preventing that regulation of the dose in which the secret of successful treatment consists.

The doctrines of cutaneous therapeutics cannot, however, be said to be settled. During the preparation of these papers, a communication has appeared in the *Monthly Journal of Medicine* (January 1855), from the pen of no less important a writer than Professor Bennett of Edinburgh, "On the Treatment of the more Common Forms of Skin Disease met with in Edinburgh," in which the accomplished author certainly lays down rules about as contrary to those which I have learned to respect, as is possible in the nature of things. The cases on which this practice is founded have presented themselves "since the addition of a ward for skin diseases to the clinical department of the Royal Infirmary". How many months this has been added does not appear, neither are we told how many patients have been under treatment; but all I have at present to say, in reference to Dr. Bennett's views and practice, is, that thirty years ago my own views very nearly corresponded with his in many points; my practice did not essentially differ: but the utter failure of topical treatment in hundreds of cases led me to study more carefully the pathology of these diseases; and, directing my remedies to the condition of the circulating fluids as the origin of local disease, I have been successful, not only in hundreds, but in thousands of cases; and, instead of having to regret, as formerly, that, by restoring the skin, I had destroyed the health, I have generally found that the freedom from skin disease has been coeval with, and dependent on, the permanent improvement of the health.

Alfred Place, Bedford Square, March 1855.

CASE OF SCIRRHUS IN THE DUODENUM: JAUNDICE.

By PHILIP H. WILLIAMS, M.D.

History. Rebecca C., aged 40 years, complained of having suffered from dyspeptic symptoms for several years, but did not remember to have been laid aside by any special attack until the present illness. The appetite and strength became gradually impaired, and the flesh wasted.

Present Attack. Commenced, about eight weeks ago, with vomiting of slightly discoloured thin fluid, preceded, accompanied, and followed by uneasiness in the epigastric region. A blister had been applied over the seat of distress, and pills had been taken without any benefit. When I first saw the patient, about five weeks ago, the skin was uniformly jaundiced. The flowing of thin dark fluid from the stomach was frequent. There was uneasiness at the epigastrium, but no decided pain nor tenderness on pressure. The abdomen was flat: the sounds, on percussion, in all the regions, were normal. No tumour of any kind could be detected. There were no spasms, no gall-stones, no fever—in fact, no indications from which the true pathology of the case could be deduced. The general symptoms were simply those that attend the absorption of bile, namely, thirst, furred tongue, dark urine, and constipation.

Treatment. Small doses of calomel and henbane were given every four hours for two days, with a mixture containing prussic acid, bicarbonate of potash, and spirit of nitric ether. Diet, beef-tea. The bowels acted; but, instead of presenting the clay-like appearance which I expected, the motions consisted of a dark fluid somewhat similar to that which flowed from the stomach: it differed in being a little thicker and offensive, the fluid from the stomach being perfectly free from odour. The sickness was allayed so that a cup of beef-tea was retained for six or eight hours; but the relief was only temporary. At the end of a week, the jaundice, with the other symptoms, remained. As no pathological cause could be discovered, an unfavourable prognosis was given, and, at the end of a month, was verified by the death of the patient. The vomiting became more frequent, so that no nourishment

could be conveyed into the system. Emaciation made steady progress, and exhaustion became complete.

Post Mortem. When the abdomen was opened, the duodenum was lying where the transverse colon should have been found, and formed a bag which looked exactly like a second smaller stomach, and contained, as did the stomach itself, a quantity of dark thin fluid. On tracing the duodenum downwards, a scirrhous deposit, about the size of a walnut, was found in the gut, below the point where the biliary and pancreatic ducts enter. The disease seemed to have commenced in the wall of the gut next to the pancreas, into the head of which the deposit had slightly extended. The remainder of the small intestines, together with the whole of the large intestines, were remarkably diminished in calibre. The liver was congested, but quite free from disease. The gall-bladder was full. All the viscera were healthy. The scirrhous mass in the duodenum almost blocked up the passage, so that the bile which was constantly secreted was passed upwards into the distended portion of the duodenum, where it lodged (before reaching the stomach, and being ejected) for a sufficient length of time to allow absorption of the colouring matter to take place. The pylorus was quite healthy.

Dispensary, Worcester, March 1855.

PERISCOPIC REVIEW.

SURGERY.

GLEANINGS FROM THE JOURNALS.

SURGICAL TREATMENT OF ABSCESS OF THE BREAST.

The surgical treatment of mammary abscess forms the subject of a paper by M. CHAÏSSAIGNAC in the *Gazette Médicale* for January 20th and 27th, 1855.

The author makes the following classification of these tumours: 1. Abscesses external to the gland (perimammary); 2. Abscess within the gland (endomammary).

The first class comprehends subcutaneous and subglandular abscesses. The subcutaneous abscesses are divided into simple phlegmonous, lymphatic, and diffused. The subglandular abscesses are either simple phlegmonous, or hygromatic—i. e., seated in the submammary serous tissue.

The endomammary abscesses are divided into canalicular and interlobular.

1. *Perimammary Abscesses.* Subcutaneous abscess of the lymphatic or angioleucitic kind is one of the most common forms of mammary abscess. Its symptoms are, rigors at the commencement; redness and more or less swelling of irregularly arranged parts of the breast, or reddish streaks proceeding from the breast towards the axillary gland; painful engorgement of the glands in the axilla; and finally, when suppuration has taken place, a conical tumour with a soft base, regularly circumscribed, and independent of the gland.

Phlegmonous perimammary subcutaneous abscess is also very common, and is distinguished by pain, heat, and swelling; by the formation of a projection corresponding to the part of the breast which is most hard and red; by the generally large size of the abscess; and by its being generally alone.

Perimammary diffused abscess commences with very acute lancinating pain, and a sense of violent constriction of the gland; a diffused erythematous redness covers the breast; the organ swells like a sponge; and the pulse becomes small, frequent, and compressible: suppuration is soon established; the skin is perforated at several points, so as to disclose the cellular tissue dead, and as if imbued with a milky pus: finally, the whole of the subcutaneous cellular tissue is attacked, and the gland is as it were dissected out by the successive death of the parts invaded.

Subglandular abscesses of the phlegmonous kind commence with general swelling of the breast, and deep-seated pain, and the ordinary general symptoms of rigor, fever, etc. When fluctuation is formed, there is an oedematous state of the breast or the adjacent parts. Fluctuation cannot be readily detected unless by palpation at the lateral parts of the breast.

The symptoms of *hygromatic posteromammary abscess* are nearly the same as those of the phlegmonous form; and, if the