. After this, she saw the physician-accoucheur of one of the London hospitals, who pronounced her to be suffering from retroversio uteri, and from that only. Previously to her admission, I had seen her once with my friend Mr. Walter Byant.

On admission, she was pale and exsanguineous, but cheerful, and expecting to go out in a short time, as she was engaged to be married. She was free from pain, but passed sleepless nights, suffering great pain at the catamenial periods, which latterly had occurred once a fortnight. Three weeks had now passed over without an appearance.

On examining externally, a tumour of considerable size was found in the hypogastric region. On examining per vaginam, a tumour, about the size of an egg, somewhat painful to the touch, was felt in the posterior part of the vagina, encroaching on the rectum. In front of this, the os and cervix uteri were felt, and the tumour appeared to move with the uterus. The cervix was considerably elongated, but otherwise, the os was perfectly healthy in colour and smoothness. The body of the uterus was larger than natural. Between the tumour felt posteriorly and the os and cervix uteri, there was a deep groove; but it was difficult to pronounce whether the tumour was the fundus uteri bent downwards, or whether it was uterine or ovarian, and attached to the posterior surface of the uterus. I endeavoured to introduce a small gum elastic bougie, so as to ascertain the direction of the cavity of the fundus, but neither the bougie nor the uterine sound could be introduced beyond the cavity of the cervix by gentle pressure. I then bent the bougie in the direction of the tumour, but it could not be made to enter it, the cervix being evidently contracted to an unusual degree.

There had been no swelling of the legs, nor difficulty of micturition. The pulse was 120, weak, small, and rendered quicker by any excitement. The tongue was clean, but slightly red at the tip, and the lips were parched.

On the 22nd of June, she was worse than she had previously been. The night before, she slept badly, having been kept awake by a severe pain, which extended from the loins down to the calf of the left leg. There is a slight coloured discharge from the vagina, but it is the time for the catamenia. She frequently feels as if about to faint; complains of uneasiness and pain in the right iliac fossa.

On the 24th, the flow of the catamenia ceased; but, on the 26th, the secretion returned, and came in gushes. This had generally occurred at the periods since the beginning of her illness. On the 29th, the discharge again disappeared. The day afterwards, she had a slight fainting fit, and was a little griped and purged. From this time, watery, and sometimes fetid discharges took place from the vagina,

with occasional diarrhœa, until the 19th of July, when she had an attack of peritonitis, which was chiefly confined to the right iliac region. She had before this frequently complained of pain in this situation.

As the uterus was certainly increased in volume, this, with the irregular hæmorrhages at the catamenial periods, and the non-sanguineous discharge present, without any sign of disease of the os uteri, in the intervals, seemed to me to point to the existence of polypus, tumour, or some other disease of the uterine cavity, and I felt desirous of ascertaining, if possible, the actual condition of the interior of the uterus. With this view I had introduced, on the 11th of July, a small elongated sponge-tent; and, on the 14th, a second of larger size. By this means I was enabled to pass the finger about an inch into the uterus, but no polypus or tumour could be detected in this situation. The direction of the uterine cavity was found to be nearly natural.

On the 23rd, dulness on percussion was very evident about two inches and a half from the anterior superior spinous process of the ilium, towards the linea alba. Shiverings had several times been observed. The urine was now found to be decidedly alkaline; its specific gravity was 1·014, and quantities of triple phosphates, and some oxalates, were seen under the microscope. There was evidently more fulness on the right than on the left side of the abdomen, and an obscure sense of fluctuation was felt in the enlarged part. The pulse had not been below 120 since the appearance of the peritonitis, and sometimes reached 140. All this time she was greatly troubled with an aphthous state of the mouth and fauces, which rendered it very difficult for her to take even liquid nourishment.

From the end of July to the 18th of August, the case progressed without material alteration, except the steady increase of debility; the urine continued decidedly alkaline, and the pulse high, and there was occasional diarrhœa and strangury. At the time of her admission, and on two or three occasions subsequently, the chest was carefully examined, but no sign of thoracic disease could be detected. On the 18th, cough was first observed, and she complained of a burning sensation in the throat and upper part of the chest. On the 20th, she expectorated purulent and deeply fetid matter for the first time. There was now found to be loud whiffing inspiration and expiration below the right clavicle, and dulness on percussion over the same spot. After this, the chest symptoms rapidly progressed. She became weaker and much thinner; the urine continuing alkaline; the cough troublesome, often producing vomiting; the pulse quick; nights sleepless; tongue covered with aphthæ; vaginal discharge continuing; and, within a day or two of her death, she suffered greatly from pain and constriction across the lower part of the chest,—for all of which symptoms various remedies were used, with only temporary relief, and she died from an attack of hæmoptysis, at five o'clock P.M., August 29.

AUTOPSY. *Thermometer* 56. *Twenty-one hours after death. General appearances.* Body in second degree of emaciation; rigor mortis well marked both in upper and lower extremities. Slight flattening under the right clavicle. Fulness of the right external jugular vein. Post-mortem congestion of the more dependent parts.

*Thorax. Right side.* Recent adhesions of the right pleura. The lobes of the right lung were all bound together by recent adhesions.

External puckering of the apex of the right lobe, on cutting into which numerous grey, hard, semi-transparent tubercles are seen. Middle lobe non-crepitant, except at its base, and quite infiltrated with the same sort of grey tubercle; it sank in water. Lower lobe also non-crepitant; and at one inch and a half from the diaphragmatic, and one-third of an inch from the posterior, surfaces, there was a cavity of about the size of a walnut, with a clot of blood occupying its centre: there was tubercular infiltration of the remaining portion.

*Left side.* Bridle-like adhesions between the costal and pulmonary pleuræ. Puckering at the apex of the left lobe to a greater extent than in the right. On cutting into it, some of the grey and other tubercles were found to be softening: the rest of the lobe was generally healthy. Lower lobe healthy and crepitant, except at the upper part, where there is a small collection of tuberculous matter.

*Heart.* Small, and very firmly contracted (post-mortem); valves, etc. apparently healthy. Quite empty of blood.

*Kidneys.* Both healthy.

*Pancreas.* Firm and healthy.

*Spleen.* Large and soft; filled with blood.

*Liver.* This viscus was enormously enlarged.

*Stomach and intestines.* Were found to be quite healthy on their mucous surfaces, except at the caput cæcum coli, where there was a small ulcerated spot.

*Bladder.* The walls were of the natural thickness, and the mucous tunic appeared healthy, except that it was extremely red, and injected with blood, the injection taking an arborescent appearance.

*Peritoneum.* There were recently-formed adhesions between the parietal surface of the peritoneum and that covering the small intestines. Those on the left side were easily torn through; but on the right, at a point corresponding to the lower margin of the liver, and an inch to the right of the umbilicus, there were very firm adhesions, on breaking through which the finger passed into a cavity bounded above by the lower margin of the liver, below by the transverse colon, and anteriorly by the peritoneum. On tracing onwards, the cavity was found to occupy the whole of the right lumbar region, and then to dip over the brim into the pelvis, with the whole of which region it had communications. It was filled with purulent offensive matter, and the peritoneum bounding it anteriorly had tubercular matter deposited on its surface.

*Uterus and Ovaria.* The uterus was of large size. On cutting into the cavity of the fundus, the mucous surface was found to be disorganised and covered with a shreddy pulpy-looking membrane, which was evidently the uterine mucous membrane in a state of tuberculous disorganisation. This extended to the whole of the triangular cavity of the fundus. The cervix, and the mucous membrane lining the cervical cavity, were perfectly healthy. The substance of the parietes of the uterus was also in a healthy condition. The left ovary was not found in the normal position. It lay deep in the pelvis, behind the fundus uteri. It was of large size, but it was so firmly adherent that it was broken up by the force necessary to remove it. It consisted for the most part of tuberculous and purulent matter, without any traces of normal structure of the ovary. The right ovary was in its natural

position; it was in much the same condition as the left, but less advanced towards softening. It was larger than natural, but not nearly so large as the right ovary. No direct connexion could be traced between the uterine and the ovarian disease, or between the uterus and ovaria, and the large peritoneal abscess.

REMARKS. The symptoms and physical signs, however puzzling during the progress of the case, and particularly at its commencement, require little comment when seen by the light of the post-mortem appearances. It is to be regretted that a microscopical examination of the discharges from the uterus was not made, as this might at once have revealed the nature of the tuberculous affection. The hypogastric fulness at the time of her admission depended probably on tuberculous deposition in the peritoneum, which afterwards softened. The tumour behind the uterus, and which had been mistaken for the fundus, and might readily have been so by the most experienced practitioner, was evidently the left ovary enlarged by the deposition of tubercle, and adhering to the posterior surface of the uterus. The hæmorrhage from the uterine cavity, in the early stage of the disease, no doubt depended upon the tuberculous disease of the mucous membrane. The time when the extensive peritoneal suppuration took place was marked by the alkalinity of the urine, and the alkaline urine in turn caused vesical irritation, the marks of which were found after death.

## II. CASE OF POLYPUS OF THE UTERUS.

On the 17th of April, I was consulted by an unmarried lady, aged 27, who complained of dysmenorrhœal and leucorrhœal symptoms. She had been ill for about eight years, during which time the catamenia had been profuse and attended by great pain, leucorrhœa being very frequent and sometimes profuse in the intervals. In the early part of her illness, there had been great irritability of the bladder and meatus urinarius. During the three months before her visit to me, her health had given way greatly; she was unable to walk without pain, her appetite and digestion were impaired, her complexion had become pale and bloodless, and she suffered from almost constant pain in the lower part of the back.

On making a digital examination, I found the os uteri perfectly closed; it was not tender to the touch, its surface was perfectly smooth and regular, and nothing appeared to exist of a nature to call for specular examination. The body of the uterus was felt to be voluminous and weighty: but, from the abdomen being full and rounded, it could not be felt above the pubis. As the os uteri was closed, and as the flow of blood from the uterus had always occurred at the catamenial periods, I did not at the time suspect polypus, but considered the case to be one of inflammatory hypertrophy of the uterus. I prescribed an astringent injection to check the leucorrhœa, and ordered the bichloride of mercury internally.

On the 7th of June, I was requested to visit Miss —— in the country. She had had an alarming hæmorrhage from the vagina a few days before, which had been arrested with great difficulty, and left her in a very weak and nervous condition. It occurred this time also at a catamenial period, and on examination, the os uteri was perfectly closed; the size of the uterus remained the same as at the

former examination. The pain during the hæmorrhage had been excruciating. In consultation with Mr. Litchfield of Twickenham, who attended Miss ——, the probability of there being a uterine tumour was discussed, but no satisfactory conclusion could be arrived at. The acetate of lead with morphia was prescribed, and the necessary means were agreed upon in case the hæmorrhage should recur.

In the night of June 14th, I was again hastily summoned to Miss ——. The day before, she had been seized with violent pain and flooding, which gave great alarm to her relatives. She lost on this occasion a large quantity of blood, and was at once reduced to a state of the greatest debility. The pain was so intense that she could only be kept in bed with difficulty. Mr. Litchfield had been sent for, and in addition to other measures, gave a dose of the ethereal tincture of ergot, with a view to check the hæmorrhage. The medicine had this effect, but it aggravated the pain greatly. When I arrived she had been taking grain doses of morphia at intervals of two or three hours, the hæmorrhage had abated, and the pain had remitted under the influence of the morphia for some hours.

On passing the finger into the vagina, the cause of all the mischief was at once evident. The cavity of the vagina was occupied by a large polypus; but it was of such a size that the os uteri could not then be reached. Its root was also felt to be of large size. It was evident that the ergot had fortunately, by bringing on a miniature labour, caused the sudden expulsion of the polypus from the uterine cavity; which, otherwise, would probably have remained many weeks before it had made its appearance externally, to the great risk of the patient's life, as, only a few days before, the dilatation of the os uteri had not even commenced. The patient and her friends were much tranquillised by the discovery which had been made, and it was resolved, at an early period, to remove the polypus by ligature.

On the 17th, the tumour could be felt within an inch and a half of the os externum, protruding like the bag of membranes, only more solid; the leucorrhœal discharge was profuse. In the afternoon of this day there was a very slight return of the hæmorrhage, but without pain; after which, the white discharge continued. Owing to the descent of the polypus, the os uteri could now be reached. It was open to the extent of half-a-crown, this extent being a measure of the size of the stalk of the polypus, which was attached to the fundus uteri.

It was decided to apply the ligature on the 19th. Before the application was performed, the rectum and bladder were emptied. We used the double canula of Niessen and Gooch, with the windlass of Laundy, for tightening the ligature from day to day; the ligature itself was the strongest ligature-cord which could be procured. The patient had never been examined, except digitally, and the hymen remained, though the ostium vaginæ was unusually distensible for the virgin state. There was, indeed, the same relaxation of the walls of the vagina which is frequently observed in cases of abortion, occupying two or three days for the completion of the process; and we had determined, if possible, not to destroy the hymen. The patient was placed on her back, at the edge of the bed, the feet resting on two chairs, and the ligature being adjusted on the canula, the two tubes of the instrument,

held closely together, were introduced at the perineal outlet of the vagina, and passed behind the tumour to the upper and posterior part of that canal. The two tubes were now held at their extremities, one in each hand, and being slowly separated at the upper points, were carried easily round the root of the polypus, and made to meet again in the anterior part of the vagina, in front of the polypus. The two tubes being held firmly together, and the ligature drawn moderately tight, the finger was passed into the vagina to ascertain that the ligature had passed round the stalk of the tumour, and that it did not include any portion of the os or cervix uteri. This being done, the apparatus for fixing the tubes was slid up along them and secured, when the ligature was tightened by the windlass until the patient began to complain of pain. A few further turns were made beyond this point, in order to obtain the death of the polypus as speedily as possible, and then the windlass was a little relaxed again. The windlass was now fastened, and left projecting from the anterior part of the vagina, care being taken to secure the patient from being hurt when changing her position, and to prevent any disarrangement of the instrument. In about ten minutes from the commencement of the operation, the patient was again in bed.

In the operation for ligaturing polypus uteri, the patient is generally directed to be placed on her left side; but lying on her back is certainly the most favourable position for the operator. The two tubes containing the ligatures are usually introduced at the side of the polypus, and then one of them is passed round the whole circumference of the tumour until it is brought in apposition with its fellow. It is, however, difficult, if the tubes are introduced in the shallower part of the vagina, to pass one of them round the deeper posterior portion of this canal, when it is filled by a large polypus. The plan I adopted possesses manifold advantages. The tubes were introduced to the greatest depth at the first step of the operation, and in passing them round they had to be withdrawn somewhat, in consequence of the diminished depth of the pelvis anteriorly. The instrument was fastened at the anterior part of the vagina, the situation in which the shortest possible length of the instrument remains in the passage. If the instrument be allowed to remain at the side of the vagina, or in the posterior part of the canal, a greater length is necessarily left in the vagina, and more irritation ensues. No disturbance of the bladder or pain in the vagina occurred in the subsequent management of the present case.[1]

[1] On referring to my case-book, I find, that a few days before the present operation, I removed, with a pair of blunt pointed forceps, a vesicular polypus, of the size of a small pea, from the external surface of the os uteri of a lady, who had been drained by unremitting hæmorrhage for many months. In this case, the catamenia were irregular, not occurring except at intervals of many weeks, but the sanguineous discharge was incessant. Every kind of astringent and styptic, internal and external, had been resorted to in vain. On bringing the os uteri within the field of the speculum, and wiping the surface, a small vesicular mass was seen, with the blood distinctly oozing from it. The blood seemed to filter through the tissue at this spot. The vesicular mass was very small, and I have little doubt that it was nothing more than one of the villi found in this situation in a healthy uterus, enlarged and increased in vascularity. From the time of its removal, no hæmorrhage whatever occurred; and, as the patient regained her

The patient remained the first day or two after the operation extremely weak, and only able to take very small quantities of nourishment. During her illness of many years, her appetite had always been capricious, and now it was more so than ever. The ligature was tightened by turning the windlass daily. Infusion of chamomile was injected frequently, and a weak solution of the chloride of zinc was tried, but this caused so much pain that it was not repeated. The rapidity of the death of the polypus was no doubt heightened by the excessive heat of the weather; and the smell produced was excessively disagreeable to the patient and her friends, in spite of everything which could be done locally and in the air of the apartment to obviate it. On the 22nd, while tightening the ligature, to my infinite chagrin, it snapped. I however fastened it as well as possible, and as I could then obtain nothing suitable for a ligature, I resolved to leave matters as they were until the morrow; and then to pass another ligature if it should be necessary. But when I was prepared to do this, I found, on withdrawing the instrument, that the polypus was so nearly cut through, that by twisting I was enabled to separate it; after which I slowly drew it through the os externum. This was on the fourth day after passing the ligature. The polypus weighed one pound and three quarters; but it was so soft and elongated, that it passed through the distensible hymen without lacerating it. The vagina was now carefully washed out, and injections ordered frequently, to bring away the discharge which might issue from the stump of the polypus. On examining afterwards, the os uteri was found patulous, but capable of contracting upon the finger—just as it would be in an abortion at three or four months.

After the exit of the tumour, the patient suffered much greater distress than in the interval during which the ligature was applied. There was great depression, the pulse being very quick and extremely feeble, the weak action of the heart alternating with palpitation. Sickness was constantly present, nourishment taken by spoonfuls was rejected, and the stomach behaved still more irritably towards medicines. The insomnia was distressing, and continuous. After trying everything that could be devised to allay the gastric irritability, but in vain, we determined to let the stomach rest entirely, and to support the patient two or three days by injections of soup and beef-tea. This was done, and with excellent effect.

The discharge continued profuse for several days; the fever was at its highest on the 25th, when the fetor was intolerable. At that time, also, the depression, and the irritability of the stomach and heart, was such as to make us entertain the most serious fears for the life of our patient. Indeed, on more than one occasion, she seemed to be actually dying. I have no doubt that the discharge was absorbed, and that it

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health, the catamenia returned. Not many days after the occurrence of these two cases, a uterus was shown to me as being of unusual size, taken from a patient who had died of disease of the heart. On cutting into the cavity of the fundus, two black masses were observed, which, at the first glance, were taken to be coagula from their colour, but they were in reality two polypoid tumours, attached by pedicles to the fundus uteri. On the outside of the same uterus, a small fatty tumour was observed. This had probably been a fibrous growth, which had degenerated into fatty matter. The patient had been drained by hæmorrhage, but the existence of polypus had not been suspected.

had poisoned the blood; at least, we could account for the symptoms in no other way. The most severe distress of all was caused by the retention of the discharges in a peculiar way. Injections were ordered at stated times, to clear out the vagina; and it was observed that very little discharge made its appearance. Besides the gastric and cardiac irritation, she now suffered from tympanitis and pain in the epigastrium, with dry hot skin, and a pulse at 130. On making an examination at this time, I found the os externum resisting and painful; it was closed by sphincteric contraction, and the vagina beyond it was largely distended with fluid, consisting of the accumulated discharge and injections. On introducing the finger, the contents of the vagina pumped out with loud explosive noise, and the patient was instantly relieved from the more urgent of her sufferings.

The misery caused by the fetor of the discharge, may be conveyed by the words of a note I received at one of my summonses from her sister, a lady who watched her with the greatest affection. "My sister says she should be better satisfied if I were to tell you myself what her sensations are. The medicine she took last night made her vomit, and she felt then as if what she threw up tasted of the discharge; and afterwards the bed-clothes, herself, those who came near her, the food she tried to eat, all seemed impregnated with it to a horrible degree: and when she fell asleep for a few minutes, on waking, her mouth seemed full of it." I have spoken of her as being poisoned by the discharge and the fetor, and the term is scarcely too strong. Her blood was certainly impregnated, either by the smell or by the absorption of the liquid portion of the discharges. Three distinct series of depuratory efforts appeared to be thus produced. The patient was first affected with fetid and profuse perspirations; then with diarrhœa; and some time after, she had a crop of furuncular suppurations, which I attributed to the same source.

On the 27th, she was still very ill, had slept only one hour the night before, and complained of much pain in the right iliac fossa. With respect to medicine, morphia, in pill, was retained better than anything else prescribed for the sickness; but it produced other discomforts, by locking up the liver. Hydrocyanic acid, ether, champagne creasote, ice, and various other remedies, were tried without much good result. The pain in the iliac region was relieved by a sinapism; it was evidently dependant upon the looseness of the bowels.

The vaginal discharge slowly diminished, and after this the most distressing symptoms subsided. I continued to see her daily until the 30th, when she had so far recovered, that from that time I only saw her at intervals. The irritability of stomach subsided; she took food, and at first vegetable, and then ferruginous tonics. In the middle of July, she had so far recovered as to be able to take a short ride daily; and at the end of two months, she went to the sea-side. It was here that the furuncular eruption came on. She was still, however, quite unable to walk more than a few steps. I saw her before her departure for the sea, when she was complaining of fulness of the abdomen, and a sense of uneasiness in the pelvis. The patient herself was afraid of dropsy, or a return of her disorder. On examination, there was just the feeling we find two or three weeks after labour, but no swelling of the feet or ankles, and no fluid to be detected in the abdomen. The

urine was of proper specific gravity; there was no albumen; the quantity secreted in the twenty-four hours was natural. The uterus was found to be still larger than natural, and in a state of partial prolapsus. The latter condition was the cause of her being unable to walk. On her return from the sea-side in September, as the sense of bearing down, and difficulty in walking or standing for any length of time continued, with some amount of leucorrhœa, the cold water douche, with a tannic acid injection, were prescribed. These measures produced her complete recovery; the catamenia appeared naturally, and she was able to take proper exercise, becoming, in fact, "quite well."

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## ON VENEREAL AFFECTIONS OF THE EAR.

By WILLIAM HARVEY, Esq., Surgeon to the Royal Infirmary for Diseases of the Ear.

THE ear is subject to both the gonorrhœal and syphilitic forms of the venereal disease: in the present paper I shall confine my remarks to gonorrhœal otitis and otorrhœa.

As far as my reading has informed me, this disease of the ear has entirely escaped the notice of British surgical writers; I am not aware that even a single case is on record either in our systematic works on surgery, or in any of the English medical journals; and I am, on this account, the more anxious to call the attention of the profession to what I have found to be a most formidable and destructive disease.

Every surgeon is familiar with an obstinate form of infantile otorrhœa which occurs shortly after birth, not unfrequently destroying the organ, and producing, as a consequence, both deafness and dumbness for life. Is the lining membrane of the external meatus, like that of the conjunctiva, susceptible of the contagion of gonorrhœal matter, and the specific inflammation which constitutes that disease? This very natural inference has for many years suggested itself to me, in reflecting upon these most miserable cases. My attention was, however, newly awakened to this possibility by the following case, which occurred in my Dispensary practice in the spring of 1849.

J. B., a baker's man, aged twenty-three, had been confined to his bed for ten days with gonorrhœal inflammation of the urethra and swelled testicle. The account he gave of himself was, that during his confinement in bed, he had been seized with intense itching in his ear, accompanied with paroxysms of pain; and shortly afterwards, there issued a profuse yellowish discharge from the meatus auditorius externus. The pain in some measure subsiding shortly after the discharge had set in, he delayed speaking of it to his medical attendant for two days. Upon examining the ear at this period, I found the auricle red and swollen, a profuse discharge from the meatus, and the mucous membrane red and thickened. Having cleansed the parts from the discharge, for the purpose of more accurately examining the condition of the membranum tympani, I found this membrane already