CRITICAL DIGEST OF THE BRITISH AND FOREIGN MEDICAL JOURNALS.

ANATOMY AND PHYSIOLOGY.

CLARKE ON THE STRUCTURE OF THE SPINAL CORD.

MR. J. LOCKHART CLARKE, in a paper on the Structure of the Spinal Cord, published in the *Philosophical Transactions* for 1851, gives the following summary of the principal facts described by him.

The posterior grey substance, at the lower extremity, and in the dorsal region of the spinal cord, consists only of a single mass; and the substantia gelatinosa there extends uninterruptedly across from one to the other. The nerve fibres of the grey substance, including those of the *substantia gelatinosa*, are not grey fibres bearing nuclei, like those of the sympathetic, but fine tubules. Two considerable columns of caudate vesicles (*posterior vesicular columns*) in intimate connexion with the posterior roots of the nerves, extend the whole length of the cord; commencing small at its lower extremity, increasing in size in the lumbar and cervical enlargements, and terminating at the upper part of the medulla oblongata. The number of caudate vesicles, particularly in the anterior grey substance, is in direct proportion to the size of the nerves. The column of vesicles into which, in the cervical region, the spinal accessory nerve may be traced, extends down the cord as far as the lumbar enlargement. A considerable branch of the spinal accessory nerve, after entering the grey substance through the lateral column, may be easily traced to the caudate vesicles of the anterior cornu. The spinal accessory is the only nerve immediately attached to the lateral column. The posterior roots of the spinal nerves are immediately attached to the posterior white columns only; and the anterior roots to the anterior columns only; but fibres from both these roots, after traversing certain portions of the grey substance, pass out again into the white columns. Neither the anterior nor the posterior white columns are connected by a transverse commissure. The central portion of the grey substance, immediately surrounding the spinal canal, is not a commissural structure, but a layer of fine fibrous tissue for supporting the walls of the canal, which is lined with a layer of columnar epithelium.

PRACTICE OF MEDICINE AND PATHOLOGY.

ALLIN ON RETRO-PHARYNGEAL ABSCESS.

We abridge an article on Retro-Pharyngeal Abscess, by Dr. D. C. M. ALLIN, from the *New York Journal of Medicine* for November 1851.

The formation of abscesses between the posterior wall of the pharynx and the cervical vertebræ, is not so rare as the general silence of writers on the subject would lead us to believe. A number of cases are, indeed scattered throughout the periodicals; but they lose much of their utility, by not having been hitherto grouped. The author's attention was directed to the subject by two cases, which he observed in the New York Hospital in 1850: in the first of which, the symptoms were attributed during life to laryngitis; and in the second, to syphilitic ulceration of the throat. He has met with reports of fifty-eight cases; which he has tabulated at the end of his paper.

Retro-pharyngeal abscess has been met with in an infant in the first month, and in the adult of sixty years. Of the cases recorded, however, most were observed in children under ten years. The more frequent occurrence of abscess at this period, perhaps, in many instances, is attributable to an hereditary scrofulous diathesis. In nearly all these patients, the disease is traceable either to an inflammation, enlargement and suppuration of the

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lymphatic glands, behind the pharynx, or to caries of the vertebræ. The irritation and tendency to inflammation, always attendant upon the process of dentition, may also have some influence. Two distinct forms of abscess require attention: the *acute* or *idiopathic*, depending upon a local acute inflammation; and the *chronic* or *symptomatic*, consequent upon disease primarily affecting the cervical vertebræ. These varieties present many points of resemblance, both in their effects upon neighbouring organs, and in their surgical treatment; but in their origin, progress, pathological conditions, and medical treatment, there are many and strongly-marked distinctions.

ETIOLOGY. 1. OF ACUTE ABSCESS. *a. Predisposing Causes.* Retro-pharyngeal abscess may be the result of an hereditary scrofulous tendency; or of syphilis; of long-continued habits of intemperance; of difficult dentition; or of that state of the system, and locally, of this region, resulting from various cutaneous diseases, and especially those complicated with soreness of the throat, such as scarlatina, variola, and others.

b. Exciting Causes. One of the most common exciting causes is exposure to cold and damp air, followed by an inflammation in the pharynx itself, this inflammation proceeding to suppuration, the pus being deposited between the proper pharyngeal fascia, and the muscles of the pharynx lying upon it. Dr. C. Fleming, in an article upon this disease (*Dublin Journal of Medical Science*, vol. xvii), asserts his belief that it frequently arises from acute inflammation of the small lymphatics behind the pharynx. In some of the cases, suppurative inflammation was induced by the presence of foreign bodies in the pharynx, such as a bone of a fish. M. Mondière, and M. Prion, of Nantes, have assigned "retrocession of erysipelas of the face", as the cause of abscess of this kind. In the earliest of the cases at the New York Hospital, to which I have alluded, erysipelas of the face must have coexisted with, and it is possible that it was the cause, direct or indirect, of the abscess. Stricture of the œsophagus, or of rheumatism, has been mentioned as a reason for inflammation and acute abscess in this region. Sometimes the abscess is developed without any assignable immediate cause.

2. OF CHRONIC ABSCESS. *a. Predisposing Causes.* These are of the same character with those of the acute form.

b. Exciting Causes. Chronic abscess behind the pharynx is referrible, in nearly every instance, to caries, or to tubercular disease of the cervical vertebræ. The process of formation in *psoas* abscess is precisely identical with that connected with the upper portion of the vertebral column.

The irritation and subsequent inflammation produced by the presence of a fish-bone, may be, indirectly, the origin of a chronic abscess, by producing, primarily, caries of a vertebra. A case of this kind, the bone piercing the pharynx, and entering the body of one of the vertebræ, is recorded in the *London Lancet* for June 1847, p. 581.

SYMPTOMS. 1. OF THE ACUTE ABSCESS. The premonitory signs, like those of nearly all inflammatory affections of the throat, are, an undefined sensation of local uneasiness, stiffness in the back of the neck, accompanied with chilliness, followed, in a greater or less degree, by febrile excitement. These general symptoms are soon succeeded by pain and soreness in the throat, aggravated during deglutition. Febrile excitement is not, in all cases, well marked, for very frequently the feeling of chilliness is continuous. In very young children, the commencement of the disease may be attended by convulsions. Associated with the pain and soreness of the throat, there is not unfrequently œdematous swelling of the anterior and lateral portions of the neck, sometimes very extensive, and liable to occupy the attention to the neglect of the actual source of danger. This symptom is also common to this disease and to œdematous laryngitis, an affection in which it is of exceedingly great importance that an early and accurate diagnosis should be made.

As the disease advances, pain and soreness of the throat are increased; a

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peculiar fulness about the fauces, and a sensation as of some foreign body arrested at the base of the tongue, are experienced; deglutition becomes difficult and painful; the patient complains of excessive thirst; the respiration, at first attended with a slight snuffle, becomes laboured, irregular, sometimes hissing, at other times stertorous or roaring, or accompanied with a gurgling sound, from the passage of air through the viscid mucus, which collects about the fauces; the voice is very much changed, becoming markedly nasal, and resembling that consequent upon cleft palate; a cool perspiration, more or less profuse, appears about the head; the face and surface of the body are pallid; the pulse is sometimes full and forcible, but always quick and very frequent. If the disease is allowed to proceed, the symptoms are rapidly aggravated. The dysphagia becomes very severe, even fluids taken into the mouth being immediately rejected, chiefly by the nostrils. The breathing is more laborious, and interrupted by frequent and convulsive paroxysms of dyspnœa, or of suffocative cough, threatening immediate death. At this stage, also, in young children, the dyspnœa is liable to produce fatal convulsions. At other times, somnolency, or perhaps coma, is a prominent feature in their case. The paroxysms are induced or rendered more severe, by attempts to swallow, or by the horizontal position, and the patient consequently maintains an erect or partially erect posture. During these attacks of suspended respiration, the face is flushed, and sometimes of a dark leaden hue, the head thrown forcibly backward, the lower maxilla projected, the lips livid and cold, the tongue often protruded, and the pulse exceedingly rapid, sometimes 130 or 140 in a minute. Should the tongue be retracted within the mouth, and the patient requested to protrude it, it is spasmodically thrust out, and returned with considerable difficulty. There is also frequently a coarse mucous râle to be heard along the course of the larynx and trachea.

Upon examining the throat, there *may be* detected more or less congestion of the internal surface of the mouth and pharynx; and, with this, there may be also swelling and redness of the tonsils, and of the epiglottis. Should the abscess extend above the level of the glottis, as is the fact in nearly every instance, a tumefaction of the pharyngeal parietes can be seen, upon which is spread out the velum of the palate. If the forefinger be passed to the posterior wall of the pharynx, a firm, elastic tumour can be felt, commonly ovoid in shape, situated between the vertebræ and pharynx, pushing forward the latter, and, in many instances, even separating the alæ of the thyroid cartilage of the larynx. The tumour may not always be found directly in the median line, and it may involve other organs in the neighbourhood. It is almost impossible to obtain, satisfactorily, the sensation of fluctuation in this region, as but one finger can be passed down to the swelling.

When the termination is fatal, death is almost always the result of asphyxia, produced by compression upon the larynx; though it may be caused by the opening, either spontaneous, or artificial, of the abscess, its contents passing into the larynx and trachea.

2. Of the Chronic Abscess. The chronic variety of this abscess is almost universally symptomatic of some constitutional disease, of hereditary or specific origin; and the most frequent of these is caries of the vertebræ. The symptoms which belong exclusively to it are manifested, principally, during its formation, and are similar, with a few local modifications, to those attendant upon vertebral caries generally. Among the earliest of these are stiffness and dull pain about the neck, posteriorly, increased by the movements of the head, and, in some instances, most severe in the evening and night. Very frequently these phenomena are, for a long time, overlooked or neglected, or attributed to other causes than vertebral disease, a neglect which involves consequences of the most serious character. As the abscess becomes augmented, these symptoms become more marked, and are sometimes accom-

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panied by partial or complete closure of the jaws. The abscess is liable to extend farther than in the acute form. The purulent matter may find its way downward, through the loose areolar tissue behind the œsophagus, even into the posterior mediastinal space, or into the lateral portions of the neck, beneath the deep fascia. In a case reported by Dr. Clark, of New Jersey, the abscess not only existed behind the pharynx, but "extended from the mastoid process along the course of the sterno-cleido-mastoid muscle of the right side, to the situation of the thyroid gland, which is fully occupied, giving the appearance of goître." All these symptoms may continue, and the abscess constantly increase in size, for an extended period, before producing any phenomena which excite alarm, and demand immediate and active treatment.

When the collection of purulent matter begins to press upon and interfere with the function of important neighbouring organs, another class of phenomena is presented. Dysphagia, increasing in severity, is followed by excessive dyspnœa, and nearly all the symptoms of acute idiopathic abscess. In the latter stages of many cases of the chronic variety, fever, of a low typhoid character, makes its appearance, and, unless it is promptly met and skilfully treated, death will inevitably ensue. The alleviation of the dysphagia, too, by opening the chronic abscess, is not always as satisfactory as in the acute form; for, by the long-continued tension, and greatly increased thickness of the posterior wall of the pharynx, its elasticity and contractile power are very much impaired, and the obstruction of the canal continues nearly as complete as before the opening.

Diagnosis. A local examination by the eye, or the finger, or by both, will generally reveal the true character of the disease: but this examination cannot always be satisfactorily effected. This is especially true in very young children, for obvious reasons, so that diagnosis must be derived principally, if not wholly, from the rational signs: and complicated, as these sometimes are, with convulsions, or cerebral derangement, they are very liable to misinterpretation.

The disease which most resembles *acute* pharyngeal abscess, and with which, therefore, it is most liable to be confounded, in the earlier period of life, is *croup*. Very many are identical with those which occur in the course of an ordinary case of croup. There are, however, some well-marked points of difference between the two diseases. In the first place, the commencement of an attack of croup is very different from that of pharyngeal abscess. In the former, the peculiar crowing cough marks the beginning of the disease, in almost every instance, and difficult and audible respiration is present from the first; in the latter, the crowing cough is never heard, and dyspnœa, increasing *gradually* in severity, is always and necessarily preceded by difficulty of deglutition, which is seldom urgent in croup. Again, in croup, the difficulty of breathing is often very much relieved when the head is low, and is not increased by external pressure upon the larynx; in retro-pharyngeal abscess, the assumption of a horizontal position is immediately attended with most severe aggravation of the dyspnœa, and pressure against the larynx produces a similar effect, though in a less degree. In croup, the voice is at first hoarse, then weak and whispering, but always distinct; in pharyngeal abscess, there is an obstructed nasal or guttural modification.

A specimen of a singular form of retro-pharyngeal abscess, the symptoms having been attributed to spasmodic croup, was exhibited at the first meeting of the Pathological Society of London, by Dr. Peacock. "The sac of the abscess, which was the size of a small egg, was seen situated between the bodies of the upper cervical vertebræ and the back of the pharynx, not causing, however, much projection of the latter, from its being flattened in front. In connexion with the anterior surface of the sac there sprang a small cyst, forming a nipple-like prolongation into the pharynx, and completely closing the orifice of the glottis. It admitted the point of the little

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finger, and was freely moveable, and perfectly translucent at its extremity and sides. The preparation was from an infant seven months old. The child had occasionally suffered from dyspnœa for three weeks, the symptoms having been very urgent for the last three days of its life. In the intervals of the dyspnœa, the respiration was natural, but the slightest exposure to cold, motion, or excitement, brought on a recurrence of the symptoms, which were attended, in inspiration, with a croupy sound."

Acute pharyngeal abscess may be confounded with *laryngitis*, with *œdema of the glottis and epiglottis*. The one can, however, be almost always distinguished from the other, if it be remembered that, in cases of œdematous effusion, difficulty of breathing is most urgent during an *inspiration;* while, in this form of abscess, the dyspnœa is nearly the same during expiration as during inspiration. The sensation communicated to the finger is very different. In the one case, a soft pultaceous swelling is felt just at the base of the tongue, and the epiglottis, swollen and curled upon itself, is detected with comparative ease; in the other, the tumour is hard and elastic, situated *behind* the larynx; and the epiglottis may be felt or seen entirely free from œdema. The more rapid progress of inflammation, and the total absence, or comparatively small degree, of dysphagia in laryngitis, will also aid in the diagnosis.

Chronic pharyngeal abscess has been mistaken for stricture of the œsophagus, for syphilitic ulceration of the throat, and for wry neck. Thorough exploration, then, is the great means by which this affection is to be distinguished from others occurring in the neighbourhood.

PATHOLOGY. The appearances presented by abscess in this region do not materially differ from those of abscess elsewhere. The only peculiarity worthy of special notice is connected with the chronic variety. One of the causes of this form is scrofulous disease of the vertebræ; and it is an important fact that, while in the lumbar and dorsal regions the *bodies* of the bones are the seat of the disease, in the cervical region it ordinarily is confined to the *articular surfaces*. For this reason, in long-continued cases, in which the abscess has been opened, and the disease has not been arrested, dislocation of the vertebræ may take place, and death may be the result of laceration or compression of the spinal cord.

PROGNOSIS. In cases of its acute variety, if the disease is recognised, and the proper treatment employed, a favourable termination may be expected. If it passes unrecognised, and no spontaneous or accidental opening into its cavity be made, death is certain. In chronic cases, the result of treatment is not always so satisfactory. The existence of an abscess may be definitely ascertained, and immediate and essential relief afforded by opening it; yet the disease of the bones may not be benefited by treatment, but continue to annoy the patient, until dislocation, or want of nutrition, terminate the case. In chronic cases, too, the pus may extend downwards, in the loose areolar tissue behind the œsophagus, into the thorax, death being produced by an inflammation of the pleuræ and lungs, induced by this contact of purulent matter; and again, it is possible, that the prognosis may be modified by the formation of metastatic abscesses in one of the important internal organs, as the liver, or the lungs.

TREATMENT. The proper treatment is divided into *surgical*, or that adapted to a removal of the immediate cause of the urgent symptoms, and *medical*, or that by which the patient is restored, as nearly as may be, to his original condition.

The surgical treatment of retro-pharyngeal abscess must be the same in both the acute and chronic forms. A temporary relief to the alarming dyspnœa has sometimes been afforded by laryngotomy, performed under the idea that the disease was croup. The alleviation of the dyspnœa has been prompt, and apparently satisfactory, but a speedy return of all the fearful phenomena has given a fatal termination to the case. Tracheotomy has also been

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adopted, as a remedy for the same symptom, but with the same ultimate result as laryngotomy, though somewhat longer delayed. These operations, therefore, at best, are only palliative in their effects.

The only method of operating from which permanent benefit can be expected, is that of a free opening into the cavity of the abscess, through which its contents may be discharged, and the immediate cause of the dyspnœa and dysphagia thereby be, partially at least, removed. This opening may be made in various ways. Dr. Allin adopts the following method. The head of the patient being firmly supported by an assistant, pass the fore-finger of the left hand into the mouth, raise the velum palati, and press the point of the finger against the tumour. Then, with an ordinary scalpel, or bistoury, the blade being covered with adhesive plaster to within half an inch of its extremity, let a free incision be made, in the median line, through the posterior wall of the pharynx, into the cavity of the abscess; withdraw the instrument, and the operation will be completed. The pain attending the operation will not be great. By making a free incision at once, the necessity of repeating the operation is avoided, and the discharge of the purulent collection is more complete and satisfactory. No fistulous track is left to annoy the patient, and the recovery is more speedy, than when only a small opening is made. Should the position of the abscess be such, as to render it advisable that the incision be made at either side of the pharynx, particular care should be observed to avoid wounding the internal carotid artery, an accident which has occurred in opening an abscess of the tonsil.

The abscess being thus opened and the dyspnœa relieved, our attention must now be turned to the subsequent treatment of the case. And here we find it necessary to recur to our former divisions of this abscess into the acute and chronic forms.

The treatment adapted to cases of acute pharyngeal abscess, after the purulent matter is discharged, consists in the external application to the neck of emollient and soothing remedies, such as poultices or warm fomentations, until the urgent symptoms shall have been entirely relieved, and the quantity of discharge from the abscess shall have been much diminished. When this result has been obtained, the recovery may often be facilitated by the employment of some astringent gargle. A very excellent combination for this purpose is the following: ℞. Biboratis sodæ ʒij; tincturæ myrrhæ ℥j; syrupi simplicis ℥ss; aquæ puræ ℥viss. Misce. Generally, tonics, and in many cases, even stimulants, may be required. For the fulfilment of this indication, probably no better article can be recommended than the sulphate of quinine.

This treatment, in connection with a nourishing diet, steadily persevered in, will, in almost every instance, restore the patient to his accustomed health, the time required for his complete recovery being subject to some variation.

In the medical treatment of chronic abscess behind the pharynx, our principal assistance must be derived from constitutional remedies, and these will differ according to the cause of the abscess, whether scrofula, syphilis, or caries of the vertebræ. Rest, tonics, and nourishing diet are chiefly to be relied on.

ARREST OF DEVELOPMENT A SIGN OF CRETINISM.

At the meeting of the Academy of Sciences, on November 17th, 1851, M. Baillarger read a memoir on arrest of development, considered as a characteristic sign of cretinism.

Cretinism is supposed by some to be essentially connected with more or less congenital deprivation of intellect—idiocy. Others add to this a state of physical degradation as a requisite condition. M. Baillarger assigns to cretinism, as a peculiar essential character, arrest of organic development.

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He has examined the subject with regard to the organs and functions, especially those of dentition and puberty.

In some cases, he has ascertained that the second dentition did not commence until from the eighteenth to the twenty-fourth year; and that at that age there were frequently no signs of puberty. In these subjects, the stature remains small, the countenance infantile, so that the individuals would at first be taken for children eight or ten years old. Like children, they have a narrow chest, a prominent abdomen, slender limbs, and no development. It is also a remarkable fact, that the pulse remains as frequent in them as in children. In conclusion, he defines cretinism as the incomplete, irregular, and often very slow development of the organism.

This definition establishes a well-marked line of distinction between cretins and idiots. In congenital idiocy, the constitution acquires its full development, and the cerebral system alone is arrested in its evolution. [*L'Union Médicale*, 20th November, 1851.]

KUNZMANN ON THE DIARRHŒA OF CHILDREN.

DR. KUNZMANN, of Löwenberg, in an article published in the *Journal für Kinderkrankheiten* for September and October 1851, states that he has arrived at the following conclusions:

I. Cases of diarrhœa in children are to be divided into *sporadic* and *epidemic*.

II. Sporadic diarrhœa arises from various causes, chiefly from such as give rise to irritation or inflammation of some part of the mucous membrane of the intestinal canal.

II. The treatment of sporadic diarrhœa depends on the causes, which must be removed, on the amount of inflammation present, and on the amount of exhaustion which the child has suffered. Special rules cannot be laid down, as the cases vary much; and it will depend much on the sagacity of the physician to determine whether he is to use emetics or purgatives; leeches or fomentations; neutral salts or emulsives; astringents, stimulants, or opiates.

IV. Epidemic diarrhœa in children occurs under two principal forms—dysenteric (enterocolitis, enteritis), and choleriform (*diarrhœa choleriformis, cholera infantum*). Less marked cases sometimes occur, and sometimes appear as mild diarrhœa, sometimes as mild gastro-enteritis or colitis, sometimes as diarrhœa with typhoid symptoms.

V. The treatment of these epidemic forms must be much more decided than that of the sporadic, inasmuch as the type is more strongly defined.

Dr. Kunzmann has had opportunities of witnessing an epidemic of each form of diarrhœa—the dysenteric and the choleroid; and he describes the symptoms which he observed in each form; these, however, will be understood from the designations. The dysenteric form attacked children from three years old to ten; the choleroid, children from five months to ten years.

TREATMENT. In the dysenteric diarrhœa, Dr. Kunzmann found no indications for blood-letting; not even when there was active fever, great tenderness of the abdomen, severe colic, and tenesmus, did he deem it proper or advantageous to apply leeches. In very severe tenesmus he used clysters, first of lukewarm water, then of cold water. As an internal remedy, he gave at first small doses of castor-oil; and, when there was very active fever, hot skin, and very severe pain in the abdomen, he alternated this with small doses of calomel, with carbonate of magnesia and gum. When the inflammation has somewhat lessened, and when the skin was cooler and the dejections less copious, he found carbonate of magnesia with bismuth and charcoal very useful. To a child from three to five years old, he gave gr. i or gr. ij of bismuth, gr. iv or gr. v of carbonate of magnesia, and the same quantity of charcoal of poplar wood, every three or four hours. Sponges

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dipped in cold water were also applied to the anal region. With these remedies, he obtained favourable results.

In the choleriform diarrhœa, observed last summer, the treatment was more difficult. Sometimes the vomiting was so violent, and the children collapsed so rapidly, that there was no time for medicine. Happily, these cases were the exceptions. When the tongue was loaded, and there appeared to be a bad taste in the mouth, emetics of ipecacuanha with oxymel of squills were very useful. In other cases, Dr. Kunzmann gave moderate doses of carbonate of soda; and he has a very high opinion of this remedy. The inclination to vomit diminished, and entirely disappeared; and the dejections became feculent. After the vomiting had ceased, fever often supervened, with evening exacerbations. The carbonate of soda was still continued; but, in the intervals, disulphate of quinine or tincture of cinchona was administered. Dr. Kunzmann gave this, because he believed the disease to be traceable to a malaria; and the results corresponded with his expectations.

DANGEROUS GASTRO-INTESTINAL IRRITATION, AN EFFECT OF TARTAR-EMETIC GIVEN IN PNEUMONIA.

In the *American Journal of the Medical Sciences* for October 1851, Dr. Boling, of Montgomery, Alabama, calls attention to a dangerous effect which he has frequently observed to follow the use of tartar emetic in cases of pneumonia. It must be premised, that the amount given appears to have been from six to ten or twelve grains in the twenty-four hours: and that the effect in question seems to have been observed mostly in the Southern States. No distinct account of it is given by the Italian followers of Rasori; although, perhaps, the condition described as "loss of tolerance", may be in some instances identical with the result referred to by Dr. Boling.

The following is Dr. Boling's description of the phenomena. "Supposing the remedy to have been continued several days, the phenomena are developed much in the following manner. The patient may be seemingly doing well under the continued use of the remedy; the dulness on percussion, and the frequency of the pulse diminishing; the skin perhaps becoming moist, and the respiration improving. Suddenly in some cases, in others somewhat gradually, the patient becomes restless, the thirst is augmented, the discharges from the bowels are more numerous and thin, the abdomen becomes tympanitic and perhaps tender, the tolerance is lost, and, though he may not have done so for several days, he vomits, or makes frequent attempts to do so; the tongue becomes dry and pointed; there is jactitation present, anxiety of countenance, delirium, and perhaps stupor a short time before death. Occasionally jaundice supervenes; and in a few cases the matter vomited bears a close resemblance to that ejected in yellow fever. During the progress of the change, the pulse becomes more frequent, hard, concentrated, small, and thready. The rapidity with which the symptoms mentioned are developed varies a good deal. In some instances, death has taken place in about six hours; in every respect, up to that time, the progress of the case being apparently favourable, and the graver symptoms subdued. Often the case is protracted to ten or twelve hours, or sometimes longer.

"Simultaneously with the changes above spoken of, or, as it were, preceding them rather, more or less rapid disappearance of the signs and symptoms of the primary disease takes place. From a state of almost complete solidification of a single lung, with dulness on percussion, and bronchial respiration; in the course of four or five hours, the pulmonary tissue has become permeable, and the chest resonant and yielding a healthy respiratory murmur; a corresponding improvement in the cough, thoracic pain, difficulty of breathing, etc., proceeding at an equal rate. The rapidity with which this change in the condition of the lung takes place is proportionate to the violence and rapidity of the newly developed abdominal disease.

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"In many cases of pneumonia under antimonial treatment, although the patient may seemingly have been doing well, the supervention of the slightest tympanitis, with augmented thirst, and a tendency to diarrhœa, may be regarded with suspicion, as the probable precursors of a very grave condition; and I am now led to regard the patient's doom as almost settled, when, in addition to these symptoms, there is a *rapid* instead of a gradual removal of the dulness on percussion, *unattended with the crepitant râle of resolution.*"

Dr. Boling observes, that this affection is more readily produced when tartar emetic is combined with calomel. Except by some American writers, it does not seem to have been described; but Gölis refers to fatal enteritis as being developed under the long-continued or incautious use of calomel in hydrocephalus and croup—the symptoms of the original disease disappearing *suddenly*.

To obviate the result, Dr. Boling has adopted the plan of giving smaller quantities—three, four, or at most six grains daily in six ounces of water—in small and frequently repeated doses, viz., a tea-spoonful every half-hour; or two tea-spoonfuls every hour during the night. This plan generally succeeds. He has also tried the plan of giving the tartar-emetic in enemata—three grains every third hour, with fifteen or twenty drops of the tincture of opium in an ounce of water; the results have in general been favourable.

SIMULTANEOUS OCCURRENCE OF MEASLES AND SCARLATINA.

In the winter of 1850-51, scarlatina prevailed in Vienna; and was followed by measles. As the former diminished, and the latter began, a combination of the two was often observed. Cases occurred in which, on the third day of the eruption of measles, scarlatina appeared, occupying the interspaces between the spots of measles; the pulse was very frequent, the tongue of a purple red colour, and cerebral congestion was imminent. In some instances, measles and scarlatina broke out together; on the face and glutæal region there were scarlatina, and on the hands and feet a morbillar eruption; the pulse and tongue were those of scarlatina, and angina was violent. The simultaneous appearance of the two exanthems was always attended with much danger. Those cases were of less importance, in which scarlatina supervened after or during the desquamative period of measles. [From Dr. L. W. Mauthner's *Report of the Clinical Department of St. Ann's Hospital for Children in Vienna*, as quoted in *Journal für Kinderkrankheiten*, Sept. and Oct. 1851.]

NUX VOMICA IN ASTHENIC DROPSIES.

Serous infiltration of paralysed limbs disappears with the paralysis; which latter is sometimes cured under the influence of nux vomica. This remedy acts not only on the nerves of animal life, but also in those of organic life: it produces contraction of the muscular coat of the intestines, and is hence a good remedy in constipation from inertia of the intestinal canal. M. Teissier has been led to try whether it would act on the absorbents, so as to promote the removal of effusions connected with general or local asthenia. He relates five cases, in which the use of the medicine was successful; and he does not seem to have had failures.

In the first case, there was œdema of the lower limbs, appearing after recovery from diabetes. In a month, the œdema was removed, but the diabetes reappeared; on the removal of which, the œdema again appeared, but was cured by the use of nux vomica. In the second case, the patient, from bad nourishment, had considerable œdema of the lower limbs, and commencing ascites. Nux vomica was given. At the end of eight days, there was marked improvement; and the cure was complete in twenty-five days. In the third case, there was ascites and œdema of the lower limbs,

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following intermittent fever. Bark and iron were tried without success. Eight days after nux vomica had been first given, the patient felt cured. In the fourth case, œdema of the limbs, following typhoid fever, was cured in fifteen days.

The dose of nux vomica is from two to five centigrammes (gr. $\frac{1}{3}$ to gr. $\frac{3}{4}$) in the day.

M. Teissier as yet only asserts nux vomica to be applicable in cases of asthenic dropsy, unattended with any material obstacle to the passage of the fluids in the vessels, such as compression of a vein. [*Gazette Médicale de Lyon*, as quoted in *Gazette Médicale*, 11th October, 1851.]

SURGERY.

TUBERCLE IN THE VESICULÆ SEMINALES.

M. Bourdel, of Montpellier, relates the following case in the *Gazette Médicale de Toulouse* for November 1851. It is quoted in *L'Union Médicale* for November 27th.

Cases of tubercle in the vesiculæ seminales are rare. M. Lallemand relates only one case; M. Louis, one; M. Lebert does not mention them.

Case. In a young man, aged 23, who had died of pulmonary phthisis, and in whom numerous tubercles in all stages were found in the lungs, the right vesicula seminalis was three or four times its natural size. It was of a dull white colour, of harder consistence than natural, and of irregular form: the posterior part was curved inwards, so as to form an angle. Towards the lower part, it was soft, and fluctuation could be detected with the finger. On being cut open in its long diameter, the posterior portion was found to contain a cheesy, white, thick matter, very dense at some points. The anterior part was in a complete state of suppuration; and, on incision, some whitish unhealthy pus, containing a little cretaceous matter, escaped. There were no traces of semen, nor of partitions; but the envelope was throughout very dense and thick. The deferent canal ending in the vesicle was enlarged for four finger-breadths above, and contained tuberculous matter, part of which had suppurated. In the rest of its course, it was healthy; but the external extremity of the epididymis, on the same side, contained a tuberculous mass of the size of a nut. The ejaculatory duct was completely destroyed. The prostate gland contained two masses of crude tubercle, contrasting strongly, in their greenish white colour, with the grey appearance of the prostate.

CASE OF MOLLUSCUM DEVELOPED BY AN INJURY.

In the *American Journal of the Medical Sciences* for October 1851, Dr. H. H. Smith reports a case, of which the following is a summary.

A woman, aged 56 years, previously in good health, pinched the skin of the arm; six weeks subsequently she noticed a spherical tumour, with a broad base, firm and resisting, moveable, and with the skin unchanged; no pain in the part; no other tumours elsewhere. Ten months after this, the principal tumour had attained the size of an egg, was lobulated, and had smaller tumours around its base; indurated lymphatics extended from it up the limb, but the skin remained natural. Caustic removed the tumour, and the ulcer healed. Six months subsequently, the tumours reappeared near the elbow. Caustic applications removed a considerable part of the enlargement, but left an unhealthy ulcer, accompanied by sloughing and frequent hæmorrhage. New tumours formed above the elbow, were removed, and then, the general health becoming impaired, the limb was amputated, nineteen months after the original exciting cause. Notwithstanding the absence of lymphatic disorder about the stump, the tumours reappeared in six weeks

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upon the head, then all over the body, excited violent neuralgia, and resulted in death about two years from the first appearance of the disease. General inspection and microscopic examination indicated the presence of albuminous matter, similar to that of medullary sarcoma.

HYDRASTIS CANADENSIS IN GONORRHŒA.

In the *Ohio Medical and Surgical Journal*, as quoted in the *New York Journal of Medicine* for November 1851, Dr. M. M'CANN recommends the use of an injection of hydrastis Canadensis (yellow root, orange root) in gonorrhœa. He says that he has used it in several cases in various stages, and always with the most satisfactory results; more especially in males. The ardor urinæ, and discharge of mucus, have been suspended in from twenty-four to seventy-two hours. Sometimes he used balsams of copaiba, sometimes injections of the infusion of hydrastis alone; but with about the same results. As a general rule, one drachm of the dried root makes a pint of infusion, a syringeful of which is injected three or four times a day.

OBSTETRICS.

EVANS ON COD-LIVER OIL IN NURSING SORE MOUTH.

The following is an abridgement of some remarks by Professor J. C. EVANS, made in the *North Western Medical and Surgical Journal*, and quoted in the *New York Journal of Medicine* for November 1851.

Nursing sore mouth generally affects females of delicate constitution and spare habit. It appears during the period of lactation. The symptoms are a burning sensation in the mouth, greatly aggravated by hot drinks, attended at first by but little redness, and followed by small ulcerations upon the tongue and different parts of the buccal cavity. In some cases, instead of these ulcers, there is a diffused redness of the mucous membrane of the mouth. These symptoms are generally attended and often preceded by a burning sensation in the stomach, pyrosis, indigestion, and occasionally vomiting. The bowels are most frequently relaxed, and in some cases an obstinate diarrhœa attends. The course of the disease is often variable. It is often attended by ulcerations in the vagina and upon the mucous surfaces of the labia, which generally grow worse as the irritation of the mouth subsides, and vice versa. The wasting of the system often continues, if the child is kept at the breast, until the patient sinks.

Nursing sore mouth is a disease of debility, consequent upon the marasmus produced by imperfect nutrition and the demand made by gestation and lactation, and generally speedily gets well after weaning the child, unless it has seriously impaired the function of nutrition. Profuse hæmorrhages and copious lochial discharges favour its development.

Treatment by medication, especially mercurial, generally aggravates the disease. Nitrate of silver, tannin, etc., may at first act as palliatives, but in the end they do more harm than good. The ulcers in the mouth may generally be promptly, but temporally relieved, by the application to each of a little pure muriatic acid; but others soon appear, unless the general condition of the system is improved.

In some instances marked improvement has resulted from abandoning medication altogether, and placing the patient upon an animal diet and the free use of mucilaginous drinks.

Observing the influence of cod liver oil in preventing the wasting of the tissues of the body in phthisis and mesenterica, it occurred to Dr. Evans that its influence might be equally beneficial in the disease in question; the diarrhœa and ulcerations of the mucous surfaces being in many cases similar to those produced by the marasmus in those affections. We have

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accordingly been in the habit of prescribing it, taken in French brandy or malt liquor, as might be found best suited to the taste or most convenient, and generally with the happiest effects. Where the patient can be induced to continue its free use, it has uniformly proved beneficial, and in most cases effected a cure. If treatment should fail to relieve the disease, a resort to weaning the child should never be deferred until the patient loses her strength so that she cannot maintain the erect position.

RELATION TO PHTHISIS OF TUBERCULAR DISEASE OF THE UTERUS.

Professor THIRY of Brussels, in a clinical lecture published in the *Presse Médicale Belge* for 30th November 1851, observes, that the uterus is often the seat of tubercles. It is true that much attention has not been paid to this fact; but Dr. Thiry believes that, in many cases, where there is an apparent improvement in the symptoms of pulmonary phthisis, there is in reality a metastatic development of tubercles in the uterus.

Premising that an organ, as the brain, bones, lungs, etc., is disposed to tubercular disease in proportion to the activity of the circulation in it, the author applies this to the uterus. This organ will rarely be the seat of tubercles before puberty; but after that, in females of a tubercular diathesis, tubercles may be there deposited after they have been formed in the lung: or they may be at first developed in the uterus. In the first case, menstruation will have a salutary effect on the disease in the lungs; in the second, the uterus, at the menstrual periods, may serve as a safety organ, retarding or preventing pulmonary disease. It will be readily allowed, that, while menstruation continues, pulmonary phthisis makes little progress, or even remains latent. And, in confirmed phthisis, suppression of the catamenia is constant; and the aggravation of the disorder can be traced to the period of their cessation. Dr. Thiry has observed that, when the catamenia, after suppression, have returned in a case of phthisis in the first stage, amendment, and even apparent cure, has resulted. He mentions a case of this kind, in which he detected uterine tubercular disease with the speculum. Some time after, the same woman was attacked with severe symptoms of pulmonary phthisis: the uterine tubercles had disappeared.

During gestation, the uterus is the centre of an active circulation. If the woman, in this state, be seized with manifestations of tubercular disease, or if it be already developed in the lungs, the uterus will act as a *diverticulum*, and there will be apparent improvement in the pulmonary symptoms. But a specular examination will often shew that the tubercles have only changed their seat.[1] A greater or less quantity will be found agglomerated or infiltrated in the neck and body of the uterus; they will also be found in the placenta; and, if the woman should die during gestation, they will be found in the substance of the uterus, in the ovaries, and even in the Fallopian tubes. May not this tuberculosis of the uterine organs have some connexion with those dangerous cases of metritis which sometimes follow delivery?

After delivery, the tubercular disease may again manifest itself in the lungs, with even increased activity. Or the uterus, at the menstrual periods, may still act as a *diverticulum*. Or, if the woman suckle her child, a deposit may take place in the mammary glands, producing partial engorgement, ending in tubercular mastitis.

The diversion of tubercular disease produced by the uterus, is believed by Dr. Thiry to be analogous to what occurs in phthisical persons affected with anal fistula. [Abridged from *L'Union Médicale*, December 9th, 1851.]

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[1] Not always: as in Dr. Tyler Smith's case, published in this Journal for February last. An examination of the uterine discharges should be made, in addition to the other means of examination. ED. LOND. JOURN. OF MED.

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OCCLUSION OF THE OS UTERI COMPLICATING LABOUR—SUCCESSFUL DELIVERY BY INCISION.

DR. W. H. REYNALE relates, that he was called to attend a woman in her first labour. But neither himself, nor two other practitioners whom he summoned, could find any vestige of os or cervix uteri, either with the finger, or by the speculum: nor could a probe be introduced. It was hence determined to operate, nine hours after Dr. Reynale had first seen the patient, and thirty-three from the commencement of labour. He wound a spear-pointed bistoury within half an inch of its point, and by carrying it between his index and middle fingers, he made an incision of about two inches in length, at the exact spot where he supposed the os uteri naturally ought to have been: water followed the incision. The opening dilated upon the contraction of the womb. The incision continued to dilate very much as the natural os would, and at the expiration of two and a half hours, the patient was safely delivered of a healthy female child, weighing nine and a half pounds. She recovered without one bad symptom. [Abridged from *Buffalo Medical Journal*, as quoted in *New York Journal of Medicine*, November 1851.]

EXTRACTION OF THE CHILD BY A NOVEL PROCESS.

DR. A. E. AMES relates the following case in the *North-Western Medical and Surgical Journal* for September 1851. Mrs. H——, in labour with tenth child; in labour seven hours; pains very hard; progress slow. First presentation of Baudelocque; previous to labour, the labia majora and minora had become somewhat swollen, and as labour progressed, the swelling increased, in consequence of the enlargement of the parts. The child's head being very large, completely filling up the pelvic region, and there being no prospect of a natural delivery, and it being impossible to apply the forceps, I determined to perform craniotomy. After having made an incision through the scalp, 2½ inches in length, I raised the scalp, and passed two fingers of my right hand under it far enough, that when I made extension, the force would not come against the edges of the incision; then placing my left hand against the perinæum, I made extension with my right. This had a tendency to elongate the head of the child, and aided by the pains, which were very good from the first, the child was born alive. The wound was dressed with simple dressings. [*Charleston Medical Journal and Review*, November 1851.] How long did the infant survive?

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