disorder unlike its parent; viz., the susceptibility to some only of the symptoms of scarlatina in a severe form, with the power to propagate the same symptoms only in others; and the probable effect of "endemic contaminating causes";—the having had scarlatina already—*plus* the being subjected to its poison and endemic contaminating causes at the same time: and, in Groups 5 and 6, it would seem that the latter may exist, as many of the cottages in that village are on the banks of a little stream into which their sewage is discharged. In that place, too, the sore-throat has prevailed for the last two autumns.

But let us further suppose, that the prevailing *epidemic constitution*, so well observed and described first by Sydenham, may be of a different character from that which has ordinarily prevailed; and it would not be difficult to suppose that even cases like that of Dr. Semple might depend on this cause—*modified scarlatina poison.* "There is no kind of fever which displays a greater diversity in its nature and complications, according to the prevailing epidemic constitution, than scarlet fever." "Some epidemics are remarkable for the number of cases in which the eruption is not observed, the disease being characterised by the other usual symptoms, especially by the sore-throat, by the appearances of the mouth and tongue, occasionally by the desquamation of the cuticle, especially in adults; and by consecutive dropsy, these cases communicating the eruptive diseases"; or, as already quoted, "and they may thus appear (*i. e.*, without eruption) in many members of the same family". (Copland.)

One word about the diagnostic sign—the pellicular or membranaceous exudation on the fauces. What is it? and what is its value? In the article "Angina Membranacea", under which title Dr. Symonds treats of this disorder in the *Library of Medicine* by Dr. Tweedie, the exudation is described as consisting of "*albuminous* pellicles"; and by Dr. Copland, in his article "Throat—Pellicular Inflammation of", it is defined as "an exudation of a buff or grey coloured *lymph* in spots or patches". These exudations, we are further informed by writers, vary in their consistence, being in some tough and membranaceous, in others soft and pultaceous. What I have examined have been rather soft and *glutinous*, more resembling some forms of mucopus than membrane. And as it has been objected by some, that in scarlatina the appearances of exudation are limited to the tonsils, while in true diphtherite they may extend all over the fauces, I will describe only what was taken from the *pharynx* of a patient in Group 7—a young woman attacked since the commencement of this paper, and referred to in a note in the last number. In my first examination of her throat, I observed only a generally diffused redness; but, on a second examination, by depressing her tongue very considerably, there was seen behind and below the right tonsil, on the side of the pharynx, a yellowish white patch, a portion of which was detached by forceps, and instantly placed in the microscope; when was seen a mass of granular or globular matter, which, on the addition of acetic acid, presented good specimens of cells with one to four nuclei—good *pus*-cells; none of the striated appearance of mucin—none of the appearance of connective tissue. But then these pus-cells may have been formed from pellicles of albumen, although the throat-affection was quite recent; for, in works on pathological histology, we are instructed, "Pus appears to be developed from a principally albuminous exudation, which, as was first remarked by Rokitansky, is in many cases combined with one of a fibrinous nature," etc. (Wedl's *Pathol. Histol.*, p. 299.) So that what was an albuminous pellicle may become rapidly converted into a pus-clot, and the diagnostic sign disappears. And surely an *epidemic constitution*, capable, as we have seen, of changing so much of the character of scarlatina, is capable of causing some such change in the state of the capillaries of the fauces as shall induce an exudation of albuminous matter a little more extensive than usual, and not so quickly converted into pus, and so not so readily removed from the surface as in ordinary cases of scarlet fever.

If, however, cases of sore-throat not presenting the *pellicle* of Copland's *pellicular inflammation*, the *membrane* of Dr. Symonds' *angina membranacea*, the *skin* of Bretonneau's *diphtherite* or of the more modern French physicians' "*couenneuse*"—if these cases are nevertheless cases of *diphtheria*, we have a delicate piece of diagnosis to make out.

In the fifth group, there was a fatal invasion of a family by sore-throat soon after two domestics had returned to it, after being in contact with scarlet fever, and, to all appearance, having suffered from that disease in their own persons. Sore-throat spread through that large family, from one to another, till all in the house had had it, except the father and the two youngest children. A more striking instance of proved infection seldom comes under the notice of the physician than in the chain of cases narrated in that group. An instance as convincingly proving the infectiousness of *so-called diphtheria* has very recently occurred in my own family. A little girl, my niece, returned with her grandmama from a visit to the seaside perfectly well. In about twenty-four hours, she was attacked with sore-throat, pronounced to be diphtheria, and she speedily succumbed. Her mother, who had not been from home, and was perfectly well, within a week was attacked, and nearly lost her life; and her only remaining child, who had been summoned from school to see her dying sister, was subsequently seized, but she also happily recovered. Hence it is further established, that so-called diphtheria differs not from *scarlet fever* in infectiousness.

Then we have before us cases of a highly infectious disease becoming epidemic, as scarlatina often does, and presenting, in many of the cases receiving this comparatively new name, the identical appearances seen in that disease; and, in several of the groups here detailed, we have this symptom followed by dropsy and peeling of the cuticle, although other cases from the same groups, when fatal, had been registered as cases of diphtheria. Surely, then, is Dr. Semple borne out in his statement that *sore-throats of various character are being reported as cases of one disease, and that disease diphtheria;* or else cases of an old disease, scarlatina, modified and made various by "endemic contaminating causes" (Copland), or by our old, but often overlooked acquaintance, "epidemic constitution" (Sydenham).

In Dr. Semple's paper on a "Case of Diphtheria", there was a statement that there was no evidence of connexion with scarlatina. In several of my groups, there was no such evidence. But can we always trace the first cases of a new invasion of scarlet fever itself to other cases of the same disease? And has not this very absence of evidence of infection, in regard to this and other diseases, opened up some of the most exciting and interesting controversies in medicine, as to the reoccurrence *de novo* of diseases, or, *per contra*, as to the necessity of infectious diseases always now proceeding from infected persons or matters? Who shall tell us how long the germs, probably organised, of the *materies morbi* of scarlet fever, may retain their activity or vitality when attached to the walls, the beds, and other furniture of houses?

One conclusion I have arrived at from these cases: that, if they have been cases of *diphtheria*, the name is only calculated to mislead the practitioner; while the alternative, that they were cases of *modified scarlatina* presents no great obstacle to be surmounted; for of the difficulty of tracing the infection in every case, I will say, in the words of one, whom the oftener I consult the more I admire and trust—Dr. Copland: "The difficulty of tracing infection to its source on all occasions, in this and in other infectious maladies, is by no means an argument against its existence; for causes are often inferred from their effects with greater certainty than from some other proofs upon which firmer reliance is often placed.... We know that the vitality of several kinds of seed may be preserved for many ages; and why should not the poisonous properties of an animal fluid or miasm be preserved for months, or even for years, when exclusion from the air and other circumstances favour the preservation?" (Art. "Scarlet Fever".)

Here then is a subject much needing such ventilation as the members of our Association can, many of them, assist to supply; and it is fervently hoped that some of them will come forward and furnish us with the record of their experience. Here is a complaint, which, while variously regarded in a nosological point of view, and especially while looked upon as purely inflammatory in its nature, is likely to receive at the hands of our brethren a treatment as various, and various treatments will meet with various degrees of success.

OBSERVATIONS ON CERTAIN FORMS OF DISEASE OF THE LUNGS.

By EDWARD LATHAM ORMEROD, M.D.Cantab., F.R.C.P., Physician to the Sussex County Hospital.

THE miscellaneous character of the following observations may seem to require some preface. A very few words, however, will suffice to express my purpose. While there is no need of another systematic work on diseases of the chest at the present day, did my opportunities of observation or my confidence in my own powers allow me to undertake the task; yet many

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single points in the pathology of this class of diseases are still open to investigation, and supply an object to which each one is called to contribute, according to his opportunities. This is the reason both for my having entered on this subject, and for having put forth my observations in so disjointed a form.

The following remarks relate to the three forms of disease of the lungs which are most familiar to observation; namely, bronchitis, pneumonia, and pulmonary consumption. These diseases are too familiar in themselves to require any general detailed description at my hands. But many points of their pathological history are open questions, and invite close attention.

I.—Bronchitis; Anomalous Forms of the Disease; Gouty; Relation of Bronchitis to Pulmonary Phthisis; Senile Bronchitis.

Of *bronchitis*, I have not much to say with regard to any of the topics which, according to the plan that I have proposed to myself in these remarks, might come under notice here.

Some anomalous forms of the disease there are indeed, and of tolerably frequent occurrence; fœtid bronchitis, so called, and plastic bronchitis, for instance. But I have not seen enough of these to allow me to offer any remarks on their history, or on the specific indications for their treatment. So of gouty and rheumatic bronchitis, and that form of the disease which results from repulsion of exanthematous eruptions. Bronchitis, with these rare and peculiar characters, has come under my observation rather as a curiosity of unusual occurrence than as allowing me to draw any general inferences concerning the various nature and treatment of these different forms. I may, however, say that in my limited acquaintance with them, the rational indications of treatment have commonly been very clear, and the issue favourable. If I were to name any specific remedies which have been of especial benefit in the rheumatic or gouty cases, I should mention creasote and the different preparations of tar. I have found more benefit from the employment of this class of remedies in cases which have resisted treatment on rational indications than from the use of any other means; though I feel that the results obtained are too slight to justify any great confidence in the merits of tar-water as a remedy in cases of intractable bronchial irritation.

Such are the terms which convey my general experience of gouty or rheumatic bronchitis: often a troublesome and intractable ailment—occasionally an acute and severe affection—but almost without exception a condition from which the question of danger to life is excluded. One exception, however, has occurred to me, under such striking circumstances, that its details may not be uninteresting. Perhaps I am wrong in applying the name gouty bronchitis to this case; at least, however, it may be most conveniently considered here, in connection with that condition.

Case I. *Bronchial Effusion suddenly fatal in a Gouty Subject.* A gentleman, aged 65, of a gouty family, but leading an active life, and having hitherto escaped any gouty attack himself, consulted me in 1857 on account of some derangement of the digestion. His immunity from gout had made him latterly less careful of his diet, but a slight fulness about the knuckles alarmed him; and by ordinary care and very simple treatment, he was in a few days restored to his former condition of health.

I had ceased to attend him, and he was about to return home, when one cold afternoon he took a long walk, and returning home hungry and tired, made a plentiful meal of tea and new bread. In about half an hour, pain began in the epigastrium, and this increasing, I was sent for in about three hours, after all external remedies had been assiduously employed in vain.

His face expressed great anxiety, and I feared to delay any longer to apply those remedies which, with every wish on my part to do without them, seemed to be so urgently called for. Accordingly, I sate by, and administered brandy, ether, and opium, with hot water, till the pain was allayed; and then he vomited a pultaceous matter, looking like undigested bread, and felt easier.

The pain was relieved, but the improvement was of short duration. The most violent dyspnœa set in; a pink frothy fluid welled up in streams from the lungs; he remained cold and earthy, in spite of all external applications; and he died about nine hours after the first appearance of the symptoms.

I am not sufficiently familiar with this form of disease to be able to offer any comments on this case more than will naturally suggest themselves, and to point to the fatigue and full meal as the probable starting points of the fatal symptoms. I would refer, for further information on this subject, to Dr. Gairdner's (*On Gout*, chap. XI, first edition) excellent remarks on irregular gout. I only regret that the urgency of the symptoms would not allow me to carry out fully the very judicious plan of treatment which he recommends.

These anomalous forms of bronchitis are not of so frequent occurrence as to make their occasionally intractable nature a source of daily regret and annoyance to the physician. Generally, they are rather curious than of practical importance. But bronchitis often presents itself under circumstances involving questions of more than mere pathological curiosity; as when, for instance, we have to distinguish between simple bronchitis and early phthisis. There are few questions of greater interest or greater practical difficulty than this. But all I can say here could but express, without assisting to remove, the well known difficulties of this class of cases. To take for instance the often recurring question of the explanation of sudden hæmoptysis: I could only repeat how, with others, I have hoped that the hæmorrhage might prove to result from a simple inflammation of the bronchial membrane, relieving itself in this way, just as inflammation of the Schneiderian membrane sometimes does. It would only be to add how, with others, I have been too often disappointed, as the hopeful view of the case was clouded over by unequivocal symptoms of phthisis; and I regret to say, that I could add nothing more than others how the grounds of these fears may be removed, nor even how the fears may be reduced to certainties at an earlier period.

For the affairs of life, it is indeed of the most serious importance to be able to distinguish at the earliest period between transient bronchitis and pulmonary consumption. But our inability to do this is less to be regretted in a purely therapeutical point of view, inasmuch as the knowledge, if we had it, would often be of no particular use for treatment. For the assurance that the disease is really phthisis, and not simple bronchitis, does not necessarily involve any change in the treatment of the case. Many a case of phthisis is, for all practical purposes, a case of bronchitis throughout its entire course; all that we can do for its relief being limited to the removal of the bronchial symptoms. The pulmonary symptoms of phthisis, for the relief of which we are most frequently consulted, are more nearly allied to bronchitis than to any other disease of the lungs. Pneumonia and pleurisy come and pass away again with all their danger and distress; but these are only occasional and intercurrent complications: and when they have passed away, the disease reassumes its habitual characters, which, for the most part, are those of bronchitis.

Passing to the opposite extreme, from these rare and peculiar cases to that form of disease from which we habitually take our ideas of bronchitis, this may claim a short space here. Scarcely under any other name does so much human suffering come before us, and teach us as it passes so little of what may be done to relieve it. Alike in the workhouse, the hospital, or in private practice, the recurrence of each severe winter surely brings with it a large and painful experience of senile bronchitis, the same and as hopelessly intractable under all these different conditions.

In the bronchial affections, indeed, which these patients have in common, and in their common mode of suffering, there is the closest mutual resemblance. But, in other less obvious respects, there are sometimes differences which it is of the greatest moment to apprehend and turn to practical account. These idiosyncracies, however, are not to be comprehended by any general rules, each case is properly a study in itself.

It must be borne in mind that the intractable character of these cases as a class, is due rather to the circumstances under which the disease occurs, than to the disease itself. It is needless to say, that the apparent mortality under this head of acute bronchitis, is unduly increased by deaths which should properly have been attributed to other causes. But, limiting ourselves to the legitimate subjects of consideration in this place, there is enough to explain the ill success of our treatment. The condition of their lungs, which these patients have been content to call healthy, is, for the most part, an abiding condition of the most serious disease. Much of this may be merely incidental to the general wear and tear of advancing life, just like arterial disease. In many cases, however, we may connect this state of habitual pulmonary obstruction with consecutive disorganisation of the heart or kidneys, which, in its turn, aggravates the original malady. And so it happens that, while the structure of the aerating surface of the lungs is disorganised by chronic changes, or the access of air is shut

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off by accumulated secretions, our means of relieving these parts through the kidneys are sorely crippled by renal disease; or the inflamed bronchial membrane is kept in a state of passive congestion by a diseased heart. Again, the bowels and kidneys, through which we might hope to relieve the lungs by a large watery discharge, though they may be healthy, will often, under these circumstances, resist the action of all ordinary remedies. Yet we must not inconsiderately adopt the more violent means, which would be allowable or advisable under other circumstances. For, in the first place, the general condition is often such as would render the employment of active measures so hazardous, that the immediate danger more than balances the chance of ultimate benefit from their use. And again, even if we were to succeed in our immediate object, yet, from the diminished sympathy between different organs which attends on advancing age, the action, which it cost so much to set up, might have no further favourable influence on the pulmonary disease. Large as the mortality is under the circumstances, yet I have been often much more surprised at the recoveries than the deaths. For sometimes, where there were all the usual probabilities of a fatal issue, some happy idiosyncrasy has rescued the patient from danger. A free purging or a free discharge from the kidneys has relieved the oppressed lungs, and with a flow of the secretions the patient has passed at once into a state of comfort and safety.

Such cases, however, are too rare to give more than very slender encouragement. I think that any great confidence in the power of our remedies generally over the disease, would imply but a slight acquaintance with senile bronchitis coming with the cold weather almost in an epidemic form. The strength seems to go all at once, and we cannot reasonably expect time for the trial of more than one remedy. And suppose that this should fail to meet the specific requirements of the particular case, we look hopefully to the effect of some remedy as yet untried. But as to those which I have seen tried, I am free to confess that I have found more good to result from a rise in the temperature of the atmosphere with a clear sky, conditions which no art can perfectly imitate, than from any, however carefully devised, plan of treatment.

Reviews and Notices.

PRACTICAL MIDWIFERY, COMPRISING AN ACCOUNT OF 13,748 DELIVERIES WHICH OCCURRED IN THE DUBLIN LYING-IN HOSPITAL DURING SEVEN YEARS. By EDWARD SINCLAIR, A.B. T.C.D.; and GEORGE JOHNSTON, M.D.Edin. Pp. 574. London: Churchill. Dublin: McGlashan and Gill. 1858.

ILLUSTRATIONS OF DIFFICULT PARTURITION. By JOHN HALL DAVIS, M.D., Physician to the Royal Maternity Charity, London. Pp. 284. London: Churchill. 1858.

THE two works now before us are mainly statistical, and, therefore, any comments upon them which may suggest themselves must be chiefly comments on hard facts. But, even on that view, statistics may differ essentially in their value—especially medical statistics. Thus, we may have arrangements of facts dependent solely on the laws of nature, as well as of facts modified by individual practice or management. Let us take as an example the statistics of forceps and craniotomy deliveries given by Dr. Davis at page 50 of his work—Simpson craniotomising once only in 1,417 cases; while Lever, Churchill, and Collins, have craniotomised as often as once in 186, 149, and 141 cases respectively, or about ten times as often as Simpson. And in the next page, where some foreign statistics are given, we find that, while the French average of forceps cases is one in 243 deliveries, the forceps has in Germany (*i. e.*, at Berlin, by Siebold) been used as often as once in every seven deliveries! In like manner, comparing the London and Dublin practice, as given in the two works under notice, we find that, in the Dublin practice, there were 200 cases of forceps and 130 of craniotomy, out of the total of 13,748 deliveries; while, in the London practice, there were only seven cases of forceps and nine of craniotomy, out of 7,371 deliveries, making the proportions stand thus:—

	Forceps.		Craniotomy.
Dublin	1 in 68	....	1 in 105
London	1 in 1053	....	1 in 819

Statistical information, however, of either kind, must always be of great value; and, therefore, we cordially welcome the appearance of the two works whose titles head this article.

Valuable and interesting exceedingly as both these books are, they differ somewhat from each other in their kind of merit. The London book prefaces its record of detailed cases by some brief introductory observations on difficult parturition in general, including some elementary instruction on the mechanism of labour; on the causes and management of difficult labour; on the use of instruments, etc., etc.; on some portions of which we shall feel under the necessity of offering a few comments. The introductory matter in the Dublin book, on the other hand, is limited almost entirely to information respecting the general arrangements of the Dublin Lying-in Hospital, and the practice pursued in it; and also respecting the plan to be carried out in the book itself, in the arrangement of condensed statistical reports, as well as in the selection of cases for detailed report. There is no *teaching* in the Dublin book, but what may be gathered from a study and analysis of the cases related; and, next to study at the bedside, perhaps this is the soundest teaching. In short, while the London book tells us what is to be done, and how to do it, the Dublin book tells us rather what *was* done, and how it was done. The Dublin book, moreover, is profusely enriched with elaborate tables, in which every possible kind of information is given, in a conveniently condensed form, concerning all that occurred naturally, and all that was done artificially, in the large number of deliveries recorded. Again, while both the books, in their record of cases, are calculated to be of great value to the busy practitioner as books of reference, or even as substitutes for individual experience, the London book has the advantage over the other of greater portability; it may be the pocket companion and bedside adviser of the country accoucheur, in his desolate and solitary career, in positions of difficulty and doubt, where a *consultation* is simply impossible.

We regret that we have not space at our disposal to do anything like justice to the immense mass of facts recorded in these two valuable publications. We must generalise.

Commenting, then, on the general instruction conveyed in them, we must say that it strikes us as a disadvantage that a great deal of the experience recorded is experience at *second hand*. We have not the *whole* truth. Dr. DAVIS or Dr. JOHNSTON, as the case may be, is sent for only in the event of difficulty or danger arising in the hands of a pupil or a midwife, whose, perhaps inadequate, report on previous stages or symptoms must be received. "Had any difficulty occurred, an entry by myself would have been made in the register." (Davis, p. 275.) He had not seen the case at all. It is, indeed, matter for regret that, in works such as those before us, this disadvantage is a necessity. It is matter for regret that country practitioners, whose experience is almost exclusively at *first hand*, and who could, therefore, tell us the whole truth, do not more frequently record and communicate that experience: we do not mean by reporting single cases—that is done perhaps too often; but by giving all their experience. Selecting some of the admirably convenient forms given in the Dublin volume, our numerous country readers would find but little difficulty in recording and tabulating the whole of their obstetric experience.

Dr. Davis has, of necessity, in a work treating of "difficult parturition", some introductory remarks on instruments. He gives us, as we have already hinted, some valuable statistical information on the comparative frequency with which craniotomy and the forceps or vectis have been used by different accoucheurs. It strikes us forcibly, however, that in London practice the last named instruments are not used often enough, while craniotomy is practised too often in comparison; in Dr.

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