

life to be labouring under hernia. A large swelling in the groin was found to consist of a cyst with thin walls, which projected from the inguinal canal through the external ring, and mounted upwards on the aponeurosis of the external oblique muscle. The testicle, which was lodged in that part of the sac situated in the inguinal canal, was quite small, like the undeveloped testicle of a child, but it was healthy and free from adhesions. The cyst contained about eight ounces of fluid, was sacculated, and had no communication with the abdomen. The left testicle, situated in the scrotum, was somewhat small, but sound in structure. Mr. Curling noticed the difficulties of the diagnosis in this rare form of hydrocele, which might readily be mistaken for an irreducible hernia.

Mr. CURLING also showed a specimen of

UNDEVELOPED LEFT TESTICLE,

detained in the groin outside the abdominal ring, the right testicle, situated in the scrotum, being hypertrophied. He read a description of the case, furnished by Mr. Page, of Carlisle, in whose practice it occurred, and remarked on the rare occurrence of hypertrophy of this organ.

CIRRHOSIS OF THE LIVER, WITH BILIARY CALCULI.

Dr. GIBB exhibited some biliary calculi, which he had taken from the body of a man seventy-three years of age, who had long been addicted to intemperance, and died apparently from old age. The lungs were healthy, but some old pleuritic adhesions were present; the heart was enlarged, together with its large vessels, and its valves were studded with atheromatous deposits; both coronary arteries were also affected with atheroma. The liver was small, hard, and nodulated, and in a state of cirrhosis of the hobnailed variety; the gall bladder was almost completely imbedded in its surface, and filled with four calculi; three of these were uniform in size and colour, whilst the fourth, the size of a robin's egg, was white, and consisted of pure cholesterine. The surface of this calculus was crystalline, this being due to an aggregation of flat and foliaceous crystals of cholesterine, as seen under the microscope, strongly resembling the well-known mineral selenite, or crystallised sulphate of lime. This calculus blocked up the cystic duct, and had become encysted, the gall-bladder being quite empty of bile. The spleen was enlarged, and covered with irregular hard white patches, of a cartilaginous consistence, in size from that of a crown-piece to a pea. One of the interesting features of this case was the presence of a distinct cyst around this oval calculus, which no doubt was the reason of its possessing such a beautifully-crystalline surface.

Dr. GIBB also exhibited two specimens of

INSPISSATED BILIARY CALCULI,

removed from old women, one especially, who died of old age, and in whom nothing unusual was found, excepting two fibrous tumours growing from the walls of the uterus, the size of a walnut and marble respectively. Both of these calculi had now crumbled into pieces; they were of a blackish-brown colour, and weighed ten and seventeen grains.

MULBERRY RENAL CALCULI FROM THE HORSE.

These were three most perfect specimens, shown to the Society by Dr. Gibb, taken from the kidneys of three different horses that died of chronic disease; as informed by Mr. W. Curran, late house-surgeon to the Royal Free Hospital, (to whom Dr. Gibb was indebted for them,) one died of pulmonary phthisis, another of abscess of the liver, and a third from renal abscess associated with pyelitis. The weight of each was considerable, and all were composed of oxalate of lime. They were covered with minute crystals of the same substance, visible to the naked eye, and as they possessed a brown colour, they resembled in a striking degree fine crystals of ferruginous quartz. Dr. Gibb had reason to believe that the presence of crystals on the surface of calculi is rare, although they are described by Dr. Golding Bird and Dr. Owen Rees; and of those which do occur they are almost invariably the octahedral forms, both opaque and transparent, of the oxalate of lime.

HARVEIAN SOCIETY.

THURSDAY, FEBRUARY 4TH, 1858.

DR. HAMILTON ROE, PRESIDENT, IN THE CHAIR.

THE PRESIDENT, upon taking the chair for the first time, thanked the Society for the honourable position in which he

was placed, spoke of the increasing importance of the Society, of the practical value of the papers read, as well as of the discussions which followed, and urged in the latter a rigid adherence to the particular subject before the meeting.

DIPHThERITIS.

Dr. FULLER exhibited a fibrinous cast of the pharynx ejected by a patient suffering from diphtheritis. It was above four inches in length, tubular in form, and remarkably firm in texture. The patient, a child eleven years of age, was attacked with sore throat and fever on the 12th of December last. On the following day the fever and sore throat had increased, and were accompanied by excessive dyspnoea, and inability to swallow. Mr. Meehan, of Taunton-place, was sent for, and found the tonsils and the whole of the pharynx covered with a thick cream-coloured exudation, the skin of the entire body being red with a rash resembling scarlatina. The throat was cauterized with solid caustic, and other remedies were adopted, but without relief. On the morning of the 14th, the child was absolutely struggling for breath, when suddenly she ejected the fibrinous cast laid before the Society. From that moment recovery commenced, and before the evening the fever and rash had disappeared, and she was breathing tranquilly. Aphthous ulceration of the mouth continued for two or three days longer, but before the expiration of a week from the date of her seizure, she was up and dressed, and perfectly well.

Dr. HEADLAM GREENHOW related a case of diphthérite, which he believed to be of similar character to the disease described by Bretonneau, of Tours, and identical with the malignant sore-throat which has recently prevailed in Essex, and other parts of this country. A child, aged eight years, after slight catarrhal symptoms, composed of sore-throat without much fever, and unattended by any form of exanthem. The throat was swelled externally, but the child continued to play and sit up as usual, until the evening before its death. At the end of four or five days there was difficulty of breathing, and then only the child came under treatment. The breathing was slightly stridulous, and the child complained of sore throat, but the external swelling had almost subsided. Internally the fauces and throat were coated with what appeared to be an ash-coloured exudation. The little patient became suddenly worse during the night, and speedily died. On examination after death, the pharynx and tonsils were covered with a loose friable granular exudation; the membrane below the exudation was unhealthy and aphthous, especially on and near the tonsils. This form of exudation only extended to the rima glottidis, but the larynx and first inch and a half of the trachea were lined with a tube of croupy false membrane, which already partially detached, only adhered to the subjacent membrane by a few points, which presented bloody specks when the false membrane was removed. With this exception the mucous membrane underneath appeared almost healthy, and presented but very little vascularity. A small detached portion of the false membrane, and a pellet of the granular exudation were lodged in the rima glottidis, and may, perhaps, have accelerated the fatal termination of the case. The remainder of the trachea was healthy.

WESTERN MEDICAL AND SURGICAL SOCIETY.

FEBRUARY 19TH, 1858.

WM. MARTYN, ESQ., V.P., IN THE CHAIR.

Dr. FINCHAM read a paper

ON CASES OF ACUTE INFLAMMATORY DISEASE, WITH SPECIAL REFERENCE TO TREATMENT.

The cases, which were mainly drawn from the author's note-book at the Westminster Hospital, consisted of acute inflammations of the lungs, pleuræ, and heart—chiefly of the first two, in the form of pleuro-pneumonia. The object of the paper was to show that, in an immense majority of such cases, the antiphlogistic treatment is not necessary, and that patients will recover under very simple treatment,—as by diaphoretics and counterirritants, sometimes under stimulation pushed to the fullest extent, sometimes under what is practically no treatment at all. After alluding to the success which had now, in the experience of so many, followed the omission of the antiphlogistic plan as a rule in inflammatory disease, the author called attention to the principle which he believed to underlie the management of all such cases, especially of pneumonia. This principle was to regard local inflammations as the result of a previous unnatural condition of the blood, and

so to place them in the category of fevers. "For what, after all," he said, "is the characteristic of a large majority of what are called fevers, whether eruptive or otherwise? Is it not constitutional disturbance followed by local inflammation? What is scarlatina, but such disturbance followed by inflamed throat? what, erysipelas, but the same, followed by inflammation of the head and face? what, dysentery—what, typhoid fever, but the same, issuing in inflammation of the mucous membrane? Now in all these there are the full signs of inflammation, effusion, &c.; and yet no one thinks of bleeding, mercurotization, or the use of antimony. What is usually and wisely done in such cases is to watch them well, and to moderate, if possible, local action, trusting in the main to the powers of Nature if no urgent symptoms are present. Such is the practice in favourable cases; but should the powers of Nature be failing, then the fullest use of stimulants—no matter what the period of the disease, no matter what amount of local inflammation be present—is necessary to sustain the flagging system. Now if, under this principle of treatment, inflammations will subside in fevers, why should we not expect the same to take place in analogous diseases? The cardiac inflammation of rheumatism and of Bright's disease is doubtless an effect of an unnatural condition of the blood; and the difference between these inflammations and those in connexion with fevers, is that in the latter the morbid agent is introduced from without—in the former, generated from within. Why, then, should we expect to cut short by large bloodlettings an inflammation so arising as rheumatic pericarditis, when we do not expect to do so in erysipelas? The *origo mali* in both cases remains the same, notwithstanding the abstraction of blood." The author then proceeded to extend this view to pneumonia, characterised as it is by the most palpable constitutional disturbance,—e.g., the marked initiatory rigor, followed by the symptoms of local inflammation. He considered that the most reasonable theory of the disease was to regard the inflammation of the lung, not as the *direct* effect of cold on the lungs, but as due to retained and altered secretions, especially of the skin, thrown back upon the blood through atmospheric impressions; and that it was as reasonable to expect to cut short the herpetic eruption so common in pneumonia, as it was the pneumonia itself. On the ground, then, of an identity, or at least of analogy, in the pathology of acute inflammations and fevers proper, it was urged that a treatment similar in principle should be adopted in both class of cases.

Mr. KEEN exhibited

A SPECIMEN OF CARDIAC APOPLEXY.

The patient had died suddenly, and the heart generally was soft and flabby. The right ventricle presented in its interior a large fibrinous clot, which was quite dry and had fringed edges, and with difficulty peeled off from the endocardium. Corresponding to this adherent clot, and intermixed with the carneæ columnæ was an extravasation of blood, with bands of lymph extending through it. The thickness of the wall of the ventricle was increased to three-quarters of an inch, the substance beyond and around not exceeding a quarter of an inch.

The Society then adjourned.

Correspondence.

"Audi alteram partem."

OXYGEN GAS IN SCARLATINA.

To the Editor of THE LANCET.

SIR,—It gave me much gratification to see, in THE LANCET of the 13th inst., Dr. Francis' apparently well-marked instance of the power of oxygen in scarlatinoid disease. Since that gentleman has done me the favour of appealing to my experience regarding the propriety of extension of the treatment to such cases as those of Mr. Browne, which appeared in a previous number of your journal, I beg to request the insertion of a few lines in reply.

The potent effects of the gas, as detailed by Dr. Francis, are precisely such as I should *à priori* have expected. Although I have had little or no practical experience of the employment of oxygen in this particular class of disease, yet reasoning by analogy led me some time ago to venture its recommendation.

I had frequently noticed the immediate and indubitable advantage derived from this remedy in judiciously selected cases of rapidly-spreading ulceration and sloughing, in cachectic and even syphilitic habits, also in low erysipelatous inflammation. Dr. Francis very aptly remarks that in his case there was "simply a tendency to extinction of life from the overpowering noxiousness of the poison; and I apprehend that it is in just such cases in practice where we shall derive most benefit from the gas." And, again, that "the vivifying effects of oxygen upon his system.....permitted the successful operation of those remedies which would have utterly failed to exert their therapeutic efficacy without it." This precisely accords with my own views expressed on former occasions, and I thank Dr. Francis for the corroboration, which, I trust, may not be long confined to one or two practitioners.

As in Dr. Francis' case, so in allied ones, such as Mr. Browne's, I cannot but regard the employment of oxygen as a *sine quâ non*, or at least as a moral necessity on the part of the practitioners, when other means are evidently failing to afford relief, and the patient is approaching that stage which immediately precedes the symptoms indicative of rapid dissolution.

In the details of Mr. Browne's cases, it is specially to be remarked, that the medical attendant did not see them until four or five days after the commencement of the illness, and perhaps it may not be *mal à propos* for me here to say a few words suggested by this fact.

A few years ago (previous to my having, by means of a really efficient and portable apparatus, the power of extensive application which I have since enjoyed) it was my lot to meet with a great variety of cases of scarlatina and its modifications, in hospital practice as well as in the country. Recollections of close and careful observation have led me to the conclusion that diphtheritis is certainly not a new disease, but that it is a type or modified form of scarlatina, which has simply become much more common, and therefore more commented upon, than formerly; and, moreover, that to regard it as a close ally of croup is not sound pathology. Irrespective of the totality of the symptoms evidencing the connexion of diphthêrite with scarlatina, the zymotic and extremely infectious characteristics of the former ought, I believe, to separate it entirely from the idea of croup. To concentrate the attention on one symptom—the *quasi-croupy* exudation, its *frequent* tendency to affect the pharynx primarily, and to spread downwards to the trachea, would appear to be a somewhat narrow view of the matter. It must be granted that ten or twelve years ago, scarlatina, in its symptomatology, was far more uniform than it has been latterly. Diphthêrite, however—this *at present more common* phenomenon of scarlatinoid disease—has been for some years ushered in (as most of us know) by various modified forms. The most common that I have seen is what might perhaps be designated rubeoloid scarlatina, the eruption often bearing the precise character of measles, (as likewise in its catarrhal aspect,) while the throat affection, malignancy, and danger, pointed clearly to scarlatina. For this form I have frequently had whole families under my care, in houses rich, well ventilated and drained, as well as poor and evil in a sanitary point of view. The cases usually occurred successively, and I used carefully to inspect the earliest as well as the more advanced stages of the throat affection.

Such observation demonstrated to my satisfaction that during epidemics of a scarlatinoid character the throat affection, when seen from the very commencement, presents considerable variations, even in members of the same family residing in the same house: the true fibro-plastic exudation, the red and swollen tonsils, the deep-red and even livid tumefaction throughout the palate, fauces, and pharynx; these and intermediate varieties all proceeding to more or less extensive ulceration and sloughing. Equally eccentric likewise have I seen the cutaneous eruption—sometimes rubeoloid, sometimes scarlatinoid, sometimes absent. Reflection upon such facts, in connexion with observation on the various capacities for resisting the poison, and the precise condition of the various functions in each patient at the period of incubation of the poison, compelled me to acknowledge that under different aspects the disease is still essentially scarlatina.*

Scarlatina, then, being subject to a variety of modifications, according to the previous state of health of the individual attacked, as well as peculiar atmospheric influences and local circumstances, I believe that certain general principles of treatment must hold good in all cases. Mr. Browne's patients, not having been examined for several days after the outset of the attack, may or may not have had the fibro-plastic exudation

* "Diphthêrit" is certainly not a new disease, since M. Bretonneau suggested the name for an epidemic at Tours during the years 1818-21.