She finds that if she takes cold there is slight mistiness for a day or two. During the last month there is slight return of sight in the left eye. She can now perceive the window-frames.

Case III. L. N., aged 30, single, a dressmaker, was admitted under my care on June 8th. Two years since the sight began to get dim and misty; she had had pain from time to time in the temples across the forehead; after each attack the sight was less good. A year ago, she became decidedly worse. The pain in the eyes and temples was more severe, and the sight was so much affected that she could no longer see anything distinctly. She could only read large print, and see to do the coarsest work, and this very indifferently. She had not menstruated for two years.

On admission, the pupils were large and fixed; the refractive media were turbid. Ophthalmoscopic examination showed dilated veins on both retinæ. The optic discs could only be seen imperfectly; they appeared slightly cupped. The eyes were very hard, and the anterior chambers and corneæ were flattened. She complained of iridescent vision, and pain in the eyes and head. She was given a watch, but she could not positively tell the face from the back. She thought she could distinguish very large type, but the attempt to read caused pain and dizziness in the head. The ciliary muscle was divided in both eyes.

June 18th. She had had no pain since the operation. The irides had assumed the natural size, and acted perfectly. This morning she threaded a needle, and read some ordinary sized print. She said she had not seen so well since the first attack two years ago.

August 13th. The sight continues satisfactory.

Original Communications.

SCROFULOUS DISEASES OF THE EXTERNAL LYMPHATIC GLANDS:

THEIR NATURE, VARIETY, AND TREATMENT.

By P. C. Price, Esq., Surgeon to the Great Northern Hospital; the Metropolitan Infirmary for Scrofulous Children at Margate; etc.

I.—Inflammatory Conditions of the External Lymphatic Glands in Scrofulous Subjects.

[*Continued from page* 600.]

Recognition. The correct appreciation of this form of glandular enlargement is, as already observed, of very great importance, as it at once relieves the patient of much anxiety, and enables the surgeon to adopt measures which, when correctly employed, are very frequently followed with the greatest advantage. But due recognition is oftentimes attended with difficulty, for there are certain abnormal conditions of the lymphatic and other parts, which more or less closely resemble enlargement from slow chronic inflammatory disturbance.

The following conditions are those which appear to possess a more or less close analogy. *Firstly.* Hypertrophy of lymphatic glands from apparent non-vascular derangement. *Secondly.* A true tuberculous condition of the glands. *Thirdly.* Encysted and fatty tumours. *Fourthly.* Chronic abscesses. *Fifthly.* Goître or enlargement of the thyroid gland.

Firstly. Chronic inflammatory glandular enlargement is not always easy of distinction from that form of hypertrophy which obtains without any apparent inflammatory action. In an early stage, and when arising from any cause which is likely to lead to vascular disturbance, this kind of enlargement may, as a rule, be more generally anticipated. But there are occasions when no discriminative examination will serve to distinguish it, save that afforded by manipulation. To the touch, such enlargements will generally be found less hard, more elastic, and less defined, than those arising from simple chronic hypertrophy. Nevertheless, the pain on handling, no matter how slight, is often the only deduction that can be obtained from manipulation. In still more dubious cases, therapeutical management is the sole means which enables a correct appreciation of the nature of the affection; for while the resolution of hypertrophy, the result of a low and tardy form of inflammation, is sometimes comparatively easy, the resolution of that resulting from non-vascular causes is much more difficult. Chronic inflammation, although of a very low form, is, moreover, more rapid in its progress, frequent in its relapses, and ordinarily attacks such glands as are not commonly included in non-inflammatory hypertrophy. In young people, as well as in those more advanced in years, both forms of enlargement are frequent, although chronic adenitis is more usually the immediate result of certain appreciable causes. Both forms are met with in the cervical and facial glands, although true hypertrophy is more commonly limited, I believe, to the deeper layer of the glands of the neck, and, unlike inflammatory glandular lesions, at least, so far as I am aware, very rarely involves the glands of the armpit and groin.

Secondly. In the earlier stages of development, the greatest difficulty is often experienced in ascertaining whether enlarged glands seated in the neck, etc., result from simple inflammatory changes or from decided tuberculous degeneration. A variety of comparisons will, however, frequently enable the surgeon to pronounce as to the specific action that is taking place, although the analogy is often so strong that an early and direct decision is often impossible. The difficulty of early appreciation is, however, further increased owing to tuberculous depositions seldom ensuing before some enlargement of the glandular structure has taken place. When the increase in size is unaccompanied by any marked symptom of a decided tuberculous character, arises from any known causes, and exhibits a tendency to resolution, then, in all probability, the glandular mischief is devoid of any specific complication, and entirely depends on temporary derangement of one or more portions of the lymphatic system. At a later period, provided the affected glands have attained considerable dimensions, and that tuberculous disease exist definitely marked in other portions of the body, then it is more than probable that the deposition of tubercle has become the direct source of irritation. Should destructive inflammation ensue, and extend to the cellular tissue and skin, additional evidence will be still more in favour of tuberculous complication; while an examination of the pus, should suppuration occur, will at once decide any further doubt. But, as will be presently shown, deposition of tubercle is oftentimes unaccompanied, or followed, even at a remote period, by inflammatory changes, ending in ulceration and suppuration. A sure diagnosis in such instances is therefore, as may be readily conceived, of still greater uncertainty; and the surgeon will oftentimes have to wait patiently, till time and the use of therapeutical means have decided the correct nature of the puzzling affection.

Thirdly. Encysted and fatty tumours, when situated on the neck, especially near the base of the lower jaw, and in and over the parotid gland, often give rise to some speculation as to whether they may not be closely simulated by chronic glandular swellings. I have often myself been struck with the near analogy that exists between these various morbid conditions; and experience has taught the value of careful investigation before pronouncing as to their precise nature.

When an encysted tumour is situated near to one or more of the cervical lymphatic ganglia, an erroneous impression, without regard to certain symptoms, is by no means improbable; but if the cyst become inflamed, its due recognition, as M. Guersant has pointed out, is at once easy, by reason of the peculiar nature of its contents. One point of importance, as bearing on the diagnosis of an encysted growth is, that while it is comparatively infrequent to find a single gland included in chronic inflammation, to the exclusion of others forming, perhaps, the same plexus, it is equally rare to find more than one encysted tumour occupying the same region, without it be on the hairy scalp. Manipulative distinction, a careful insight into the nature of the origin and duration of the enlargement, and an inquiry into the constitutional habitus of the individual, will generally at once lead to a truthful appreciation.

With regard to the similarity existing between fatty tumours and simple chronic inflammatory swellings of the lymphatic ganglia: I have known such growths, occupying the region of the neck and armpit, to give rise to the suspicion of glandular enlargement, although the soft, elastic, and generally painless character of the adipose swelling, usually allows a correct diagnosis.

Fourthly. It is by no means infrequent to find chronic abscesses presenting points of almost positive identity to this form of glandular disturbance; and the analogy is oftentimes so close, that great care is required in arriving at the real nature of the swelling. Although fluctuation is not always obtained in the case of chronic abscess, still it is generally appreciated;

and this alone will often serve to point to the right character of the doubtful tumour. But there are occasions in which, as every surgeon of experience must admit, considerable doubt is cast over the nature of a swelling suspected to consist of fluid; and I have more than once known a simply enlarged gland treated as a chronic scrofulous abscess.

Fifthly. Goître and certain specific enlargements of the thyroid gland, especially when one of its lateral lobes is only affected, may give rise to suspicions that the swelling is dependent on chronic inflammation of one or more of the lymphatic glands. I know of no better criterion whereby to judge of suspicious thyroid development than by noticing the effects produced on the gland by the act of swallowing. Should the swelling remain stationary, it will, in all probability, be a lymphatic or any other affection; but if it be associated with the movements of the upper portion of the windpipe, then, without doubt, some thyroid development will be indicated. For this practical hint I am indebted, as I am for many other valuable clinical facts, to my friend and distinguished former teacher, Mr. Fergusson, for I do not remember having seen it mentioned in any surgical work.

Pathological Changes. The simplest form of low and tardy inflammatory action taking place in a lymphatic gland is accompanied with swelling dependent on a greater or less injection of the vascular portion. Should this vascular excitement suddenly be arrested, diminution in the size of the affected gland ensues; but if it extend, more permanent increase in bulk follows, as the result of exudation. On examining a gland thus altered, it is rare to find the enlargement dependent on the existence of serous infiltration, even to a slight amount, as is usually the case in more acute forms of lymphadenitis. The increase is more dependent on a plastic material which fills up the areolar portion, and, if not absorbed, leads to a permanent thickened and consolidated condition, and the entire gland appears converted into a fibroid structure. When the mischief has been localised to one or two spots of the gland, only partial alteration ensues, and consequently only a certain portion of the glandular function is interfered with.

Under various stages of subacute and chronic inflammation, a closer investigation will afford the following particulars:—Should the enlargement be characterised by rather a high state of vascular excitement, the cut surfaces of an included gland will present a pinkish or even reddish hue. Should the fibro-plastic material have somewhat universally replaced the true glandular structure, a translucent, white, firm, tough appearance, will be detected, which perhaps, on pressure, especially if of recent formation, will exude a hyaline fluid. On the other hand, if the development of fibro-plastic matter have been slight, the gland will preserve a pale yellow colour. It by no means follows, however, that because a gland remains for an indefinite period affected, its functions are lost or greatly impaired, although considerable induration with atrophy of the true parenchymatous tissue may result.

Provided, therefore, that no untoward causes, either constitutional or local, ensue during the various stages of this affection, resolution or permanent enlargement results. It has already been observed that resolution obtains through reabsorption of the exuded material, and that permanent hypertrophy depends on the formation of a new substance, which is either incorporated with the true glandular structure, or else takes its place, causing complete or partial obliteration of its functions and normal constituents. But, before reabsorption can remove this product, various abnormal conditions may overtake the gland. Inflammation, either simple or specific, is apt to lead to vital changes. Not unfrequently the mere handling of an enlarged gland is sufficient to excite increased and dangerous inflammatory symptoms; while exposure to cold and various constitutional causes not uncommonly admit the lighting up of destructive vascular excitement.

I have occasionally known frequent and, perhaps, rather rough manipulation of a glandular swelling, to lead to rupture of the minute vessels bordering the new tissue that has been formed, and thereby occasion ulceration and suppuration, especially in those instances in which a decidedly scrofulous constitution existed. It will be presently seen that a fruitful source of destruction to simply enlarged glands is the accession and localisation of tuberculous depositions. Should the additional inflammation excited pass on to suppuration, the character of the purulent fluid will be influenced in proportion to the more or less well marked scrofulous diathesis of the individual in whom the mischief occurs.

[*To be continued.*]

Transactions of Branches.

CAMBRIDGE AND HUNTINGDON BRANCH.

ON THE NEWLY PROPOSED TREATMENT OF ACUTE INFLAMMATORY DISEASES.

By JAMES CARTER, Esq., Cambridge.

[*Read at Cambridge, July 10th*, 1860.]

I WISH to direct the attention of the present meeting to the subject of the nature and treatment of acute inflammatory diseases. This is at any time one of the most important questions connected with practical medicine which can engage the attention of the profession; but just now its importance and interest are greatly increased in consequence of the propositions as to both the nature and the treatment of acute diseases, which have of late been brought forward by physicians of repute and experience; and that, too, with a degree of confidence, and with such probability of more or less truth, as absolutely to demand our earnest consideration. The recently proposed theory to which I allude is a bold one: it is this, that the ordinary so-called antiphlogistic treatment is unnecessary for the cure of acute internal inflammatory diseases; and that the supposed necessity for such treatment rests upon an untenable hypothesis as to the nature of inflammation and of fevers. If, by experience, this theory should prove to be founded on truth, it must necessitate, on the part of the vast majority of us, such a degree of modification both as to our ideas of the nature as well as of the treatment of acute diseases, as would amount to a complete revolution.

It was the conviction of the great importance of this inquiry, and of the necessity of its immediate consideration, which induced me to bring the matter before the present meeting.

I think the evils of the old antiphlogistic plan, especially a too long persistence in it, have been long recognised; and I feel that I have but to appeal to the present meeting for confirmation of the fact, that for many years past there has been going on a gradual change in the treatment adopted by the majority of the profession for the cure of acute inflammatory diseases and of fevers. This change, I would remark, has been a progressive one; and that, too, continuously, uniformly, and steadily progressing in one and the same direction—namely, in the direction of conservatism; that is to say, in the *more* frequent use of means which support, and the less frequent employment of measures which diminish, the vital powers.

The active employment of depletory measures has been altogether abandoned in the treatment of many forms of disease which were formerly supposed to require them, and are much more moderately applied in all diseases than formerly. As an example, general venesection, in the practice of most of us, has, I suspect, become the exceptional rather than the general practice; and so of other antiphlogistic remedies which I need not specify. But I confess I was not aware of the extent to which the necessity of this change was admitted, by the very fact of its being adopted, until I entered upon the present inquiry.

With the object of ascertaining the mode of treating acute diseases adopted in the present day, I have carefully looked through the reviews and periodicals for the last few weeks, and I am much struck by the almost universal abandonment of active antiphlogistic treatment. For instance, in the last volume of *Braithwaite's Retrospect* (the volume for June), I find the following acute diseases referred to, which are thus treated:—*Gout.* Dr. Garrod says, give moderate doses of colchicum; and if plethoric, take a few ounces of blood; but if the vital powers be feeble, give ammonia, and no colchicum. *Acute rheumatism*, Dr. Inman says, is aggravated by venesection and purgatives; and Dr. Markham advises opium and colchicum. If pericarditis supervene, local or general bleeding to a small extent is necessary. But he says, "Be cautious not to injure your patient by depletion, nor delay too long the use of stimuli. . . . . There are many cases of pericarditis, especially the non-rheumatic, in which stimuli are necessary from the very beginning." In *tubercular pneumonia*, Dr. Gairdner says, "Give antimony, but in such doses as do not prostrate, and *combine it with diffusible stimulants.*" Mr. Fergusson advises