

The
TRANSACTIONS
OF THE
BELFAST
CLINICAL AND PATHOLOGICAL
SOCIETY



Andrew George Malcolm

The
TRANSACTIONS
OF THE
BELFAST
CLINICAL AND PATHOLOGICAL
SOCIETY

1853 – 1862

WITH OTHER MATERIAL

2nd Edition

Ulster Medical Society

BELFAST
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WHITLA MEDICAL BUILDING

LISBURN ROAD, BELFAST

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J.I. LOGAN

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In memory of all those whose sufferings are described in these Transactions but especially the children.

PREFACE
TO THE SECOND EDITION

Largely through the efforts of one man, a new society, the Belfast Clinical and Pathological Society, came into being in 1853. It was to last nine years. The objects of the society were: "the Cultivation of Practical Pathology, Diagnosis and Therapeutics, . . . ; the establishment of a Pathological Museum; and the keeping of Records, to indicate the progress of discovery in Medical Science."

In this it was designed to complement, not replace, an older society, the Belfast Medical Society, which had been formed in 1806 and revived in 1822. The minutes of the first meeting of the revived society, held on 8 June 1822, show that the object was to provide a medical lending library for the use of the members.

Between 1822 to 1828, six recorded clinical presentations were made to the Society, all within the few months from November 1822 to June 1823. The first was two cases of *Cynanche Laryngea*, read by Dr James McDonnell, and the last was a case of *Croup* presented by Mr Coffey.

On 7 November 1842, Dr Andrew George Malcolm was elected a member. He was not a regular attender in his first year, and until 7 October 1844 played no part in the administration of the Society, other than taking the chair at his first and third meetings. He and a fellow member were then asked to update and reorganise the library catalogue. On 2 December 1844 they reported that their task was completed and it was resolved that "the warmest thanks of the Society be given to these gentlemen."

It was also resolved at the same meeting that "... in addition to the routine business, communications from members upon Medical and Surgical topics and reports of cases should be received and discussed." Malcolm records that Dr J. M. Saunders was the proposer of this resolution, and, as will be seen later, it was Saunders who presented the first case under the new rules. Malcolm strongly supported the concept and he was one of the members of the subcommittee set up on 3 February 1845 to submit proposals for the regulation of the case presentations.

Also proposed on 2 December 1844 was a change in the time of the meeting from 11.00 am to 7.00 pm. This was agreed on 3 February 1845 and the first evening meeting took place on 3 March 1845. It was at this meeting that the report of the subcommittee was presented and agreed, and, immediately afterwards, Dr Saunders gave an account of a case of *Haematocele*, and Dr Dill presented a case of *Lupus with Hypertrophy*. Malcolm presented specimens of lungs affected by *Phthisis* on 7 April 1845, the first time post-mortem specimens seem to have been brought before the Society.

On 4 August 1845, Malcolm was included in a subcommittee to consider the setting up of a Pathological Museum. He presented the report to the Society, and he made the subsequent arrangements, and it is quite possible that it was he who proposed the formation of the Museum.

The extent of Malcolm's part in the proposals to present clinical material and to set up the Pathological Museum is open to speculation. But regardless of who was behind them, it seems clear that Malcolm must have thought that while the Society welcomed presentations at the monthly meetings, it was unable or unwilling to significantly expand its activities in the way that he desired. He began to think about a new society and wrote to the London and Dublin Pathological Societies, requesting advice and copies of their rules. The reply from the London Pathological Society is dated 29 June 1852.

In the summer of 1853, he and others (the "Promoters"), issued a prospectus requesting those who would be interested in starting a local pathological society to attend a meeting in Malcolm's house at 49 York Street at 8 pm on Friday 12 August. The idea was obviously well received as the Belfast Clinical and Pathological Society was constituted on 2 September 1853 and forty-nine persons, ("original members"), had joined by 30 September 1853. Another forty-seven joined by the end of the first year.

Although there were plans for sending a communication to the Belfast Medical Society, there is nothing in the minutes of that society to suggest that it was received. Indeed, the only reference to the Belfast Clinical and Pathological Society in the Belfast Medical Society minutes in those early days occurred in February 1854 when some discussion took place regarding the handing over of the Pathological Museum. There is no record of animosity between the old and new societies. It would have been a little surprising if there had been, considering that many practitioners would have been members of both.

The Belfast Clinical and Pathological Society met weekly on Saturdays at 3 pm from the end of October to the beginning of May. All contributions were to be original, or were to be original translations from authentic foreign records. They were expected to fall into the following categories:

- Cases of interest;
- Statistical reports;
- Novel modes of practice;
- Morbid specimens of pathological or general interest;
- Replies to medical queries posed by members;
- Brief clinical facts of practical interest.

The Society offered a microscopical and analytical service, so that if a member excised a tumour or found an unusual sample of urine, he could post the specimen to the society and receive a report on it from the appropriate committee. This could have been particularly useful for a country practitioner.

In accordance with the third object of the Society, abstracts of each meeting were to be sent weekly to every member and to one of the Dublin journals, and the *Transactions of the Belfast Clinical and Pathological Society* were to be published annually.

The weekly abstracts were handwritten and lithographically printed on flimsy paper. Only twenty-three examples are known to survive, all from the 1856/57

session. The Dublin Hospital Gazette (New Series) was published in seven volumes from 1854 to 1860, starting too late to print the abstracts for the first session, and ending too early to print those from the eighth and ninth sessions. It did, however, print all those in between. The Dublin Journal of Medical Science printed the abstracts for the ninth session only.

Copies of the separate annual *Transactions* for only five of the nine years of the Society's existence are known to exist. Those years, and the libraries where the copies are held, are shown below:

	Ulster Medical Society	Queen's Medical Library	Linen Hall Library	Univ. Lond Library
1853-54	●	●	○	●
1854-55	○	●	●	○
1855-56	○	○	●	○
1856-57	○	○	○	○
1857-58	○	○	○	○
1858-59	○	●	●	○
1859-60	○	●	○	○
1860-61	○	○	○	○
1861-62	○	○	○	○

It is likely that for 1856/57 and 1857/58 the annual *Transactions* were printed but are missing, and for 1860/61, and 1861/62, they were not printed. Because the series was incomplete, it was thought useful to assemble all the records of the meetings of the Belfast Clinical and Pathological Society and publish them. For the second edition the proceedings of sessions one and eight have been added so that all nine sessions are now included, some of which are more complete than others. The contents have been taken from available volumes of the annual *Transactions* and from the *Dublin Hospital Gazette* and from the *Dublin Journal of Medical Science*. The compiler regrets that he did not record and cannot now recall which institution supplied which session's text but is grateful to all who contributed. Everything relevant to the Belfast Clinical and Pathological Society has been included but not material related to individual members of the Society nor material related to other aspects of Belfast medicine. The membership lists are taken from various sources. Mr David Crawford, one time Librarian at the Queen's University, discovered Surgeon Browne's Presidential address in the National Library of Medicine, Bethesda, USA and arranged for a copy to be supplied.

These records offer a valuable insight into the minds and the daily practices of the medical practitioners of Belfast and Ulster over a century and a half ago. They were busy with childbirth, with injuries due to falls from heights and other accidents, with syphilis, with infections of skin, soft tissue and bone, with typhoid and typhus, with tuberculosis, with the consequences of rheumatic heart disease and with a lot else. There were no true specialists. Even the local ophthalmologist, Surgeon Samuel Browne, R.N., had a very busy general surgical practice as can be seen from the

variety of cases that he presented to the Society.

The purpose of the Society was to encourage a scientific approach to medicine and perhaps this influence can be seen by comparing the report, in the third session, of a hand deformity of a child whose mother had been frightened by a lobster during pregnancy, with Dr H Murney's review of head injuries in his presidential address in the ninth session.

Malcolm died of rheumatic heart disease in his 38th year, in September 1856, just a few months after he completed his year as President of the Belfast Clinical and Pathological Society. An obituary will be found on page 143 of this volume.

The Belfast Clinical and Pathological Society came to an end in 1862 when it amalgamated with the Belfast Medical Society and the Ulster Medical Protective Association to form the Ulster Medical Society. In 2017 the latter continues to thrive. It still has some of the books of the Belfast Medical Society but it no longer offers the facilities of a lending library nor the microscopical examination of pathological specimens.

* * *

Doubtless many errors remain in this transcription and the compiler would be obliged if these were brought to his attention via > archivist@ums.ac.uk <

Any information regarding the location of other copies of the *Transactions*, or any material relating to the Belfast Medical Society, the Belfast Clinical and Pathological Society, the Ulster Medical Protective Association, or the early Ulster Medical Society would be gratefully received.

Introductory General Meeting

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY

INTRODUCTORY GENERAL MEETING.

2nd September, 1853.

ANDREW MARSHALL, M.D., IN THE CHAIR.

ATTENDANCE OF FIFTEEN MEMBERS.

RESOLVED,

I.—That the "BELFAST CLINICAL AND PATHOLOGICAL SOCIETY" be now duly constituted, and that the Laws agreed to by the Promoters, and as now amended, be considered "the Laws of the Society, and be binding on all its Members."

II.—That the Members now present, and all to whom the circulars summoning this Meeting were forwarded, who give in their adhesion on or before 30th. September, do constitute the Original Members of the Society, and that all practitioners desirous of joining subsequently, shall conform to the preliminary regulations laid down in the Laws, III and V.

III.—That the Session of 1853-4, be duly opened on the 8th October, proximo; and that the President elect be requested to give the Inaugural address.

IV.—That the subscription for the Session 1853-4, be due on the 8th October, proximo.

V.—That a general circular drawing attention to the Laws, and giving a list of Officers and Members, be forthwith issued to as many Practitioners of the North of Ireland as the Council may deem proper; and that a short advertisement be inserted in the Dublin Medical Journals, announcing the formation of the Society, and requesting co-operation.

VI.—That the Secretaries shall issue the weekly circulars to all Resident and Honorary Members, and such of the Non-Resident as shall defray the expense of postage.

LAWS OF THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

I.—NAME AND OBJECTS.—The Society shall be called "The Belfast Clinical and Pathological Society," whose objects shall be the Cultivation of Practical Pathology, Diagnosis and Therapeutics, by means of the accumulation, and Analysis of appropriate Cases and Pathological Reports, and Public Discussion thereon; the establishment of a Pathological Museum; and the keeping of Records, to indicate the progress of discovery in Medical Science.

II.—MEMBERS.—The Society shall consist of Ordinary Resident and Non-Resident, and Honorary Members—the number unlimited.

III.—QUALIFICATION.—The Candidates for Membership shall be regularly qualified Physicians or Surgeons.

IV.—ANNUAL SUBSCRIPTION.—The Annual Subscription shall be Ten Shillings to Resident, and Five Shillings to

Non-Resident Members, payable on the first day of Session, or, if a new Member, on the day of his election.

V.—ELECTION.—The Candidate for Membership shall be proposed by two Members at one Meeting and balloted for at the next; one black bean in five to exclude—and, prior to Ballot the legality of his Qualification shall be duly certified, and his Subscription paid.

VI.—HONORARY MEMBERS.—Honorary Members shall be elected only at the stated Annual Meeting; the names of Candidates to be entered on the Minutes at least one month previously, and proposed by four Members. When elected, they shall be free to all the privileges of Membership, except share in the property, without Subscription; and in the ballot for Honorary Members, one black bean shall exclude.

VII.—OFFICERS.—The Officers of the Society shall consist of a President to be elected annually by a majority of votes, not re-eligible for three successive years after expiration of office, but entitled, as Ex-President, to be placed on the Vice-President list; Five Vice-Presidents (two of whom shall be chosen from the Non-Resident Members), exclusive of Ex-Presidents, two General Secretaries, and a Treasurer, all to be elected annually by a majority of votes; and after expiration of office, eligible for re-election.

VIII.—THE COUNCIL—ITS FORMATION AND DUTIES.—The Council shall consist of the Office-bearers, and Members of "The Microscopical" and "The Museum" Committees. The duties of the former Committee shall be to report on any Specimens contributed to the Society by members for Microscopic Examination; and those of the latter shall be to take charge of the Museum, receive and put up Morbid Specimens, and report on same when required by the Society.

The duties of "the Council" shall be to make all the necessary preparations for the ordinary Weekly Meetings—to examine the contributions of Members, and select for reading such as may be eligible—to conduct the financial and ordinary business of the Society—make Bye-laws and other regulations not provided for in the stated laws of the Society—report at the Annual Meeting upon all the proceedings of the Session—and draw up the Annual Transactions.

IX.—DUTIES OF THE GENERAL SECRETARIES.—The General Secretaries shall keep a Record of Minutes, enter the Cases and notices received, or remarks furnished, in their respective Books, and summon and attend all meetings of the Council and Society.

X.—DUTIES OF THE TREASURER.—The Treasurer shall keep an account of all Receipts and Disbursements, and furnish his financial statement twice during the Session, also at the close, and whenever required by a vote of the Society.

XI.—CASE PAPERS.—Each Member shall be supplied with forms of "Case Papers," having the annexed heading to guide him in drawing up the contributions which he may furnish. "The reporter is requested to note particularly the following points, in the reading of his case, viz.:—If from any author, the particular volume and age; if original, the place and date; in any case, the age, history, management, impressions regarding same at different periods, the termination, and P. M. Examination, if any."

XII.—MEMBERS' CONTRIBUTIONS.—The Contributions shall be of the following description:—

- 1.—CASES, shewing unusual sequence, or co-existence of diseases.
- 2.—Do. shewing any practical lesson, point, or caution, useful in practice.
- 3.—Do. exhibiting any rare form, complication, exception to the laws of Diagnosis, Pathology, or Therapeutics; or unusual interpretation.
- 4.—Summaries of Medical Statistics to prove frequency of type, average of age, and mortality, and effects of remedies in any disease, or other point susceptible of proof by Statistics.
- 5.—Reports on novel modes of practice in any disease.
- 6.—MORBID SPECIMENS of Pathological or general interest, with or without case, or for Microscopic or Chemical examination.
- 7.—Replies to Medical Queries proposed by Members.
- 8.—Brief Clinical Facts of practical interest.

All contributions to be original, or original translations from authentic Foreign records, not generally accessible to Members.

XIII.—THE SESSION.—The Session shall commence on the last Saturday in October, and terminate the first in May; and the ordinary meetings shall be held every Saturday, at Three o'clock Afternoon: and the Annual Meeting, the first Saturday in May.

XIV.—BUSINESS OF THE ANNUAL MEETING.—The Business of the Annual Meeting shall embrace the following subjects, viz.:—

- 1.—The Report of the Council.
 - 2.—The Report of the Auditors.
 - 3.—The announcement of the New Office-Bearers and Council Members.
 - 4.—The closing address of the retiring President.
- XV.—BUSINESS OF THE ORDINARY WEEKLY MEETINGS.—The ordinary sittings shall be limited to One Hour—five Members to form a Quorum. The following shall be the order of proceedings for the Current Session:—
- 1.—The Chair to be taken by the President: if he be absent, by the Senior V. P. present.
 - 2.—The Minutes of the previous meeting read and signed.
 - 3.—Announcements from the Council.
 - 4.—The Proposal of Candidates and Election of new Members.
 - 5.—The following in such order as the Council may direct, viz.:
 - a.—The Exhibition of Morbid Specimens.
 - b.—The Results of Microscopical and Chemical Examinations.
 - c.—The Reading of Cases.
 - d.—Brief Notices of Clinical Facts and Summaries of Medical Statistics.
 - e.—The Exhibition of New Instruments and Medicines.
 - f.—Papers on New Modes of Treatment.
 - g.—Debates on Doubtful Points in Medical Practice.

XVI.—VISITORS.—Medical Students, of at least one year's standing, shall be admitted as Visitors by Official orders of Members only.

Any Medical Practitioner, not being a Member, may

be admitted as a Visitor once only during a Session, on being introduced by a Member who shall write the name of the Visitor in the Proposal Book of the Society.

XVII.—RESERVE FUND.—One Fourth of the Subscription money shall be set aside as a Reserve Fund, and deposited in Bank, in the names of the President and Treasurer for the time being, to the credit of the Society.

During the Recess, if the state of the ordinary finances permit, a volume of Annual Transactions shall be prepared and published for free distribution among Members only.

XVIII.—BOOKS OF THE SOCIETY.—The Books of the Society shall consist of the following:—

- General Minute Book
Council's do.
General Proposal Book
Treasurer's Account Book
Treasurer's Receipt Book
General Case Book
General Note-Book for Record of Discoveries, Inventions, and interesting Medical notes
Pathological Museum Record
Microscopical Reports
Document Book.

XIX.—PROPERTY OF THE SOCIETY.—The Property of the Society shall not be disposed of except by the unanimous vote of a Special Meeting. Due notice of intention to take such a vote shall be given in a Special Circular to all Members, one month previously.

XX.—DEFAULTERS.—No fines whatsoever shall be imposed on Members; but in case of Subscriptions more than two months due, and after two successive notices from the Treasurer, the names of the defaulters shall be struck off the Roll of Members, and they shall be ineligible for re-election during the remainder of the current Session.

XXI.—EXPULSION OF MEMBERS.—Members may be expelled for unprofessional conduct by a vote of the Society, provided that such vote be carried by three-fourths of a Meeting of at least twelve Resident Members, and that due notice of the intention to take such a vote, with grounds of the charge, be given to each Member eight clear days before meeting.

XXII.—PRIVILEGES.—It shall be a privilege exclusively granted to Members, to receive at any time Reports from "the Microscopical Committee," upon any specimens which they may furnish for examination.

XXIII.—NOMINATION AND ELECTION OF THE OFFICE-BEARERS AND COMMITTEES.—All Members to be nominated for Office-Bearers and Committees shall be proposed by the Council, or a vote of the Society, eight clear days before election; and every Member shall receive due notice thereof, that he may be enabled to forward names for Nomination.

The election of Office-Bearers and Committees shall take place thus:—Each Member shall send forward to the Secretaries his Ballot-paper, properly filled with the names he shall select from the List of Nominees, which will be furnished to him. These names, so returned, shall be examined by the Council and

Auditors, whose report thereon shall be submitted at the Annual Meeting.

XXIV.—AUDITORS.—Two Auditors shall be appointed on the last meeting in April, whose duties shall be to examine the Treasurer's Books, and report on the state of the finances at the Annual Meeting; and also act in conjunction with the Council, in examining the Ballot-papers received from Members.

XXV.—FUNDAMENTAL LAWS.—No case shall be presented to the Society, and no specimen preserved in the Museum, without the previous sanction of the Council. All new proposals shall be inscribed in the Proposal Book, and signed by at least two Members, before being considered by the Council or Society.

No new Rules or Alterations shall be made, except at the three meetings prior to the Annual one, or a special one summoned for the purpose, by the President and Two Vice-Presidents, and due notice of intention to propose such Rules or alterations, shall be given in the circular.

THE FOLLOWING MEMBERS WERE THEN DULY ELECTED AS
OFFICE-BEARERS FOR THE SESSION, 1853–54:

President

* T. H. PURDON, A.M., M.B. (T.C.D.), F.R.C.S. (I.)

Treasurer

* J. H. HALLIDAY, M.D. (Glas.)

General Secretaries

* A. G. MALCOLM, M.D., (Edin.)

* G. F. WALES, L.F.Ph. and S. (Glas.)

Museum Committee

J. M. PIRRIE, M.D. (T.C.D.)

J. S. ARMSTRONG, M.R.C.S. (Eng.)

J. W. STRONGE, M.B. (T.C.D.)

H. M. JOHNSTON, L.R.C.S. (I.)

Secretary

* RICHARD ROSS, M.D. (St. And.)

Microscopical Committee

T. H. PURDON, M.D.

A. G. MALCOLM, M.D.

Secretary

* H. MURNEY, M.D. (Edin.)

The Council

Members marked thus [*] constituted the Council.

THE FIRST ORDINARY MEETING.

8th October, 1853.

J. C. FERGUSON, M.B., in the absence of the President,
was called to the Chair.

Attendance:—Members, 23; Students, 2.

I. Dr. ROSS exhibited two plaster casts of the foot and leg, modelled from an inmate of the Union Workhouse, which illustrated the permanent effects of an extensive burn received in infancy. The patient was a female, aged 35, who, when one year old, received the burn. In the course of a year afterwards, she was able to walk, and never after required crutches, though the deformity was exactly similar to that of a case of *talipes equinus*. The casts were taken in September, 1853, and were presented by Dr. J.S. Reid, physician to the Union Fever Hospital. Dr. Ross, in the course of his observations, recommended numerous small incisions, instead of one or two large ones, for the removal of deformities consequent on burns.

Dr. STRONGE drew the attention of the Society to the full and perfect development of the gastrocnemii muscles, and contrasted it with the condition so frequently found in congenital deformity of the lower limbs; in the latter, he observed, the gastrocnemii muscles present so poor a state of development, as to appear as if they had been sliced away by the stroke of a knife, commencing at the popliteal space, and ending where the *tendo achillis* begins to form. The casts before the Society resembled closely the natural deformities. They were taken from an adult, in whom the injuries occurred very early in life, and after growth and development had so changed the structures that the deformities might be mistaken for congenital. Dr. Stronge believed the condition to which he had alluded would aid surgeons in contradistinguishing the affections.

II. Dr. MALCOLM exhibited two wax casts, modelled from the kidney of a patient who died at the General Hospital, with the symptoms of confirmed "Bright's Disease." The model presented a condition precisely similar to that illustrated in Bright's Reports (Pl. ii., figs. 1, 2, and 3). In his remarks thereon, Dr. M. alluded to the various morbid appearances of the kidney observed in this disease, which precluded all idea of it being a single definitive lesion. Dr. Bright himself did not pretend to define it accurately. Since the date of his Reports, microscopical research had clearly shewn that several very distinct lesions had been included under the generic term; and, even yet, a difference of opinion exists as to the nature of the *gray deposit* (well illustrated in the cast) which supplants the natural tissue of the cortical portion. Johnson's view, as being based upon recent careful microscopic and clinical observations, is perhaps entitled to the greatest regard. It certainly explains most satisfactorily the pathology of these lesions, and connects them with the diagnostic signs observable during life. He divides them into four great classes, viz.:—

1. Acute Desquamative Nephritis, characterized by these serial changes, viz.:—1st, morbid blood; 2nd, stimulation of the secreting cells of the kidney,

producing rapid desquamation; 3rd, checked secretion; 4th, retarded circulation, distension of the malpighian vessels, and escape of serum and a fibrinous material which coagulates in the tubes, and escapes with epithelial cells, in the form of "epithelial casts," and sometimes (from rupture of the over-distended malp. capillaries) "blood casts." This form may exist without permanent organic change.

2. Chronic D. N., characterized by chronicity of epithelial desquamation; arrest of the reproduction of epithelium; clearing away of the contents of the tubules, which leaves the basement membrane, for the most part, bare; the tubes eventually become atrophied, and surrounding tissue collapsed; the malpighian bodies become more distinct, their capillaries become thickened and opaque, the muscular coats of the arteries hypertrophied, and the condensed tissues give the appearance of the so-called "granulation." Some of the tubes contain unorganised fibrinous or albuminous material, which appears in the urine, in the form of "large waxy casts," having a diameter of the full calibre of the denuded tubules; and sometimes so abundant in the kidney as to give it the appearance, on section, of a mass of yellowish-white wax, a little variegated—the "waxy degeneration" of the author. Some tubes may dilate and grow into cysts, while others become the receptacles of oil cells in considerable quantity.

3. Non-Desquamative Disease.—This also occurs in an acute and a chronic form, and is characterized by a granular and opaque condition of the tubular lining, and the general absence of the desquamating process, save in a few tubules, (whose epithelium is still normally retained), from which "small waxy casts" issue and appear in the urine. It is under this condition that the more advanced anatomical appearances (such as are depicted in Bright's Reports, pl. iv.,) may be observed, and which correspond to Gairdner's "waxy degeneration." The kidney rarely becomes atrophied in this form; but in general it becomes larger, paler, and more wax-like, in proportion to the duration of the disease.

4. Fatty Degeneration.—A not uncommon sequel to the third form, and distinguished during life by the presence of "oily casts and cells" in the urine. It sometimes supervenes upon the first form, but after an intermediate non-desquamative condition. (For illustration, see Bright's Reports, pl. ii., and Rayer's Work, pl. viii.) In addition to the character of the kidney under the third form, there is a certain amount of "characteristic granulations of a yellowish-white colour scattered through the cortical substance," these being deposited in certain sets of tubes only. Hence this lesion has received the name of the "granular fat kidney;" another is designated by Johnson "mottled fat kidney," and is characterised by a mottled appearance, and by the oil being almost universally deposited in the epithelial lining, or interior of the tubules themselves. The proportion of fatty matter in this form is larger than in the former, and it may exist a long time before any albumen in the urine, or other ordinary indications, can be observed.

These four conditions include all the changes usually

due to Bright's lesion; and hence the deposit referred to at the beginning of this notice, may be deemed an albumino-fibrinous substance—the basis of the cast, thickened malpighian bodies, and tubular walls, or oily matter, according as the degeneration is inflammatory or fatty.—(See Catalogue of Museum, No. 2.)

III. Dr. MALCOLM exhibited a good specimen of Farre's *Tubera circumscripta* of the liver, which he had also examined microscopically, and found to contain ordinary "cancer-cells." As one of the examples in which *enlargement* of the liver may be distinguished during life, Dr. M. pointed out the principal distinctive marks of this and other lesions characterized by the same feature, viz.:—*pure hypertrophy*, the results of hyperaemia; *the nutmeg liver*—hypertrophy of the secreting substance, or of the ordinary adipose tissue contained in the liver; *the fatty liver*, or morbid accumulation of fat in the liver, of which the so-called *waxy liver* is a variety; *the lardaceous liver*, characterised by the infiltration of the hepatic parenchyma by a gray albuminous and lardaceous-gelatinous substance, whose nature has not been yet clearly ascertained; *abscess*; and *hydatids*;—the other affections of the liver do not increase its bulk.

IV. Mr. H.M. JOHNSTON exhibited a dry preparation of *calcareous aortal valves*, which presented a good illustration of stenosis.—(See Catalogue of Museum, No. 1.)

V. Dr. MALCOLM exhibited some drawings of the *Achorion Schœnleinii*, taken from a recent specimen of the crust, in a case of *porrigo favosa*; and pointed out the importance of distinguishing thereby this affection of the scalp from chronic impetigo, which occasionally resembles the former, more especially in the dry state.—(See Pl. 1, and Catalogue of Museum, No. 3.)

THE SECOND MEETING.

15th October, 1853.

The President in the Chair.

Attendance:—Members, 21; Students, 3.

The PRESIDENT delivered the INAUGURAL ADDRESS of the Session, deferred from the First Meeting, in consequence of his unavoidable absence.

VI. Dr. MALCOLM exhibited a coloured cast of a lung, illustrative of the pathological effects of the pulmonary apoplexy of Laennec, and described the varieties and distinguishing features of the lesion; and particularly referred to its differential diagnosis, from merely bronchial haemorrhage and the effects of rupture of the lung. Dr. M. also alluded to the interesting fact, that "haemoptoic infarctus very often occurs without haemoptysis.—(See Rokitanski's Path. Anat. Day's Trans., vol. iv., p. 67. Catalogue of Museum, No. 4.)

VII. Mr. HANNA introduced a patient presenting well-marked *facial paralysis*, and gave a slight history of the case.

VIII. The PRESIDENT read the following case of perforation of the stomach:-

Mrs. B., subject for several years to gastralgia, soon after eating, and continuing for some hours, at times very severe, was at length relieved by the use of nitrate of silver. After some months it returned: about this time she was suddenly attacked (immediately after taking tea) with intense pain in the left side of abdomen, spreading thence over the entire. She vomited once. I saw her next morning, about twelve hours after, in the following condition: sunk expression in forehead, eyes clear, voice good, complaining of pain when asked; abdomen tender and rather tympanitic; pain now more towards pubes; little urine passed; bowels confined; nausea, but no vomiting; thirst, tongue whitish, not dry; pulse 130 compressible.

She gradually sank and died at six, p.m., twenty one hours after first attack. On a P. M. examination was detected a circular aperture close to cardiac orifice; the edges of opening thick and slightly inflamed. The stomach was otherwise perfectly healthy. Intense inflammatory appearances were observed over the whole peritoneum.

Pain, chiefly in pubic region, accompanied with enlargement of abdomen, was remarked by the late Dr. S. S. Thomson, to have been very prominent in all the cases he met with.

IX. Dr. MALCOLM read a case of blue tinging of skin, due to intense Pleuritis, which is recorded as having occurred in the practice of Dr. Marcket, of Guy's Hospital, London, in 1804.—(See Ed. Med. and Surg. Journal, vol. i.)

X., XI. Dr. MALCOLM exhibited and described Sibson's spring percutor; also, a larynx-syringe, for injecting nitrate of silver solutions. The former of these has been tested in the General Hospital here, but found to be inferior to the hammer and pleximeter of Pierry and Bennett and not by any means so convenient as the stethoscopic percutor which is made by affixing a ring of india-rubber to the ear piece of our ordinary stethoscope.

XII. The PRESIDENT exhibited and described several œsophageal bougies, and a brush for the removal of foreign bodies.

THE THIRD MEETING.

22nd October, 1853.

The President in the Chair.

Attendance:—Members, 19; Students, 5.

XIII. Dr. MALCOLM exhibited two coloured casts illustrating Capillary Apoplexy of the brain (after Cruveilhier). The one (marked 51) represents a portion of the left hemisphere. Upon the surface we remark three small patches, presenting in one, slight capillary injection, and in the others, the well-marked anatomical characters. The margins are perfectly defined and separated from the adjoining tissue by

small partial sanguineous effusions.¹

The cast (marked No. 332) represents capillary apoplexy of the right hemisphere. Upon the surface of its convolutions we see a large injected patch, having a peculiar dotted appearance. The cerebral substance is destroyed partly by excessive congestion, and partly by rupture; and in the centre we find an enormous sanguineous clot.

This form of apoplexy is mostly met with in the gray part of the cerebrum, where the vessels of the pia are most numerous; and instead of the ordinary clot which we meet with in the internal parts, there are innumerable points of extravasation—ecchymoses, which, in the mass, presents a slightly elevated reddish appearance on the surface of the hemisphere. When, in the course of time, the venous tint becomes altered to a fawn hue, the state then presented has been named by Durand-Fardel and Cruveilhier "the yellow plates or patches of the convolutions." Cruveilhier compares the hue to that of chamois leather. The mass varies in density, from a soft and pulpy to a dense indurated consistence. The convolutions become wasted, and Ramollissement frequently occurs in the substance beneath. There are many causes besides external violence for this affection; and among the most common (according to Hasse) is hypertrophy of the left ventricle of the heart. It is most frequent between the ages of 60 and 70.—(See Catalogue of Museum, Nos. 5 and 6).

XIV. Dr. MURNEY exhibited a specimen of ossified pericardium, and two of ossified falx cerebri.

The specimen of ossified pericardium was taken from a male subject, about 60 years of age. The body was plump, with considerable deposits of fat. The heart and all other principal organs were normal; a tendency, however, to ossific and calcareous degeneration was noticed in different situations. The arteries burst in many parts (from atheromatous and calcareous deposits in their coats), during the act of injection in the dissecting room. The thyroid cartilage was almost completely ossified. The circumference of the intervertebral fibro-cartilages, between the different dorsal and lumbar vertebrae, were also ossified for the thickness of a quarter of an inch.

The larger specimen of ossified falx cerebri was about two inches in length, and the full depth of the falx: it was evidently an extension of ossific deposit from the crista galli of the ethmoid bone; it was taken from a male subject about 65 years of age. The smaller specimen was met with in a male about 40 years of age;

¹ Dr. M. mentioned that the casts were once in the possession of Dr. Felix Thibert, the celebrated Pathological modeller to the Faculty of Medicine at Paris. They are prepared by a process hitherto unknown in this country. The material is unalterable, and the colouring indelible. In 1839, a medical commission (MM., Andral, Breschet, and Cruveilhier), reported upon them most favourably to the Royal Academy of Medicine at Paris. In 1843, MM. Dumeril, Roux, Majendie, and Larrey, presented a similar report; and in this and the following year, medals were awarded to Dr. Thibert for his valuable discovery. Since the death of Thibert, the establishment passed into the hands of M. Bourgery, whose widow is the present proprietress.

it occupied a similar position to the preceding, but was not more than one inch in length. In both cases the arachnoid membrane was opaque on the upper parts of the hemispheres of the brain; and the veins beneath the membrane were congested. No unusual ossific deposits were noticed in other portions of the bodies.

No information could be obtained as to the previous history of any of these cases.

The specimens were brought before the Society, as they were considered interesting from their comparative rarity, Dr. Murney remarking, that in the examination of considerably more than 300 subjects, he had not met any specimen of similar deposit in the Pericardium or Dura Mater.

XV. Dr. MALCOLM read the particulars of a case of hydatids, contained in an immense abdominal cyst connected with the mesentery, for which paracentesis was performed, under the idea that ascites existed.—(See Ed. Med. and Surg. Jour., vol. i.) An interesting discussion ensued as to the diagnosis of such cases from ascites and pregnancy, the latter of which has also been occasionally supposed present under similar circumstances.

XVI. Mr. WALES read the notes of a case of ruptured intestine, from a fall after a meal, which was mistaken for the effects of metallic poisoning.—(See Dub. Hosp. Rep., vol. for 1817.)

XVII. Dr. HALLIDAY read a case of lumbar abscess, which burst into the intestine.

Thos. C., aged 21 years, first visited on 26th April, 1853, stated, that eight days before he had been lifting a heavy weight, when he was seized with a severe stitch or pain in his back.

On examination, I found a large and nearly colourless swelling occupying the left lumbar region. On percussing the spine carefully, I could discover no tenderness whatever. There was, however, great constitutional disturbance, with intense local pain. Leeches, hot stuping, and alterative doses of sub. mur. hyd., with opium, were prescribed, which afforded some relief. Three days afterwards, he had well-marked rigors, and, on the 3rd of May, a tumour was observed in the left iliac region, extending into groin.

On the morning of the 4th, when he awoke from a short sleep, he found that this tumour had disappeared. During all this time, the swelling in lumbar region had been increasing in size, and becoming softer, and on the 6th, the bowels (which had been obstinately constipated for three or four days previously) relaxed, and a large quantity of pus was passed. Immediately after, the latter swelling also subsided. Visiting him on the 7th, I found the spot where the abscess had been level with the surrounding parts, and having a baggy, soft feel. All pain was gone, and, under a slight tonic treatment, the patient rapidly regained his usual health, which, I should have stated, was good.

XVIII. Dr. LYNCH read his notes of a case of coma from uræmia simulating apoplexy, which was remarkable from the suddenness of the cerebral symptoms, under

circumstances not likely to excite suspicion of the real malady.

Mrs. ___, age 64, became suddenly comatose, or apoplectic, while in bed, on the 29th September last, about three o'clock in the day. Three hours after, I saw her for the first time. In the morning, she felt sudden and severe headache, and was unusually heavy and drowsy, but took breakfast, which she vomited, with some bile. For three or four days previously, she had been complaining of cold and cough of a bronchitic character. All her life, she had enjoyed good health, though subject to winter cough for many years. She was strictly temperate. She never had the slightest œdema, or trace of anasarca, nor any symptom of cardiac disease. The pulse 108, not forcible. The temperature of the skin and extremities diminished, and the coma very complete. The eye fixed and unwinking, and the pupil contracted to the size of a pin's point. The respiration noisy and characteristic, with the expulsive flapping of the cheeks in expiration. In fact, the respiration became tracheal on the second day, and the body suffused with clammy perspiration. The face and limbs became livid, or of a dark leaden hue, relaxation of the sphincters and symptoms of approaching dissolution seemed rapidly advancing; yet, notwithstanding, she emerged from and survived this condition of circumstances, so as to give sanguine friends hope; became conscious, and was able, though feebly, to converse with and recognise relatives, for several days. During this interval, I was enabled to procure some of her urine, the examination of which revealed the true nature of the case to be Bright's disease. Tongue had a thick white creamy coat. Pulse rose to 116, weak. For the last two days, she gradually relapsed into the former state of insensibility, and sank, eleven days after the first seizure, without spasm or convulsion. Dr. Lynch since ascertained, from relatives, that she never had scarlatina, swelling of the face, ankles, or hands, double vision, numbness, or difficulty of speech, and made no complaint of weak back at any time. On the other hand, however, she had drowsiness, giddiness in head, singing in ears, and irritability of the stomach, as indicative symptoms.

XIX. Dr. STRONGE exhibited and described a new tracheotome.

XX. Dr. MALCOLM exhibited and described an improved porte caustique, for use in cases of spermatorrhœa.

THE FOURTH MEETING.

29th October, 1853.

The President in the Chair.

Attendance:—Members, 19; Students, 4.

XXI. Dr. MALCOLM exhibited a rare form of abdominal tumour, forwarded by Dr. Philip Russell, Bangor. The particulars of the case were these:—James H., aged 33, took ill with severe pain in the left hypochondrium and back, towards the end of May, 1853. This continued until a hard tumour, of the size of an orange, could be felt in the place where the pain originated, which latter

became more aggravated as the disease progressed. There was no other disturbance of the digestive organs than occasional vomiting. The tumour rapidly increased; and, simultaneously, his health became greatly impaired. In the beginning of October, the tumour seemed almost to fill the abdomen, without much distending it; and, on examination, it was hard, and seemed divided by a sulcus, without fluctuation or impulse. Extreme debility, anorexia, and agonizing pain were the principal symptoms. In addition, there was some haematuria, and distension of the right testis, from effusion into its tunica vaginalis. A variety of treatment (principally anodyne) was employed, without avail; and he expired on 20th October. A post mortem examination disclosed the following appearances:—The tumour occupied the epigastrium, and extended into the left hypochondrium, and downwards to the posterior brim of pelvis. On opening the abdomen, the colon formed a semicircular boundary below it; the omentum was strongly attached to the base of the tumour at the spine; the liver and stomach formed the superior boundary; and the small intestines were almost covered by the tumour and colon. Within these limits, it appeared like a circular tumour, of a purple colour, and irregular on the surface. In order to remove the tumour, the anterior ligament of the spine had to be divided. The tumour encircled four inches of the aorta, and the commencement of the iliac arteries. The vessels, though small, were healthy, and sent their branches through the tumour to the colon. The kidneys had undergone a slight "fatty degeneration," and were intimately connected with the tumour. The anterior layer of the peritoneum adhered to the tumour at one point only, where, under the impression that matter was present, a practitioner had made a puncture, one month before the patient's death. The other abdominal organs were healthy. The right testis was enlarged and soft, and, on section, some brain like fluid escaped. There was some bloody effusion in the left pleura.

The tumour was examined microscopically. No cancer cells were detected. Small cells or nuclei, 1/3,000 inch in diameter, were noticed in great abundance. These, with a few oil-cells, and two or three compound cells, when viewed, *en masse*, presented a light yellow-gray aspect. Around this was an olive structure, somewhat like fibrous tissue, coloured; and, surrounding all, a blood-red mass, composed principally of vessels. The dimensions of the tumour were 6½ x 5 x 4 inches, and weight, 2lbs. 2½ oz.; of irregular outline, lobulated externally, and of dark olive and purple hue, generally hard, but yielding on firm pressure.—(See Pl. ii.)

XXII. Dr. MALCOLM presented several casts and drawings representing a malignant tumour of the ilium *in situ*; and gave the following history of this interesting case, which is a remarkable instance of the close simulation which Carcinomatous disease, in its formation, may bear to ordinary acute inflammation:—

Eliza M'C., aged 50, married, was admitted into the Belfast General Hospital, February 11, 1851. Though of a spare figure, she had always enjoyed good health until about nine weeks previously; and her countenance was

certainly not indicative of any constitutional disease. The certificate of admission stated that she was suffering from rheumatism of the left hip. On the usual inquiry, she mentioned that she had taken ill with pain in this region, which also extended along the anterior aspect of the thigh, was not relieved by a change of position, and yet was not increased by moderate exercise. Her pulse was 96, full and soft; the tongue furred, and white all over; the appetite was of late impaired; and frequent insomnia was induced by the severity of the suffering. On examination I detected a swollen and tender part, situated in the left iliac region. The tumour was indistinct; yet, from the tenderness, increase of temperature, and some degree of fulness, the fact of its existence was sufficiently made out.

A difficulty now arose as to the nature of this tumour. It presented all the appearance of an inflammatory swelling, likely to end in suppuration; and this view seemed confirmed by the absence of any indications of a chronic blood disease.

Leeches were, therefore, applied, with the effect of relieving the tenderness. Nevertheless its size steadily increased, so that, on the 6th of May, the circumference of the abdomen, including the tumour, measured thirty-four inches. In this interval the patient became perceptibly emaciated, while the left thigh and leg gradually enlarged. At this time the tumour was dense, tender, and deeply fluctuating; and much pain and difficulty were felt in moving the limb. Soon a marked change occurred, both in the general and local condition. The pulse rose; the emaciation rapidly progressed; she became at times delirious, and her memory defective. The most elevated part of the tumour assumed a purplish appearance, and the pain was constant, and occasionally agonizing. The contrast presented by the appearance of the two limbs was striking in the extreme, the circumference of the left thigh, at its upper third, being fully thirty-two inches, or about three times that of its opposite. The left ilium also greatly increased; and it was evident, on examination at this date, that the osseous structure was involved. Complete prostration now ensued, and she expired early in the following month. A careful examination of the diseased structure was made shortly afterwards, when it was found that the entire cancelli of the ilium were hypertrophied to an enormous extent, and charged with soft gelatiniform cancer.

It is more than probable that, for some weeks after the commencement of the disease, there was no evidence of the existence of a tumour. It is not very wonderful, therefore, that the neuralgia was ascribed to local rheumatism, which the case was supposed to be by the practitioner whom she first consulted. Then, when the tumour did make its appearance, the difficulty was not much diminished, for there was no symptom at all indicative of the real disease. On the contrary, the febrile symptoms, and the result of local examination, seemed to place the inflammatory character of the case beyond all doubt. The progress, however, soon disclosed its real nature.—(See Catalogue of Museum, No. 24.)

XXIII. Mr. HANNA introduced a child—B. O'N., aged one

year and ten months—with a large congenital tumour at the upper part of the cervical region. This is a case which very much resembles "Spina bifida;" but, from the history, and a careful examination, it would seem to be a congenital steatomatosus growth. I had an opportunity of seeing the child a few days ago, and I found him in excellent health. The tumour is still increasing and uncircumscribed, and communicates to the fingers that elastic and woolly sensation characteristic of steatomatosus formations. I consider the case could not be "Spina bifida," from the situation of the tumour, and the fact that he is nor was not subject to any convulsive or paralytic affection.

XXIV. The PRESIDENT exhibited and described Hardy's apparatus for the local application of chloroform.

THE FIFTH MEETING.

5th November, 1853.

J. C. Ferguson, M.B., in the Chair.

Attendance:—Members, 15; Students, 6.

XXV. Dr. MALCOLM read the notes of a case presenting the co-existence of phthisis and cystitis.

This case was first seen by Dr. M. on January 28, 1851. Mary Patterson, aged 12, of slight frame, though of florid and healthy appearance, began to complain, three months previously, of pain and uneasiness of the loins, which she ascribed to cold. In two weeks' time, micturition became frequent and painful, and her general health became so much affected that she had to confine her self constantly to bed. Since this, she has had variable health, but the dysuria and other symptoms of urinary irritation persisted. The dribbling of urine was incessant. She lay with legs flexed on pelvis. The pulse was 132, skin dry and hot, and face flushed. Over the abdominal surface, chloasma exists in a well marked form. Within the previous month has complained of her throat, and last two weeks of cough. No physical signs of organic disease of chest at this time detected. The treatment was suited to the cystitic disease, accompanied by astringents, opiates, and tonics, as diarrhoea of a most obstinate character set in soon afterwards. She died on 23rd March. On a post mortem examination, the bladder was thickened and ulcerated, and the left lung presented extensive tubercular infiltration, and a cavity in the apex close to the posterior surface.

The case was supposed, at first, to have been one of simple chronic cystitis; then, when the appropriate treatment failed, the spine was looked to, but with no better result. An anterior examination of the chest was made, but the disease, being located in the posterior part, remained undetected.

The co-existence in this case is most unusual. Louis rarely found the urinary organs the seat of any lesion. In no case, among 120 analysed in his work, was the bladder diseased. The same is true of 60 other cases subsequently observed at "La Charite," and 200 subjects opened since, only furnished two instances.

The case shows the necessity of very careful, and even minute, examination of the lungs, in all cases of

general debility and marasmus in young patients.

XXVI. Dr. MALCOLM read a case in which protrusion and enlargement of the tongue persisted for four years.

This case occurred in the practice of Dr. W. R. Clanny, of Bishop-Wearmouth, and is reported in the *Edin. Med. and Surg. Journal* for July, 1805.

R. H., a boy, aged 5, when first submitted to treatment, was suffering from worms, and had every appearance of scrofula, as indicated by op. tarsi, and cicatrices under the chin. His tongue, which had begun to swell before he was a year old, was enlarged in all directions, and lolled out of his mouth, the point reaching considerably below his chin. It was rough and fissured. The incisors were gone, and the molars diseased. He could not articulate. Vermifuge medicines acted effectually, and a large number of worms were expelled; but, though his health was benefited, the tongue remained unaffected. It could, indeed, by force, be pushed into the mouth, but, immediately on withdrawing the hand, it burst out as before. By keeping the jaws firmly fastened together after returning it, and, with few intermissions, keeping it so for five weeks, the tongue eventually assumed its natural size and appearance, and perfect articulation was gradually accomplished.

XXVII. Mr. H. M. JOHNSTON read the notes of a peculiar case of malingerer in medical practice, in which it was attempted to substitute common earth-worms for intestinal.

XXVIII. Dr. MURNEY exhibited and described a specimen of cancroid tumour of the leg.

The tumour was circular, about two inches in diameter, of a light flesh-colour, projecting about three-eighths of an inch from surrounding skin. On viewing some of the fluid portion under the microscope, a number of epidermic cells are seen, separate and in clusters, the latter surrounded by a considerable quantity of molecular and granular matter, with many oil globules, and a few compound granular corpuscles. There were, also, a number of circular and oval shaped bodies, transparent, unaffected by acetic acid, which I considered to be nuclei set free by the disintegration of their cells.

XXIX. The SECRETARY exhibited an enormously hypertrophied leg, received from Dr. Kidd, Ballymena, and read the following notes supplied by that gentleman:—

Mr. R. B., aged 31 years, resident about a mile from the village of Cloughmills, on the road leading to Ballymoney, in the County of Antrim, where he follows the business of a linen manufacturer, consulted me about a fortnight since, in consequence of a disease which he had in his right leg, and which rendered him unable to follow his avocation. He says that the first symptom of the illness attacked him in the year 1830, by his feeling, when getting out of bed one morning, an acute pain in his knee, but there was neither redness nor swelling at this time. In about a week, however, it became greatly swelled and painful; and in three weeks after, it was thought that an abscess had formed in or about the

joint. A puncture was therefore made, but no matter was discharged. In a few days after this, matter began to come away, and the limb above the joint continued to discharge for seven or eight years, at the end of which period many inches of the femur were removed from the thigh. This part of the extremity then gradually healed up, but the leg below the knee remained extremely swelled and painful. I do not know the remedies that were applied, but, no doubt, both they and the medical men consulted, were many.

At the time I saw the patient, the extremity was an immense size, and he was perfectly unable to make any use of it; he also informed me, that the pain was so severe in it, that he was almost entirely deprived of sleep. The disease appeared to have extended to the foot, as it was also greatly enlarged. Seeing there was no hope of doing the patient good by any mode of treatment, except by amputation (an opinion which Dr. Moore, of Ballymoney, and Dr. Moore, of Loughgill, also formed), I recommended him to submit to the operation, to which he at once agreed; and on Tuesday, the 1st inst., the two gentlemen above-named, and myself, removed the limb, cutting it off very close to the body.

Thinking the specimen possessed some points of interest, I have already sent it to the Society, who, I presume, have examined it. I saw the patient once since he lost his leg; and I also heard of him on the 9th of November, and I am glad to say he is doing favourably. He says he sleeps well, and is, comparatively speaking, free from pain, and enjoying happiness that he has not experienced many years before.¹

With reference to this case, I may now add that the patient continues quite well, and enjoys excellent health. October 2, 1854

A KIDD

XXX. Dr FERGUSON exhibited the recent parts in a case of *foreign body in the trachea in situ*, for the removal of which tracheotomy was performed.

XXXI. Mr. JOHNSTON exhibited portions of the intestine in a state of ulceration, which occurred in the course of typhoid fever. The ulceration was limited to the lower portion of the ileum and the coecum. The fever continued over a period of nine weeks. The tongue presented a persistent grey fur, unaffected by treatment. There was thirst, but no diarrhoea, nor tympanitis. Slight tenderness over right iliac region. Patient became greatly emaciated, and gradually sank.

THE SIXTH MEETING

12th November, 1853.

Andrew Marshall, M D, in the Chair.
Attendance—Members, 23, Students, 15.

XXXII. Dr MALCOLM exhibited several specimens of "Kousso" and read a report on its history, use, mode of

¹ Upon a section of the soft parts, it was observed that the muscular tissue was atrophied but the adipose and cellular greatly augmented and in the interstitial spaces some infiltration of fluid. There was no appearance of tubercular matter or pus A G M—(See Catalogue of Museum No 9)

administration, and the result of recorded trials, from which we extract the following—

ITS HISTORY—Dr. Brayer, a French physician, resident at Constantinople in the year 1823, sent a specimen of the flowers to the Prussian botanist, Kunth, who saw it was a new plant, and gave it the name of *BRAYERA anthelmintica*, which was afterwards adopted by De Candolle. Lamark (1811) had previously named it *HAGENIA*, in compliment to Dr J. C. Hagen, Professor at Konigsberg, and Bruce (1768), in his "Travels in Abyssinia, had noticed it, and called it *BANKSIA*, after Sir Jos Banks. Kosso, and Cusso, are synonymous terms.

Dr R. Dickson, London, was the first to recommend its use in this country, which he did in these terms—"The utility of vegetable bitters (as a vermifuge) is proved by the fact that wherever the bog bean or the tormentil grows, however damp the pastures may be, the rot never infests the sheep." * * * "Scarcely any other article (than oil of turpentine) need be employed, unless the disagreeable smell and taste be objected to, when the *BRAYERA anthelmintica* should be given, as at once safe and efficacious. We might naturally expect this result, he adds, "since it belongs to the same natural family tribe as the tormentil, viz, the Rosacea—(See Pen Cycl, vol ii). Yet, in the face of this declaration, we find Pereira, in 1850, stating his opinion that, "As it belongs to the Rosacea, which are distinguished by astringency, Kousso presents a remarkable instance of a drug, whose peculiar effects could not be *a priori* known, by a knowledge of its botanical or chemical composition—(See Pharm Jl, for July, 1850).

DESCRIPTION—The *Brayera* is a tree which grows in Abyssinia, and attains an altitude of 20 feet. It is found everywhere on the table land of N. E. Abyssinia, and appears to require an elevation of between six and seven thousand feet for its growth. It has a small flower, of a greenish hue, which tint, in the tips and edges of the petals, eventually becomes reddish purple. The fragrance is similar to the combined odour of the leaves of tea, hops, and senna. The officinal plant is gathered for medicinal purposes before the seeds are quite ripe, and whilst a number of flowerets remain unchanged. The taste is feeble, senna like, acrid, and unpleasant, but not so, immediately when taken. Its peculiar property, as vermifuge, resides in the acrid resin, which is neutral and soluble in ether and alcohol. The odour is due to a volatile oil, to which, also, its anthelmintic property may be in part ascribed. An infusion of Kousso strikes a dark olive tint, with a solution of the sesqui chloride of iron.

EFFECTS—All modern travellers in Abyssinia are agreed as to the great success of this drug with the natives, with whom it has been in great repute for upwards of 200 years. Its physiological effects are mild. Sometimes a sense of heat, nausea, and thirst, are excited, but, in general, it is necessary to follow up its use with a purgative, to insure decided results. It prevails against both the *Tænia solium* and the *Bothrioccephalus lata*. In Switzerland, where the latter abounds, it has been most effectual.

A single dose may kill all the worms, but cannot prevent a recurrence. The Abyssinians resort to the

medicine monthly. The restrictions on the use of common salt may be an agent in the propagation of the worm so generally in this country.

The drug is cheap in all parts of Abyssinia, except at Yangaro, whose sovereign retains the exclusive use of it. In Europe, how ever, its price reached the enormous sum of 35s per ounce, and at one time, one of the French pharmaciens had a monopoly of the entire European supply. It is now about 1s 6d.

MODE OF ADMINISTRATION—It should be taken in the morning, fasting, the only preparation necessary being that the last meal of the preceding evening should be slight, and the evacuation of the bowels by a mild purgative is desirable. Half an ounce of the powdered flowers are infused for a quarter of an hour, in 10oz of lukewarm water, a little lemon juice is then added, and the whole swallowed at two or three draughts, at short intervals. The bitter taste is covered by lemon juice and cold water taken immediately afterwards, and its action is promoted by tea, without sugar or milk. After the lapse of three or four hours, should there be no alvine effect, a dose of castor oil, or a saline purgative, ought to be administered.

RESULT OF RECORDED TRIALS.—The drug has been employed with great success in France, by MM. Chomel and Sandras, and by Drs. Budd, Todd, and Gull, and others in England. An analysis of 24 recorded cases gives the following results:—The average duration of vermic symptoms was four years and four months, but varied from 16 months to 16 years. The average time of action was five hours, and ranged from three to seven. The average length of the worm was 16 feet, but varied from three to thirty feet. Fifteen of the reporters observed that the head came away; nine that it did not. Vomiting or other unpleasant symptom was rare—in general, the medicine acted without uneasiness.

Dr. LYNCH had used it in one case unsuccessfully; and 17s. 6d. was paid for the dose. Notwithstanding the failure, he was disposed to give a favourable opinion of its merits, from the accumulated pro-testimony adduced.

Mr. H.M. JOHNSTON tried it once, but unfortunately the medicine was almost immediately returned.

Dr. YOUNG, Holywood, has employed it with great success. The worm was brought away, and with immediate and permanent relief. He had great confidence in it.

XXXIII. Dr. STRONGE exhibited a specimen of a rare form of exostosis of the Tibia, which he had procured through the kindness of Mr. Mulholland, surgeon to the Union Workhouse, and said that the specimen was worthy of notice, inasmuch as that being found with an immense mass of diseased structures, superimposed exostoses were formed on it—some nobulated in form, others drawn out, as it were, into fin-like processes. He believed the mass in which the bones (the fibula was also engaged) to have been malignant.

Aneurismal and other benign tumours resting on bone, usually produce absorption of the osseous structure, whereas, in the case before them, the effect was quite the opposite. In cases of doubt as to whether tumours are malignant where the bone can be felt, and

this condition found to exist, this distinction might assist in diagnosis.—(See Catalogue of Museum, No. 10.)

XXXIV. Dr. ROSS exhibited a *cancroid tumour of the lip* recently excised; and insisted on the importance of using constitutional treatment for the cure of the cancerous diathesis, after surgical operations in such cases. He was satisfied that, if this rule were generally adopted, there would be fewer cases of a return of the disease.

XXXV. Mr. HANNA exhibited a cast of the elbow, taken from a patient, in whom a fracture of the humerus simulated dislocation.

XXXVI. Dr. MURNEY exhibited the brain of an idiot, aged 18, in which there was enormous enlargement of the lateral ventricles, from *hydrocephalus*. The quantity of fluid which poured forth on the removal of the brains, was stated to be nearly 40 oz. The early history of the case could not be accurately ascertained, farther than that it was known that the individual was subject to epilepsy.

THE SEVENTH MEETING.

19th November, 1853.

The President in the Chair.

Attendance:—Members, 19; Students, 19.

XXXVII. The SECRETARY read the report of a case of Hepatic disease, contributed by Dr. JAMISON, Newtownards.

The patient was an inmate of the Newtownards workhouse, aged about 40, tall and emaciated, and had a remarkably rigid, erect gait. He never had an acute illness, and did not present himself for treatment till one week before his death; but he had been long remarked as having a most irritable temper, which was evidently morbid. His chief physical complaint was irritability of stomach, and, on examination, Dr. J. noticed a very great enlargement of the liver. He became jaundiced shortly before death, but at no time had he dropsy. On a post mortem examination, the liver was found extending to the spleen, and of great depth over the stomach, which was contracted, but with hypertrophy of its muscular coat. The surface of the liver was nodulated with white tumours, whose interior presented the appearance of lard. A few gallstones were found in a small gall-bladder, and he had an old and rather large hernia. The chest was not examined. The disease of the liver was evidently an example of Farre's tubercle, which, it is well known, may exist for a lengthened period without the usual indications of hepatic disease.

XXXVIII. Dr. H. A. STEWART read some particulars of the case of *aneurism of the ascending aorta*, for which the common carotid was tied by the late Dr. Sanders, Belfast, under the impression that the innominata was the vessel affected.—(Dr. S.'s MS. is dated April 8th, 1839.)

This case was supposed to be aneurism of

innominata. The tying of the carotid on that side was proposed when all constitutional means had failed, and when certain death threatened the patient, and soon, from the rapidly increasing size of tumour.

The common carotid was tied about the usual place, and the patient bore the operation well. There was almost no blood lost. Considerable diminution in the bulk of the tumour almost immediately succeeded. When put to bed, the pulse was 98, and it afterwards fell during the day to 80. He was bled twice within twenty-four hours after the operation. Next day he expressed himself as greatly relieved, and the pulsation of tumour had very considerably abated, as had also its size. This improvement continued for four or five days, and all appeared to be going on favourably enough, when a sudden change took place—evidently the result of the bursting of the sac, which carried him off in a few hours.

On a post-mortem examination, the aneurism was discovered to be one of the ascending aorta, not of the innominata, as supposed, and of great size. The part which gave way had been attenuated to the utmost degree, so that the exact spot could not be determined. It was on the anterior aspect of the tumour, however, and corresponded with the part which had produced absorption of portion of the first and second ribs, and protruded under and above the clavicle. The walls posteriorly were lined with thick layers of fibrine, which appeared to have been deposited in succession after the operation. They adhered tenaciously, and contributed greatly to fill up the cavity of sac.

The result of this case, though unsuccessful, is, I conceive, rather favourable to the operation; and I feel convinced that, had it been performed at an earlier stage in this, or were it tried in any smaller aneurism of the innominata, or even of the arch of aorta, it might be attended with better success.

I should have stated that the patient was bled once on the day previous to the operation, and that his pulse usually ranged from 80 to 96 in the recumbent position, but immediately on being raised to the sitting posture it became greatly accelerated, frequently numbering 140. It was generally intermittent.

XXXIX. Dr. PIRRIE read a case of *aneurism of the thoracic aorta*, contributed by the President.

I was requested to visit Mr. C, reported to have been three weeks ill with bronchitis, for which he had been bled. I found him suffering from very frequent cough, copious, frothy, mucous expectoration, pulse 90, face rather purplish, respiration distinct over entire chest, with slight cooing in both sides, clear on percussion. I could detect nothing abnormal in the circulating organs. He slept pretty well, but distressed with cough on lying down. He is a stout, healthy-looking man. He improved much for four days, with a sedative expectorant mixture, when one side of the sputum (which was occasionally muco-purulent) was streaked with dark-coloured blood, pulse 84, respiration quiet, but inspiration rather difficult, as in asthma. For this he was leeched and blistered, and felt relieved the next day. Haemoptysis returned more copiously in two days. The chest was now clear in every part on percussion,

respiration very feeble on left side, puerile on right, inspiration tracheal, no dyspnoea, no cooing, but slight mucous rale all over left side, voice unaffected, no pains in any part, nor dysphagia. Question: was it tracheitis or ulceration, tumour, or aneurism pressing on left bronchus? There was no bruit discoverable, nor dullness in region of aorta. Suspecting the former, I ordered venesection to 8oz. Slight faintness followed. Next day haemoptysis was lessened, but there followed a copious discharge of dark blood from bowels, to which he said he was subject.

He continued to improve till 13th day, when he said he felt "quite well." There was less tracheal sound in respiration, which he says he has observed for several weeks or months. About three hours afterwards, however, whilst washing himself, florid blood welled up his throat, and he died instantly. No post-mortem ex. was obtained. Some friends told me that for months he complained of something wrong in his chest. The sound of respiration without dyspnæa, feeble murmur on one side, whilst clear on 'percussion, and the haemoptysis, led me to diagnose aneurism; the carotids and superior veins, as also radials, presented nothing abnormal.

XL. Dr. HALLIDAY introduced a patient presenting *cancer of the breast*, in an open state, with one or two axillary glands affected.

THE EIGHTH MEETING.

26th November, 1853.

William M'Gee, M.D., in the Chair.

Attendance:—Members, 20; Students, 14.

XLI. Mr. ARMSTRONG exhibited and described Casts with Daguerreotypes of a *fibro-cartilaginous tumour of the neck*.

XLII. Dr. JAMES MOORE exhibited one-half of a *diseased lower maxilla*, affected with *osteosarcoma*, and gave the following history:—

A Norwegian sailor presented himself at the hour of visit, anxious to have two loose teeth (right first and second molars) extracted. Having observed an unusual appearance of the jaw, I examined as to the state of the bone, feeling apprehensive that it was diseased, which, upon further observation, I found to be the case. I recommended his immediate admission into Hospital, in order that he might be submitted to operation, which, upon the usual consultation, was performed after the following manner.

From the extent of the disease, it was found necessary to remove the entire right side of the jaw, from the symphysis to the condyle. A V-shaped incision, with the apex downwards, was made from the commissure of the lips to the angle of the jaw. The flap was dissected upwards, and the diseased bone isolated by dissection. The saw was now applied close to the symphysis, so as to divide the maxilla, and afterwards at the angle, where the forceps was used to make the division complete. The diseased portion was now removed from its internal muscular attachments.

In the course of the operation, there was consid-

rable haemorrhage, which interfered much with its progress. The soft parts were brought together in the usual way, and perfect union established, without any apparent deformity. He left the Hospital in the course of a fortnight, and I have since learnt that he continues well, with the power of mastication but little impaired.

XLIII. Dr. LYNCH exhibited a diseased liver, weighing sixteen pounds, which presented a good example of Farre's tubera diffusa.

XLIV. Dr. HALLIDAY exhibited a Carcinomatous tumour of the breast, recently excised from the patient introduced at last meeting.¹

XLV. Dr. HORATIO STEWART exhibited and made some observations upon an extensively ulcerated leg, which he had recently amputated.

XLVI. Dr. YOUNG, Holywood, read a paper on the utility of dilute sulphuric acid in diarrhoea and vomiting.

This remedy was systematically introduced by Mr. Griffith in the "Lancet," in the month of October, 1851, and since that time there have been very many papers and letters on the subject in all the medical journals of the day. The moderate use of astringent mercurials, Hyd. c. eretā and P. Dov., along with the remedy, is advocated by some, but the wholesale condemnation of chalk mixture and catechu is pronounced by all. Dr. Hill reports four cases in "Braithwaite's Retrospect," vol. 26, p. 98, treated by the acid alone. Its advantages are that it is a very grateful and agreeable remedy, that it is a very cheap one, and that it is more rapid in its action and less liable to be followed by secondary fever than any of the remedies in general use. Some say it ought only to be used in certain descriptions of the complaint, as, for instance, the violent form of English cholera, approaching to the Asiatic, but Mr. Shepherd, of Enfield, reports at length in the same No. of "Braithwaite's Retrospect," six of what he calls indiscriminate cases of diarrhoea; and, again, in 1852, in only one instance out of fifty cases of diarrhoea, many very severe, and some bad English cholera, did he notice a failure of the acid treatment. Mr. S. arrived at the following conclusions.—1. More efficient than alkalies, or astringents, or opiates. 2. More rapid. 3. Increases the tone of the mucous membrane. 4. Marvellous effects in the worst cases.

As to the rationale of the system, only one of the writers says anything on the subject. Mr. Shepherd says it seems to act in a more rational and scientific manner by increasing the tone of the mucous membrane of the alimentary canal, rather than by simply constricting its pores. This I think a very vague, unsatisfactory, and doubtful explanation. I am not at this moment prepared to give any definite answer as to its modus operandi. There can be no question of its sedative properties, though how it acts as sedative is more difficult to say. I think it both astringent and refrigerant.

The following cases are selected as illustrations:-

1. Eliza L., aged 30, a labourer's wife, mother of six children, generally in robust health, was seized with severe cramps in the abdomen and extremities, followed by violent vomiting and purging, on the 21st of July, 1852. I was sent for at five in the morning, and was told the woman had cholera. On visiting her, I found her tongue covered with a light bilious fur, countenance anxious, pulse feeble and frequent, extremities cold, evacuations very fluid but bilious, vomiting everything swallowed, and bringing up by painful retching quantities of acrid bile. I prescribed heat to the body and extremities, a little brandy and water, and gave a calomel and opium pill, with directions for one to be taken every hour. I paid a second visit at 9, a.m., and though I found the purging and cramps considerably relieved, the vomiting and constant nausea were in no way abated. I ordered the pills to be continued every third hour, and a tablespoonful of the following mixture to be taken every hour:—R. acid sulph. dil. Drs. duas. mixt. camph. unc. sex. M. I returned in the evening, and by that time every symptom had disappeared but a slight degree of nausea, which left her in a few hours. I have notes of six cases very similar to this, in all of which I used the acid with great success in allaying vomiting and nausea. I was rather timid about giving it by itself, and in all my cases I accompanied it with opium and mercury, in some of their forms. Without an exception, it was considered a most agreeable remedy, and the speedy subsidence of the retching made it a favourite medicine. I increased the dose from ten minims to twenty, and had no reason to regret the change, and I intend, when an opportunity offers, to give it a fairer trial and test its value unaided by any other medicine.

2. Mrs. H., a lady in excellent health, but very fanciful and nervous, after imprudently indulging in a very indigestible meal, was seized with sharp pains in the bowels, and diarrhoea. She took some castor oil, which, for a time, gave relief; but next day she was worse, and excessive nausea and vomiting, on attempting to sit up in bed, were added to the other symptoms. The tongue and pulse were not much affected; but the stools were very offensive, though full of bile, and in their glairiness and tenacity, were dysenteric. I gave her blue pill and opium in the hope that more healthy bile might come down, and, accordingly, on visiting her the next morning, there was a great improvement in the discharges, and the pains had almost gone, but, strange to say, the vomiting and nausea were as bad as ever, with this important difference, however, that, whereas she threw up large quantities of mucus charged with bile, she then only vomited any pill or drink she took. I prescribed twenty drops of acid sulph. dil. in a suitable vehicle every third hour, and to continue the pills. On my evening visit, there was not much improvement. She had only taken one dose of the acid, but found it very agreeable. On asking her reasons, she knowingly replied—"Oh, the acid, you know, it would make my bowels as bad as ever." After some difficulty, I persuaded her to allow me to judge what was best to be done, and she promised to take the bottle regularly. Next morning she was quite well, and had taken four doses.

¹ After the lapse of three months, there seemed no indication of a relapse. The cicatrix was apparently healthy.

She was confined to bed but three days.

Dr. MALCOLM supplied the following additional particulars in reference to the introduction and use of this remedy:—Dr. Conwell, of the Madras establishment, in his work on the liver, London, 1835, says "the danger (in excessive secretion of bile) arises not from the increase of the secretion, but from the presence of that secretion in the intestinal tube; hence the first object is to destroy the acrid properties of the bile in the duodenum. A dilute solution of sulphuric acid will effect this object."—*Medical Gazette*, Feb. 26. 1853.

Dr. Neligan (Ed. 1844) notices (p. 33) dilute sulphuric acid as useful to check excessive discharges generally when dependent on debility, and in the colliquative sweating and diarrhoea of phthisis.

Dr. Muller (Stoke-Newington), 1852, gives abstract of twenty-seven cases, some very severe cholera, and several of them infants. They were generally relieved after the first day. Three doses had effect in a case of diarrhoea of three weeks' duration.

Mr. Cox (Kensal-town, 1853), claims to have been the first who tried the acid in cholera. An Austrian remedy, however, analysed by Dr. Herapath, of Bristol, 1851 ("Lancet," August 3), consisted mainly of sulphuric acid.

Mr. North, of the York Union, found the sulphuric acid valuable in that form of epidemic diarrhoea, characterised by profuse watery evacuations, severe cramps in extremities, and consecutive fever. He administers it in doses of half a drachm with tincture of cardamoms, at intervals of one to three hours, and the effects were cessation of the vomiting and purging, return of heat, and abatement of all symptoms. Six to eight doses sufficed, to ensure convalescence in two or three days. When it failed after a few doses, he gave it up.—*Med. Gazette*, Feb. 12, 1853.

THE NINTH MEETING.

3rd December, 1853.

H. Carlile, M.D., in the Chair.

Attendance:—Members, 13; Students, 19.

XLVII. Dr. LYNCH exhibited a recent specimen of *ulceration of the oesophagus* at the inferior third. At one part of the ulcerated portion, there is slight thickening of the coats to the extent of one-half inch square, and one-third inch in thickness. Section of this indurated part presents a gray, gristly appearance, with tubercular deposit in the centre which can be squeezed out. This deposit, and the juice from surface of the section, under the microscope, presented the usual features of cancrroid disease.

XLVIII. Dr. MURNEY exhibited the recent parts in a case of *aneurism of the arch of the aorta*. The patient died with apoplectic symptoms, and a clot of blood was found effused between the parietal bone and the dura mater. The history was imperfect.

XLIX. Mr. DALY exhibited a blighted foetus, or monster, which was considered so novel that the Professor of Anatomy was requested to examine and report upon it at next meeting.

THE TENTH MEETING.

December 10th 1854.

The President in the Chair.

Attendance:—Members, 19; Students, 4.

L. Dr. LYNCH read the notes of a case of ascites, in which paracentesis was performed sixty-two times.

Dr. ROSS adverted to Dr. Simpson's mode of performing paracentesis in cases of ascites, without a bandage.

The roller is not used until the water is drawn off, just as we do not think of bandaging a woman until the child is expelled.

Dr. R. has operated in this way several times, and he can strongly recommend Dr. Simpson's improvement. The patient of course, is placed on the side.

Dr. FERGUSON made some observations on the difficulty of diagnosis between ascites and ovarian dropsy.

THE PRESIDENT related some interesting analogous cases involving valuable practical hints. 1. In a case of ascites, the trocar was passed but no fluid came, until after penetrating four inches through the fat of the parieties, five gallons slowly flowed off. 2. A Planter afflicted with dropsy, while homeward bound, tapped himself on board by means of a lancet, with a large silver pencil case and tooth-scraper for a trocar. 3. Twenty-five years ago, in the Isle of Man, a case occurred in which the catheter was introduced and left (recorded in the Lancet). The case terminated favourably. 4. A case was examined by the late Dr. S.S. Thomson and himself. There was a fulness in the right iliac region, but no tumour. One month after a tumour was noticed in the right groin. The patient was sent to Dublin, and the practitioners there reported the tumour in the left side. On her return the tumour was still felt in the right side. It gradually increased, and at length suppurated and burst, giving exit to a quantity of hair. 5. A patient of the late Mr. J.Q., was seen by him. She had leucorrhœa. Nitrate of silver solution was applied and the disease disappeared. A tumour soon afterwards appeared in abdomen. Another practitioner was consulted, who distinctly pronounced it ovarian. The operation of removal was decided upon. The patient consented, took leave of her friends, and went to the country under the apprehension of the worst result. Prior to the appointed day, however, she was delivered of the tumour by ordinary parturition.

LII. Dr. MALCOLM exhibited a cast of the anterior half of the chest, modelled from a patient ten years after recovering from *Empyema*, for which paracentesis was performed. The following is the history of this interesting case:—

Margaret M., aged 14, resident at Greencastle, Carrickfergus road, was attacked with pleuritis of right side, on 13th July, 1843. The early symptoms were headache, insomnia, and other febrile symptoms; a transient appearance of urticaria, followed by the vomiting of bilious matter; pain in right side, some dyspnoea and cough, while the usual frottement was detected on examination. She was bled on 24th, had calomel and jalap purgative, and a tartar emetic mixture. The pain continuing, though the general

symptoms subsided, a blister was applied, and the administration of calomel and opium at once commenced (on 26th.) On August 1, in the course of five days she was under the influence of mercury, which seemed to have disagreed, as diarrhoea set in and continued for several days, and was accompanied by much tenesmus. On 7th September, it was reported that she had still some cough and dyspnoea, with pain; and had emaciated and was easily tired by a little exertion. At this date, the physical examination disclosed very considerable pleuritic effusion, which, with such symptoms as indicated the supervention of hectic, was evidently purulent.

The right side of chest was universally dull, and the respiratory murmur only heard at the root and apex. Its semi-circumference was fully an inch larger than its opposite. The respiration in the left lung was, as is usual, puerile. The pain was felt rather as a soreness. The pulse was quick and feeble, skin hot, and at times profusely perspiring; and she presented very much the general appearance of a case of phthisis. At this date, inunction, with the comp. ointment of iodine, with a very small proportion of ungu. hyd., was directed to be used on the affected side. On 14th, fluctuation under the right mamma, in the intercostal spaces, was evident; and on the 17th, I performed paracentesis in the usual way and place. About one pint of fully formed purulent matter was discharged on the first day. A supporting roller was put on, and a poultice applied. The discharge continued very free for some days, then ceased, but again resumed, and so on alternately several times, till at length a sinus became formed, which continued discharging for five months after.

As she had left that part of the country a few weeks after the operation, I heard nothing of her till the following March, when it was reported that she was doing well.

On 17th May, of this year, I was surprised by a visit from her, and embraced the opportunity of making special inquiries and a minute examination, which I repeated several times since, up till 26th ult., the last day on which I saw her.

1853, May 17.—Called to-day. Countenance sallow, spare, but enjoying fair health. Says the discharge continued for five months; never any pain since; no cough of any consequence. Examined:—no dulness—H.S. propagated rather distinctly through right side—R.M. free, but less marked; menses frequently absent—very irregular—absent at times for several months; complaining lately of soreness at epigastrium and round right side. (Ordered a bitter infusion, and some iron and aloes pills.)

June 7:—Some colicky pains complained of on 5th. On 4th menses appeared, but disappeared on following day. (Ordered pills of rhubarb and iron.)

August 31.—(Ordered ol. jecoris aselli.)

November 26.—Found herself so much better after the oil, that she only consumed the 4oz. ordered; has remained well since, but menses absent two months; continued fresher and strength improved; has no pain in side or epigastrium; but, on walking quickly or over-exercising, finds herself very short of breath; appetite and sleep excellent; speaks of the habitual coldness of

her feet; is nervous, and has occasional palpitation. Ex: R.M. free, but slightly less marked at right base. Semicircular measurement of right side, 13½ inches; of left, 14 inches. From spine to 5th–6th rib, on right side, 5 9/10 inches; left 6 3/8 inches; no bronchophony; dulness only from seventh rib down; E.M. at apex natural.¹

Dr. MALCOLM, before concluding, noticed the following facts and opinions in connexion.

MODE OF OPERATION.—Hippocrates advised the perforation of a rib, which was revived in 1841, by M. Reybaud. Lænnec advises the puncture to be made between the 5th and 6th ribs, at the interdigitations of the external oblique and serratus magnus. The patient should lie upon the affected side afterwards, with the wound open, and a cupping glass applied, if necessary. Blackiston reviews the recommendation of Sculpetus (1672), to use an exhausting syringe to relieve the lung and allow it to expand. Davies introduced the ground needle in operating. Copland recommends successive evacuations, and rather favours the old idea of operating upon the patient in a warm bath. Crampton recommends the digestion of the diseased cavity; and Williams advises warm water to be so used.

It is not a little strange that Louis positively states that he never saw a case in which the operation was indicated.

STATISTICS AS TO RESULT.—Watson remembers only having seen two cases of perfect recovery. Blackiston observes that in the course of two or more years, the affected side may become nearly natural, and out of seventy-eight cases, there was a reduction by contraction of the affected side, by one inch, in eight cases only; a slighter diminution in fourteen; and an equality of measurements in the rest, (fifty-six.) The left side was affected in fifty-eight of these cases, the right in twenty; and, as to ultimate terminations, fourteen were still subject to cough, five of whom had this symptom previously. Fifty three were certainly not phthisical, fifteen were alive, but state of health not ascertained, and ten were lost sight of. Lænnec says the operation is rarely followed by success, and adds, that the "lung never returns to the original size." T. Davies has noticed twelve recoveries out of sixteen cases, where recourse was had to the operation. H. Roe was of opinion that no case perfectly recovered when the operation was delayed after six weeks from the commencement of the effusion.

LIII. Dr. CARLILE exhibited the foetus upon which he was requested to report at last meeting, consisting of a body without extremities, about six inches in length. On dissection, it was found to contain a rudimentary osseous system, formed by a spinal column, skull, pelvis, and a portion of a scapula. The spinal column and skull contained a spinal cord and brain, in a low stage of development. With the spinal cord were connected several pairs of nerves, supplying the trunk.

1

ABBREVIATIONS.—

R.M.—Respiratory Murmur.

E.M.—Expiratory Murmur.

H.S.—Heart's Sounds.

No organ of sense, except the skin, and a minute rudiment of the tongue, could be discovered. The trunk contained a single cavity, in which no viscous was found, except a small body somewhat resembling, in colour and shape, a kidney. The cavity of the trunk was occupied by a plexus of arteries and veins, forming numerous anastomoses, and connected with a great number of small vessels, by which the various parts of the body were supplied. In front, the plexus was connected with two vessels which passed through an opening in the skin somewhat resembling an umbilicus, and formed an umbilical cord, which was probably conjoined to a placenta; but this part of the foetal structure had not been preserved.

This foetus afforded a striking example of a continuous movement of blood being maintained by capillary vessels, without the assistance of the heart's action. It appeared to be a foetus in which, at about the age of three weeks, the further development of organs had been arrested, in connexion, probably, with the absence of thoracic and abdominal viscera, and of the higher organs of sense; and that, in this imperfect condition as to type, it had continued to grow, until it had reached the size before-mentioned.

Its osseous system contained a very small quantity of calcareous substance, with the exception of the skull, which was hard, an eighth of an inch thick, and consisted, apparently, of a single bone. There was a rudiment of one-half of the lower jaw, in the state of cartilage.

LIV. Dr. MALCOLM exhibited a recent specimen and wax-cast of cirrhosis of the liver, and gave the following history:-

T. Q., aged 44, of sallow complexion, a labourer, was admitted on 1st December, with ascites. His legs and abdomen were greatly swollen. The history showed that he had had cough for a very long time previously to the supervention of ascites, which commenced three months before admission. The examination of the chest showed bronchitis simply, with elevation of the liver above its usual point, in consequence of the pressure of the fluid. The urine was scanty, but otherwise unaffected. The right hypochondrium was somewhat tender on pressure, but little or no complaint made. Pills of squill, digitalis and blue mass with hippo, were ordered every eight hours. On 6th, he was tapped, but only a small quantity of fluid, of a clear amber hue, was got away (say two quarts); and on 8th, at 8 p.m., he sunk. On examination, the only disease discoverable was in the liver, which presented the appearance observed in the wax cast. The kidneys were healthy, and all the viscera examined. The sallowness assumed more of the jaundice hue on last three days.

THE ELEVENTH MEETING.

17th December, 1853.

The President in the Chair.

Attendance:-Members, 20; Students, 18.

LV. Dr. JAMES MOORE exhibited a recent specimen of Fibrocystic Tumour of the Neck.

The subject of this operation was a man of 50 years of age. When he first consulted me, the tumour presented a globular appearance, about one inch and a half in diameter, and situated above the sternum, between the insertions of the sterno-mastoid muscle. When in the recumbent position, he complained of difficulty of breathing, which caused him to incline his head forward and to one side for relief. He also experienced difficulty in deglutition. The surface presented a purplish hue, with numerous venules ramifying over it. To the touch, it was evidently a sac containing fluid, extending deeply between the muscles and behind the sternum. Auscultation presented distinct murmurs, which, to many who examined it, suggested the idea of aneurism; but Dr. Moore was satisfied, from manipulation, that it was a cyst totally unconnected with the vessels whose impulse, however, it transmitted. The operation was commenced by making two elliptical incisions, leaving an inch of skin between the sections; and the cellular connections were then dissected on the tumour itself, which was gradually drawn outwards, until it was everted in an entire state. Upon passing the finger down into the bed of the tumour behind the sternum, to the extent of two inches, the pulsations of the vessels were vividly and fearfully felt. The wound was brought together by a series of sutures, and healed by the first intention; and the patient left the hospital within eight days perfectly well.

Mr. H. M. JOHNSTON referred to a case which he had witnessed, and in which, during the dissection of the tumour, from beneath the angle of the jaw, such a volume of blood burst forth, that it was supposed the internal jugular had been opened. A piece of sponge was immediately inserted in the wound, and carefully retained by manual pressure for some days, ligature having been placed around the remainder of the cyst. The patient recovered; but the sponge never made its appearance.

THE PRESIDENT mentioned a case in which a wound in the neck was caused by a wooden sword, which transfixed the neck, entering behind the thyroid cartilage on the right side, and coming out under the left ear. The child recovered without a single unfavourable symptom, after the first violent gush of blood succeeding the removal of the wood. The wood was merely a fragment, the sword having been broken off, and the extremity about a quarter of an inch deep. It was so firmly grasped by the soft parts as to require a pair of tooth forceps to withdraw it. It passed behind the pharynx, and there was not the slightest dysphagia throughout the entire time he was in Hospital.

LVI. Dr. MALCOLM exhibited a cast and daguerreotype, illustrative of the following case of Facial Paralysis, from disease of the external ear.

Edward M., aged 55, labourer, but formerly a gardener in Tyrone, nine years ago, first observed an eruption over right temple, which, in three to four years, extended to the ear. Suppuration and ulceration, attended with much pain supervened, which resulted in loss of the lobe and a portion of the body of the ear, closure by lymph-deposit of the external meatus, and

great induration of the neighbouring integuments. Three years ago, paralysis of the *portio dura* suddenly occurred, but without his consciousness. He has been treated in the Lisburn Infirmary, (July 1852) the Belfast Dispensary, this summer, and Union Hospital, lately; but the ulceration never completely cicatrized. He was mercurialized six years ago without success. The only points in the previous history worthy of mention are, that he was annually in the habit of getting himself bled, and had syphilis at 18 years of age. The sore bled on two occasions profusely, viz., two years ago, and about five weeks ago. The local treatment consisted of leeching once, various lotions, nitrates of silver and iodine caustics, and poulticing.

The face presents a well-marked example of complete paralysis of right *portio dura*. The tongue is protruded to the sound side. The sensation is perfect. The right eye he cannot close, and epiphora on this side is frequent, with dryness of the nostril. He complains frequently of headache and tinnitus aurium. The deafness is very slight; the sight a little dim. Pains of neck, head, and back he frequently experiences. In sudden expiration, as in blowing the nose, he feels a sense of rattling in the right ear. He finds it impossible to continue his employment, in consequence of constant vertigo which attacks him when at work.

Dr. M. remarked that this was a good example of "Bell's Paralysis." From the enlargement of the mastoid process, it was probable that caries had commenced. There were no indications as yet, of cerebral complication. In regard to the diagnosis of the engagement of the internal ear, Arnold has stated (1831) that the saliva from Wharton's duct, on the affected side, is diminished, if the nerve be injured when passing through the temporal bone: also, dryness of the mouth, with alteration and diminution of taste in the corresponding side of the tongue; and further, (according to Bidder, 1836) the *velum palati* is directed to the affected side. The deformity of the open eye, which is the cause of conjunctivitis, was proposed by Dieffenbach to be relieved by division of the *levator pulpebrarum*.

Dr. STRONGE considered the case before them to be one of caries of the bones of the ear; and that its chronicity, the length of time, which had elapsed, and the brain remaining free, one of the strongest points in favour of the view which he had taken. In support, he alluded to the case of a lunatic, a specimen of whose disease he had seen, some years ago, presented at the Dublin Pathological Society, where the caries had existed for many years before the mischief extended to the brain—the patient eventually dying of abscess of the brain, with sloughing of the dura matter covering the petrous portion of the temporal bone.

LVII. Dr. MALCOLM submitted the result of a microscopic examination of two specimens of cholera excretory fluid, received on the 5th and 14th inst., respectively, and forwarded by Dr. Halliday. The objects presented to the eye were similar to those sketched in Plate v. In both instances the so-called "cholera cell" was observed. In a report on the cryptogamic theory of cholera, given in the first volume of the London Journal

of Medicine, it is noticed that a vegetable parasite had been observed in the perspiration of cholera in 1849, and in cholera evacuations, by Dr. Jenner, in the same year. The cryptogamic theory had been previously advocated by Dr. Wallace, of New York, 1845; Dr. Gowdell, 1848; Professor Mitchel, Philadelphia, 1849, and Dr. Scott Alison. In the autumn of 1849, Dr. Brittain and Dr. Swayne, of Bristol, examined the rice water evacuations, in which they observed peculiar bodies which they considered characteristic, if not the very agents causing the disease. Dr. Brittain afterwards discovered similar bodies in the atmosphere of an infected locality; and still more recently, Dr. Budd detected them in the water of several districts where cholera had prevailed.

The principal ingredients in the cholera evacuation, Dr. Swayne considers to be the following:—

1st. A large quantity of thin serous fluid which contains mucous cells in abundance. 2nd. Little or no tinging of bile. 3rd. The usual debris of organic matters from the food. 4th. Epithelium in small quantity. 5th. The presence of phosphates and lithates, more rarely uric acid and oxalic of lime, and seldom any chloride of sodium. 6th. The presence of the cholera bodies.

These observations created considerable interest, and induced many observers to enter into the inquiry.

Mr. Busk, of the London Microscopical Society, on October 17th, demonstrated that the large bodies figured by Dr. Swayne, are nothing else than a species of *uredo*, a kind of smut frequently found on wheat, and specimens of which Mr. B. found in a loaf of brown bread, purchased at Greenwich. The smaller annular bodies, Mr. B. considers, are only starchy granules. In the *Lancet*, for Nov., 1849, appeared a report from a Sub-Committee of the College of Physicians, London, upon the same subject. This Committee (Drs. Baly and Gull) were charged with a commission to test the results published by Messrs. Swayne and Brittain. The conclusions they arrived at were as follows:—

1. That they could not find, either in the atmosphere or the water of infested localities, any bodies resembling the so-called "Cholera fungi." 2. That Messrs. S. and B. have confounded under the name of "annular bodies," "cellules of cholera," or "cholera fungi," substances altogether distinct. 3. A great number of them appear to be matters taken as aliment or medicaments. 4. Those of them whose origin is doubtful, are evidently not fungi. 5. The most remarkable of them are found in the alvine discharges of the subjects of diseases, essentially different from cholera.

These conclusions have been since confirmed by many observers, amongst whom we may name Mr. Griffith, (Med. Gaz., December, 1849) whilst Drs. Bennett and Robertson (Edin. Monthly, Nov., 1849) had, previously to the appearance of the London Report, impugned the accuracy of Messrs. S. and B.'s researches. These gentlemen, nevertheless, rejoined and reiterated the principal points which they at first endeavoured to establish. Charles Robin, in commenting upon this subject, in his recent work, "*Historie Naturelle des Vegetaux parasites*," Paris, 1853, brings forward fatal objections to the theory of Messrs. S. and B., derived from a criticism of the microscopic

examination, furnished by these gentlemen; and concludes his notice by observing, with much confidence, that these bodies are not solely of vegetable origin, but that some are carbonates, and others, most probably, calcareous concretions, such as are met with in serous tissue; and some others resemble the eggs of certain hepatic parasites.

THE TWELFTH MEETING.

24th December, 1853.

The President in the Chair.

Attendance:—Members 17; Students 3.

LVIII. Dr. MALCOLM read some notes on the treatment of erysipelas, by the tincture of muriate of iron.

JOHN HUNTER distinctly recognises the peculiar character of erysipelatous inflammation. He says, "I suspect that this inflammation has very little of the adhesive in its nature." If this be so, we may infer that other means than the so-called antiphlogistic measures may possess value in the treatment of erysipelas. It was not, however, until recently, that public attention was directed to the particular efficacy of the Tr. sesquichil Ferri, of which the only mention in therapeutic works, was in reference to its occasional use in the last stage of Erysipelas; or, generally, as a tonic in the decline of this malady. Its curative agency had not been suspected prior to the year 1825.

In April, 1851, a paper was read before the Medico-Chirurgical Society of Edinburgh, by Mr. George Hamilton Bell, upon this very subject. He considers the capillaries in erysipelas to be in an atonic state—and hence, accounts for the success which he has found to attend this peculiar treatment of erysipelas—a mode which, he says, he has resorted to in every case of the disease he attended, for upwards of a quarter of a century, without having failed in a single instance. In administering the iron, he premises a free action of the bowels, and commences with fifteen drops every two hours. If the case be particularly severe, he employs twenty-five drops, and perseveres in this plan, no matter how high the fever or delirium may be. The only local application he makes use of is cotton wadding, with a dusting of hair powder. In the paper referred to, he gives details of seven cases, four males and three females—one complicated with rheumatism, and another with gout.

Five had the head or face for its seat; one the ankle, and one the toe. The duration of the illness was respectively as follows: 5, 6, 7, 7, 8, 12, and 22 days. The diet was generous in all; and the only adjuvants were purgatives and occasional anodynes.

Dr. Charles Bell, 1851, suggests its use in puerperal fever, as being a kindred malady. His opinion of its value is also very decided. He says it is quick in affording relief, and rather improves the system and prevents relapse. He insists on the importance of bringing the system fully under its influence. His illustrations are 14 in number—eight males and six females; two infants, one child, eight adults, and three aged. Seven were of the head and face; three of the leg; two of the vulva; one of the ankle, and one of the toe. In all,

the success was complete.

Dr. M. concluded by giving the results of his own experience, which was highly favourable to the treatment, and quoted the following cases which occurred in the practice of Dr. Christopher Black, Belfast, as corroborative evidence.

"A. B. and T. L., females of the ages of 38 and 22 respectively, were seized with phleg. erysipelas of face and head, accompanied with the usual febrile symptoms. The diseases, in both cases, were sthenic and idiopathic, and accompanied in the elder, especially, with great derangement of the digestive organs—a foul tongue, violent head-ache, &c. There was cellular infiltration in the elder female, which extended to one side of scalp and across forehead, with tendency to coma. The younger presented the disease in a comparatively mild form. I healed them both with scruple doses of the T. ferri, simply dissolved in water, and given every two hours. I premised this treatment, with a single mercurial purge, in the more severe case. I was greatly struck and gratified with the result after 24 hours' use of the iron, the tongue had sensibly cleaned—swelling of parts subsided—tendency to coma lessened—and in two days they were both nearly convalescent." (December 17, 1853).

Dr. YOUNG believed that erysipelas was constitutional and asthenic, and that, therefore, the treatment should be stimulant, rather than antiphlogistic, and threw out the idea that the action of this preparation of iron might be not merely constrictive, but also antiseptic.

Dr. ROSS had used the tincture of the muriate of iron in several cases of erysipelas, and with very great benefit.

Under its use he found the quantity and sp. gr. of the urine much increased. He attributed its usefulness in this disease to its action as a tonic and as a renal depurant.

The PRESIDENT observed copious diaphoresis produced, and particularly noticed its favourable influence in dysentery, retention of urine, and spasmodic stricture.

Mr. H.M. JOHNSTON adverted to the increase of strength of the preparation of iron referred to, according to the last Dublin pharmacopæia, as having been found inconvenient in practice.

LIX. Dr. MALCOLM read the history of a most interesting case of *aneurism of the thoracic aorta*, which was for years mistaken for rheumatism.

I saw the case which I am now about to submit to the Society, on 26th of June, 1845, in conjunction with Dr. E., of N. On that occasion there was a distinct pulsating tumour at the upper part of the left interscapular space. There was no murmur as distinct as we meet with in ordinary aneurism, but a slight roughness in the arterial stroke. There was neither tenderness nor pain in the tumour itself; but pain was felt and confined to the left lateral and cardiac regions, and assumed, thus, more the character of neuralgia than rheumatism. His appearance, though still that of a large frame of middle height, presented some degree of emaciation, compared with what it was a few months before. From this period, till 2nd August, when he suddenly expired,

morphine and prussic acid were frequently administered to give relief from the repeated spasmody paroxysms of pain.

Having known some of the particulars of the history of this case, which presents many points of great interest, I made special inquiries to elicit, if possible, details in extenso, and have been so far successful as to be enabled to present something like a connected view of the principal features.

The case was seen by the late lamented Carmichael and Graves, of Dublin; Dr. S. S. Thomson, of this town; Dr. K., of B., and Dr. S. of H.; besides Dr. E., of N.; Dr. M., of M.; Dr. D., of D., and myself.

There is a good deal of obscurity touching the commencement of the affection. It was believed by his friends, that a severe fall from a swing, in the year 1837, might have been to some extent a cause, more especially as the injury was felt most severely at the region afterwards affected. At intervals, for some indefinite time, (which has not been accurately determined) but certainly prior to 1839, he complained of what was supposed to have been rheumatic pains, especially about the left scapula, and occasionally (say once or twice) in the right arm, and shoulder, and neck.

About the month of March, 1848, the pain became constant, and particularly severe at night, and resisted various means employed. Amongst these was the following prescribed by Dr. M. of M., viz.:—Dec. Sarzac co. uncias quat ter die. Tr. Guaiaci vol. unciam, et sp. Etheris nit. semunciam, of which one drachm was ordered night and morning, and a pill, containing about two grains of blue mass, and three grains of Dover's powder, at same times. I cannot ascertain whether this last was persisted in to produce mercurialization, (though I am induced to believe it did) but certain it is this line of treatment, was attended with no good effect—for we find that, on 27th May following, he went to Dublin and consulted the late Mr. Carmichael, who ordered a mixture of colchicum with carb. magn. solution and tr. opii, to be taken night and morning, and a croton liniment to be applied to the painful part; at the same time advising exercise and a course of warm bathing.

With a view of carrying out Mr. Carmichael's instructions, he took a house at a watering place; but he was unable to continue the bathing, for, at the second trial, he was so ill that he felt apprehensive of worse results. Though he took this bath above 100°, he felt quite cold—and dreading inflammation, sent for his medical attendant, who bled him from the arm—and with Mr. C.'s concurrence (23rd June) put him under a course of mercury, which answered remarkably well; and, for a time, he remained perfectly free from pain; and he and his friends had every hope of enjoying a complete recovery. Soon after he resumed his business he began to feel the old enemy. This was in August, and in September, he visited Harrogate and Buxton, still under the impression he was labouring under rheumatism. Dr. E., an eminent physician, of B., prescribed iod. pot. and bicarb. pot in dec. sarz.; and Dr. S., of H., nearly the same, but without effecting any relief. He returned and spent the winter at his residence, N., in very indifferent health. Early in 1849, he visited Belfast, and put himself

under the care of the late Dr. S. S. Thomson, who examined him most carefully, but was unable to make out any new indication for treatment.

At this time (February) it appears that the character of the pain seemed to change. The sensation had now more of the sharp and burning feeling experienced in neuralgia. Some time after this he returned home, and one night particularly he was seized with such excruciating pain, that all the usual remedies for urgent suffering available utterly failed. A blanket, wrung out of boiling water, was wrapped over his back before the fire, and yet his nose and forehead were icy cold. At this juncture, his medical attendant arrived, who prescribed a stimulant and large opiate which gave some gradual relief. On the following day he felt much as usual, and in the month of May he was enabled to revisit Dublin; but on this occasion to consult the late Dr. Graves, who, after repeated and careful examination, yet, like all the others, viewed the case as one of rheumatism of the muscles of the side, which would gradually wear out, and most confidently told his friend that all his organs were as "sound as a bell."

Dr. G. at first ordered dry cupping, which, indeed, was the principal thing directed. In the course of a few days he returned, and contented himself with corresponding with Dr. G., who, on 15th May, ordered strychnine 1/28 grain every 6th hour. In the letter prescribing this treatment, he says, "if duly persevered in, I have, I can assure you, very great reliance on its efficacy, and confidently hope that in the course of four or five days it will materially diminish the patient's suffering." He further advised the maintainance of a constant eruption on the skin, over the painful parts, by means of croton oil; and the use of morphine, if it should be deemed necessary. At the conclusion of his note he adds, "I have scarcely any doubt as to the success of the means; but, in case of their failure, I have no objection to a trial of the water cure under proper superintendence. It is proper to mention that this last remedy was suggested by the friend of the patient, and Dr. Graves' opinion asked as to its propriety. In consequence of hearing unfavourable accounts, Dr. G. wrote again, on 21st May. In this letter he expresses himself as disposed to try a course of mercury, and the application of a very large blister over the affected part. At the same time, the strychnine was stopped. This was fortunately not attempted, for it was just at this time that the true nature of the case became apparent. Dr. E., of N., who saw him about the months of February or March, 1848, was in close attendance, and having had, on several occasions, apprehensions that the case was not rheumatism, examined him carefully every few days during the progress of the tumour towards the surface. Towards the close, the torturing pain rather diminished, and the paroxysms, appeared at longer intervals, but in the last week his general health perceptibly broke up, his appetite failed, his stomach became irritable, his feet felt always cold, his nights more restless, and large doses of morphine were continually in use. On 2nd August he suddenly expired. About forty-eight hours before the fatal issue, he complained of a kind of smothering, his respiration became hurried, vomiting set in, but only a little blood was

ejected. At intervals he seemed to sleep, and it was out of a short sleep that he suddenly raised himself in bed, called for the Dr. and open air, and immediately sank back and breathed his last. On next day a post mortem examination was held, which disclosed the following particulars:-

August 4, 1854.

"On removing the sternum, a large coagulum of blood presented itself, occupying the left cavity of the pleura. It was found, on further examination, that this coagulum filled the whole cavity, the left lung being compressed and collapsed. On removing the blood, a large sacculated aneurism of the aorta was observed, with a considerable aperture communicating with the left pleural cavity. The aneurism was full of clotted blood, and on passing the hand into it, there was found to be a great destruction of the ribs and spinal column, large portions of three of the former, where they join the spine, were removed, so as to permit the aneurism to pass backwards, where it appeared during life, between the posterior margin of the left scapula and spine, covered only by the skin, superficial fascia and deep fascia, with some muscular fibres.

The extremities of the ribs on both sides, as they occupied the aneurism, were externally sharp and uneven.

The disease occupied about four inches of the aorta, commencing below the left subclavian, and was divided into two portions, an anterior and a posterior, with a communication through the ribs. The posterior portion was much the larger.

There was some dilatation of the ventricles of the heart, and the lungs were healthy."

A. E., M.D. AND SURGEON.

The following observations have been kindly furnished by the gentleman under whose care the patient was principally placed.

N__y, 4th February, 1852. The diagnosis was, indeed obscure, in consequence of the tumour taking a backward direction, so as to cause absorption of some of the ribs and vertebra. The unyielding nature of these structures was the cause of protracting the sufferings of the patient, as well as obscuring the nature of the disease for a long time. From all I can determine, he must have laboured under the disease for a period of at least two years, and the prominent symptom was, severe, violent pain in the left side, extending round to the inferior angle of the scapula, and sometimes across the spine. The pain, however, came and went to such a degree, as sometimes to leave him easy for weeks together. No information could be obtained from the use of the stethoscope for a long time, and only when the aneurism approached nearer the surface.

In such a case, the character of the pain is, I think, at first, the only diagnostic symptom: and it is peculiar; and, to one who has witnessed the sufferings of a patient so afflicted, a strong suspicion of the disease may be formed from this symptom alone. However, it requires to be confirmed by stethoscopic examination. I was able to diagnose a case of aneurism of the aorta, just below the diaphragm, since meeting the case

referred to, and was the first to suspect the disease, on the first visit, by the character of the pain, and then by detecting a pulsating tumour by the stethoscope.

This case ended fatally and most suddenly.

In addition to this, and by way of further illustration, I may here append a brief abstract of the contents of a letter from a near relative.

Mr. S. was subject to attacks of what was termed and treated as rheumatism, for some time prior to 1839, and frequently since; but, excepting in a protracted or inflammatory illness, no physician was consulted. Dr. D-n (already referred to) saw him in one or two of these; and Dr. E-e first prescribed for him about 18 months prior to the fatal event. Dr. E-e had had very early misgivings as to the case being rheumatism, and rather discouraged violent exertion, or the use of electricity, for, the latter of which, Mr. S. was most anxious, in consequence of having heard such wonderful accounts of its utility. All Mr. S's friends agreed in thinking his residence unfavourable, and a main cause of his malady (it being in the immediate vicinity of a canal); but Dr. E-e did not, and from close observation, he felt convinced that the weather had no influence in his case, and that stimulating remedies were invariably injurious.

The stethoscope was resorted to on every seizure of pain. Dr. Graves used it each time they met, and on last May, in Dublin, when the burning sensation and palpitation were complained of, after an examination, Dr. G. remarked that "rheumatism was more painful than dangerous," and assured his friend "it would wear out of his strong frame."

Mercury was administered till ptyalism was induced, on three different occasions; and in his last illness, without any good result. Neither cough, hoarseness, nor dysphagia was observed at any time; nor indeed did the breathing become affected till the last few days prior to death, when there was a diminution of the pain. The appetite always remained unimpaired, save during the last eight days, when irritability of the stomach, with coldness of the feet, was complained of, and which was then ascribed to indiscretion in diet.

Dr. M., in his observations upon this remarkable case, stated, as his opinion, after duly considering the whole history, that the injury received in 1837 was the starting point. This injury probably set up a chronic, circumscribed aortitis, or such a state as permitted of the formation of aneurism, subsequent rupture, and the formation of false aneurism, in Feb. 1849. It appears also that pleuritis had set in, in June 1848, and again in conjunction with the ulterior changes. Obscurity in the diagnosis of aneurism is by no means rare, and the case in this respect is only an additional illustration of the imperfection (as yet) of our diagnostic art. Nevertheless, important improvements have been recently announced, which will, doubtless, give us material assistance. Dr. M. here alluded to a remark of Dr. Walshe (1851), that there is frequently a diastolic, or basic impulse in cases of aneurism of the arch, which, with dull percussion-note, diminished respiratory murmur, vertebral gnawing, and intercostal neuralgia, might confirm our suspicions. Dr. Billing (1853) attaches much importance to the "resilient

pulse," which he tested in two remarkable cases, where no external or any estimable symptoms of aneurism existed. One was only the size of a hen's egg—"the smallest aneurism of the aorta ever detected during life, and by the resiliency of the pulse alone." (p. 88.)

Dr. Stokes, in his recent admirable clinical work (1853), has made some pertinent and telling observations bearing upon the point in question, and based upon the unerring voice of nature herself. "The error of declaring the absence of organic disease," he says, "in consequence of the want of physical signs, has led many of our brethren into disagreeable positions; and it must not be forgotten that in physical examinations, negative results furnish significant indications; indeed, nothing should awaken our attention sooner than the occurrence of important symptoms, without there being signs to account for them." (p. 106.) Dr. S. further observes that aneurism should be suspected when we find well-marked forms of thoracic suffering co-existent with an unimpaired state of the general health, and notices the constriction of the diaphragm and dyspnoea from phrenic irritation, caused by aneurismal tumour, and that dysphagia may be expressed by pain, without there being any difficulty in deglutition.

Dr. Law insists much on the character of the pain which, when in lancinating paroxysms of agony, and at other times of a dull boring description, he considers almost pathognomonic; but when this is found in conjunction with the expansile impulse, the diastolic pulsation, and the second sound heard most distinctly in the course of the aorta, all doubt may be silenced. Hope's diagnostic, the double jog in the descending aorta, with murmurs, is by no means a constant phenomenon. It is seldom, however, that we meet with a case presenting at an early stage sufficient indication of the existence of aneurism. Crisp, in his large experience and great researches, acknowledges that he has met with numerous examples of large aneurism in the chest, which were not discovered by the most experienced stethoscopists; the case of the celebrated surgeon, the late Mr. Liston, was a complete confirmation of this observation.

Statistics show that the descending aorta is engaged but rarely in comparison with the other parts of the thoracic portion. Bizot gives the following ratio of 87 cases:-40 were of the ascending aorta, 31 of the arch, and 16 of the descending. In 32 the heart was healthy, in 30 the walls were hypertrophied, and two were of the fatty description. Of 82 cases, 64 were false, 10 mixed, and 8 true. Of 108 cases, according to Hasse, 36 occurred between the ages of 50 and 60, and of 175 of Crisp's cases, 104 occurred in the same period of life.

THE THIRTEENTH MEETING.

7th January, 1854.

J. H. Halliday, M.D., in the Chair.

Attendance:-Members, 10; Students, 3.

Dr. MALCOLM gave additional particulars respecting the case of Thoracic Aneurism, read at last meeting, which are included in the report of that date.

LX. Mr. HANNA read the notes of a case of Cervical

abscess communicating with the lung, as follows:-

My patient, J. B., was aged 42, about five feet eight inches in height, of a square-built conformation; his appearance indicative of a lymphatic temperament, a bleacher by occupation, and exposed to a variety of temperatures. A brother and two sisters had died of phthisis: another sister of dropsy. He was uniformly temperate in all his habits. He never remembered having taken any preparation of mercury, and had always enjoyed good health, except on one occasion, when a young man, he became affected with acute anasarca, caused by exposure to cold; but from which he recovered without the physician's care. About four years and a-half before death, his health began to fail; and, simultaneously, a small abscess formed over the wrist joint, which burst and continued discharging a white, thin, inodorous, flaky pus, until a small piece of bone came away, when it healed with a depressed cicatrix. Another formed over the tibia, which burst and discharged a fluid similar to the other, for two years, until a spicula of bone came away, when it, in like manner, healed.

He now began to lose flesh rapidly; the appetite became impaired, and the bowels irregular. Two years before his death he was seized with rigidity of the muscles of the neck, the motions of which became subsequently imperfect, and pain extending up along the occipital region and between the shoulders, was complained of, and continued very constant until a small tumour formed at the posterior inferior triangle. After the formation of this tumour the pain diminished. He now began to experience frequent rigors. Six months before death, I saw him for the first time. He was thin, very much emaciated, had some cough and dyspnoea. Physical examination elicited dullness at the superior lobe of right lung; respiratory murmur quite inaudible; breathing tubular, with intense bronchophony, almost amounting to pectoriloquy. From a point opposite the inferior angle of the scapula, downwards, the chest was quite clear on percussion, and the respiration peurile.

The left lung was also clear on percussion, and respiration a little modified; but no prolonged expiratory murmur, in either lung, could be detected. He has noticed, for some time, a feebleness in the extremities, with some want of sensation. The abscess in the neck appeared about the size of a large orange, not perfectly circumscribed, nor painful on free manipulation, but fluctuating freely.

There was no discoloration of the skin. He felt some pain when the spinous processes of the fourth and fifth cervical vertebrae were percussed, and complained of dysphagia.

About three weeks after I first saw him, he came one evening and told me he had vomited, in the morning, about half a-pint of very green, foetid pus. On examination, the abscess, by pressure, could be made level with the skin; but, when the pressure was removed, it became distended, and, to use his own language, "he heard and felt a glugging sensation." It continued much the same for a period of about six weeks, when the cough and expectoration ceased; the abscess again became distended, and fluctuated freely for some time

when it began to present an inflammatory blush, and eventually made its way to the surface. The discharge had a similar character to the matter expectorated. It was at this time that air could be felt and heard issuing from the external aperture. The discharge continued, more or less, until death, which took place from the exhaustion of hectic.

From the history of the case, it would appear that the cervical abscess resulted from a diseased state of the cervical spine, and the communication with either the lung or bronchial tube would seem very obvious, on account of the distension of the cavity on inspiration, previous to its opening externally, and perhaps on account of the scrofulous character of the disease. We are told by authors, that scrofula rarely or never commences after 32 or 35 years of age, but there are always exceptions to a general rule; and, taking into account, that a sister and a brother died of phthisis (which is only modified scrofula) the depressing occupation of the patient, and moreover, the insufficiency of nutrition, all these, I say, would conspire to lower the vital functions, and actively manifest the slumbering diathesis which in a more youthful state was undeveloped, simply in consequence of the vigorous action of the assimilatory functions.

LXI. Dr. MALCOLM exhibited several wet preparations representing various forms of pulmonic induration, and availed himself of the opportunity to make some remarks upon the different forms of hardening of the lung, which are met with in post mortem examinations. The following varieties are usually observed:-1. Induration around gangrenous excavations. 2. Do. after haemoptysis, succeeded by pneumonia. 3. Do. around a tubercular cavity (Swett). 4. Do. after ordinary pneumonia (Swett) (Laennec). 5. Do. from pneumonia affecting the interstitial tissue, causing dilatation of the bronchial tubes and contraction of the lung, viz., Cirrhosis (Corrigan and Rokitanski). 6. Brown induration, with intermixed soft and yellow patches (Andral). 7. Gray do. (Andral and Chomel). Laennec was acquainted with but a small number of cases of chronic pneumonia. Andral observed that, out of 112 cases of pneumonia, only one lasted more than 30 days. Chomel noticed only two cases of the disease in 200 dissections annually. Forbes considers it rare as a chronic disease, but common as a sequel. Swett, of New York (1852) speaks of its rarity, and recognizes the distinction between it and Cirrhosis. Hasse likewise notices its rarity. He states that it is scarcely ever due to acute pneumonia, but that it coincides most frequently with the formation of tubercle. He lays down three varieties:-1. Pneumonia primary, causing deposit of tubercle. 2. Tubercle primary and pneumonia combined in progress. 3. Tubercular cachexia first. The most usual appearances are the following:—"The lung is distended, preternaturally heavy, and completely impermeable to air. On section, the surface is gray, with yellow and white stripes, and arborescent patches of black pigment intermixed. The whole mass is hard, incompressible—yet fragile—dry, and not granulated." Andral's brown induration is comparatively rare—more acute and accompanied with moisture of the lung; the

heart is also generally hypertrophied.

The preparations exhibited, represented forms 3, 4, 5, and 6, as above; and Hasse's description accurately pertained to one of them.

THE FOURTEENTH MEETING.

14th January, 1853.

James Patterson, M.D. in the Chair.

Attendance:—Members, 20; Students, 13.

LXII. Dr. MALCOLM read the result of the microscopical examination of sputa, in a case of phthisis pulmonalis. The matter was principally composed of pus cells and tubercle in the form of granules. Tubercular dust it might be called. Dr. M. took occasion to advert to the common opinion that it is an easy matter to diagnose tubercular expectoration by the unaided eye. He showed that, on the contrary, there is no such facility, as even with the aid of the microscope it will be occasionally impossible. Lebert (1845) says "La matière tuberculeuse ne s'y trouve ordinairement pas comme telle dans l'expectoration des phthisiques." And again, "La matière tuberculeuse, ayant conservé ses globules, ne se rencontre que rarement, dans les crachats. Nous ne l'avons presque jamais observée d'une maniere indubitable." This author gives the following list of matters which may be found in the sputa of phthisical patients.

I.—NON SPECIFIC, or common to many diseases. 1. Saliva, with mucus and buccal epithelium. 2. bronchial epithelium. 3. Mucus cells. 4. Vibrios. 5. Blood cells. 6. Crystals. 7. Pigment. 8. Large Globules. 9. Granular Globules. 10. Pus-cells, "fréquemment déformes et racornis." II.—PROPER. 1. "Des Grumeaux," or small pellicular expansions—a basis for the tubercular deposit, probably false membrane, from cavities. 2. Masses similar in appearance to the foregoing, but composed of the molecular granules, which proceed from diffluent tubercle. 3. Amorphous mineral granules, which may proceed from cretaceous matter. 4. Tubercle itself—(doubtful). 5. Pulmonary fibres—diagnostic of the ulcerative stage, "et un indice certain de l'existence de cavernes."

In summing up, Lebert concludes that he is forced to admit that microscopic examination does not aid us in facilitating the diagnosis, at least in the incipient malady. At the same time, he throws out this consolatory observation—"Il est bien possible que l'état ultérieure prouvera que les masses granuleuses, les débris de fausses membranes, les globules de pus racornis, et les grains minéraux ont plus de valeur pour le diagnostic, que nous ne leur en attribuons pour le moment."

LXIII. Dr. MALCOLM exhibited two wet preparations illustrating the effects of empyema.

One of these referred to a case which occurred at the Belfast General Hospital some years ago. A child, aged six years, was admitted, with an apparent abscess of the breast. Empyema was readily detected, and the communication with the supposed abscess indicated by the alternate expansion and falling in, induced by

inspiration and expiration. The child died in the course of a few days. Paracentesis, or rather opening of the abscess, was contemplated, but the moribund state of the patient prevented its adoption. On examination, it was found that the communication was made by several openings, and that the matter had burrowed under and amongst the Pectorales fibres. The lung was exceedingly atrophied by pressure, and lay close to the posterior wall. Respiration was, of course, limited to the root, and even here must have been very imperfect. Two points of interest present themselves upon considering this case—the effort made by a natural process to evacuate the pus, thereby indicating the utility of paracentesis—and secondly, the unusual position of the intercostal apertures, which were much higher than is found to have been previously observed.

LXIV. Mr. ARMSTRONG read the notes of a case of fatal hæmorrhage, following the extraction of a tooth in a hæmorrhagic subject, as follows:—In the course of my practice, I have met with a case of hæmorrhage, in consequence of the extraction of the second molar tooth of the lower jaw of left side. The patient was a labourer on the Co. of Down Railway, aged 28, generally healthy, with fair complexion, and eyes light-blue; height, about five feet nine inches, and conformation in proportion. He had been subject to most troublesome hæmorrhage from the slightest wounds. In October, 1851, having suffered much from a decayed tooth, he had it extracted, contrary to the advice of his friends, as they were aware of the difficulty experienced on former occasions, in stopping the bleeding, often from the slightest injuries. The tooth was extracted about two o'clock p.m. When he went home, he was still losing a good deal of blood, but as he said himself, "he thought little of that," as he generally lost a great deal from the most trifling cut, before he could get it stopped.

I was called in to see the case next day, about one o'clock, this being 23 hours after. His strength was much exhausted, the surface and the face blanched, the pulse scarcely perceptible, and the extremities cold. I examined the place from which the tooth was taken; I found the blood still oozing from it; I made a small pledget of lint, cone-shaped, dipped in Tinct. Matico, and placed it in the cavity with the apex down, which stopped the hæmorrhage immediately. I ordered him wine, an egg beat up with sugar and sweet milk, to be given as he could take it; also, warmth to the feet. I called about four hours after; no return of bleeding, but very much exhausted; no appearance of reaction; to continue the wine, &c. Called next morning; no improvement, but no return of hæmorrhage. The poor fellow died about 12 o'clock, noon, 46 hours after the tooth was extracted.

Dr. HALLIDAY suggested transfusion in these dangerous cases.

Dr. FERGUSON observed that death from hæmorrhage, after bleeding had been once stopped, was exceedingly rare.

Mr. H. M. JOHNSTON commended the internal use of acetate of lead in such cases, and related a case in point. He considered that, in the case read, there was

no doubt of the existence of a hæmorrhagic diathesis.

Dr. MACLAUGHLIN, Lurgan, also detailed an interesting case in which the reinsertion of the tooth, plugging with cork, &c., and the actual cautery, all failed, but which ultimately yielded to a succession of two to three grain doses of acetate of lead, with opium.

Dr. YOUNG also mentioned an instance of its efficacy, in which the actual cautery and other means failed.

Dr. LYNCH had more faith in the dilute sulphuric acid, and latterly, in five grain doses of tannin, to arrest the hæmorrhagic tendency.

Mr. JOHN AICKIN had the greatest confidence in wet lint, sprinkled freely with acetate of lead powder, with pressure, both in epistaxis and the case under consideration.

Dr. C. BLACK had used, with success, the tincture of muriate of iron.

Dr. FERGUSON said that it should be recollected, that as the last remedy employed seemed to be generally the most useful, so time may have had some efficacy, and should not be overlooked in our estimating the value of, and bestowing our commendation on, every particular remedy.

THE FIFTEENTH MEETING.

21st January, 1854

The President in the Chair.

Attendance:—Members, 16; Students, 10.

LXV. Dr. LYNCH read some notes on the treatment of delirium tremens by chloroform, and related the particulars of two cases in which he had recently administered this drug. 1. J. M., aged 36, had been drinking to excess for three weeks, and was ill six days in delirium tremens, when he came under his (Dr. L's) care. There had been constant wakefulness for the last six days and nights, and the delirium was becoming violent. It was a first attack. Dr. L. gave him 30 drops of chloroform, and repeated it in three hours. He did not require more. Sleep was induced, and he soon after quite recovered.

In the other case, which was a second attack of the malady, the same treatment was pursued, but the patient died suddenly on the second day. Dr. L. was inclined to place but little reliance upon its use in this disease, more especially as he had found other, and these the usual remedies, in general, quite successful.

Dr. PIRRIE considered its action beneficial as an adjunct to opium, which, therefore, need not be given in such large doses as when alone, and mentioned a case in which it had been necessary to continue the use of opiates for a lengthened period. In this case Dr. Pirrie found that a few drops of chloroform, added to the opiate draught, greatly increased its efficiency. Thus he found that 20 drops of chloroform, added to 20 drops of the liquor opii sed., had as much effect as 80 drops of the liq. opii given uncombined.

Dr. LYNCH, in reply to a question, stated that the form which he had found best adapted for the use of chloroform was exactly the opposite of that in which tartar emetic would be indicated.

LXVI. Dr. MALCOLM exhibited the recent parts in a case

of abdominal aneurism, and related the following history:—R. E., aged 30, a moulder in a foundry, married, formerly intemperate, of a pale and anxious countenance, and latterly much reduced in weight (2½ stone since Oct.), was admitted on Jan. 11th ult., complaining of much lumbar pain, especially at left side. The pain was pretty constant, but at times very severe, particularly on turning himself. He could not ascribe any other cause than over-work, heavy lifts, &c., which may have strained his back. He was treated as for rheumatism, and was repeatedly blistered over lumbar region. The pain extended down thighs, anteriorly and posteriorly, and was frequently of a shooting character, but generally gnawing. Suspecting aneurism, from the character of the pain, I examined the course of the aorta, anteriorly and posteriorly, but could detect no murmur, impulse, or tumour. The tenderness over the lumbar region was very great. I then examined the urine, and found it highly albuminous, and afterwards, under the microscope, immense numbers of epithelial cells from the tubules and regular casts, such as we meet with in desquamative nephritis. He had some vomiting eight days before admission, and his pulse, on admission, was 96, and languid; and urine, besides being albuminous, was deeply charged with lithates. Believing that renal congestion existed at any rate, I had him cupped. On 11th, I ordered an alkaline alterative aperient. On 12th, the pain was still complained of; but on 13th, at 2 p.m., he became suddenly ill with intense suffering across his loins, and especially down thighs, and over abdomen. He actually cried out from the severity of the pain. Stupes relieved, but he became afterwards faint, and in this way remained till the hour of his death, which occurred at half-past nine on 14th. A post mortem examination was held, when the following was the result:—Upon laying open the abdomen, the several viscera presented quite a healthy appearance. Just over the symphysis pubis, a considerable amount of blood was observed between the muscles and peritoneum; and, on further examination, an immense tumour, of a dark mottled appearance, occupied the whole of the left lateral region of the abdomen, from the diaphragm to the ilium. This tumour was rather of an oblong shape—smaller above and below, and bulging at the centre, or corresponding to the umbilical region. There was no fluid in the peritoneal cavity, but on opening the sac it was found filled with clots of dark blood which had been poured out from an aneurism of the abdominal aorta, at the bifurcation, and dissected the parietal layer of the peritoneum from the muscles. On removing a large portion of the clots, the muscles of the affected part were found softened, and the fourth lumbar vertebra quite carious. On removing the left kidney, the renal arteries were so much diseased as to break across. The removal of the abdominal aorta was attempted, but only the part corresponding to the opening of the aneurism could be procured. The thorax was examined, but no lesion was discovered there.

Dr. M., in commenting upon this case, referred to the unusual site of the aneurism, which prevented the physical examination from being decisive. Statistics proved the most frequent site to be the cœliac axis and

adjoining portion of aorta. The renal symptoms might very readily mislead. At the same time, they were quite explicable by the result of the post mortem examination. Dr. Stokes notices psoas abscess as having been supposed present in a similar case, and refers also to one of apparent malingering, which really turned out to be the genuine malady—aneurism. Others have observed similar cases mistaken for tabes mesenterica, renal disease, rheumatism, and neuralgia, so that it is by no means an easy matter to detect abdominal aneurism when situated so low down as in the present instance.

Dr. HALLIDAY has noticed cramps in the legs as a symptom of abdominal aneurism.

The PRESIDENT remarked on the difficulty of diagnosis in some cases, and related two in point. 1. case of aneurism at the cœliac axis; 2. case of pancreatic disease, which presented simulating symptoms.

LXVII. Dr. HALLIDAY read a report of two cases of congenital hydrocephalus as follows:—1. Mrs. T., aged 23, whose first confinement occurred on the 18th Dec. last, up to which time she had enjoyed good health, was visited by Dr. A. at two o'clock on Sunday morning, when the membranes having ruptured, the nates were found to present. After some time one of the feet was brought down; and when the child was so far expelled that the cord could be felt, it was found not to pulsate, and a short time after, it ruptured without haemorrhage. At this stage of the labour, great difficulty was experienced. No correct idea was, or could be formed, as to the nature of the obstruction; and as the head, from the amount of distension, was not permitted to pass fully down into the pelvis, it was with much difficulty that the forefinger of the left hand could be got into the mouth of the child.

After exerting some pressure in this direction, the child at the same time being doubled up upon the abdomen of the mother, the finger was got upon the upper lip, and from this on to the forehead, and so, after considerable tugging and trouble, the child was got away, when it was found that the head was greatly enlarged from hydrocephalus. As usually happens in this class of cases, the child was dead. The mother did well. 2. The second case occurred in the practice of Dr. R. B. Mrs. F., aged 25, in second confinement, was visited by him at 10 p.m. for the first time, when he examined and found the head presenting. From this time to 10 a.m. the following morning, the labour was exceedingly strong, and the head felt as if descending gradually, until the tumour, as it seemed, began to dip through the os externum; but at half past 12 o'clock, no advance having been made, the doctor determined to apply the forceps, by which, after they had slipped several times, he was enabled, partly by using their blades as levers, to extract the head, which was greatly distended by hydrocephalus. It was of an elongated form when got away, but immediately assumed the rounded, and was fully as large as a full grown adult's. The child was a male, of dwarfish length, but with all parts much developed, club-footed, and covered with naevi materni, which the mother attributed to a fright

she received from a big-headed man, when she was about three months pregnant. Indeed she expected that the child would be marked, and asked, when it was born, if it was not so. It died a short time after birth. The mother did well.

Dr. BRYCE instanced a case of congenital hydrocephalus, in which ascites and anasarca existed. The child referred to lived about two minutes. It was born on the 13th May, 1853, and its mother was delivered again, nearly ten months after, (on 6th March, 1854,) of a six-and-a-half months' child, which was completely anasarca. It lived about twenty minutes. In this latter case, the placenta was diseased, and about three times the size of a placenta at the full period of gestation.

Dr. LYNCH related the case of a woman aged 22, whose first child was an interesting example. It was reported that she was in labour ten days before delivery was effected, in consequence of the great size of the cranium from hydrocephalus. The case occurred at Carnlough, in 1842.

Mr. DALY related a case of congenital hydrocephalus, which occurred two years ago. Three quarts of fluid were drawn off. The cranium was entirely cartilaginous.

Mr. H. M. JOHNSTON had a similar case in May ultimo. The labour was tedious. Delivery was effected by the forceps. The chief difficulty in their application was owing to their slipping repeatedly off the head.

THE SIXTEENTH MEETING.

28th January, 1854.

J. W. Bryson, M.D. in the Chair.

Attendance:—Members, 17; Students, 16.

LXVIII. Dr. FERGUSON read the notes of a case of measles, with very unusual complications.

Dr. BECK referred to two similar cases occurring in his practice, one in which the throat symptoms had all the appearance of scarlatina. The other had the symptoms of *muguet*, well marked, and was characterized by the sudden appearance of intestinal complication accompanied with fatal sinking. As every epidemic has a type of its own, it is of the utmost importance in practice to discriminate its peculiarities early.

LXIX. Mr. H. M. JOHNSTON read the history of a very interesting case of rheumatic endocarditis complicated with *chorea*, and terminating fatally, as follows:—Upon Thursday, Nov. 17th, 1858, I was asked to visit a little girl aged ten years, who had been complaining slightly for a day or two, and was not looking well. This was her first illness, and her friends considered her a healthy, hardy child. I found her rather feverish: skin hot: thirst: pulse above 100, not very full: tongue coated with a yellowish fur: bowels freed by domestic medicine. She was in bed, and unable to stand. Upon examination I found that she had severe pains in the ankles, which were cedematous, puffy, and somewhat swollen, with redness and tenderness over the lateral ligaments. There was no synovial effusion, but the child complained when I moved the joints. No other joints

were at that time engaged. She complained of a catch in the chest, and of uneasiness about the cardiac region, but there was not much distress of countenance. At night she became more feverish. Upon examination of cardiac region, I could detect no friction sound, or any unnatural dulness; but there was increased action of the heart—the palpitation being quite visible, and a loud bruit de soufflet was heard most distinctly over the apex, and becoming less intense as you moved the stethoscope towards the base of the heart. The respiration was quiet and healthy, and I could detect no pleuritis. My diagnosis was—rheumatism with endocarditis. The rheumatism I considered of a fibrous character. I ordered a powder containing calomel and scammony, to be followed by a purgative saline draught. The next morning I found that the medicines had acted freely, but that the ankles were more swollen and painful, and that during the night she had complained of uneasiness, with a feeling of constraint in the chest. The heart's action was increased, and the bellows-murmur quite distinct over the mitral orifice. I ordered twelve leeches to be applied over the cardiac region, and put the patient upon calomel and opium. The leeches produced, I might say, the effect of a general bleeding, and after their application the bruit became less intense, and the constraint felt in the chest was relieved.

Upon Sunday, the 20th, the system acknowledged the influence of mercury; and, at the same time, there was a corresponding improvement in nearly all the symptoms, general and local. As the mercury was acting rather freely upon the bowels, I diminished the dose and increased the opium, giving one grain every third or fourth hour. During the ensuing week, up to Saturday, Nov. 26, the case progressed upon the whole favourably, and appeared to promise a happy issue. I may mention that upon Tuesday, the 22nd, as I thought, there was an unnatural click with the heart's second sound, over the aortic valves, and as the bruit was still very audible and the urine scanty and high-coloured, I ordered a few more leeches over the heart, and a mixture with nitre and digitalis, and continued the mercury and opium according to circumstances. At this time the swelling and uneasiness in the ankle joints had almost disappeared.

Knowing that such attacks, although apparently recovered from, are often the groundwork of future heart disease, I thought it right to request Dr. Purdon to visit her with me upon Friday, the 25th. He did so, and having examined her carefully, expressed his concurrence with the view of the case previously taken, considering that the aortic valves were also engaged.

I may mention that there was no further development of any rheumatic symptoms in any other of the joints, except in one of the elbows. Dr. Purdon recommended me to keep up a gentle action of the mercury, to continue the opium also, to apply a blister over the cardiac region, and to give her a mixture hydrocyanic acid, and liq. potassæ in infusion of orange peel. Up to this period, our prognosis was favourable as regarded the present, guarded in respect to the present illness becoming the origin of future mischief.

Upon Friday and Saturday, the 25th and 26th, it was

observed that when a powder was given to the child, she would give her head a very curious shake. This, I may say, was the first developed symptom of any spasmodic complication. I considered it voluntary at first, as if to assist in swallowing the powder; and did not think of its value as a premonitory symptom, until Sunday, 27th. Upon Saturday the child was going on so favourably that I did not think it necessary to see her more than once. Upon Sunday, I was requested to visit her early in the morning, when I found that she had passed a restless, sleepless night, had complained of seeing objects of varied colours in the room, and had constant jactation of head, arms, and limbs. The pulse beat 104, and I cannot say that there was any increase of fever. There was now no doubt but that the child had gotten chorea. She was quite conscious, but unable to retain her arms, head, or lower extremities in a state of quiet. All of these parts constantly tossed in the most unmeaning and fitful manner. The eyes rolled through the sockets. When asked to protrude her tongue, she would, as it were, hesitate for an instant, and then thrust it suddenly out, and as rapidly withdraw it. She complained of no pain except the uneasiness in the bowels of a griping character. The view I was now inclined to take of the case was, that the chronic affection was functional, that we had, as it were, "excitement of the nervous system without strength," and to allay this I thought it right to exhibit opium freely, and to omit the mercury. Dr. Purdon suggested, in addition, the application of a liniment, composed of chloroform in compound camphor liniment, to the spine.

During Sunday, the poor child had no rest. I hoped, however, that the night would bring with it refreshing sleep, and consequent cessation of the spasms. In this, I was sadly disappointed. I remained with her myself, and gave her two grains of opium every third or fourth hour, watching the effect. This being a very large dose for a child of her age, I hourly expected that it would have had the wished-for anodyne influence. We only succeeded in obtaining for her two short sleeps, one of forty minutes, and a second of about one hour's duration. During sleep, the spasms ceased, if I except a subsultus in the muscles of the fore-arms which seemed to awake her. She complained of being sleepy, but she was unable to keep her eyes closed, owing to the spasms, and when she would awake from a short slumber, the spasms were as general and as severe as ever. Upon Monday morning at eight o'clock, I gave her the last dose of opium, which I felt justified in exhibiting; and notwithstanding having given it such a full trial, the choreic spasms seemed to me to be increasing in severity, and new sets of muscles were becoming engaged, especially those concerned in the functions of deglutition and articulation. Dr. Purdon saw the patient with me at nine o'clock, A.M. As the opium had so signally failed, and there being a fear of exhaustion from the constant jactation and want of sleep, he suggested a trial of chloroform. At this time her pulse was about 112, and after examination of the heart, Dr. Purdon remarked that the murmur was not so loud as upon Friday, but more of a whizzing character, and heard distinctly along the course of the aorta.

We gave her the chloroform, allowing her to inhale it from a handkerchief, Dr. Purdon watching its effects upon the pulse. He observed that just as she was coming under its influence, it suddenly rose in frequency, and seemed as it were to falter, but in a few seconds it again became steadier, fuller, and slower, coming down from 112 to 104. It had the happy effect of completely allaying the spasms, and the poor exhausted child enjoyed quiet repose during the greater part of Monday, the chloroform being occasionally administered according to circumstances. In the evening, we thought it well to suspend its use for a little, but were disheartened in finding the spasms almost as severe and as general as ever. The muscles of the eyes, mouth, larynx, and those of mastication, &c. being all engaged. At first, she was brought under the influence of chloroform with considerable ease, about half a drachm being used, after which she showed symptoms of awaking at intervals of about twenty-five to forty minutes, and then required its re-application for a very short period. Once or twice during the day we suspended its use for a little, in order to let her have some nourishment and medicine. Upon Monday night, we thought it advisable to have the additional advice of Dr. Stephenson, when it was agreed upon to give colchicum and digitalis in moderate doses every second hour, also an assafoetida enema, and that the chloroform should be again given in case the child did not sleep without it. During the early part of the night, the spasms were more confined to the upper half of the body, and were not so violent, but there was no sign of her getting sleep. She complained occasionally of seeing images in various colours before her eyes; and being so very restless, I again tried the chloroform, but not with the same happy effect as before. She now resisted its influence, a much greater quantity being required to produce the anaesthetic influence. It seemed to excite her, and above all, it produced such an alarming effect upon the pulse, as to make me dread a suspension of the heart's action; and when I did succeed in getting her under its influence, she very soon awoke, suddenly and excited. I was afraid, therefore, to press it further, and merely continued the exhibition of the medicines we had agreed upon. She lay awake the greater part of the night, but the spasms were not so violent, and were more confined to the upper part of the body. At our consultation upon Tuesday at eleven o'clock, A.M., we thought her somewhat better, but the heart's action was very tumultuous, the bruit much louder than when last listened to, still of a whizzing character, and heard along the course of the aorta. At five o'clock, P.M. she was worse; the jactation was more severe and more general. She complained of her heart; the bruit was very loud, and the pulse smaller and quicker. (I may here mention, that we could not at any time detect evidence of any affection of the pericardium.) Our patient having been so much exhausted during the entire day by the spasms, with Dr. Purdon's assistance I gave the chloroform another trial, but it did not succeed. It excited the child. She resisted its influence, and the pulse rose to 140, and became very small and faltering. We now gave her an opiate enema, and five

grs. of oxide of zinc every fourth hour. From Tuesday evening to Wednesday morning, various remedies were tried with the view, if possible, of abating the spasms and procuring rest; of these I may mention the internal use of tincture of Indian hemp, of camphor dissolved in chloroform, and the external application of ice to the spine, all however, without any permanent benefit. Though the pupils were contracted, and there was a wish to sleep, the constant movement of the muscles prevented it. It would be difficult to picture the painful scene upon Wednesday. Our remedies had failed one after the other in bringing relief. The choreic spasms were now general all over the body. The muscles of the orbit—those of deglutition, articulation, and even of respiration, being all affected. There was occasionally opisthotonus. The patient was tossed from one side of the bed to the other. Frequently she was, as it were, obliged to utter a scream, and the arms and limbs were thrown carelessly and wantonly about. The pulse now became small and quick, 128 to 140, but neither intermittent nor irregular. The heart's action was tumultuous, and the bruit loud and whizzing. During this day we had the head shaved, and a liniment composed of croton oil and ung. hyd. fort, rubbed over the head and spine—all, however, to no purpose. Symptoms of exhaustion began to show themselves; the extremities became cold. The little sufferer continued conscious to the last, but the spasms unsubdued; until from exhaustion, death afforded that relief which our art could not procure. She died at ten o'clock upon Wednesday night, the choreic symptoms having existed about five days.

I have thus given the details of this melancholy, yet interesting case, faithfully and fully. In conclusion, I would suggest two or three points to which I would wish more especially to direct the attention of our society, and upon which to elicit their opinions: 1st, Is it not rare to find chorea supervening so early, as a complication of rheumatism or endocarditis? 2nd, Is it not still less frequent to find it terminating so rapidly fatal; and have any of our members met with a similar case? 3rd, Was the chorea a functional affection, or did it depend upon an organic cause? 4th, How far was it dependent upon the valvular obstruction destroying the balance of the circulation? or was it a concomitant effect of the same cause as the cardiac disease, viz. the rheumatic diathesis? 5th, What suggestions would our experience of chloroform in this case originate?

The connexion between rheumatism, endocarditis, and chorea, has of late years engaged the attention of some of our most eminent modern practitioners. There is still, however, considerable difference of opinion as to the relation they bear to one another. Out of an analysis of one hundred cases, Dr. Marshall Hughes concluded that rheumatism stood second as the exciting cause of chorea, and that it appears to operate by originating pericarditis, but he does not state how pericarditis operates in producing chorea. Dr. Todd in the Lumleian lecture for 1849, discusses the connexion between endocarditis and chorea. He considers that the mitral bellows-murmur heard in these cases, is always due to an organic lesion, and that both affections, namely, the endocarditis and the chorea, are

concomitant effects of the rheumatic diathesis. That the three affections, viz., rheumatism, cardiac disease, and choreic complication, do often co-exist, we have no doubt, but to explain their relation to each other constitutes the difficulty. As far as I have been able to investigate the subject, I find that three explanations have been offered, one by Copeland and Watson, viz., that when chorea supervenes, there is a marked disposition of the rheumatic affection to recede from the joints, and attack the internal fibro-serous membranes; and that, therefore, when we have chorea as a complication, we might infer the existence of an inflamed theca. This theory might appear to receive some support from the case narrated above, inasmuch as the joints were not so acutely affected as is usual, and the severity of the spasms causing even opisthotonus, led you to suspect the spinal cord to be considerably engaged.—The second theory is, that the cardiac affection may operate as an eccentric cause, producing irritation of the afferent nerves, and upon the principle of the reflex function, thus originate the irregular movements. The third, and I may say the latest theory, is that of Dr. Begbie of Edinburgh, who, regarding the chorea as a blood disease, advances the opinion in the Edinburgh Monthly Journal of Medical Science, for April, 1847, that the association of rheumatism, cardiac complication, and chorea, is owing to their being the concomitant effects of the same cause, namely, the specific disorder of the circulating fluids. This, in our consultation, appeared to me the view taken by Dr. Stephenson, and the basis of his suggestions, as he wished if possible to rid the system of the poison.

Dr. PIRRIE adverted to the existence, in a case of cholera treated by calomel, of spasms similar to those of chorea, and asked, could the action of the mercury given in this case have had any such effect?

LXX. Dr. HALLIDAY introduced a patient aged ten years, having a *mammary tumour* of an obscure character, which he deemed of the nature of varix. Several members examined the swelling, but no decided conclusion was arrived at.

THE SEVENTEENTH MEETING.

4th February, 1854.

The President in the Chair.

Attendance:—Members, 20; Students, 13.

LXXI. Dr. ROSS read a case of *ulceration and perforation of the small intestine*.

This person, a girl, aged nineteen, had first fever with intense, general bronchitis, which complication masked the intestinal affection, and it was not until several weeks after the fever, and at the subsidence of the bronchitis, that the enteric complication showed any evidence of its presence. Perforation of the intestine and an artificial anus near the umbilicus followed. The girl died extremely emaciated about seven months after the commencement of the fever.

LXXII. The SECRETARY read a case of *uterine hydatids mistaken for pregnancy*, contributed by Mr. MADDEN,

Portglenone.

Ann Johnston, aged thirty, mother of two children, was seized on the 1st December, 1853, with severe uterine haemorrhage. She had not menstruated for the previous three months, which, coupled with the presence of the usual symptoms, induced her and myself to believe that she was pregnant. Confinement to bed, and the usual appliances, were tried, but only with partial good effect. On the 8th, the discharge became very profuse. When I visited her, she appeared very nearly drained of blood. On examination, I found the os uteri dilated to about the size of a shilling. Believing that her safety depended on the speedy expulsion of the uterine contents, I infused two drachms of ergot of rye in eight ounces of water, and desired her to take two ounces of this every half hour until expulsive pains would be induced, which took place shortly after taking the second dose. On examination then, I found the vagina filled with what I believed at first to be coagulated blood, but what proved to be a large mass of hydatids—altogether, there was about two quarts. The hydatids were of various sizes, from that of a grape to some as small as coriander seed, and a great many of them adhered firmly to what appeared to be deciduous membrane, the others floating through mucus. The haemorrhage ceased immediately after their expulsion, and she is since recovering as steadily as could be expected.

Dr. MALCOLM remarked that the subject of the foregoing case was particularly interesting on account of its practical bearing. The diagnosis of uterine hydatids prior to ocular demonstration, was a matter frequently of extreme difficulty, and hence the necessity of carefully noting the points most relied on whenever practicable, such as the following:—1. The disproportionate size of the abdominal tumor, which is sometimes as large as in a seven months' pregnancy, though menses may have ceased only three. 2. The touch gives a uniformly soft and fluctuating feeling. 3. The frequent gushes of water or blood. If the test by "ballottum," and the result of a stethoscopic examination in addition, give any decisive answer, the diagnosis may be certain. Obstetric authors differ as to the necessity of conception, Sir Charles Clarke and Dr. Blundell believing that it is not necessary, while Dr. Montgomery states that hydatids invariably result from impregnation.

This brings us to the *questio vexata*, What are these hydatids? Are they really animals, or are they morbid products, as fibrous or serous cysts? Laennec, Owen, and Lallemand, considered them the former. Ashwell and Vogel, the latter. This last author (Giessen, 1838), gives a very full account of them, and divides them into two classes, the genuine and the spurious. 1. The former is the *echinococcus hominis*, which consists of an external vesicle adherent to, and formed by the original structure. This external vesicle originates in coagulated fibrine, which becomes organised, and consists of fibrous tissue. The inner membrane is lined with epithelium; within this membrane is a second shut sac, transparent, structureless, but laminated, which behaves like coagulated fibrine also; inside this cyst, a fluid exists which encloses or deposits the animalcules

which agglomerate like sand. Each animalcule is provided with a series of hooks at one extremity, and four suckers behind—the body tapers to a tail obtusely. These little animals are one-eighth to one twentieth line long, and one-sixteenth to one-thirtieth line broad, lie free in the cyst, or adherent, and sometimes in small vesicles floating in the cyst. The detection of the hooks is diagnostic of the genuine hydatid. The principal organs wherein they are found are the liver, spleen, kidneys, brain, and lungs, and the effects of their presence are those of mechanical pressure—suppuration, abscesses, fistula, &c. 2. The acephalo cysts of Laennec are deemed spurious by Vogel. These vary in size from that of a millet seed to that of a large orange. They possess an external cyst which is organised; within this, a second cyst, and a clear fluid which includes smaller vesicles attached to the inner wall, solitary or multiplied. They contain no animalcules or hooks, and are eventually convertible into cretaceous concretions of this class. Vogel considers that hydatids of the peritoneum, cystic moles of the uterus, and encysted dropsey may be reckoned as examples.

The PRESIDENT observed, that the usual tests for the diagnosis of uterine hydatids as laid down in systematic works are frequently faulty in practice. The aqueous gushes not unfrequently occur in gestation; a few cases in point were adduced.

Dr. FERGUSON related the case of a lady who apparently went through her full time, yet the issue was nothing but hydatids. A curious case occurred in Sir Patrick Dunn's hospital, and had been the subject of a clinical lecture, in which pregnancy really existed, but was not discovered, (though in the eighth month,) before the detection of the stethoscopic signs. Dr. F. has heard the foetal sounds as early as the fourth month; the circumscribed character of the placental murmur is important to note.

Dr. BECK noticed a case of dropsey of the amnion, which simulated ascites; it was a case of twins. Labour came on in the sixth month—with the first came away four ounces of liquor amnii; with the second, two gallons. The case afterwards did well.

LXXIII. Dr. MALCOLM exhibited some calcareous bodies which were expectorated.

Dr. M. mentioned that these bodies were lately found in the sputa of one of two patients, with whose cases he had recently become acquainted, and some particulars of which he would now submit to the notice of the Society. He considered them particularly interesting in consequence of their comparative rarity, and of the difference of opinion which exists as to their value, as indications of the curability of phthisis. Dr. M. adduced the opinions of the chief Pathologists from Laennec down, whence it appeared that the majority are in favour of Bennett's view, briefly stated in the Edinburgh Monthly for October, 1847. These researches demonstrate not only that the calculi alluded to are evidences of degenerated tubercle, but have traced their formation in all its stages from crude tubercle into cretaceous and even calcareous formations of stony hardness. No pathologist can doubt that these latter are owing in the majority of instances to

the drying up of tubercular deposits in the lungs; and that they can be formed by themselves is an idea that does not merit any lengthened refutation. At the same time, it must be remarked with Swett (New York, 1852), that every little stone like or bone like concretion that is formed in the lungs, is not necessarily a converted tubercle. This condition may result also from a small deposit of lymph which passes gradually into a cartilage-like or bone like condition; or it may be owing, as some think, to a partial ossification and obliteration of the small bronchial tubes. From a review of the cases presenting this peculiar expectoration, it would appear, that they are chiefly characterized by chronicity, mildness of symptoms, and the maintenance of a comparatively fair share of health. Hæmoptysis has rarely occurred. The original deposit of tubercle was in general isolated and small in quantity. To prove the rarity of these cases, it is only necessary to quote the opinion of Louis, (edition of 1825, Syd. Trans., 1844); "I have neither observed one in hospital nor in private practice; yet in private, as is well known, the persons in attendance upon patients preserve everything connected with their excretions with singular care."

The cases above referred to are briefly as follow:—

1. Mr. W. H. B., aged twenty-six, short stature, somewhat florid complexion, and highly nervous temperament, had been in good health till the year 1840, when in a jumping feat, he received a severe injury of the right knee. This brought on synovitis, from which he suffered for a considerable length of time. Ulceration of the cartilages ensued, and at length partial dislocation, and eventually complete ankylosis terminated the case. His health was re-established, and remained so till 1844, when he observed for the first time some not very urgent pectoral symptoms, such as cough, pain, palpitation, &c., but especially the appearance of small chalky concretions in the expectoration. He has observed these to the amount of four or five masses annually since. The largest did not exceed the size of a one-grain opium pill. The exterior was always rugged, and had the appearance of being detached from larger portions. In 1846, he was confined to bed for several weeks with symptoms of inflammation of the base of the left lung, for which he was bled and blistered. He made a slow recovery, hectic having appeared before convalescence was established. Since this period, though never confined to his room, he has been frequently annoyed with cough and sudden attacks of dyspnoea, with a marked disposition towards sensible perspiration, especially at night. His pulse keeps uniformly between eighty and ninety, and the temperature of the skin unusually high. As a musician, his exercise of the voice is attended with an unusual degree of fatigue.

From one of his former attendants in the south of Ireland (A. Wood, A.M. M.B.), I have ascertained that his constitution in 1846 was considered exquisitely strumous. Indeed, Dr. W. has not the slightest doubt that there is a considerable amount of scrofulous deposit in the bronchial glands in this case. Cretaceous and gritty matter he has seen often (?) in other subjects, in the expectoration, and always in the highly

strumous constitution. From the same source I have heard that Mr. B's father died of Scarpa's diffuse aneurism of the aorta, and that on a post mortem examination, the aortal valves and the thoracic aorta were studded with calcareous and gritty deposits. Mr. B's mother died of an immense abscess of the right lung. Dr. W. is disposed to believe that the same tendency to this form of arterial deposit exists in Mr. B. himself.

2. H. W., a German, aged thirty six, of dark complexion, came under my care in small-pox, in January last; his height is five feet seven inches, and his weight averages ten stone. In his childhood, and up to the fourteenth year, Mr. W. had experienced repeated attacks of epistaxis, which occurred at times to a great and alarming extent. In 1837, whilst engaged in a college duel, a pistol-bullet struck him above the right ankle on the outer side, shattered the fibula, and lodged in the soft parts between the bones. With the effects of this injury he was confined to bed for eleven months, his recovery having been considerably delayed in consequence of having exerted himself too soon. His present fibula is almost entirely a new formation, as the old bone was removed in part, directly by the injury, and in part, by subsequent necrosis. A few years after, he was severely attacked with typhus fever, which confined him for a lengthened period; and in 1844, he was seized with intermittent fever. From this date he remained in fair health till July, 1852, when he became affected with rheumatism, which assumed a chronic form, and did not entirely leave him till the following year. He did not, however, enjoy respite long, for in April, 1853, he was attacked with bronchitic symptoms, and about the 6th of that month, with hæmorrhage of the lungs, to the extent at one time of half a pint. The hæmoptysis recurred in May, and again in August; and since that time, slightly, on several occasions, until the month of October ultimo, when there suddenly appeared, after a fit of coughing, a chalky substance in the expectoration. (See Catalogue of Museum, No. 22). Since this period he has had, occasionally, catarrhal cough, but has never observed a trace, either of blood or lime in the expectoration. From the small-pox he made an excellent recovery, and has continued to enjoy the best of health. His pulmonary vital capacity is now a hundred and sixty cubic inches.

Dr. M. in conclusion, expressed his opinion, that the bronchial glands in both instances, were the seat of the calcareous deposit.

Dr. FERGUSON had had very lately under his care a similar case, which simulated phthisis in some of its general characters, but the physical signs were absent. Has met them occasionally in the lung, but rarely in phthisis; in one case they were associated with dilated bronchial tubes. Is satisfied that they are not generated in the lung's substance, and not necessarily an indication of phthisis.

Dr. YOUNG suggested that they might spring from calcareous changes in the cartilages of the bronchi, resembling, perhaps, calcareous bodies in the neighbourhood of joints.

Dr. MURNEY, in the course of his dissections, has noticed them close to the bronchial tubes, and beneath

the pleura on the parenchyma of the lung, but without any appearance of tubercular deposit in the rest of the lungs.

The PRESIDENT mentioned, as the result of his experience, that these bodies generally occurred in phthisical habits, and were rather a favourable indication; and he adduced cases in corroboration. He also mentioned an instance of the expectoration of the arytenoid cartilages.

THE EIGHTEENTH MEETING.

11th February, 1854.

The President in the Chair.

Attendance:—Members, 18; Students, 10.

LXXIV. Dr. PIRRIE exhibited a recent specimen of pericarditis, which occurred *during the progress of phthisis*, without the production of any of the usual symptoms of that disease.

Mr. H. M. JOHNSTON mentioned two cases in which the disease was latent—one in particular, of which the principal phenomena were inflammatory fever, pain in the right lumbar region, and cerebral symptoms, without any complaint referable to the cardiac region. There existed hyperæsthesia of the surface, and the case was supposed to be one of cerebro-spinal arachnitis.

LXXV. Dr. MALCOLM exhibited a specimen of pericarditis *with atrophy*, occurring in the convalescence of fever. The particulars are subjoined.

A female, aged thirty-six, was admitted into the Belfast General Hospital (when I was a pupil), in the ninth day of fever. In the course of eleven days, she began to convalesce, and was doing very well up to the period of attack, which occurred ten days afterwards, or thirty days after the commencement of the fever. She was now suddenly seized with rigors, vomiting, and apparent prostration. The vomiting persisted in defiance of all treatment, and in eighteen days she expired. The heart affection was altogether undetected; the symptoms of gastritis, which were temporarily relieved by repeated doses of calomel and opium having completely masked all other phenomena; and indeed, the usual pain and dyspnœa were not present in this case.

Besides the interest of this case in a clinical point of view, it has features of importance, when considered pathologically. Dr. Stokes considers the connection with fever very rare; he has never met one case—though he says it is not unfrequent in typhoid forms of disease; and in all such cases it is generally latent.

Dr. R. Smith (Dublin), says he has met *atrophy* equally with hypertrophy associated with pericardial adhesion.

An interesting discussion followed the reading of this paper, as to the cause of atrophy under the circumstances mentioned, and the physiological effect on the muscular development, from chronic pericarditis.

Dr. STRONGE, in accounting for atrophy being the occasional result in cases of pericardiac inflammations, suggested that when pericarditis so terminated, it

would be found that not only the pericardium but that the heart itself and endocardium would be found involved, and that by the continuity and propinquity of tissue, the coronary arteries and nerves of the heart could not escape being implicated—and that thus from thickening of the coats of the arteries less blood would be received by the heart—and by the same process, the nervous power being diminished, atrophy would follow as a natural result of impaired vascular and nervous supply. He believed that an analogous effect of impaired nervous energy is to be found in the atrophied condition of the muscles of the thigh and leg, after an attack of sciatica, and of deficient arterial stimulus in brain-softening, the imputed result of diseased heart.

Dr. S. did not wish to urge this view of the case as the correct one, but thought that future investigations may throw more light upon a subject so interesting, where we have diametrically opposite results from apparently like causes. Where pure and uncomplicated pericarditis constituted the disease, he believed the result would be hypertrophy, but that on the other hand, where the heart's envelope, together with its substance, were involved in inflammatory action, atrophy would be the diseased condition present.

The PRESIDENT mentioned the particulars of a latent case in a man aged fifty, in which the pericardium was entirely and intimately adherent; the complaint was dropsy, for which he was treated by two eminent medical men in town, about twenty years ago. He was supposed to have had disease of the heart, and had laboured under rheumatic fever fifteen years before.

LXXVI. Dr. PIRRIE exhibited the recent parts in a case of pleuritis, in which death occurred by cerebral effusion.

Dr. P. mentioned that this case had been ill eight weeks. On a post-mortem examination, there was observed intense congestion of the pia mater, and in the thorax well marked pleuritis, with effusion of lymph and fluid. In this case there was also an abnormality of the pulmonic valves, which presented four segments, two of which were very small, as if subdivisions.

The PRESIDENT had attended a case in which the friction sounds were heard by a spectator standing at the foot of the bed; also a very slow pulse (only sixty five), in a case of phthisis and pleuritis combined. The co-existence of the two diseases is a fact of much importance, and to be remembered in attendance on pleuritic cases. Variety in the rational symptoms also requires to be remembered, as he has observed absence (as mentioned) of quick pulse, frequently of pain, sometimes cough, and occasionally for some days, of physical signs, when he suspected pleuritis to have been in existence either on the diaphragm or between the lobes of the lungs. He was led to infer this from the pain, cough, rapid breathing, &c. being present for two or three days before the stethoscope indicated it.

LXXVII. Dr. PIRRIE read a case illustrating the utility of chloroform in treating injuries of the eye in children.

In the early part of last summer, a child, aged about six months, received a foreign body in the eye, which

afterwards turned out to be the point of a thorn of a rose-bush. It was imbedded in the cornea, and remained so for several days, having resisted various attempts, both domestic and professional, for its removal. When I first saw the case, the eye was considerably inflamed, and the foreign body being exceedingly minute, and almost of the same shade of colour as the eye itself, it was with some difficulty, from the impatience of the child, and the impossibility of keeping the eyeball at rest that it (the thorn) could be distinguished; and any attempt to remove it as long as the child had the power of moving the eye-ball would have seriously imperilled the safety of the eye. Under these circumstances, I suggested the use of chloroform, which being assented to by the parents, I had the pleasure of seeing the chloroform act most satisfactorily, and was thus enabled to remove the thorn without the slightest difficulty. The child was itself again in a few minutes, and the eye was quite well next morning.

The PRESIDENT mentioned an instance of injury by a thorn, which caused opacity of the capsule of the lens, which subsequently yielded to the use of mercury. It might be called a case of traumatic cataract.

Dr. ROSS instanced a similar case, in which the lens was dislocated by a blow on the eye by a stick. The lens became quite opaque in a day or two, and severe ophthalmia supervened. Much benefit followed the use of leeches, calomel and opium, and belladonna.

LXXVIII. Dr. HALLIDAY read the particulars of a case (communicated by Mr. SAMUEL REA), in which *the abdomen of a newborn child was lacerated, and the intestines protruded*, in consequence of a strain upon the funis in delivery:-

Early on the morning of the 4th February, 1840, I was called in much haste to attend in her second confinement, Mrs. M—. the wife of a farmer three miles from town, in the county of Down. Upon entering the apartment, I found the woman upon her knees at a chair, and ascertained that she had, a few minutes previously, given birth to a healthy, full-grown female child. As it was crying and struggling vigorously, I immediately proceeded to tie and divide the funis, when to my surprise I discovered that a large rent had been made in the parietes of the abdomen of the child, through which a portion of the intestines had protruded. Before the child was separated from the mother, which was done as quickly as possible, the displaced portion of intestine, had by each successive scream and struggle of the child, increased to rather more than the size of a man's shut fist. With some difficulty, caused by the screams and struggling of the child, the intestines were replaced, and the rent about three inches long, being the segment of an irregular circle of about three inches diameter, was brought into close apposition by three interrupted sutures, secured by adhesive plaster, a compress and bandage. Union by "the first intention" took place within the first forty-eight hours, and the wound was quite healed by the end of the first week, when my attendance ceased, the child and mother doing well. I never afterwards saw the child, but on making inquiry, found that it had ceased to "thrive," and died when a month and three days old.

The length of the funis in this case did not exceed sixteen inches. The child was expelled with much force, and in the absence of even an intelligent nurse, was allowed, without protection, to fall to the floor. Had the woman been in the recumbent position, even without medical or other assistance, it cannot be supposed that the shortness of the funis would have produced any inconvenience, and no doubt, this accident would not have occurred.

THE NINETEENTH MEETING.

18th February, 1854.

P. Lynch., M.D. in the Chair.

Attendance:-Members, 12; Students, 8.

LXXIX. Dr. MALCOLM gave a sketch of the clinical history of the use of *large doses of quinine in continued fever*, and read two cases from his own practice:-

Some time about 1640, the value of Peruvian bark was practically known in the treatment of ague, but its use in the continued fever, which we in these countries are accustomed to meet, has been of comparatively limited application. The general doctrine in our works on Materia Medica is, that it is valuable in all cases characterized by atony of the muscular fibre, by profuse discharges, in convalescence from fevers and acute disorders, and in periodic, febrile, and nervous affections. It is also stated by some, as extremely useful in the advanced stage of typhus; but as Eberle, of Philadelphia (Ed. 1847) mentions, it was considered contra-indicated, when the tongue and skin were dry, when delirium or convulsive twitches were observed, or any abdominal tenderness existed.

In 1843, on 17th January, Louis presented a report at the French Academy, on the essay of Dr. Broqua, relative to the employment of sulph. quinæ in typhus, in large doses. This is the earliest mention I can find of the subject under consideration. This report had a negative effect, and suggested fresh inquiry, as the conclusions did not seem at all decided.

In 1846, in the pages of the Gazette Medicale, M. Boucher gave the results of a series of investigations on the use of quinine in large doses in typhoid fever, or the form most usually met with in the Parisian Hospitals. While stating that no serious consequence ensued in doses of thirty grains, that nausea, and sometimes vomiting, with some slight heat in the oesophagus, were about the worst symptoms produced—that the eruption was not modified—that the general state, and not the intestinal affection, is affected—that the headache disappears to be replaced by a feeling of heaviness—and that sleep is rather promoted than otherwise; he also mentions that the convalescence seems rapid, though the amendment is sometimes transitory—that the nervous phenomena and slowness of pulse which characterize the full action of the drug, cease when it is suspended, and that it is not a special treatment, but very often serviceable when combined with other means. In the following year (1847), Dr. Baldwin, of America, experimented on animals of various kinds (dogs, &c.) with a view to ascertain the special physiological results of large doses, and to

determine its degree of danger. These effects were extreme restlessness, tremulous movements of head, partial paralysis of the extremities, oppression of breathing, convulsions, sometimes diarrhoea and vomiting, and frequently great excitement of the pulse. He observed that fifteen or twenty grains was a fatal dose; also, that the traces, post-mortem, were a dark defibrinous condition of the blood, congestion, of the lungs, and a highly vascular state of the gastro-intestinal tract.

M. Brecquet in a memoir submitted to the Academy of Sciences, Paris, and reported on by MM. Andral, Rayer, and Lallemand, about the same time, observed the following results on the animals experimented on:—

1. Cerebral excitement and convulsions. 2. Vertigo, twitchings, apparent intoxication. 3. Respiration not affected. 4. Inflammation of the mucous membranes, but not severe. 5. Slight dysuria, &c. 6. Uterine haemorrhage. 7. Numbness and coldness of surface, petechiae, ecchymoses. 8. Blood-globules destroyed and fibrine diminished—which conclusions are not very different from the American account.

These experiments, and the statements of Trousseau, Duval, and other French authors, prove, however, that injurious effects may sometimes arise from the administration of large doses, even in intermittents (for which it was long used heroically), and might have damped medical enterprise in this direction. But no such thing. Dr. Dundas of the Northern Hospital, Liverpool, and author of "Sketches of Brazil," set to work, on the assumption that all fevers are identical, and tried the ague treatment in many hundred cases of the 1847 epidemic, with the greatest success. His plan was to give it early, say before seventh day, premising a free action of the bowels and an emetic. He gave ten to twelve grains every two hours, for the first twenty-four hours, and afterwards three grains thrice daily. If it disagreed, he omitted the remedy, repeated the emetic, and after twenty-four or thirty six hours resumed. He puts in the proviso, however, that the cases must be uncomplicated. Dr. Dundas, it may be said, was the first who regularly introduced this treatment into these countries, and after five years experience, he is still of opinion that it is the most advantageous treatment, and is calculated to shorten the duration and mitigate the symptoms of fever. His followers have been numerous.

Mr. Steele (1847), in his extensive practice in the fever ships in the Mersey, never found any remedy which appeared to cut short the disease, or modify the symptoms, in the same decided manner as quinine, when fairly tried. Dr. Stevenson, of the Birkenhead Fever Hospital, noticed an improvement on the second day of treatment, and ultimate recovery even in such cases as presented the following alarming condition:—Face pale and shrunk, but occasionally flushed; delirium; convulsive startings; dull, heavy countenance; sordes; dry and brown tongue; rapid and small pulse; involuntary evacuations, and sometimes intestinal haemorrhage. Mr. Fletcher, of the Manchester Fever Hospital, considered it of great use in all uncomplicated cases of typhus; but even in cases attended with bowel complaint, he observes that its early administration may check the progress of the disease. In eighty cases,

he observed the following results:—1. Cinchonism established permanent convalescence in forty-eight hours, in the majority of cases. 2. Five-sixths of the typhoid cases became convalescent within fourteen days. 3. In young subjects, the proportion is raised to nine-tenths. 4. In the pneumonic complication, with rose-coloured spots, the eruption disappears under its use, but an active fever supervenes, requiring recourse to antiphlogistic means. 5. In all cases of well-established pneumonia, enteric, or cerebral complication, the treatment is unsuccessful. Mr. Hayward, of Liverpool, tried it in eighty cases: all but three were successful. He employed opium and stimulants in conjunction, and gave doses varying from four to seven grains every two hours (generally four to five grains). Twenty-seven were in the first stage, fifty-three in the second. Three died. In seventy-nine there was improvement within twelve hours, and cinchonism was always produced. The following analysis of the symptoms will show the character of the cases:—In thirty-nine, diarrhoea or vomiting were the first symptoms—forty-one had headache—all had tenderness of the abdomen—seventy-three had delirium, of whom twenty-one very seriously—all had a dry, brown, and cracked tongue, with great thirst—and twenty-four were covered with petechiae.

Dr. Goolden, of St. Thomas' Hospital, used it successfully in eight cases of typhus gravior. One case had as much as 180 grs. In another case, when the pulse was 140, and delirium and diarrhoea present, after four doses (8 grs. every 2 hrs.), the pulse fell to 80, and perspiration came out freely.

The late Dr. Graves wrote most favourably of its use, in the Dublin Quarterly Medical Journal for March, 1852; and Dr. Kelly, of the Drogheda Fever Hospital, in April, 1852, used it in eight cases with the happiest results. One of them was a man, aged 55, who, on the tenth day, had delirium, quick respiration (40), pulse 120, dry and brown tongue, copious eruption, subsultus, involuntary evacuations, and a temperature of only 90 degrees. In two days, he was convalescent under the quinine, and was discharged on the 21st day.

Dr. J. M'Ivers, in the Dublin Quarterly, writes that he used it in nine cases, of which only one failed. On the 13th day, in one very bad case, 100 grs. brought about convalescence in three days.

Were we to rely upon the clinical facts thus given, we might be led to view this remedy as an established treatment, but there is another side of the picture which must be shown before we can judge of its true value.

The opponents of the treatment who have published are Professor Bennett and Dr. Robertson, of Edinburgh Infirmary, Dr. Barclay, of St. George's Hospital, London, and Dr. Corrigan, of Dublin.

In the session 1851-2, Dr. Bennett tried it in eight cases, in seven of which there was no marked improvement, and, in one, the cerebral symptoms were aggravated.

Dr. Robertson's cases were all failures.

Dr. Barclay observed three separate effects: 1. Marked depression; 2. Reduction of the pulse without general prostration or sickness; and 3. Results entirely

negative. Of 26 cases without eruption, the average duration was ten days before admission, and twenty-one after, but the quinine cases averaged eight days before admission, and twenty-three after.

Of fourteen cases spotted, but with doubtful intestinal lesion, the general average was eight days before, and twenty-two after; under quinine, it was ten and twenty-six respectively.

Of eleven cases spotted, and with undoubtedly ulceration of the bowels, the general average was seven and thirty-three, while, under quinine it was fifteen and thirty-seven; giving, it will be observed, a general conclusion that the quinine treatment, in place of cutting the fever short, actually prolonged it beyond the average.

Dr. Corrigan, in his recent work on fever (1850) objects to the use of quinine in large doses, because it is apt to produce great irritation of the mucous membrane, and depresses the pulse. He details two cases, both young males, aged twenty-three and thirteen respectively. On the sixth day, with pulse 88 in the former, after an aperient, he gave five grs. every three hours for two days; on eighth day, maculae appeared, with a dry skin and tongue, and diarrhoea. On the twentieth day, he was discharged to the convalescent ward.—In second case, on the second day, with a pulse 112, a dose of ten grains quin. (with cal.) was given, and, on third day, five grains every two hours, which, however, was discontinued in the evening (probably after three or four doses), tinnitus aurium having supervened; on fourteenth day, convalescence was established. He considers, however, that in the relapsing fevers, with creamy tongue and perspiring skin, it is useful in moderate doses.

I shall now give you, briefly, two cases in my own practice, and conclude with a few observations:—1. James W., aged seventeen, a sailor, with fair complexion, and apparently in previous good health, was admitted 15th December, ult—then ill four days of fever.

This case had had ague formerly, at Montrose, and the present illness commenced with a marked rigor. His pulse gradually rose till the eighth day, (but, even on the fifth day, when agitated, it rose suddenly to 156 from 108) when it numbered 160. There was some delirium, with attempts to get out of bed, a flushed face, moist tongue, and a peculiar craving appetite. Up to this date he had, been taking the ordinary diaphoretic saline, some wine, and, at bedtime, a dose of camphor, and pulv. dov. On the eighth day, I commenced the quinine, in five gr. doses every three hours. The first day he took six doses, when the pulse fell to 186, and he had more sleep; on next day, three doses, when it was omitted, but resumed on twelfth day. This time he had five doses in succession, with the effect of reducing the pulse to 124. On the twelfth day, four doses, and afterwards only two gr. doses thrice daily till sixteenth day, when the pulse numbered but 108. At this time the tongue was clean, and the general symptoms all improved, as in perfect convalescence. In a few days, however, the bowels became relaxed, and the pulse again rose, till, on the twenty-sixth day, it numbered 144, and the sounds of the heart, on

examination, presented the foetal character observable in typhus-softening. The diarrhoea was readily checked by ordinary means, and his general state was excellent, but the irritability of the heart's action was remarkably persistent. At this stage I used two-drop doses of the medicinal hydrocyanic acid, with some effect; but, though he got strong, and was most impatient on being confined to his ward so long, the irritability did not entirely subside while he was in hospital, which he left on January ultimo.

Here we observe one of the results noted by M. Boucher—viz. the temporary fall of the pulse; and, as to the after excitement of the heart, it is difficult to say whether it was due to Dr. Stokes's softening, or the unusual effect of the quinine. It is not improbable that idiosyncracy may have had some influence. The following note appears in Dr. Stokes's recent volume, p. 517:—I once observed, in a case in which large doses of sulph. of quinine had been administered, the sudden production of an extraordinary palpitation.

The action of the heart was tumultuous, irregular, and to the highest degree vehement and distressing; a loud, bellows murmur attended the systole, but I cannot say whether it was propagated into the arteries.

2. One of the nurses of the hospital, aged 32, came under my care on the 2nd Feb., then ill of fever four days. The eruption was just appearing, the pulse 132, the skin hot, much thirst, and tongue loaded; and considerable debility was evidenced. On the following day, the prostration was more marked, and the respiration was anxious, with moaning and headache, injected and suffused eye, and hot scalp. After shaving the scalp, administering a refrigerant lotion, and clearing out the bowels gently, she was put under five grs. doses of quinine, in conjunction with ammonia and wine. This was repeated every six hours regularly for three days with a slow, but appreciable amendment after the first four doses, and she was out of danger by the tenth day, which is a shorter time than we are generally accustomed to meet with in typhus cases.

From what, then, I can gather as to the use of this remedy, I am led to believe that certain points are established on this question:—

1. The symptoms of cinchonism are chiefly nervous, characterized by vertigo, tinnitus, heaviness, and fulness of head; by a marked reduction in the pulse, and by depression, with nervous tremors and copious perspiration.
2. Early and uncomplicated cases seem best adapted for its use, more especially as the condition of the heart, and the blood in fever are hourly deteriorating.
3. There seems no ground for supposing that enteric lesion will be induced by cinchonism; but when this lesion is present, the effects of the remedy are manifestly injurious.
4. An inordinate excitement of the heart may be induced by cinchonism.
5. The old notion of a dry and brown tongue, delirium, subsultus, and dry skin, being contra-indications is not confirmed by recent experience.
6. Its effects are rapid, and remain some time after the omission of the medicine. Hence they require watching.
7. Headache disappears, and sleep is induced in the favourable cases.
8. Children and persons of nervous habits of body are very susceptible to its influence.
9. The mass

of evidence is in favour of its utility.

As to my own opinion of the drug as a main treatment in continued fever, I think the opponents have failed to prove their case; yet I admit the trials, are too few to entitle us to a final verdict. Dr. Barclay's evidence is completely negative, while Dr. Corrigan has not fully tried its power. Comparative experiments on its use in the three forms of continued fever are yet desiderata. Dr. FERGUSON had no experience of the use of this remedy in large doses in fever, and believed that doses beyond two grains were rarely beneficial, and held strongly to the therapeutic opinion of Cheyne and Barker. It is anti-periodic in large doses, totally irrespective of fever; and neuralgia is the only disease wherein he would employ this heroic treatment with any confidence.

LXXX. Dr. MACLAUGHLIN, Lurgan, exhibited a recent specimen of *pericarditis*, which occurred during an attack of acute rheumatism.

Sarah A. M'K__, aged thirteen, was admitted into the infirmary of the Lurgan workhouse. On the 9th February, 1854, she was moaning, and evidently suffering distress from difficulty of breathing. Her pulse could scarcely be felt, and she complained of great pain over the left side of the chest. She got a draught of aromatic spirits of ammonia in camphor mixture. Her mother stated that she had been working in a damp shop, and on the 31st January, was seized with severe pains in the head and back. The next night she complained of pain in her right knee and shoulder, which became very red and swollen; for this, she got purgative medicines from the dispensary doctor of the district. On the 6th February, she was seized with an acute lancinating pain in the left side, confined chiefly to the region of the heart. The morning after her admission, her countenance was extremely livid, skin hot and dry, breathing rapid and laboured, (50 in the minute,) pulse 140, feeble and intermittent, tongue covered with a white fur, knee and wrist joints red, swollen, and painful. A friction sound was heard all over the right side, and a bruit with the first sound heard over the upper part of the sternum. The impulse of the heart could scarcely be felt; its action feeble. The abdomen was tense, tympanitic, and very tender on pressure. (Eight leeches were applied to the region of the heart; two grains of calomel, and one sixth of a grain of opium ordered every three hours.) A turpentine enema removed the distension and afforded so much relief, that she was enabled to lie on her left side, which she had not done for some days previously. On the 10th, she slept better, not moaning so much, and felt somewhat relieved, but the pulse was very irregular, and about a hundred and thirty. (To continue the pills.) On the 11th, she was very restless the entire night, moaning constantly; her countenance still very livid, and breathing very much hurried; great dulness over the region of the heart, and absence of friction sound; bruit very distinct at the top of sternum. (A blister to be applied to the cardiac region. To continue the pills. Half a drachm of mercurial ointment to be rubbed in every three hours.) On the 12th, her breath was slightly mercurial, but the gums not at all affected;

pulse was more feeble and irregular. She had a barking cough without any expectoration; and dyspnœa became so urgent that she was obliged to be propped up in bed, and her expression at this time curiously enough was, "My heart is breaking!"¹ Death put an end to her sufferings at an early hour on the 13th.

In this case the heart presented different points of suppuration in the intermuscular structures; the valves were healthy, yet there was a systolic bruit during its entire progress. There was also effusion into the right knee joint; and the habit not being scrofulous, the case had altogether much the appearance of one of purulent absorption.

I have made several post-mortem examinations of both acute pericarditis and endocarditis, and never found ulceration as a result. Therefore, I am disposed to think it of extremely rare occurrence in such cases. In old chronic affections of the heart, I have seen slight abrasion of the membrane, which had some appearance of ulceration, but I never before met with ulceration in acute pericarditis.

THE TWENTIETH MEETING.

25th February, 1854.

J. C. Ferguson, M.B. in the Chair.

Attendance:—Members, 19; Students, 10.

LXXXI. Dr. MOORE, Ballymoney, exhibited a specimen with drawing of same, *in situ*, of a pendulous tumour of the labium, and related the following particulars:—

The patient, Mary G__, aged forty-five, mother of three children, consulted me two years ago, about a tumour the size of an apple, with a pedicle about three inches and a-half in length, attached to the left labium externally, and to the wall of the vagina internally, and hanging down like the pendulum of a clock. She stated that it commenced about seven years ago. It was then of the size of a pin-head, but latterly had increased very much; and from its pendulous character, and the consequent annoyance the patient suffered on making the slightest exertion, her health was becoming seriously impaired. The "catamenia" were regular as regards their occurrence, but considerably in excess, and previous to each menstrual period, the tumour became irritable and painful. On the 21st April, 1852, I removed the tumour—having applied a ligature close by its base, and with the scalpel cut the pedicle about the middle. The patient lost only a few drops of blood, and on the 24th, I allowed her to return home. After the lapse of a few days, the remaining portion of the pedicle exfoliated. This preparation of the growth will show its character, and the accompanying rude sketch will give you an idea of the parts as they were when I first saw them. The patient is now in the enjoyment of perfect health, and the only trace of the tumour is a slight thickening on the edge of the labium, scarcely distinguishable. In the last number of the "Dublin Quarterly Journal of Medical Science," amongst the reports of the Metropolitan Pathological Society, I find

¹ This she complained of more or less from the beginning, but not to the same extent as on this day.

a case bearing a close resemblance to the one I have just read, which was admitted into the Richmond Hospital under the care of Mr. Fleming.—(Vide "Dublin Quarterly Journal of Medical Science," page 225.)

In this case, which is analogous in many respects, I think the attachments of the tumour must have been deeper seated than in my case, in which the wall of the vagina internally and the labium externally were alone implicated. As to the character of the growth, I cannot pronounce with certainty, inasmuch as I did not make a section of it, but I believe it to be fibrous. At a recent meeting of the Dublin Obstetrical Society, Dr. M'Clintock exhibited a specimen of a large fibrous tumour in the right labium, the removal of which had been performed by Dr. BRUNKER, of Dundalk. In connection with this case, Dr. M'Clintock drew attention to the fact of its having been the right labium in which the tumour was situated, adding, that in his own, and in the recorded experience of Dr. Robert Lee, the right, and not the left labium, had almost invariably been the one to which a preference was given by morbid growths, whether of a fibrous nature or of the encysted and much more common kinds. The case of the woman (G_) is an exception to this rule, the abnormal growth being attached to, and having its origin in the left labium.

LXXXII. Dr. MURNEY exhibited a recent specimen (forwarded by Dr. R. F. DILL), presenting extensive ulceration of the trachea in phthisis.

The early history is unknown. The patient was admitted into the Military Hospital, Belfast, 1st Nov., and died Dec. 21st, 1853. Tuberclie was deposited in all parts of both lungs and the bronchial glands—especially the apex of left, and the lower part of right lung. Dr. MURNEY mentioned, in the course of his remarks, that in 110 male cases examined by Louis, fifty-five presented ulceration of the trachea. According to that author, this pathological state is met in the proportion of one-half the male subjects of phthisis, and one fourth of the female; and the cause he considered to be due to the irritating influence of the sputa most commonly passing along the posterior wall of the bronchi and trachea. Dr. MURNEY considered a more satisfactory reason might be found in the presence of a considerable quantity of glandular structures in the course of the ulceration, and as these bodies are at all times highly vascular, inflammatory action would be most easily aroused.

Dr. FERGUSON differed from Louis as to the cause, judging from this and other cases, because the ulceration is not limited to, or always present in, the site mentioned; he believed that tubercular matter was deposited in the follicles generally, agreeably to the laws of tuberculosis.

Mr. AICKIN stated as his experience that these cases were generally rapidly fatal.

LXXXIII. Mr. AICKIN read a case, illustrating a source of error in Medico-legal examinations for suspected arsenical poisoning.

Having been called upon a few years since to examine the body of an infant supposed to have been

poisoned by its reputed father, the symptoms so far as could be learned, were those resembling poisoning by laudanum. I proceeded to examine the body, in which I found no lesion of structure or appearance of inflammation. I removed the stomach for analysis of its contents; and having been suddenly called away, I took a piece of room-paper (the room being papered), wrapped up the stomach in the inside of the paper and locked it in a cupboard until the next day, when, with Dr. Andrews' assistance, I proceeded to analyze its contents. A trace of morphine was obtained, but not so much as enabled me to say that the child had got sufficient to cause its death; but on testing the fluid in the stomach for arsenic, it showed distinctly that arsenic was present in pretty large quantity. As the symptoms which I found the child had had, were not those of poisoning by that mineral, and finding no mark of inflammation, I felt that I could not go forward and prove that the child died in consequence of its exhibition. Being at a loss to account for its presence, I immediately thought that the paper might contain arsenic. I brought a piece of it in, which had been thrown out in the yard; and found that a yellow colour in the printed paper contained a large quantity. It was at once evident that the stomach, though placed on the opposite side of the paper, had absorbed it during the night through its coats, and the fluid it contained had been thereby impregnated.

This is a case I conceive, of much interest in medical jurisprudence, as, first, exemplifying the great care that should be used in the chemical analysis in such cases.—Secondly, as proving that absorption of arsenic will take place after death, and that it may be found in the different viscera, thereby suggesting the plea that the arsenic was introduced *after* death with the view of inculpating an innocent person, which plea was actually set up some time ago in a case of poisoning in Armagh, prevented a prosecution, and led Professor Andrews of this town, and Dr. Kidd of Dublin, to institute special experiments on this point. The former of these gentlemen found arsenic in the kidney, and a trace of it in the liver of a dog, into whose stomach it was injected a few hours after death. I think, in the absence of proof that the person had actually got the poison—medical evidence would not be complete had the person been affected with the usual symptoms of arsenical poisoning, and unless inflammation of the mucous membrane of the stomach which could not occur after death had been observed.

Dr. Kidd, I believe, published his experience in the "Dublin Quarterly Journal." Beck says, that when arsenic is introduced into the rectum of an animal *after* death, it has no chemical effect upon the texture, but leaves a deep red stain with a defined margin resembling extravasation, while arsenic introduced *before* death produced the regular appearance of inflammation, the red colour gradually subsiding into the healthy tint of the surrounding membrane.

LXXXIV. The SECRETARY read the following report of a case of dropsy of the amnion, communicated by Dr. W. F. ROGAN, Londonderry.

On February 7th, 1854, I was asked to visit Eliza P_,

a butler's wife, in tolerable circumstances. I found her in bed, very weak: she said that she had dropsy, and was also seven months gone in pregnancy. On examination, I found her abdomen enormously swollen, very tense, and fluctuation evident over the entire surface. She was much larger than one pregnant with twins at the full time. I could feel the movements of the foetus distinctly at the upper part of the swelling; the shape of the uterus was preserved, and its fundus pressed against the end of the sternum without raising it. The cartilages of the ribs were not much pressed out, and the flanks did not bulge, when she lay on her back. There was no difficulty of breathing, and no anasarca till about five days before I saw her, when her legs became oedematous. A vaginal examination showed the cervix uteri much expanded, and an impulse could be felt through it on percussing the abdomen; the os uteri was open, and the bag of waters could be felt. As she was daily increasing in size and the skin over the abdomen much cracked and fissured, and as she could not lie down, but slept in a chair with a handkerchief tied round her neck, suspending the abdomen, I determined to puncture the membranes; on doing this, I evacuated a large tub-ful of fluid. The uterus immediately contracted on the child, and after an interval of eighteen hours, it was expelled with but a few pains. The child was not anasarcous. It lived about an hour. The placenta was thrown off without haemorrhage, and was fully double the circumference and thickness of an ordinary one. The mother continues to do well.

This woman was ever remarkable for her size when pregnant, and a very large quantity of water was always expelled; this was her tenth child.

LXXXV. Dr. JAMES MOORE exhibited a dried preparation of one-half of a *diseased lower maxilla*, removed by excision.

The subject of this operation was a woman about nineteen years of age, who had a hard tumour about the size of a hazel-nut on left ramus of the jaw, which in four years gradually increased to the size of a hen-egg, and became very firm, and evidently of the character of bone. A curved incision was made from the commissure of the lips to the angle of the jaw; the soft parts dissected off; and two-and-a-half inches of the left side of the jaw sawn through, leaving the articulating condyle. There was considerable haemorrhage. The wound was brought together by sutures through the mucous membrane and through the skin, and healed by "the first intention." After two months, there was scarcely any difference in the appearance of either cheek. The macerated bone presented a tumour about the size of a hen-egg, smooth on the surface but having spicula radiating to the centre, and either end, where the saw was applied, being perfectly healthy. Mastication and speech were unimpaired. The woman has since been married, and during courtship the husband was not aware of her defect.

THE TWENTY-FIRST MEETING.

4th March, 1854.

William M'Gee, M.D. in the Chair.

Attendance:—Members, 17; Students, 7.

LXXXVI. Dr. MALCOLM exhibited a cast of an arm of a lady exceedingly enlarged, the result of *carcinoma of the breast*, involving the axillary glands; and read a history of the case as thus communicated by Dr. THOMAS THOMPSON, R.N.:—

It is nearly twelve months since I first saw this case. It was then in the stage of open cancer, with a deep foul ulcer in the centre of the breast, from which blood occasionally flowed very profusely. The discharge of blood took place as a matter of course, just in proportion to the destruction of blood-vessels in the mamma during the progress or extension of ulceration. The glands of the axilla, too, were very much enlarged, and the same scirrhouss hardness characterized them as well as those portions of the mamma which had not reached at that time a state of ulceration. Erysipelas in the arm next set in, but seemed to yield to treatment very readily. The attacks of it, however, became very frequent, and being always ushered in by a shivering fit, followed by general pyrexial symptoms, left her in a very weak, exhausted state, until it at length produced a permanent and very painful swelling of the whole arm, of which you have a cast.

The treatment in this case consisted of those remedies, general and local, which possess most power of mitigating pain and supporting her strength, for I could not hold out, either to her relatives or herself, the least prospect of a cure.

LXXXVII. Dr. MALCOLM introduced a patient, presenting a rare example of *varicosity of the upper extremity*, and part of the parieties of the trunk.

David R___, of Carnmoney, aged forty five, was seen by me on 1st March, 1854. He is about 5 ft. 10½ in. in height, and weighs 12st. 51bs.; complexion sanguine; and has always enjoyed good health. The varicosity was noticed at birth, but then to a small extent, gradually enlarging till it assumed its present appearance when he attained his twenty-first year. Some twenty years ago, he complained of much pain in it. The late Dr. Purdon saw him at that time, and advised the constant application of cold water dressings, and a roller, under which the arm soon became free from all uneasiness. His only complaint since, has been the annoyance arising from the weight of the tumours, and their interference with the proper use of the hand and arm. The varicose tumours extend from the left hand to the right of the sternum along the inner side. There are nine clusters in all, four of which are very large. The maximum circumference of the fore-arm and arm is 13 and 14½ inches respectively. After walking some distance, the tint of the tumours at wrist assumes a reddish purple instead of the blue which prevails. It is easy by continued pressure of any one tumour, to empty it of the blood; and when by accident any of them is penetrated as by a thorn, the blood spurts out in a continued stream two yards distance. Phlebolites are distinctly felt in some parts of the tumours, the

trunk, especially posteriorly, is covered with the eruption, called *Chloasma*, which appeared three years ago.

The PRESIDENT related the case of a girl aged four years, who had a similar tumour under the chin, and also mentioned the case of an old lady who had varicose veins in the neck.

Dr. BRYSON referred to a very interesting case of varicose aneurism of the ear, which was sent to him from "the Glens" to be extirpated, but which was successfully treated with the concentrated decoction of oak bark and alum, a remedy he had found efficacious in uterine haemorrhage, in consequence of which, he keeps a quantity ready preserved with creosote always in the house.

LXXXVIII. Dr. MALCOLM submitted some notes upon the use of *lemon juice*, *citric acid*, &c, in acute rheumatism, and read a case from his own practice.

A young man aged twenty five, requested my attendance on 16th January, ult. He was stout built, and apparently of good constitution. He stated he had been six days suffering from his present illness. For seven years past, he had been annoyed with symptoms of urinary irritation—dysuria, and pain of back, but not for many months latterly. All the joints are affected, red, swollen, and tender.

He is quite unable to move without suffering.—Pulse 96; tongue much loaded, bowels free. (Ordered 10 grs. of Dover's, and 2/3 gr. of tartaric emetic at bed-time; and of citric acid 2 drs., lemon juice, 3 oz. and lemonade *ad lib.* every day.) Second day,—pulse 88. Third day,—pulse 84. (Hyd. et rheum every alternate night.) Sixth day,—pulse 80, pains easier. Tenth day,—pulse quiet, pains quite better, can walk about the room. Sixteenth day,—pains gone, (quinine ordered).

1. This treatment was introduced by Dr. O. Rees, in 1849, who published a pamphlet thereon. The acute and gouty forms were the most benefited, but to the cachectic and syphilitic, it was not applicable. His dose was *semuncia ad unciam ter indies*, but latterly he increased it considerably.

2. Dr. Babington, his colleague, has used it in doses of 6 oz. to 8 oz. thrice daily.

3. Dr. Golding Bird has given in his adhesion, and considers it *in modo operandi*, of the same class as *acetas potassæ*, cream of tartar, and alkalies generally.

4. Mr. Dalrymple, of Norwich, speaks warmly of its success. It reduces the pulse, abates the fever and pains, and all without the depressing effect so common in convalescence under other treatment.

5. Mr. Hancock, of Charing Cross Hospital, in February, 1852 published in its favour.

6. Dr. Peltier of Montreal, advocated its claims in August, 1853, in the strongest terms. "Invaluable but simple mode," "none has given me," he says, "so much satisfaction as *lemon juice*."

Dr. Perkins, of Brussels, and Dr. Pepper, of Philadelphia, have been also very successful in this particular use of the remedy. Indeed, I find no evidence of its inutility. Its *modus operandi* is unfortunately unknown; but we possess abundant proof as to the nature of its therapeutic effects, which are briefly—diminution of

the pulse, promotion of the urine and diaphoresis, and the total absence of injurious effect, even in the largest doses.

Dr. BECK had used this remedy in two cases with iodide of potassium. The acute pains had ceased in three days, and the cases afterwards did well—one slowly. Both were entirely free from cardiac complication, either during the disease or since.

Dr. HALLIDAY had tried it successfully in acute rheumatism, in the case of a child aged eight years. The fever and pains subsided on the fifth day. His experience of it in chronic rheumatism was not favourable.

The PRESIDENT employed it in a recent case, but had to give it up early in consequence of colic having been induced. He instanced an interesting example of rheumatism in a child which occurred five times within a few years, and each time paralysis supervened. There was no heart complication.

The PRESIDENT also noticed as useful in certain forms of the malady, the most common remedies, *colchicum*, as advised by Scudamore, purgation by Hamilton, opium by Corrigan, *guaiacum* by Dr. Roots, and mercury and iodide of potassium, by various authorities.

LXXXIX. Mr. JOHN AICKIN read a case of two *placentæ* to one birth.

This case occurred in the subject of retention of the *placentæ*, on extracting which, with the hand, two *placentæ* came away; one about 3 inches in diameter, and the other 2½, connected by the membranes of only one funis. The presumption from such an occurrence is, that it had been a case of twins, and that one foetus had been separated at an early period. It is not impossible that one of them might have been retained without the knowledge of the practitioner.

XC. Mr. AICKIN also exhibited an instrument of his own construction, for the support of the funis in cases of prolapse of the cord.

I had had in practice three cases of prolapsed funis. In the first case the labour went on with the cord down: in the second, I endeavoured to introduce the cord over one of the extremities, but it still dropped down: in the third, turning was resorted to. In the three cases the lives of the children were lost.

Turning, though effectual, is not unattended with risk; accordingly, I bethought me of some such plan as the instrument exhibited, which is proposed for supporting prolapsed funis, and consists of a gutta percha ribbon about an inch broad, and two lines in thickness, with a forked extremity, about eighteen inches long, which may be allowed to remain after putting up the prolapsed funis, until the head would be so far advanced that the funis could not pass.

Dr. BECK had observed in two cases, the children saved by the rapidity of the labour, and believes it impossible to retain the cord above the head by any contrivance, that will not do more harm by retarding the labour than good by saving the cord from pressure. In these cases, the object should be to expedite the delivery by any means necessary for that purpose

consistent with the safety of the mother, as delivery is the only effectual means of removing that pressure from the cord, which in a very short time will inevitably destroy the child's life.

THE TWENTY-SECOND MEETING.

11th March, 1854.

The President in the Chair.

Attendance:—Members, 14; Students, 6.

XCI. Dr. MALCOLM exhibited a wax cast of a spinal cord in its entire length, presenting an example of *ramollissement*, with intense congestion of the membranes, modelled from the recent parts, in a case reported by Mr. HARRISON of Ardglass, who kindly supplied the following particulars:—

Mr._____, had been, for the last fifteen years, complaining of what at first was considered rheumatism, and for which he was under the care of the most distinguished practitioners in London. About twelve years ago, during a short walk at his residence in Ireland, he sprained his foot, as he thought; and, upon getting out of bed the following morning, he remarked—"I feel as if I had lost the use of my leg." From that time he experienced gradual loss of power of the left ankle and leg, which increased very slowly, and was accompanied occasionally with severe neuralgic attacks of the most excruciating character, particularly if the digestive or urinary apparatus were out of order. Indeed, it was most remarkable how quickly the symptoms were relieved by the mere action of the bowels or a burst of perspiration. To pass over years of suffering and anxiety—about one year and a-half ago, it was remarked by his friends, that frequently he misnamed places and persons; and much apprehension being felt, he went to Cheltenham in search of health. There, matters grew worse; the urine became retained; the speech impaired; and as he found no improvement, he returned home. On his arrival, I was surprised to find him so much altered—scarcely able to walk, and his powers of expressing himself nearly gone. The catheter had to be passed twice a day—an operation which he had been doing for himself for some months; but, finding that he constantly injured the urethra and produced much haemorrhage, I latterly performed it myself for him. He was, in fact, in a state of dementia. All his powers failed. He became incapable of giving expression to his ideas. His memory was greatly impaired, particularly as to the recollection of recent events. His temper became very irritable when corrected for the mistakes into which this defect led him. Any indiscretion at his meals frequently brought on severe neuralgic attacks, with jerking and rigidity of his limbs and in his sides, particularly his left. He never complained of his head, and rarely of his back. About two months before his death, he got into a violent rage, when once contradicted by some of his family, and to these paroxysms of passion he became latterly more subject. Matters went on in this manner up to the day of his final seizure, which occurred under these circumstances.—Having got up rather early one morning, he walked out; and dinner being on the table

when he returned, he went in and partook of a hearty meal, with cheese and some plum tart. About two hours after this, he became very dull and incapable of speech, and suddenly became convulsed, with decided apoplectic symptoms, which continued for four days, until death closed the scene.

The post-mortem examination revealed the following appearances. The congestion and effusion in the brain were most remarkable; a large quantity of subarachnoid effusion occupied the surface of about two-thirds of the anterior lobes, where it terminated abruptly, leaving the posterior third untouched. A large amount of effused blood covered the surface, particularly on the right side, presenting in places the appearance of *rupture* of the arachnoid. The abdominal organs were healthy; the spleen very small; the iliac nerves had an atrophied appearance, and a tint of a dirty yellow colour.¹

Dr. STRONGE directed attention to a deposit of chalk on the theca vertebralis, and asked if the patient ever had symptoms of gout?

Dr. MALCOLM replied that Mr. HARRISON had not mentioned that he had.

Dr. STRONGE believed the case was one of gouty inflammation of the cord and its envelope, which had resulted in *ramollissement*. Dr. S. has observed, in cases of softening of the cord, a peculiar jerking gait in walking, which he likened to the motion of horses when affected with "string halt."

The PRESIDENT had seen the case in question. There was no coma, and the paralysis had set in after the other symptoms had subsided. There is a great variety, Dr. P. remarked, in the progress of these cases; some assume the form of creeping paralysis, extending gradually up from the extremities, occupying years; at length the bladder becomes paralyzed, then a form of insanity of a nervous character occurs, preceded by deafness. The paralysis is rather a weakness of the limbs than complete loss of power, with an inclination to fall forwards in standing or walking. A strong suicidal tendency by starvation existed in one case. Cline (he believed) first distinctly described this form (see the "London Medico-Chir. Trans." and mentions the sensation experienced by the patient as that of having the skin covered with chamois leather. These cases were very unmanageable, but he had noticed the good effects sometimes from cupping the nape, and the use of small doses of bichloride of mercury and tincture of cantharides,—also sulphate of zinc, as recommended by Sir B. Brodie.

XCII. Dr. MACLAUGHLIN, Lurgan, introduced a patient with *brachial aneurism*. It was examined by several members; and compression of the artery high up recommended.

In reply to a question, he stated that he had thought of Bright's disease coexisting in this case.

Dr. LYNCH believed it to be of the utmost importance to ascertain whether the condition of the artery was primary or secondary, and hence to ascertain whether

¹ This gentleman (it has since been ascertained) was the subject of gout for many years.

the kidneys were implicated, as organic cardiac disease was a frequent effect of renal lesion.

Dr. FERGUSON was inclined to deem the presence of albumen in the urine unimportant in influencing the diagnosis or treatment. There did exist in this case, extensive valvular disease of the heart, and it would be material to know what relation this and the aneurism bore to each other. As to the tissues engaged, he believed that the joint was affected.

Dr. ROSS recommended pressure at the upper part of the brachial artery out of reach of the inflamed tissues, which such management would immediately relieve. He thought this case exemplified the great merit of the treatment of aneurism by compression. Here we had a broken-up constitution, and could not venture upon the use of the knife; but by diminishing the current through the artery above the aneurism, we obtained all the advantages of the ligature without any of its disadvantages.

Dr. MACLAUGHLIN, in reply, stated that the pain of the arm was considerable, but was always relieved by pressure.

The PRESIDENT said there might be a coagulum. The disease of the artery was the same as the valvular affection. It was a case of false aneurism. As to treatment, pressure accurately applied was the best he could suggest under the circumstances. As an example, he related the case of a gentleman who, from suicidal attempt, drew a razor deeply across the bend of the arm. The haemorrhage was immediately stopped by ordinary pressure, but an aneurism formed. The pulse was absent in the ulnar artery. General pressure was first applied without effect, then a tourniquet, but this rolled off the artery. At length a Dublin practitioner advised a grooved piece of wood to be accurately fitted over the artery, which sufficed after five days use, to block up the tumour. The pulse soon afterwards returned.¹

THE TWENTY-THIRD MEETING.

March 18th, 1854.

J. W. Bryson, M.D., in the Chair.

Attendance:—Members, 13; Students, 2.

XCIII. Dr. ROSS introduced a patient labouring cardiac disease, which came on in the course of syphilitic rheumatism.

J.D., æt. thirty-one, a porter, having led a dissipated life, contracted syphilis seven years ago, which was followed in a year by syphilitic rheumatism of hips, ankles, and knees, which disabled him for three months.

Two-and-a-half years after the primary symptoms, he had syphilitic sore throat, cured by mercurialization. Cardiac symptoms became troublesome eighteen months ago, and some bloody expectoration occurred eight days since.

I will present the patient to you. He exhibits well-

¹ The aneurism was cured by compression of the brachial artery, which I was enabled to do by the circular clamp. The man afterwards died of Bright's disease of the kidney.—(W. R. MacL.)

marked symptoms of regurgitant aortic disease, viz:—Visible pulsation of the superficial arteries, double soufflet over the aortic valves, besides very great hypertrophy of the heart.

I think the heart disease commenced during the attack of syphilitic rheumatism, but as often happens in such cases, it remained in abeyance for some time.

XCIV. Dr. LYNCH introduced a patient having a peculiar stricture of the urethra. He is aged forty, and four years ago had contracted gonorrhœa. It is situated near the orifice of the urethra, and is of the spasmodic form, as the urine stops suddenly at times, and at other times flows freely.

XCV. Mr. WALES introduced a patient with indurated cervical glands, over which the passage of the clavicle produced distinct crepitation. His age was eighteen. Three years ago, he began to complain of neuralgic pains of the left arm. Enlargement of the cervical glands soon after appeared. The clavicle seems to grate over the gland, and causes thereby a peculiar creaking sound.

Dr. LYNCH considered the sound due to muscular action (*tendons included*).

Mr. H. M. JOHNSTON thought the sterno-clavicular articulation affected, and in a state similar to chronic articular arthritis.

Dr. HALLIDAY deemed this only a part of the cause. He thought the glands also affected. A number of members retired to examine into this point more carefully, and on returning declared in favour of Mr. Wales's view.

XCVI. The SECRETARY exhibited the recent parts in a case of Bright's kidney and diseased aorta, contributed by Dr. MACLAUGHLIN, Lurgan.

Jane M___, aged fifty, was admitted into the Lurgan Workhouse Infirmary on the 15th of February, 1854, affected with extensive general anasarca. She stated that she had been in the habit of selling apples on the street, and was frequently exposed both to wet and cold—to which she attributed her present ailment. She had been in good health till three months ago, when she was seized with pain in the lumbar region, accompanied by feverish symptoms, which terminated in a few days, but was followed by swelling of the feet and ankles. The swelling gradually increased, and became so great that, unable to follow her avocation, she applied for admission into the Lurgan Workhouse. On admission, she was generally anasarca; the surface of the body had a pale waxy appearance; she had cough and slight difficulty of breathing, and, on examination, diffused crepitation over the posterior part of right lung. Her tongue was clean, appetite good, and bowels regular. Her urine was pale, very abundant, and highly albuminous, as shown by heat and nitric acid. A blister and expectorating mixture relieved the cough and difficulty of breathing. Small doses of elaterium and cream of tartar had the effect of removing the anasarca very materially. She was then put on Gallic acid, and iron. She continued to improve up to the 8th of March, when she was seized with violent vomiting—everything she ate or drank being immediately rejected. I gave her

citrate of potash in effervescence, creosote, hydrocyanic acid, opium, &c., all without the slightest benefit. The only thing that appeared to give her relief was small quantities of iced water and brandy. She became worse every day, and died on the 13th of March, apparently from the exhaustion which the gastric derangement produced. There was no evidence of any cardiac affection throughout her disease, though there was some fluid in the pericardium after death (probably an ounce.) There was more or less effusion in all the serous cavities.

The PRESIDENT believed that the so-called Bright's disease is not inflammation. The deposit observed is not tubercular, and yet it is not inflammatory, though he could not otherwise designate the malady than "a phase of inflammation."

Dr. LYNCH ascribed great importance to the existence of this lesion, which is invariably characterised by the deterioration of the vital fluid.

Dr. BRYCE was induced to think that there was a good deal of "fashion" in medical theory, as well as therapeutics.

XCVII. Dr. MALCOLM introduced a patient with extensive scrofulous ulceration of the tongue. Mary A._, aged fourteen, was the first of four children. The three others died at the ages—three months, fifteen months, and ten years, respectively—the last, of "decline." She has been in a spinning-factory for the last two years, and always complained more or less of irritative dyspepsia. Her present illness commenced one year ago as a sore throat. Ulceration set in at the base of the tongue on the right side, with little or no uneasiness, and gradually progressed until it involved at least one-third of the entire organ. Its appearance is that of an ordinary indolent scrofulous sore, with scarcely any sensibility. The lymphatics of the neck sympathise.

A discussion ensued as to the best means of relief, amongst which the oleum morrhuae was prominently referred to.

THE TWENTY FOURTH MEETING.

1st April, 1854.

The President in the Chair.

Attendance:—Members, 15; Students, 14.

XCVI. Dr. FERGUSON exhibited a specimen of a bronchial polypoid formation.

Dr. Patton of Tandragee, had sent him the specimen. A countryman¹ in apparent good health, had been troubled with occasional cough; and one day brought up by expectoration, the substance here exhibited. The substance was not tubular, but consisted of concentric cylinders in close lamellæ and presented the character of lymph. The man never had hæmoptysis at any time. He was about thirty to thirty-five, tall, and phthisical-looking, pale, and with dark hair; there was very little sign of disease in the chest, except weak respiration in some points, and at others bronchitic rales—the latter not well marked. His cough was annoying at night. The

specimens seemed to Dr. P. true bronchial polypi, or rather coagulable lymph, like the false membranes in diphtheritis or croup.

The PRESIDENT considered it a bronchial exudation; and the existence of layers indicated that it might have been of the croupy character. John Hunter drew attention to this point—but in connexion with haemorrhage. Croup sometimes extends to the bronchial ramifications and is to the bronchial mucous membrane what muguet is to the digestive tract.

XCVII. Dr. LYNCH read the notes of a case of a calculus passed by the urethra.

A man from Saintfield, aged fifty-eight, had been complaining some time of haemorrhage and bronchitis. Then his bladder became irritable, and an abscess and fistula formed in the neighbourhood of the anus. His general health was such that an operation was not deemed advisable. After a time of suffering, he passed this calculus. Liq. potassæ and demulcents relieved the bladder. The fistula was ultimately operated on, and he left Belfast. He continues to enjoy good health, free from uneasiness of any kind. The late Drs. Henry Purdon and M'Donnell (Belfast) saw this patient.

XCVIII. Mr. H. M. JOHNSTON introduced a child presenting an example of infantile paralysis. The paralysis originated in an attack, characterized by many of the symptoms of cerebro-spinal arachnitis—the retraction and rigidity of the neck having been particularly well marked. Both lower extremities are paralysed—the child being quite unable to support itself. Treatment has been of little avail.

Dr. ROSS believed debility was a frequent cause, and suggested the more general use of tonics, as cod-oil, chalybeates, and good diet, with sea air and bathing.

He thought that strumous children were, much more commonly than others, the subjects of this disease.

Dr. PIRRIE has noticed that this disease most generally affects but a single limb, and is associated with dentition.

Dr. YOUNG thought the prognosis of these cases generally unfavourable.

The PRESIDENT has observed them to occur most frequently in the strumous diathesis. He has also noticed much injury result to the nervous system from the injudicious use of electricity, whereby the little remnant of nervous force was unduly stimulated, and thereby weakened. He had much confidence in the administration of the sulphate of zinc.

THE TWENTY-FIFTH MEETING

8th April, 1854.

The President in the Chair.

Attendance:—Members, 17; Students, 14.

XCIX. Dr. LYNCH submitted a statement in proof of the frequent sequence (as effect) of organic cardiac disease after Bright's lesion of the kidney.

He quoted the opinions of Dr. Lees and Sir Benjamin Brodie as to the frequency of death by renal disease after operations. Many cases of Bright's disease are

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Further details in Appendix No. 1, Session No. 2.

frequently overlooked and treated for other maladies, as dyspepsia, &c. According to Dr. Watson, cardiac disease is a frequent sequent of Bright's lesion. From these statements and his own experience, he was firmly convinced of the high importance of ascertaining the state of the kidney, more especially in commencing to treat any affection of the circulatory organs.

Dr. MALCOLM believed that the weight of evidence was by no means so much in favour of Dr. L.'s view as his remarks would lead the Society to suppose. Thus Dr. Watson, (vol. ii. page 627.) speaks of disease of the heart as a very frequent accompaniment of the morbus Brightii, and of both as sometimes results of a common cause. In an analysis of one hundred cases, adduced by Dr. Bright, and on which Dr. L. lays great stress, it appears that thirty-four were instances of hypertrophy without valvular disease, and as of these eleven presented aortal lesion which was sufficient to induce hypertrophy, we can in fairness only ascribe a nett of twenty-three per-cent. due to the account of renal lesion. Again, Dr. Williams puts this point in the following terms:—"In time, the strong pulse accompanying hypertrophy of the left ventricle may cause an increased or modified deposition of nutriment in the different tissues which it reaches, particularly the parenchyma of viscera. The kidneys offered the best illustration of this, because they receive their blood only from the arterial system. In hypertrophy of any standing they are generally found enlarged and otherwise diseased, and often presenting the granular albuminous deposit which has been described by Dr. Bright."

In the second volume of the London Monthly Journal of Medical Science, page 469, he further calls the renal complication in the course of heart diseases, by the term "secondary;" and at page 502, employs the following more decided expressions:—"frequently observed albuminaria to result as a secondary affection from disease of the right side of the heart, causing a general congestion of the venous system."¹

M. Rayer is still more firmly of opinion that the kidney affection is oftener the consecutive, and lays down the proportion of twenty per-cent. as representing the frequency with which the heart disease occurs in Bright's lesion; and lastly, Dr. Copland, vol. ii. page 650, distinctly declares that interrupted circulation through the heart and lungs favours remarkably the occurrence of the chronic states of Bright's disease.

Dr. FERGUSON did not consider that Bright's disease and cardiac disease stood in the relation of cause and effect, nor did he think that any of the facts adduced by Dr. LYNCH could be deemed evidence in favour of that view.

Dr. MACLAUGHLIN likewise did not consider the heart complication as an effect, though it may supervene

upon the renal disease.

C. Mr. WALES read the notes of a case of bronchitis occurring in the person of a muslin gas-singeer, in which the expectoration was so charged with charcoal as to resemble that of pneumonia. [The singeing of muslin was done to remove "all superficial knots and irregularities" from the finished cloth.]

The proprietor of an establishment for singing muslin, after having been ill some days, sent for me. I found him complaining of oppression; slight pain in the throat; headache; thirst; pulse 115; respirations 30; great prostration of strength; tongue perfectly dry, hard and brown, inclined to blackness in the centre, though moist on edges and under surface; teeth and gums thickly covered with sordes—cough frequent and painful, attended with difficulty of expectoration; the latter extremely viscid, very slightly aerated, and in parts black, brown, yellow, &c.—Percussion-note natural throughout, except below the eighth rib, at the right interscapular region, where the sound was of a doubtful character.—Vocal fremitus very distinct throughout on auscultation; occasional mucous rales: the sonorous and sibilant distinct only on quick inspiration or coughing.—Absence of respiratory sound, in the part doubtful on percussion. From the foregoing I feared the co-existence of pneumonia. On examining the sputa again, and enquiring as to the time it became dark, I was informed that such was the usual colour. I had frequently remarked the suddenness with which my patient's tongue became dry and brown when only slightly unwell, but never before observed the expectoration, and probably would not then, but for the bronchitis. Led to re-examine the chest at the suspected part, I succeeded in hearing the respiratory murmur there, after a severe coughing fit, which brought away the obstruction. The removal of all doubt as to the condition of the part suspected, together with the explanation of the apparently pneumonic sputa, enabled me to decide on the simplicity of the case.

I have repeatedly attended this gentleman in numerous bilious and other slight attacks; and on all those occasions his tongue (though quite clean-looking in health) became dry and brown in a few hours, like one in typhus. I have observed a similar occurrence in one of the workers, so that as to the cause there could be no doubt. It is usual for workers to expectorate the coloured matter after five or six weeks' absence from the cause. The hints derivable from this case are not valueless, nor are the effects of the inhalation of these carboniferous particles unimportant in the consideration of their semblance to pneumonia alone. On the contrary, there are few diseases in which the diagnosis and prognosis might not suffer by the appearance of sordes on the teeth, and dry brown tongue, independently of the coloured sputa, which latter could scarcely be a stumbling block in the absence of an inflammatory state of the thorax. This case serves to illustrate the importance of considering how far the avocations of the patient may influence symptoms; it is likewise interesting, showing with what impunity the respiratory mucous membrane will bear the continued contact of these particles without inducing a diseased condition—the workers, so far as I am able to learn,

¹ I have long observed and taught that hypertrophy of the heart commencing occasions hypertrophy as well as change of structure in all the parenchymatous viscera. This has been most satisfactorily proved by Dr. Clendinning in a series of numerical observations of great value.—(See page 251.)

being as healthy and free from chest affections as any other class of operatives.

Dr. FERGUSON related a case of cardiac disease in which the expectoration, bore a marked resemblance to that of pneumonia.

The PRESIDENT observed, that several years ago the black tinging of the sputa of the workers in the English coal mines was the subject of discussion in the Medical Journals, and has been noticed in all systematic works since. He instanced the case of a gentleman yet alive, who was accustomed to expectorate mucus tinged with black. Perhaps as analogous phenomena, he has noticed the tongue loaded with almost black secretion as if stained with ink, and also a rare instance of the rapid cleaning of the tongue after bleeding, in the person of a prisoner in the jail who was under his charge. It was a case of pleurisy; the tongue much loaded when the arm was tied up, but perfectly clean immediately after the vein was secured. The individual was bled almost to faintness.

THE TWENTY-SIXTH MEETING.

April 15th, 1854.

Robert Stewart, M.D. in the Chair.
Attendance:—Members, 13; Students, 10.

CI. Dr. JAMES MOORE exhibited a specimen of *Carcinomatous tumour of the femur*, removed by operation.

A female, aged twenty-seven, (but with the aspect of forty-five,) began to complain, two years ago, of a pain in the middle of the thigh at outer part. For this she had been repeatedly blistered, and was variously treated under the idea of its being rheumatic. In the course of some months a slight swelling appeared at the painful part. This was repeatedly leech'd, blistered, and poulticed, without any good effect, as it continued to progress steadily and cause much uneasiness, for which she had recourse to opiates and other sedatives. When she came under my observation (about January ult.), the tumor had recently and rapidly attained the magnitude of the head of a new-born child. It was very firm, unyielding, of an irregularly globular shape, but broader at the base, and presented the usual characters of an osseous growth. Her general health was much impaired from the depressing effects of the pain; and she had the cachectic appearance of malignant disease. To the removal of the growth, by amputation, she at first objected, but after a fortnight's delay, she consented to enter the Hospital for the purpose. The operation was performed in the usual way, but the bone was divided near the trochanter, in order to secure a healthy section. No untoward circumstances occurred during, or connected with, the operation; but in consequence of constitutional debility, the stump healed with difficulty, and suppuration from the lumbar region, (where there was a bed-sore), traversed along the psoas, and discharged at one part of the stump, which was thus kept open; and after the lapse of some months, she succumbed. For the purpose of carefully examining the tumor, all the soft parts were dissected off the bone, leaving the tumor entire and exposing its structure, which consisted of

cancerous matter deposited in the hypertrophied and expanded cancelli. After maceration the peculiar spiculated appearance was well shown.—(See figure in Plate.)

CII. Dr. MALCOLM opened the debate on the question—*What is the approximate cause of anasarca after Scarlatina?* by remarking that there was still a considerable variety of opinion with regard to the share which the kidneys had in the production of scarlatinous dropsy. From the cases he had examined, he believed that these organs were always engaged, and that they were in the state, designated by Johnston, "desquamative nephritis." In support of this view, he referred to the experience of Dr. Prout, who at page 129, thus lays down his opinion:—"The immediate cause seems to consist in an inflammatory state of the whole system, involving the kidneys in particular;" and Dr. West, a special authority on the maladies of children, states at page 429 of his admirable work, that albuminous nephritis, in by far the greater number of cases, is met with as a sequel of one of the eruptive fevers, generally of scarlatina.

Dr. LYNCH believed the essential cause to be a morbid state of the blood; and that to free purgation, the anasarca generally yields.

Dr. FERGUSON said the French practitioners view it as formidable, but in his experience treatment was generally successful. As to its pathology, there is no evidence to show that it is nephritis. There is, in his opinion, an inflammatory condition of the cutaneous textures, and he considered the serous effusion a sufficiently valid proof of at least sub-acute inflammatory action. The lungs are constantly congested. There is no doubt a morbid state of the blood present, but the present affection is ulterior. With these views, he deemed the antiphlogistic treatment the only true, safe, and rational one. At the same time, he believed that the original disease, scarlatina, was asthenic in its nature.

Dr. HALLIDAY has observed both hydrothorax and cerebral effusion in cases of scarlatinous dropsy.

Dr. PIRRIE believed that renal congestion was always a precursor, and due to suppression of the cutaneous processes going on, and expressed his dissent from the opinion that it was produced by inflammation of the subcutaneous cellular tissue.

Mr. H. M. JOHNSTON deemed the evidence adduced in favour of there being cellular inflammation, quite insufficient to prove the allegation. He would certainly expect that if there existed even a slight degree of inflammation of a membrane so extensive, we would have much more constitutional irritation.

CIII. Dr. FERGUSON read brief notes of cases, showing the efficacy of quinine in sciatica, and opium in acute rheumatism.

R___, æt. 60, suffering from sciatica for a year: wasted limb, almost paralysed; remissions but no intermissions of pain. After purgation, put on Quinæ sulphas, March 4; took, up to March 15, 168 grains; convalescent; and then, (in gradually diminished doses,) up to the 23rd, took 135 grains, in all 303 grains, without an unplea-

sant symptom except a sense of fullness in the head on the 23rd which entirely disappeared on the 24th, on which day he was discharged.

M___, æt. 35, wrists, shoulders, and ankle joints highly inflamed. After a preparatory purgative, took from February 21st to 28th 30½ grains of extract. opii. aquos.; diarrhoea setting in on the 28th, caused the dose to be reduced to three grains in the twenty-four hours. No relapse; for a few days put on iodid. potass.; and then discharged.

F___, æt. 15, very acute rheumatism; from March 19th to 28th, took 39 grains of extract, opii. aquos, with solely one enema; convalescent in nine days, and discharged.

H___, æt. 40, intensely acute rheumatism; from April 1st to the 11th, took 72 grains of extract opii. aq.; no other medicine. About 12th, convalescent.

In no case, narcotism; in all, bowels free save in F___'s case; in one, smart diarrhoea which ceased on omitting opium; in no instance pericarditis.

Dr. HALLIDAY mentioned that Dr. Corrigan, Dublin, had employed this form of treatment so successfully many years ago, that his name has been generally associated with it in medical literature.

CIV. Dr. JAMES MOORE exhibited the contents of an encysted tumour recently excised from the neck at the junction of the sternomastoid and omohyoid.

This tumour presented a bruit on stethoscopic examination, and might have been readily mistaken for an aneurism of the carotid. The cyst was opened but not removed. The matter contained was cream like, and of the consistence of soft cheese. This case had been seen by other practitioners, but non-interference was recommended.

THE TWENTY SEVENTH MEETING.

22nd April 1854.

The President in the Chair.

Attendance:—Members, 14; Students, 14.

CV. Dr. LYNCH exhibited a femur and tibia which had been fractured, and in which union with great distortion had taken place.

CVI. Dr. MALCOLM exhibited a tumour which had been excised from the breast by Dr. WM. MOORE, Ballymoney, who supplied the following particulars:—

(March 14, 1854.) Mrs. P., aged about 50 years, mother of six children, a healthy woman, of a spare habit of body, consulted me about a tumour of the right breast, which she stated had existed there for more than a year. On examination, I found a hard nodulated tumour with considerable lateral attachments: the skin over the tumour of a livid hue: glands in the axilla not implicated. The patient stated that she suffered no pain from the presence of the tumour, which, with this exception, partook of all the other characters of malignant disease. After a careful examination, I advised excision of the part before the adjacent structures would become more deeply implicated.

(March 18.) I removed this tumour with the cellular

tissue surrounding the nipple, down to the pectoral muscle, dressed the wound with adhesive plaster, and prescribed an opiate.

(March 23.) Wound healed by the first intention. The case terminated most favourably.

The peculiarities in this case are, lividity of the skin covering the tumour, and its extreme hardness; in short, all the characters of malignancy except pain. I may also remark, that a considerable amount of mental uneasiness was a principal feature of the case.

The PRESIDENT related a case, in which the gland between the axilla and breast became first affected, then the nipple. It was originally fibrous, but ultimately assumed a malignant character.

The gland was removed, and no cancer cells discovered by the microscope. A few years afterwards, the malignant disease re-appeared, at first nearer the axilla; the cicatrix and breast became implicated, and the patient eventually died.

CVII. Dr. MACLAUGHLIN exhibited a heart, presenting hypertrophy of both ventricles.

The right ventricle was the part principally affected. There was a great quantity of fluid in the pericardium, also in the right pleura. The case was that of a female, aged 22, who was brought into the hospital moribund, and who lived but a few hours. Bronchitis, with intense lividity, was present. There was general oedema; and purpuric spots appeared where croton oil had been applied. The lungs were also emphysematous.

The PRESIDENT related a case of a gentleman who was attended by Mr. Hey, of Leeds. The heart was enormously hypertrophied and the aorta dilated. This gentleman was particularly fond of music. It was a remark made by the late A. Colles, as the result of some experience, that a large heart was indicative of an avaricious disposition.

CVIII. Dr. MALCOLM read some notes illustrating the value of small and frequently repeated doses of mercury in the pneumonia of children, and cited the following case from his own practice:—

James M'N___, aged 18 months, was brought to me some time in June, 1848. The mother reported that he had taken ill three days previously with cough, dyspnoea, restlessness, hot skin, and other feverish symptoms. The pulse at this time was 140, tongue furred, skin intensely hot, respiration exceedingly difficult and catching, attended with frequent moaning. Upon examination there was a marked and fine crepitating rale at the left infra-scapular region, circumscribed, and limited to that part. There was exaggerated respiration elsewhere. No comparative dulness could be observed on percussion. I ordered three leeches to the side, and four grs. of calomel, with four of hippo, divided into 24 powders, one to be given every hour. (2nd day.) Pulse 126, skin moist, but still hot, respiration much easier, and child disposed to sleep. Upon examination, crepitus much coarser and mixed with vesicular respiration. (The powders to be given every three hours only.) (3rd day.) Pulse 120, still improving, temperature a little lower, breathing same, crepitus slight and coarse, and vesicular murmur more

marked. After this he gradually improved, and within a week was freed from all fever, slight cough alone continuing for a few days afterwards. Dr. Law, of Dublin was the first who directed attention to the mode of giving calomel in very small doses, in a paper in the Dublin Quarterly for 1839; and since, Professor Thompson, of Paris, Dr. MacLagan, of Edinburgh, and Dr. Alexander Fleming, of Cork, have used it with great success in various acute diseases. Trousseau divided one gr. of calomel into 24 powders, and gave one every hour, in rheumatic fever, peritonitis, iritis, &c., and continued it for two or more days till the gums were touched; and in children's cases, every three or four hours, which was found to bring the system under the mercurial influence in five to eight days. Hebra, of Vienna, was in the habit of ordering 1-24th gr. of the bichloride three times daily in syphilis, lupus, &c., which induced constitutional effects in eight to twelve days.

As to the *modus operandi*, M. Mialhe has thrown out the idea that calomel in very minute doses undergoes transformation (into the bichloride, in consequence of the contact of an alkaline chloride, and consequently, he says, it is immaterial whether 1 gr. or 1 dr. of calomel be administered, as only a very small quantity can possibly be converted into the bichloride. Accordingly, the addition of common salt has been recommended to aid in this conversion; and, *apropos*, seamen are, proverbially, readily affected by calomel.

Dr. FERGUSON made some observations upon the *modus operandi* of calomel, and contrasted the effects of it and the bichloride. He considered that too much stress was laid upon the necessity of mercurialization, and was of opinion that this result was by no means required in all cases. He suggested that the ipecacuanha may have had some influence in Dr. M.'s case. As to local depletion in infants under eighteen months, he believed it was more likely to do injury than good.

Dr. YOUNG had several cases of pneumonia lately, and had not leached in a single case. Two had been given up. Blistering and small doses of calomel, with antimonial or James' powder had brought them all safely through. Salivation was not necessary. Hippo he considered a most valuable medicine; as, according to Dr. Budd, it increases the action of the mucous membrane, and tends to relieve the congested state of the air-cells. In corroboration of the efficacy of small doses of calomel, he mentioned a case of iritis, in which he had tried three grain doses, three times daily for a fortnight without effect. He then divided one grain of calomel into twelve powders, which brought on salivation in a single day.

Mr. WALES had had lately fifteen cases of capillary bronchitis in infants. Thirteen were leeched and recovered: two died. The latter were not depleted.

Dr. MACLAUGHLIN spoke favourably from experience, of the use of the 1-12th grain doses of calomel administered every hour in acute cases, in the chronic forms small doses failed. He never saw constitutional effects in children from the use of this medicine.

The PRESIDENT related a case of strumous hip joint in a child three years old, in which a very few doses of mercury salivated. He has known two to three grs. of

Hyd. c. creta. produce this effect, when in others 100 grs. in 24 hours failed. Nevertheless has found the small-dose system fail as often as succeed. Minute doses of Pil. Hyd. he found useful in Phillips' duodenal Dyspepsia; and the same of the bichloride in scrofulous ulcer of the pharynx.

CX. Mr. ARMSTRONG exhibited a patient affected with gonorrhoeal ophthalmia, in whom the cornea was sloughing. He remarked that these cases, when seen early, seldom failed to recover under the free application of the nitras argenti.

CXI. The PRESIDENT exhibited and explained the use of Hardy's obstetric douche.

THE TWENTY-EIGHTH MEETING. 29th April, 1854.

Robert Stewart, M.D., in the Chair.
Attendance:—Members, 8; Students, 8.

The CHAIRMAN gave notice that nominations for office-bearers would be received by the Secretaries up to 20th May, proximo.

CXII. The SECRETARY read a paper contributed by the PRESIDENT, involving a difficult point in Medical Jurisprudence. It ran as follows:—

I was directed, with the late Dr. Sanders, Belfast, to examine the person of a female who had died under the following circumstances:—Early on the preceding morning she had had a dispute with her husband, and about eleven A.M., was seen by, I believe, Dr. S., sitting up in bed in a very exhausted state with a small wound under the right breast. The pulse being feeble, she was allowed to take some spirits, after which she almost suddenly died, having conversed sensibly with different parties up to the last moment. She neither blamed nor exculpated her husband. His account at the inquest was, that he left a quarter-inch chisel on his hat, which was on a box at the door inside the sleeping room. They were disputing about a clean shirt which he wanted to put on. He shoved her out of the room into the kitchen, when she turned round and said, "Oh, Robert," and fell in the floor, and then he saw the chisel in her hand.

A post-mortem examination twenty-four hours after death, elicited the following:—No bruises on the body; a very small punctured wound about two inches below the right nipple. On tracing the wound, it passed immediately under the skin transversely across the chest to the left side; stopped abruptly opposite the costal extremity of the cartilage of the fifth rib, where it turned back, pierced it, and entered both cavities of the heart within about an inch of the apex—of course, piercing the septum, but not the posterior wall. There was a large quantity of blood in the pericardium, but very little outside, and little or none along the course of the wound. Query—How was this wound made?

There could have been no struggle against a hand inflicting one with such an extraordinary course. The tool corresponded with the wound in the cartilage, and

was only four inches long. Had there been a struggle at the angle of turning, there would have been a spreading of the canal in some manner, but there was none. It occurred to me that the woman had been holding the chisel—the point towards the side, had been driven against some resisting body, and then turned whilst the impulse was continued—thus altering the direction of the force. On examining the sleeping-room where the struggle was said to have occurred—upon the wall, close to the door frame, and about eighteen inches from the ground, were two jets of blood, indicating that the wound had been given near this; and this was the only trace of blood in the sleeping-room; and on scrutinizing the place more particularly, the white-wash was slightly rubbed off in a small patch from the casing or door frame, at the height of the wound on the right breast. Hence, it appeared to me, the whole mystery was unravelled, corresponding accurately with the lame and extraordinary story of the husband. In the struggle, the wife holding the chisel perhaps in a threatening manner, stood with her right side towards the door. Her husband endeavoured to push her into the adjoining room; in the scuffle which ensued the handle caught on the door-frame, entered and passed across the chest, when changing the direction of the impulse he turned her forwards, and with the shove, intending to send her possibly on her face, the cartilage, &c., were transfixated. At this moment, the two jets of blood gushed out along the tool, and struck the wall. The force being still continued, she staggered into the kitchen, and, there pulling out the weapon, fell.

The individual was acquitted, solely, I believe, on this evidence, as the crown lawyer considered it a "very bad case."

Mr. AICKIN remembered the trial of this man, and the general impression coincided with his own, viz., that he was guilty.

CXIII. Dr. MALCOLM submitted statistics to show the tendency to phthisis in Diabetes Mellitus.

NO.	SEX.	AGE.	P.M. EXAMINATION OF LUNGS.	AUTHORITY.
1	M.	Adult.	Tubercular consolidation at apices.	Am. Quarterly, 1853.—C. Frick, M.D.
2	M.		Lung healthy—adhesions.	Ditto.
3	F.	9	Adhesions, bronchitis, No tubercle.	Edin. Journal I., 314.
4	M.	—	Tubercle.	Lon. Med. Trans., IV—Warren.
5	—	—	Do.	Edin. Journal of 1818.
6	—	—	Do.	Do.
7	—	—	Do.	Do.
8	M.	9½	Lungs healthy.	Lancet, 1850—Becquerel.
9	M.	17	Tubercle.	Do. 1843.
10	F.	13½	Do.	Do. 1845.
11	M.	36	Lungs healthy.	Do.
12	M.	49	Do.	Dr. Watts, Nottingham.
13	M.	11	Do.	Lancet, 1846.
14	—	—	Tubercle.	" 1847—Francis Manc.
15	M.	23	Do.	" 1834—Hutchison,

NO.	SEX.	AGE.	P.M. EXAMINATION OF LUNGS.	AUTHORITY.
16	M.	30	Pneumonia of left lung.	" 1836—Elliotson.
17	M.	5	Lungs healthy.	" 1826—Venables, Healy.
18	F.	50	Tubercle.	" 1846—Vanqueler.
19	M.	62	Do.	Times and Gazette, 1854—Jones.
20	—	—	Lungs healthy—pleuritis.	Dr. Bardsley.
21	—	—	Tubercle.	Do.
22	—	—	Do., and mesenteric glands affected.	Do.
23, 24, 25	—	—	Lungs healthy—mesenteric glands in 2 affected.	Do.
26	—	—	Tubercle.	MM. Dupuyten—Thenard.
27	—	—	Lungs healthy—mesenteric glands affected.	Dr. Bardsley.
28	—	—	Do.	Dr. Forbes.
29	—	—	Tubercle.	Maracet., Lon. vol. ii.
30, 31	—	—	Do.	M'Intosh, Pr. of Phys. vol. ii.
31			16 with tuber. l5 healthy.	

The manifest result of these statistics is to show that phthisis is almost the necessary consequence or cause of death in young adults; inasmuch as it appears that 50 per-cent. were phthisical; while it is well known that a large proportion of diabetic cases occur in advanced age, and consequently, die from other lesions.

Dr. M., in corroboration of this view, adduced the opinion and experience of several leading authorities. Thus, Dr. Watson, (p. 602, vol. ii.) writes, "It (diabetes) often becomes associated in its progress with pulmonary disease, especially with tuber. phthisis. So common is this, that some persons have thought it universal, but it is not so. I have myself witnessed more than one or two dissections of persons dead of diabetes, whose lungs did not contain a single tubercle."

Dr. Wood, United States, (p. 577-9. vol. ii.)—"Tubercles are often developed in the lungs." "In the great majority of instances the patient dies of phthisis."

Dr. Copland, in the article "diabetes," p. 509—"I have never seen a case examined in which they (the lungs) were perfectly healthy."

Dr. Prout, p. 31—"As the disease proceeds, disorganization of some important organ, particularly of the lungs, commences or becomes active." P. 34—"Phthisis is the most frequent termination."

Mr. Ancell, (p. 602)—"The greater number of cases of diabetes become complicated with tuberculosis pulm. before death."

Dr. Elliotson, (1839, p. 980)—"The most common terminations of diabetes are phthisis and mere exhaustion."

From a consideration of these data, it will strike any reflecting mind, first, that the phthisical tendency should be anticipated in the treatment, for with Dr. Watt, of Glasgow, (1814)—"I must say I can hardly conceive anything more frivolous or puerile than to see

men of common sense pleasing themselves, and building their hopes on drachms and ounces of urine, while death from every other quarter is staring them broad in the face." And secondly, that in cases of suspected phthisis, the urine should be examined for sugar.

Dr. FERGUSON'S experience coincided with the result of these statistics. He had long viewed it as a disease occurring in the tubercular diathesis. Diabetes, nevertheless, is not unfrequent in old age, while we all know that phthisis prevails between the ages of fifteen and thirty-five. Occasionally we meet with cases of phthisis, however, at advanced life. Laennec has seen it at the ages of sixty, seventy, and even ninety. In a practical point of view (which, it should be remembered, should be the aim of all our observations here), the connection established by Dr. Malcolm's statistics is of much importance, as phthisis is too frequently overlooked in the management of diabetic cases. We are too easily satisfied with noting the condition of the urine. Regarding the prognosis of veritable cases of diabetes mellitus, Dr. F. expressed his firm conviction that a perfect re-establishment of the health was exceedingly rare.

Dr. ROSS suggested the use of ol. jec. aselli, as a corollary to the pathological view which the tables indicated.

Mr. AICKIN many years ago observed carefully as many as ten to twelve cases, without any appreciable disease of the lungs being discovered.

CXIV. Dr. MALCOLM drew the attention of the society to a few clinical facts in connexion with cases of eczema, presenting unusual coexistent and secondary disorder; and in introducing the subject, referred to the erroneous but too prevalent idea that cutaneous maladies were an isolated class of diseases, and were only to be met by specifics, or at least some peculiar line of treatment. So far back as 1792, Jackson, of Edinburgh, held a more correct view. In his "Dermato-Pathologia," he very justly observes, "the skin ought no longer to be called a common integument, but should be looked upon as an organ of the first consequence to all the functions of human life, and connected with all its diseases." There are three points of importance to be remembered in treating a case of eczema, viz., the causes, the condition of system under which it may appear, and the consecutive affections. The two latter are of special moment. Inflammatory diseases of the mucous membrane, for instance, are common complications, and may alternate with the appearance of the cutaneous malady. As Bayer observes, "The interchange of internal and external inflammations is well worthy the attention of the pathologist and the therapist." And as for consequences, "when children and the aged are the subjects of eczema, it often proves a disease which it is dangerous to cure." Alibert even more forcibly remarks, "The best advice which can often be given to patients advanced in life and of infirm constitution is, not to attempt the radical cure of such an infirmity as chronic eczema, if the disease be at all endurable." Without endorsing, *in toto*, such a sweeping assertion, Dr. M. related two cases which occurred in

his own practice, which, in the main, bore out the justice of the French apprehension. In one, a child, pneumonia supervened almost immediately after the cure of a chronic eczema of the leg; and in the other, an elderly man who had had the same disease in the same part, hemiplegia was the consecutive. From these facts and opinions, Dr. M. submitted the following hints as manifest corollaries:-1. That in every case of eczema, a careful examination of other organs should never be neglected, and any disorder ascertained to co-exist, treated first. 2. In the event of a negative result from such an examination, we should anticipate cerebral and gastro-intestinal affections by establishing a drain in some convenient situation, and other appropriate treatment, in conjunction with the means used for removing the cutaneous affection; and 3rdly, we should remember the special danger to which the aged and the very young subjects of eczema are liable, and act with peculiar caution accordingly.

Dr. ROSS has observed that the disease has been allowed to run on, through a mistaken idea, that the patient would suffer by attempting the treatment. In children, in whom the relations of organs are so close and so readily manifest, it is of importance to guard against the engagement of any internal organ while treating the disease. He deprecated the sole use of local remedies, but he had never seen injurious effects following the cure of eczema by judicious constitutional and local treatment.

Mr. JOHNSTON observed that amongst the more difficult cases to manage, were the forms connected with varicose veins and ulcers.

THE TWENTY-NINTH MEETING.

May 6th, 1854.

Robert Stewart, M.D., in the Chair.

Attendance:—Members, 12; Students, 12.

The SECRETARY read the list of NOMINATIONS for Office bearers and Members of Council brought up to this date.

CXV. Dr. JAMES MOORE exhibited a coloured sketch representing excessive œdema of the scrotum, &c., in a case of anasarca, and briefly adverted to the history. The patient was a man, aged sixty, who had been in Hospital lately in the physician's ward, whose scrotum, &c., were so infiltrated with aqueous fluid, that his interference by operation was requested. He accordingly made a few free incisions, and a wash-hand basin was soon filled with the liquid. It was the most extraordinary case of the kind he had met with for enormity of proportions. There is great danger from the risk of gangrene in these cases, unless the tension be removed sufficiently early, and it is yet an undecided point, whether this relief should be afforded by mere puncture or free incisions.

Dr. FERGUSON stated that it is also a questionable point how far such manual interference is of utility. In the case before the meeting, (which was under his care,) a certain amount of diffuse inflammation of the cutaneous texture ensued, which was attended with

marked depression, hiccup, and other serious symptoms. From this perilous condition, however, he recovered and left the hospital, and is still alive at this date.

Dr. BRYSON remarked that pressure has hitherto sufficed with him to relieve anasarcaous swelling of the scrotum, particularly that which follows scarlatina. This can be best accomplished with wadding stuffed into a bag attached to a suspensory bandage.

Dr. HALLIDAY had always made small punctures, and never observed any bad effects.

Mr. JOHNSTON has seen in the Dublin hospitals incisions one inch in length made over and above each malleolus in such cases.

CXVI. Dr. JAMES MOORE exhibited a coloured drawing representing *naevus of the upper lip*, in a patient aged twenty, enjoying good health. The surface occasionally ulcerated, and on several occasions the tumor had the usual appearance externally, but when the finger was introduced to make an internal examination, it felt precisely like a bag of earth worms, pressing upon the teeth and gums and three-fourths of an inch in depth. It bled, and that profusely at times. The tumor engaged the upper lip and angle, and especially the internal or gingival portion, the cheek and a small part of the lower lip. In this case, he tried the injection of the perchloride of iron, as recommended by Collingwood. The patient became faint at the moment of injection: the tumor swelled immediately afterwards, and a clot was distinctly felt. In eight days' time, it swelled again, and appeared extending. The operation was repeated. Faintness ensued as before. The tumor enlarged, and a second clot was formed. These clots disappeared, but the tumor re-assumed its former appearance. D. M., then, recommended the ligature to strangle all the parts engaged, and described the mode of performing this procedure as follows:—A pair of polypus forceps is to be introduced—thus, one blade into the inside of the mouth, and the other externally; thereby pressure could be made so as to command the circulation through the tumors. Another pair should be introduced at the opposite side of the tumor and similarly fixed. An incision is then to be made right across the tumor to the commissure of the lip through the skin, which should be dissected off the tumor. An ordinary pile-ligature needle, provided with handles, is introduced continuously at several points, so as to include about half-an-inch, and this procedure to be repeated all round the tumor. In this way the diseased structure would slough off and leave the skin intact. This operation was not performed, in consequence of the patient leaving the neighbourhood.

Dr. J. MOORE in reply remarked, that heated needles had been recommended for coagulating the blood; but he had not had any experience of this plan.

CXVII. Dr. LYNCH exhibited a patient suffering two months from *lumbar* (and probably *psoas*) abscess, which manifested itself by a fluctuating tumor, not coloured, and but little sensitive, in the lumbar region.

Upon the recommendation of the COUNCIL, the revision of the LAWS of the society was now proceeded

with, and the alterations suggested by them severally considered.

THE THIRTIETH MEETING.

13th May, 1854.

J. C. Ferguson, M.B., in the Chair.

Attendance:—Members, 15; Students, 5.

CXVIII. Dr. LYNCH exhibited the recent parts in a case of a cerebral disease. There was decided *meningitis*. Ten oz. of effused fluid in the arachnoid, with some lymph deposit, were observed. A few notes are subjoined.

Richard M'A___, aged 16, a clerk, was admitted into the General Hospital on the 9th inst. It was reported that he had been fourteen weeks ill, suffering from severe headache and pains in sides, with much accompanying debility. The headache was principally referred to the left temple. On the 6th, he began to wander slightly, and complained excessively of the headache. On 7th, symptoms were aggravated, and an incipient comatose state set in, with occasional clutching and picking at the bed-clothes. On admission the coma was complete. The pulse full, 98; skin hot and dry; pupils dilated; and bowels confined. The usual treatment was fruitlessly put in force. He died on the 10th inst.

CXIX. Dr. MALCOLM exhibited a specimen of *diabetic urine*, and took occasion to allude to some points recently ascertained in connexion therewith, and also to a new test for sugar, which had been lately proposed. Three kinds of sugar are found in the animal system—viz., 1. Glucose, or grape sugar, the ordinary element of diabetic urine; 2. A tasteless sugar, sometimes observed in cases of diabetes insipidus; and, 3. Inosite, a new form, discovered by Scherer in the juice of flesh. The first is the one in question, and differs from cane sugar by being only half as soluble, less disposed to crystallize, and in health removed out of the system by combustion. Bence Jones places the animal sugars in the digestive series of chemical transformations thus:—Starch, dextrine (elimination of *insipid sugar*); sugar (*diabetes*); vegetable acids (excessive acidity). Hence diabetes is a disease characterised by an arrest of the process of digestion, and the passing off of the saccharine element. Dr. M. referred here to M. Bernard's interesting and novel experiments, which throw much light on the pathology of this disease.—(Vide *Gazette Medicale*, 1850.) These were performed on seventy-one animals, three times on man (one on the body of an executed criminal, a second on a man killed by a gun-shot wound, and a third in a case of sudden death), seventeen species of mammalia, fourteen birds, fourteen fishes, eleven reptiles, ten mollusca, and two articulata. All of these were in full health, and during or immediately after digestion. The hepatic veins were invariably found to contain glucose. When fed upon a diet exclusively *animal* for three to eight months, and after a complete abstinence of seven to eight days, sugar was still found, having the characters of glucose. He further found that section of the pneumo-gastric caused the sugar to disappear,

while simple irritations of its origin at the medulla oblongata restored it to the urine.

His general conclusions are the following:—1. That sugar is constantly present in the animal organism, and is indispensable for the purposes of nutrition. 2. That sugar is formed in the liver by a special function, and does not absolutely depend upon the kind of food supplied. 3. That the production of sugar is dependent upon certain conditions of the nervous system. Dr. M. next alluded to the practical tests for detecting sugar in the urine, and the cautions necessary to be remembered in using them. Thus the presence of uric acid and albumen delayed the process of the COPPER test. The POTASS test acts by producing decomposition of the sugar and forming saccharine acids, but a deepening of the urine tint may take place without the presence of sugar at all. The MICROSCOPIC test is uncertain, as the torulae are not peculiar. The SILVER and the old YEAST tests are, perhaps, the most certain. In the Chemical Gazette for March 18, 1850, a new test is proposed by M. Maumene, which is founded on the fact that chlorine acts upon sugar, and in all cases a brown tint is produced, which becomes a brilliant black when dried. All sugars are thus affected, and such substances as are analogous in composition, such as lignin, paper, hemp, flax, cotton, and starch. Hence it was necessary to find a substitute which was not acted on by chlorine. White merino was selected, and prepared, thus:—It is dipped in a strong solution of bichloride of tin for three or four minutes (100 parts to 200 parts water.) Drain off, and dry, on a piece of the same material, in a water bath, and it is prepared. One drop of the urine suspected, dropped on a slip of the prepared merino, and held over a piece of incandescent charcoal, or a spirit-lamp flame, will instantly exhibit a dark stain, if it contain the saccharine element. This may be named the TIN test. It possesses the advantages of simplicity and facility of use.

CXX. Dr. MALCOLM opened the debate on the question, "What should be the Basis of our Treatment in Asiatic Cholera?" by observing that it would be most desirable if the profession were in possession of data respecting this fatal scourge, which would enable them to adopt a uniform plan of treatment. At present there existed the greatest possible variety in the use of remedial agents—a variety due to conflicting theories and empirical experience. The etiology of Asiatic cholera is still, and, perhaps, will ever remain, unsettled; and at least six different opinions respecting its nature have found advocates, thus:—1. A peculiar epidemic constitution of the atmosphere. 2. A poison, propagating itself solely by emanations from the bodies of the affected. 3. Dr. Snow's theory—a peculiar poison, received into the system by the alimentary canal, and disseminated by contaminated water, &c. 4. An atmospheric poison, reproduced only in the air. 5. Cholera matter, or poison, produced in the atmosphere by a species of ferment, and distributed, by human intercourse, through the medium of clothes, ships, &c.; and 6. A combination of opinions two and four. It is plain, then, that nothing settled in the management of cholera can be deduced from a contemplation of these

opposing theories. The fact is, there is nothing about which a unanimity prevails in the profession, excepting the bare features of the disease, its symptoms, and its morbid changes and results. It is, then, from these alone that we can hope to arrive at anything like uniformity, or at least plain views of what is to be done in commencing our plan of treatment. Even the proximate cause fails to elicit uniform views. Thus the phenomena presented have been, by several writers, likened to a fever, of which the cold and hot stages will be resembled by the collapse and reaction of cholera. The analogy seems, to say the least, far-fetched, inasmuch as reaction is but secondary, and collapse the exception in cholera. Again, the phenomena presented have been considered, by some authors, as due to a gastro-intestinal phlegmasia; but we need not delay upon this, as no uniform pathological evidence exists in its favour. Others consider that the blood is the part vitally altered, by the loss of its essential salts; and a fourth view is content with an indefinite engagement of the ganglionic system, as the solution of its pathology. Now, it is plain, deliberation upon these opposing views cannot assist us in laying down our plan of treatment with confidence. We must, then, again resort to the bare facts or natural history of the disease, not, however, omitting to employ all the aid which thorough examination of the fluids and solids may supply. There cannot be a question that the gastro-intestinal tract is in a state of irritation, and that the blood loses its watery element, mainly from this source. Secondly, that the secretions are suspended or greatly diminished, and that certain excretions are retained in the blood. Thirdly, that the circulation in all the capillaries is greatly obstructed, and a stasis produced favourable to the present elimination of albumen and productive of collapse, and ulterior reactive congestion; and 4thly, that death may result in reaction after many days, from uremia.

Using then these facts as basis, Dr. M. should deem the following plan of management to be a legitimate deduction therefrom;—1st, To apply a sedative in the first instance by way of counteracting the irritation set up in the gastro-intestinal tract. 2nd. To promote secretion or capillary action, to counteract the tendency to stagnation of the circulation, and consequent arrest of secretion; and 3rdly, To moderate the violence of the reaction, and prevent its tendencies, by appropriate eliminative remedies; not omitting to remember the necessity of restoring the impaired tonicity of the system by tonics, &c. in convalescence. In the realization of this view, a variety of remedies may be of course employed as the same object may be gained by different means. There is no specific.

Dr. M. concluded his observations by advertizing to the result of his experience in the epidemic of 1849, as embodied in a paper published by him in the "Medical Times," (vol. xx. p. 157.)

Dr. MACLAUGHLIN (Lurgan), observed many cases in the last epidemic (1849), and had employed various treatment. The large opiate plan (Dr. Hawthorne's, Liverpool,) he had tried in six successive cases: four died, and all had consecutive fever. He then resumed the mercurial treatment, and fancied that, single-

handed with this medicine, he had had a less mortality than with any other. He never saw a case of true collapse without previous evacuations, and on post-mortem examination never observed any distinctive morbid appearances.¹

Dr. LYNCH had had a long experience in Asiatic cholera, as he practised in the Cholera Hospital so far back as 1832, yet he still wished to know something of its pathology. His view might be concisely expressed by stating that there was a redundancy of the function of excretion, and a suspension of that of secretion, and as a natural consequence, prostration and the other characteristics of a true case of the disease. There was a great analogy to typhus cases. The renal and hepatic apparatus were especially obstructed; and the indication, therefore, he believed to be to arrest the excretory process and promote secretion, which he thought could not be better accomplished than by calomel and opium in combination judiciously administered.

Dr. HALLIDAY was less and less disposed to trust to any remedies. He said so from much experience. He believed there was a poison generated which, acting upon the nervous system, produced the phenomena called Asiatic cholera, and agreed with Dr. MACLAUGHLIN, that previous discharges are necessary ere collapse can occur, at least in the great majority of cases. He gave opium largely at first, and afterwards, amongst a host of remedies, he preferred the use of turpentine in half-drachm doses every half hour; and related a case of a patient who was pulseless for eight hours after one day's illness, who recovered completely in forty hours, with very slight consecutive fever. In the cold stage, calomel he could not rely on; and astringents were utterly useless in the confirmed disease.

Dr. ROSS would treat cholera according to its stages. In the first stage, or that of premonitory diarrhoea, he would give opium, sulphuric acid, and other astringents. In the second stage (collapse) he relied on the free use of turpentine externally, and on small doses of calomel frequently repeated, until there were free biliary evacuations from the bowels, on the principle that Dr. Corrigan gives mercury in fever. The third stage (consecutive fever) he considered analogous to typhus fever or erysipelas, and he relied on stimulants in its treatment, combining them with nitre, if the kidneys be inactive; and with cordial aperients, if there be constipation. If the head be much affected, cold lotions or ice to the shaven scalp will be grateful and beneficial.

Dr. YOUNG, Holywood, considered the saline theory the most reasonable of any that had been offered. Dr. Stevens has clearly shown that the salines of the blood are intimately associated with electric vitality, and that the cholera poison deranges the electric equilibrium of the body, and so causes the escape and loss of the serum (water?) of the blood and its saline contents. Dr. Y. had no personal experience of the peculiar remedies, but he would unquestionably try them if an opportunity offered. He was aware that Dr. Seaton Reid,

Union Hospital, Belfast, had tried the plan and that it failed, but he was under the impression it had not got a satisfactory trial. However, of one thing Dr. Y. was certain, that alkaline drinks should be given *ad libitum*, and that the best stimulants were camphor, ammonia, chloric ether, or chloroform.

Mr. H. M. JOHNSTON thought it best to leave the collapse cases to nature. His experience led him to place reliance in the early and free exhibition of calomel and opium. He was in the habit (if he saw a case in the first stage) of giving a powder containing 3 grs. of opium, 10 grs. of calomel, and 3 grs. or 4 grs. of camphor. If soon rejected, he repeated it. As regarded remedies, he believed their efficacy was in direct ratio to their early exhibition. If he failed in checking the disease in the first and mature stages, he had little faith in medicinal agency afterwards, excepting the assiduous application of warmth and external stimulation, with permission to the sufferers to freely satisfy their insatiable thirst. Stimulants, in his opinion, were invariably injurious in the consecutive fever. He would prefer giving small and repeated doses of calomel, with diuretics.

With regard to Dr. Young's observations in reference to the saline theory, he would remark, that according to recent examination by Dr. Robertson, of Edinburgh, the amount of salines in the blood was still considerable even in the algid stage. He considered the theory a pretty one, but in practice in this town it had proved a failure. In fact, according to Dr. R., the relative proportion of salts is smaller during the period of reaction than at the commencement or during the violence of the disease. "This result," says Dr. Robertson, "is, I think, fatal to any theory which proposes to explain the phenomena of the stage of collapse by reference to the deficiency of the salts, and holds out no encouragement for the practice of injecting saline solutions into the veins during the algid stage."

Dr. FERGUSON considered that the basis of our treatment should be a knowledge of its pathology. In 1832, he went to Sunderland to observe its character; and from his experience in that epidemic, and since, he was of opinion that the disease is a poisoning, engaging the organic system of nerves, in the same way that fever is, in his opinion, a poisoning of the animal or cerebro-spinal system. The facts in the now-extended history of the disease seem to establish a remarkable analogy to fever, and like the treatment of the latter, here there is no specific. His view, then, was simply this—to check the diarrhoea with a full opiate, and repeated, if necessary, every half hour; and in collapse he would rely upon stimulants externally and internally, and the free use of iced water—a wine glassfull at a time. The assiduous employment of turpentine staves to the extremities was, in his opinion, essential. He was opposed to large doses of calomel, though this remedy in moderation he found sometimes useful in reaction. Quinine in this stage might also be a safe tonic.

¹ (Aug.) I still think the mercurial treatment mostly to be depended on. —(W. R. MACL)

THE THIRTY FIRST MEETING.

20th May, 1854.

John Aickin, M.R.C.S., in the Chair.
Attendance:—Members, 14; Students, 2.

CXXI. Dr. JAMES MOORE introduced a patient in order to show the successful result of some operations which he thought necessary to perform to relieve a permanently closed state of the jaws, and a loss of substance of the greater part of the right cheek, which supervened upon a sloughing of the cheek, during and after fever. The patient was a young man, aged 18. When Dr. M. first saw him, the greater portion of his cheek had been lost by ulceration; the teeth projected outwards; the gums of both jaws and the side of the tongue were exposed.

Any fluid taken into the mouth, on the effort of swallowing being made, gushed from the opening, to prevent which, he was in the habit of placing the palm of his hand as a covering during each act of deglutition.

About four years previously he had had fever, had been badly cared for, living in a poor cottage in the neighbourhood of Newtowndars with his mother, a widow, who also was stricken down by the same disease, during the time that his was in progress.

The teeth projecting more outwards than usual, pressed upon the cheek, produced ulceration and the loss of substance, which occasioned the exceedingly disagreeable appearance and annoyance to the patient himself. He applied to have the opening in the cheek closed.

Dr. Moore proposed in the first instance, to cut out about an inch of the ramus of the right side of the lower jaw, (as the structures at the articulation had been so agglutinated, altered, and contracted by the healing of the ulceration as to render it perfectly immovable, and seemed as though the bones had united to each other at that articulation,) and thereby to allow of motion of the rest of the bone—having belief that the other articulation was not affected except perhaps from want of use. To this the patient would not submit, stating that he was only anxious to have the opening in his cheek filled. The patient was put under the influence of chloroform, and Dr. Barnett having extracted five of the projecting teeth, an incision was made, commencing about the centre of the upper part of the opening in the cheek, and carried round, down to the lower jaw, thereby leaving a fresh cut in the healthy parts, of the breadth of an eighth of an inch, and about five inches in length.

The lower incision was then carried down under the jaw, and a nearly circular portion of skin, and subjacent tissue, rather better than two inches in diameter, was dissected off, then turned round upwards, and by a series of sutures to its inner surface and the mucous membrane, and also by a number applied through the skin of the cheek to that of the transplanted portion, it was retained *in situ*. The skin of the wound below the jaw was then brought together by some sutures and adhesive plaster. There was considerable haemorrhage during the operation, owing to the difficulty of restraining the patient when the influence of the chloroform had subsided, of which he required an

unusually large quantity.

The wound was dressed with wet lint. Two days afterwards, the threads were removed—union having taken place by "the first intention." Some months after this, the edge of the transplanted portion, and also the portion adjoining the lower lip, were made raw to two inches in extent, and brought together with sutures as before. This also healed by "the first intention." About a year afterwards he again presented himself, and expressed a desire to have a portion of the lower jaw removed, and an unseemly angular deficiency at the commissure of the lips supplied.

This deficiency was caused by the portion transplanted from the neck having contracted to about half its original superficial surface, and by accumulated fat, which presented somewhat the appearance of an elevated tumor.

At his request, he was again put under the influence of chloroform, and the operation proceeded with as follows:—A semi-circular incision was made from the commissure of the lips to the angle of the jaw, from which the tissues were dissected, exposing its surface to the extent of an inch. There was considerable haemorrhage, and great difficulty in constraining both it and the patient, owing to his excessive restlessness and energy. Having been subdued by more chloroform, a portion of the jaw, about three quarters of an inch, was sawn out, its internal attachments separated, and the bone removed. [It was now remarked by Dr. Moore, that the respiration had stopped, and that the pulse was feeble; whereupon he opened the mouth, and with a pair of polypus forceps forcibly seized the tip of the tongue, drew it forwards, and so retained it, as in its former position it pressed upon the epiglottis, and thereby prevented the entrance of air. The respiration in a short time became natural.]

It was now found that the diagnosis was correct as to the opposite articulation being free, as the teeth could now be separated to the extent of an inch. The mucous membrane was attached by a number of sutures and the external skin in the same way. Wet lint was applied about two hours afterwards; from the exertion of vomiting, some of the lower stitches gave way, and a quantity of bilious matter ejected from the stomach was forced through the wound, thereby preventing its union. It afterwards healed up by granulation.

A month afterwards the angular distortion at the commissure was repaired by the edge being made raw, and about three-quarters of an inch of the crest of the lower lip detached by an incision into the commissure, twisted upwards and joined by sutures to the upper lip, thereby making the red external mucous surface of the lips continuous. This united, and he left the Hospital, with his appearance vastly improved, and the power of mastication completely restored.

CXXII. THE SECRETARY exhibited the recent parts in a case of *scirrhous* of the stomach, forwarded by Dr. MACLAUGHLIN, Lurgan.

Maurice B_____, aged 40, was admitted into the Lurgan Workhouse Infirmary on 2nd April, 1854. He stated that he had always been temperate and healthy, and that about 18 months previously he was seized for the

first time with sickness and vomitings which occurred an hour after taking food. He had medicine from the Dispensary which relieved him of the sickness and improved his appetite, and he continued in tolerably good health for three or four months; when the sickness and vomiting returned, accompanied with pain, which he referred to a point two inches below the ensiform cartilage, and a little to the right side. On admission there were presented extreme wasting and great debility; skin most anaemic, and in many places covered with large patches of chloasma. His appetite was very good, but he was afraid to eat in consequence of the pain and sickness. On examining the abdomen, I detected a small hard tumour about the size of a walnut, at the point to which he referred all his uneasiness. This tumour I only distinctly felt on one occasion, and a difficulty in diagnosis was the consequence, as about a fortnight previously, a medical man of considerable eminence pronounced the case to be one of melæna, not having been able to detect the tumor at all. His general health improved very much under arrow root and beef tea for food, which he was enabled to retain by taking a small quantity of opium a short time previous to each meal. He continued to eat well until two days before his death, when he was seized with convulsions, which proved fatal in 18 hours. Autopsy 24 hours after death; abdomen very much collapsed and concave; the stomach much contracted, and entirely covered by the liver; on raising which the lesser curvature of the stomach was found completely united to the liver and gall-bladder by a large cancerous mass, which, as it was *in situ*, I have forwarded for exhibition at the Society.

Dr. BRYSON observed—I have in my possession the stomach of a Mrs.— who died of scirrhus of the stomach. The disease was of fifteen years' duration. A considerable portion both of the large and small curvatures of the stomach was involved. The pyloric orifice became ultimately impervious. She vomited every article of food, and eventually died of inanition. The disease at first was considered to be gastritis. Bleeding, opium, and calomel were employed, and under this treatment she experienced relief for several months. Subsequent attacks were treated with calomel and opium alone. In the course of four years, a correct diagnosis was made; beef-tea and milk formed her diet, and half-grain doses of opium were used as required to relieve pain.

CXXIII. Dr. JAMES MOORE exhibited a small *warty tumor* which he had removed from the extremity of the penis. The prepuce had also to be removed. For this operation he recommended the use of the sharp-pointed bistoury in opening the prepuce, and then curved scissors to cut round the neck of the gland. In this way the skin and mucous membrane are cut equal, and should be joined together by a series of sutures; but by the knife alone the mucous membrane is only cut away to half the extent of the external skin, leaving a raw surface at least half-an-inch in breadth.

CXXIV. Mr. AICKIN exhibited a polypus after its removal from the nose. The tumor was of the encysted var-

iety—duration, 15 years, and occurred in a man aged 60. This was the first time any operation had been attempted.

THE DEBATE on the management of the Asiatic cholera was here resumed.

Mr. ARMSTRONG had no dependence on opium in collapse. Indeed, it was injurious when reaction occurred. He used it, however, freely at first, and afterwards depended upon stimulants, which he found useful even in collapse, especially in children.

Dr. BECK believed that the disease was the effect of a poison whose nature is unknown. He considered it contagious, but by no means so communicable as some other infectious disorders. He has observed a great number cured by half-drachm doses of tr. opii. and 5 gr. doses of calomel in pills, given at the very onset. A little later he would prefer giving the calomel (with a minute quantity of opium, perhaps), every quarter of an hour, in 2 gr. doses. Dry heat and plenty of turpentine externally. Had no faith whatever in any other treatment. As to "collapse," you may treat it as you please.

Mr. AICKIN fully believed in its contagious character. He instanced the first case which occurred in Belfast. A man arrived from Paisley, where the cholera then prevailed. From this man it spread to his relatives in different parts of the town. He remembered a memorable example which occurred in Ballymacarrett in 1832, in the person of the late Dr. Buchanan, who was a decided non-contagionist. This gentleman boasted that he would lie on a bed from which a fatal case of cholera had been recently removed, and escape unharmed. He tried, and fell a victim.

At Ardglass, forty cases originated in the infection brought by the clothes of a sailor.

At Portaferry, the disease was equally severe, and yet, in consequence of a strict quarantine, not a single case occurred at Strangford. The disease spread to Downpatrick by clothes sent from Belfast.

In 1832, at the Cholera Hospital here, he remembered that Dr. M'Cormac treated the cases pretty generally by bleeding, and calomel in large doses, and the mortality was very small. His own idea was to give opium, in large doses, at first, and restore the heat by stimulants externally and internally. The acetate of lead he considered of much benefit for arresting the premonitory diarrhoea. The action of calomel, in large doses, he believed was rather sedative than irritant, and depressant rather than stimulant.

The revision of the Laws of the Society was resumed and concluded. [See page 7 {1}.]

The CHAIRMAN announced that the Ballot papers would be issued to all Members on the 22nd instant, to be returned on or before the 26th instant.

Drs. R. STEWART and BRYSON were appointed Auditors.

THE FIRST ANNUAL MEETING.

27th May, 1854.

The President in the Chair.

Attendance:—Members, 18; Students, 4.

The SECRETARY read the Report of the COUNCIL on the proceedings of the Session, which was unanimously adopted. [See page 12 {65}]¹

The PRESIDENT announced the result of the Scrutiny of the Ballot-papers according to the report of Council and Auditors. [See page 3 {77}.]

The Auditors submitted the result of their examination of the Treasurer's books. [See page 132 {72}.] after which,

The PRESIDENT delivered the closing ADDRESS of the Session.

PROFESSOR FERGUSON, the President-elect, was now called to the chair, upon which unanimous and cordial votes of thanks were successively accorded to Dr. MALCOLM, as originator of the Society; Dr. T. H. PURDON, the first President, to whom much of the success which characterised the past session is justly due; Dr. J. H. HALLIDAY, the Treasurer, and Mr. WALES, Joint-Secretary, for their valuable services in their different official situations; after which the Society adjourned till the last Saturday in October, 1854.

NOTE TO CASE LXIX.—Since this case was read to the Society, strange to say, an elder brother of the patient was also seized with a slight rheumatic attack, complicated with valvular disease of the heart, under which, after a tedious illness, he sank. There was no development of any spasmodic affection. Upon a post mortem examination, fibrinous vegetations upon the mitral valve were observed.

THE GENERAL NOTE-BOOK.

Subjoined is a list of the SUBJECTS to which the References inscribed in the Society's Note-book for the past year pertain:

Any member desirous of procuring a copy of any particular reference may receive the same by communicating with the Secretaries, and enclosing a postage stamp.

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¹ [The figures refer to the References in the Note-Book; page numbers are those in the original; {page numbers} are those in this transcription]

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NOTE.—The pages referred to above, are those of the
TRANSACTIONS¹: the other figures, the Nos. of the
References in the NOTE-BOOK.

¹ Note: Page references in {} refer to this transcription of
the TRANSACTIONS.

ACHORION SCHÖENLEINII.

Fig 1

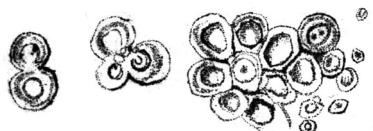


Fig. 2.

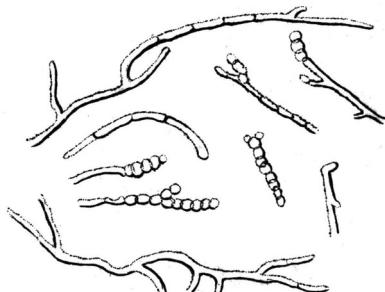
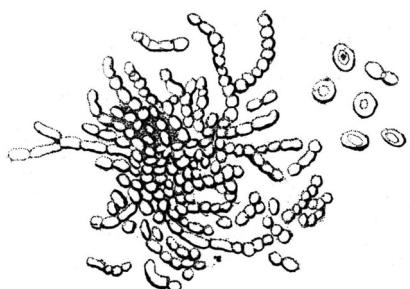


PLATE I. (AFTER BENNETT).

(See Page 23 {69}, No. 1 in List.)

Small portions of the crust taken from the scalp of a boy affected with FAVUS DISPERSUS. It presented a dirty yellow hue, was homogeneous in appearance, and evidenced some tenacity in structure. A little of the powder presented, under the microscope, the forms as sketched in Figs. II. and III. Fig. I represents the appearance of the peculiar form which the yellow crust, or rather secretion, assumes.

Exhibited by A. G. Malcolm, M. D.

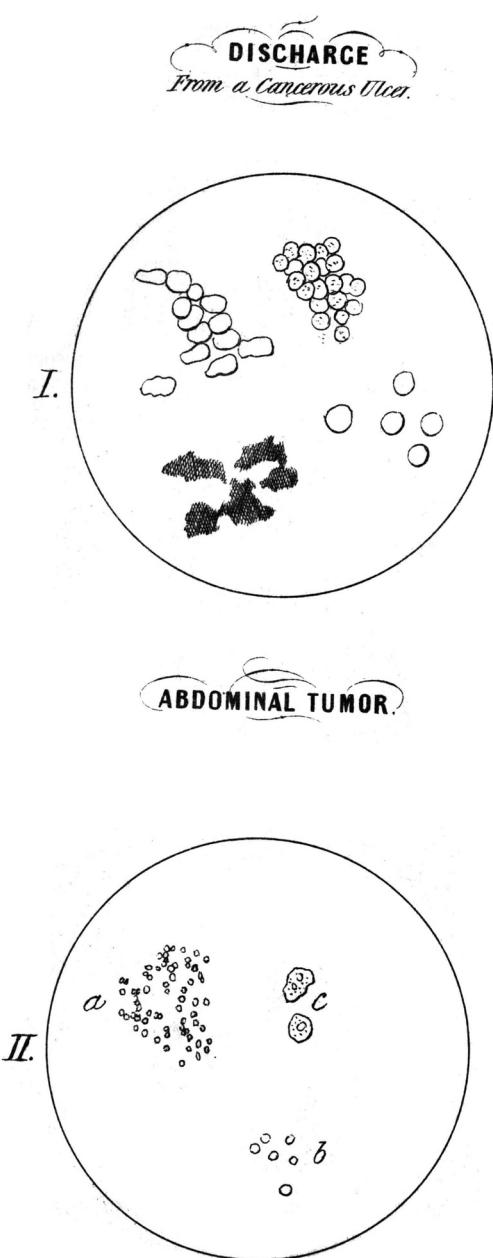


PLATE II.

Fig. 1 represents the microscopic appearance of the discharge from an ulcer which formed after removal of a CANCEROUS BREAST. Nothing peculiar was observed, as the objects represented (pus cells, fat cells, and pigment), are common to ordinary ulcerous discharge. The result of this examination is of merely negative value, and it may be analogous to what is observed in analysing the expectorated matters in phthisis pulmonalis, in which, even in the advanced stages, it frequently occurs that little or no tubercular matter can be detected.

Fig. 2. (See pp. 35-6{7}.) Represents the objects observed on the examination of a MALIGNANT TUMOR, situated across the aorta and displacing the colon. a.= cells or nuclei, $1/3,000$ in. in diameter, in great abundance; b.= oil cells; c.= epithelial cells, very few.

Exhibited by A. G. Malcolm, M. D.

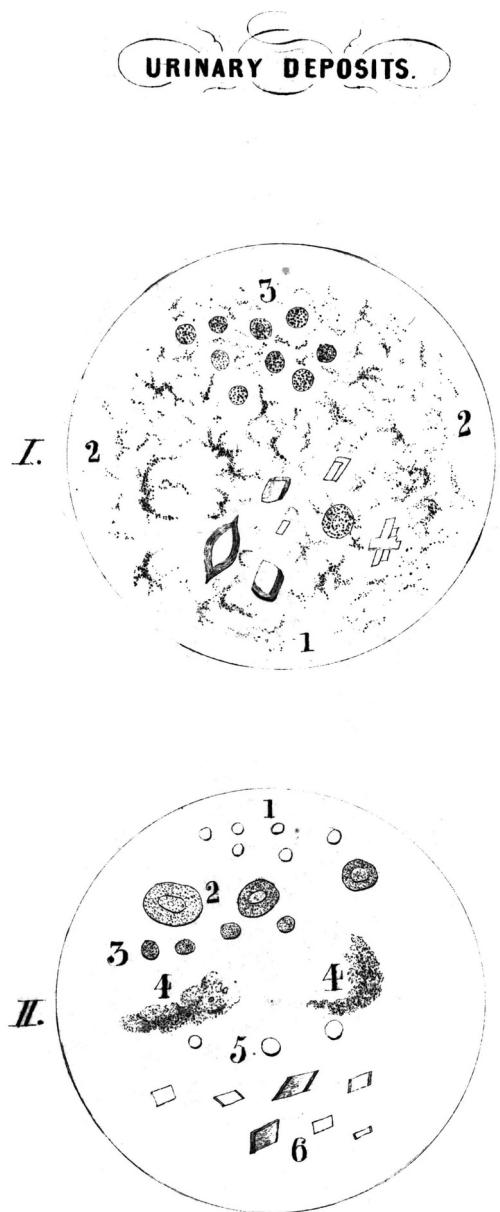


PLATE III.

Fig. 1. (See Page 23 {69}, No. 9 in List.) This deposit was from a specimen of urine in a case of TYPHOID FEVER. The urine was of a reddish orange hue, clear at the top—but very turbid below, from the presence of a copious deposit. It was slightly acid; sp. gr. 1,023; heat to 212°, partly clarified. Nitric acid darkened the tint: Aq. pot. partly clarified and gelatinized the residue. Under the microscope the deposit shewed: 1. Crystals of uric acid; 2. urate of ammonia; and, 3. numerous pus cells.

FIG. 2. (See page 23 {69}, No. 16 in List.) Represents objects observed in a deposit from urine, in a case of BRIGHT'S DISEASE, as follows:—1. Blood cells; 2. vesical epithelium; 3 mucus cells; 4. granular tube-casts; 5. oil cells; 6. crystals of uric acid.

Exhibited by A. G. Malcolm, M. D

PLATE IV.

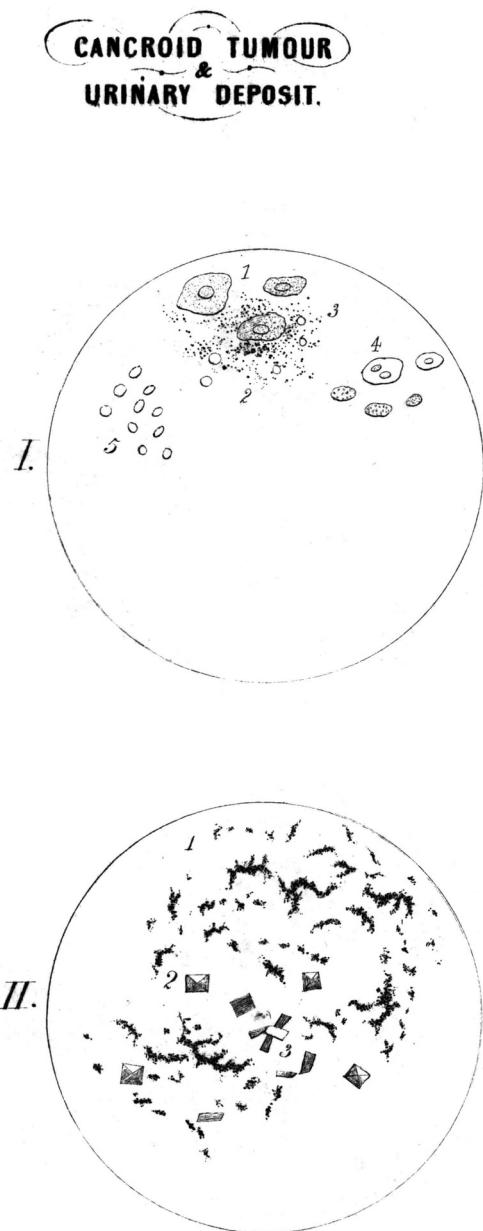


FIG. 1. (See page 23 {69}, No. 17 in List.) Represents the microscopic appearance of a CANCROID TUMOR OF THE LEG, which was about two inches in diameter, of a light pink or flesh colour, and projecting about 3/8-inch from the surrounding skin. Some of the fluid portion presented a number of (1) epidermic cells, separate and clustered, the latter surrounded by a considerable quantity of (2) molecular and granular matter, with many (3) oil cells, and (4) a few compound cells. There were also a number of (5) oval-shaped bodies, unaffected by acetic acid, and most probably nuclei set free. Generally a single nucleus was seen in each cell—some had two. The cells were irregular in shape, and the addition of acetic acid slightly increased their transparency.

Exhibited by H. Murney, M. D.

FIG. 2. (See page 23 {69}, No. 21 in List.) Represents the microscopic appearance of a deposit from urine in a case of RHEUMATISM. The specimen was pale and slightly acid, with a gray-white deposit, which consisted of (1) pale urate of ammonia; (2) octohedral crystals of oxalate of lime; and (3) a few crystals of uric acid.

PLATE V.

(See page 23 {69}, Nos. 35 and 36 in List, and page 54 {16}.) The figures in this plate represent the objects observed under the microscope in the intestinal rice-water fluid of two cases of genuine ASIATIC CHOLERA. The peculiar "annular bodies" of Swayne and Brittain are figured as seen at (a) in each drawing. The general tint of the fluid, when the solid part was commingled, was a light madder. The other subjects sketched are frequently met with in the ordinary evacuations, and consist of mucus and oil cells, some fibre cells, fungi, phosphates, and various forms of vegetable epidermis and fibre. No epithelium of the mucous membrane was detected.

Exhibited by A. G. Malcolm, M.D.

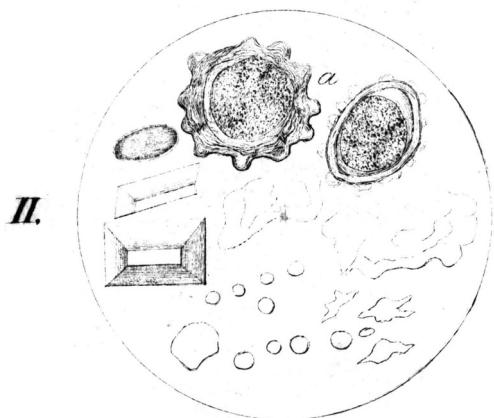
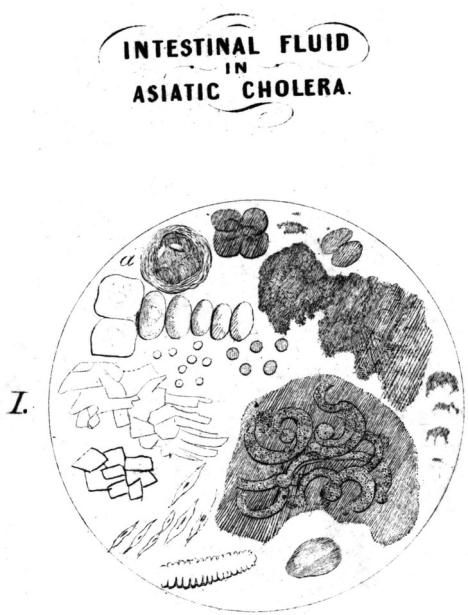


PLATE VI.

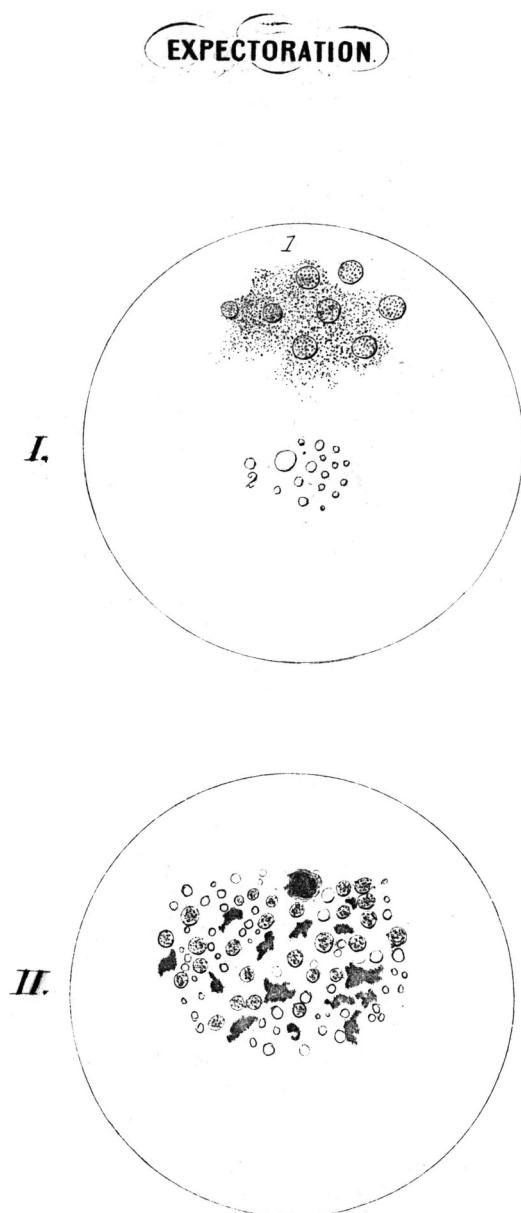


FIG. 1. (See page 23 {69}, No. 25 in List.) Represents the microscopic appearance of matter expectorated in a case of PHTHISIS PULMONALIS. The specimen was, for the most part, grayish-yellow and opaque, with some normal frothy mucus, and here and there a fawn coloured small mass. Under the microscope was observed in the former numerous pus cells, lying amidst a mass of granules, with a few oil cells, and in the latter a cluster of oil cells large and small. The granular matter was most probably tubercular dust, as it is in this form most usually observed.—(See page 65 {20}.)

FIG. 2. (See page 24 {70}, No. 52 in List.) Represents the appearance of matter expectorated in BRONCHITIS occurring in the person of a muslin gas-singer. The particulars of the case are given at page 104. The black pigment in the figure was carbonaceous, and was mixed up very closely with pus and oil cells, as sketched.

Exhibited by A. G. Malcolm, M.D.

PLATE VII.

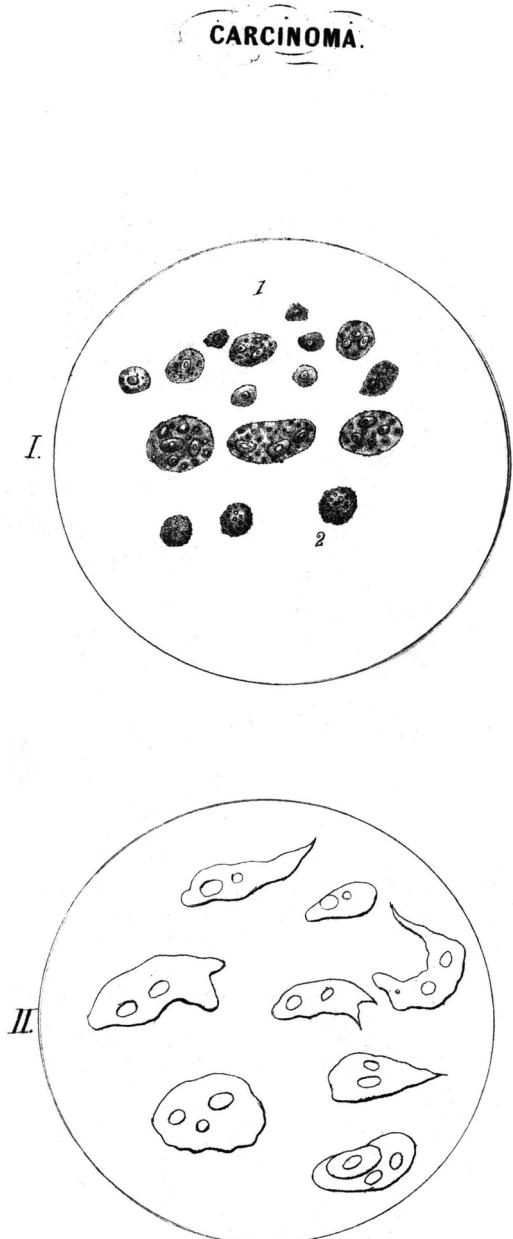


FIG. 1. (See page 23 {69}, No. 21 in List.) Represents the cells as observed during the microscopic examination of a diseased liver affected with Farre's Tubercle. The organ weighed 171bs., and presented a good example of the circumscribed and diffuse forms commingled. The medullary part under examination presented—(1), the characteristic cells of cancer, and (2), some granular masses of a globular form. The appearance is exactly similar to what is represented in Lebert's work, plate xx., fig. 10.

FIG. 2. (See page 23 {70}, No. 48 in List.) Represents the outline of cancer cells observed in a specimen of a MALIGNANT TUMOR OF THE CERVIX UTERI.

Exhibited by A. G. Malcolm, M.D.

PLATE VIII.

URINARY DEPOSITS.

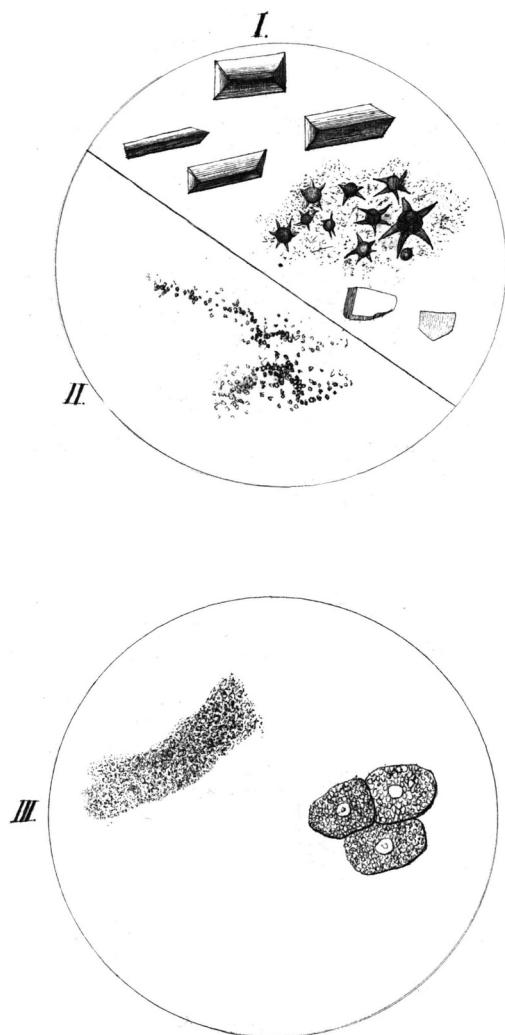


FIG. 1. (See page 24 {69}, No. 29 in List.) Represents the appearance of a deposit microscopically examined from a specimen of urine. The specimen had a strong yellow tint, with a gray earthy sediment, and of sp. g. 1,013. The figure shews the prismatic phosphates, which were in great abundance; superurates of ammonia and crystals of uric acid.

FIG. 2. (See page 24 {69}, No. 31 in List.) Represents a peculiar form of urate of ammonia, which occurred as deposit in a specimen of urine in a case of Bright's Disease. The circular bodies were uniform, showed little disposition to coalesce or cohere, and resembled vibrios. They formed, when en masse, a very copious deposit.

FIG. 3. (See page 24 {69}, No. 44 in List.) Represents a granular tube-cast, and some epithelial cells, which appeared in the deposit, from a specimen of urine in a case of BRIGHT'S DISEASE. The urine was highly albuminous, and contained blood in small quantity.

Exhibited by A. G. Malcolm, M. D.

Plates and Explanations

DOCTOR J. MOORE'S CASE OF
OSTEOSARCOMA OF LOWER MAXILLA.



PLATE IX.

Represents a sketch of a macerated portion of the lower maxilla affected with OSTEOSARCOMA. Particulars are given at page 93 {35}.

Exhibited by Jas. Moore, M.D.

DOCTOR J. MOORE'S
Case of
OSTEOSARCOMA
OF THE FEMUR.

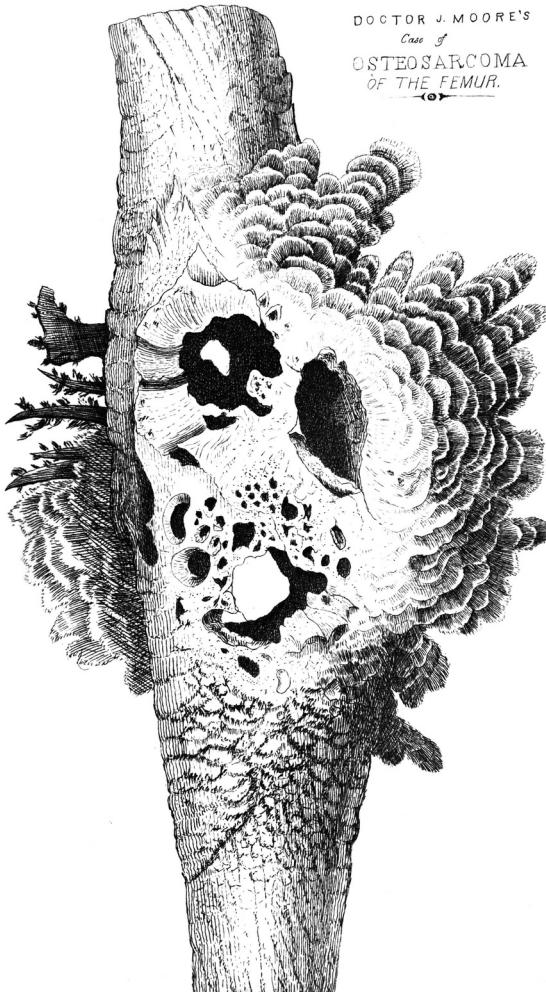


PLATE X.

Represents a sketch of a diseased portion of the FEMUR in a case described at page 105 {41}.

Exhibited by Jas. Moore, M.D.

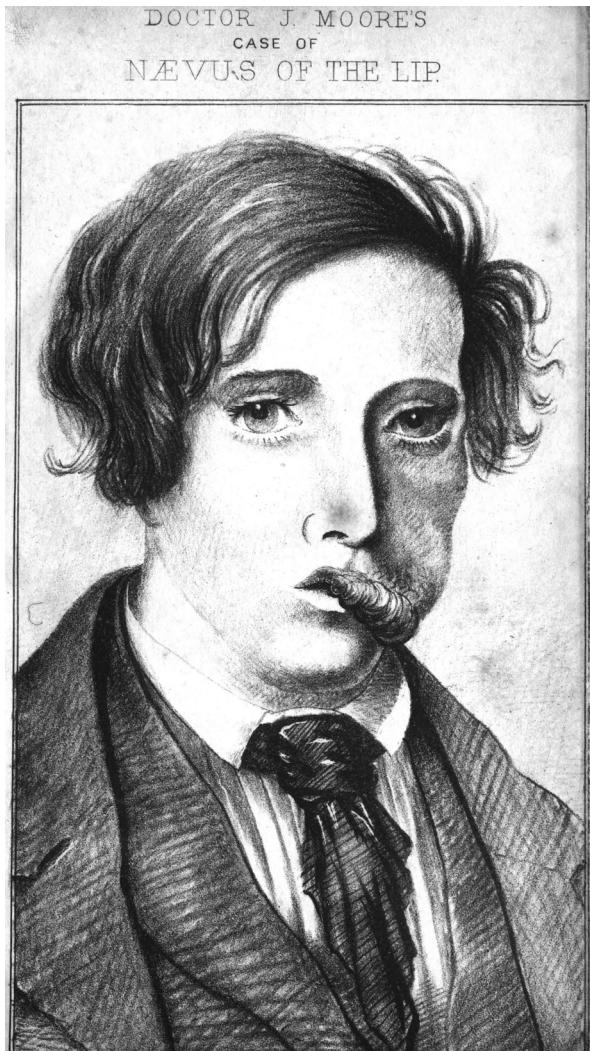


PLATE XI.

Represents the appearance of the patient with Nævus of the lip, referred to at page 115 {46}.

Exhibited by Jas. Moore, M.D.

REPORT OF THE COUNCIL,
AT THE CLOSE OF THE SESSION, 1853-54.

The COUNCIL beg to submit to the Members, the following Report of the proceedings of the Session just closed.

After some preliminary Meetings of the Promoters, the "Belfast Clinical and Pathological Society" was duly constituted on the second of September, 1853: and, by a Resolution of that date, Members of the Profession who gave in their adhesion to the new Society on or before the 30th September, were considered Original Members. These were forty-nine in number. Since that date, 47 other Practitioners have been admitted by Ballot, in accordance with the Regulations, in the following order, viz.:—

In October, 3; November, 4; December, 11; January, 15; February, 4; March, 7; April, 1; May, 2.

Of the total ninety-six Members, forty-three are resident in Belfast, and fifty-three non-resident; the latter located as follows:—

In County Down, 25; County Antrim, 15; County Louth, 5; County Tyrone, 2; County Derry, 2; County Monaghan, 2; and in County Armagh, 1.

Of the entire number, one resignation only has been received; but we regret to be obliged to record the death of ROBERT MURRAY, L.R.C.S., (I.) Rockcorry, County Monaghan, who promised to be a most valuable member of the Society and of the profession.

The Society held thirty-one meetings, commencing on the 8th October, and continuing till 27th May, with the exception of December 31st, and March 25th, on which dates, at the request of several Members, no meetings took place. They were regularly held every Saturday at Three, P.M., and were attended by an average of seventeen Members out of forty-two, who were in the habit of attending, viz.:—thirty-six from Town, and six from the Country.

By an original Rule of the Society, Medical Students of at least one year's standing, were admissible by Tickets signed by Members. Thirty-five Students availed themselves of this important privilege, of whom sixteen have received Certificates of attendance from the Council. The average attendance was about ten, weekly.

The Business of the Society consisted in the exhibition and explanation of Pathological specimens, generally of recent disease—the exhibition of new Medicines and new Instruments—the reading of interesting original Cases—the reading of the results of Microscopical and Chemical examinations, submitted by Members for analysis—brief statements of Clinical facts and Statistics—the reading of short papers on new modes of treatment, and the discussion of particular subjects for debate. From these different sources, 179 items of business were transacted by the Society.

The Pathological specimens exhibited were sixty-eight in number, and the lesions illustrated, included the most important diseases of nearly every tissue and organ in the body.

Nine Instruments of recent invention, and one new Medicine were exhibited, and their uses described.

Twenty-eight Clinical cases were contributed by seventeen of the Members.

Six papers, on new Modes of Treatment, were read; and three subjects were submitted to debate: and lastly, a few brief notes on interesting points in practice, under the designation of "Clinical facts and Statistics," were occasionally brought under the notice of the Society.

The Microscopical Committee examined sixty Specimens of Morbid products forwarded by twenty Members, including seven from the country. The majority consisted of specimens of urine and tumours. The results were submitted to the Society from time to time, as well as to the individual Members who forwarded the specimens for examination.

The Council have had it in contemplation, in accordance with the promotion of the objects of the Society, to commence the formation of a MUSEUM. To the furtherance of this object, they have received, during the Session, thirty-four Donations, consisting of plaster and wax casts, paintings and coloured drawings, and dried preparations. Their desire is, to make this the nucleus, and to limit the specimens for the Museum to the kinds of preparations mentioned, as the maintenance of such, when once prepared, will not entail any additional expense. The Council would therefore recommend that no wet preparations be received into their Museum.

From the experience of the past Session, the Council have, from time to time, observed several defects and omissions in the Laws of the Society, to remedy which, they submitted several alterations and new rules to three successive Meetings of the Society. These, they trust, will be of service in rendering more efficient the working of the Society.

As there is a small balance in the hands of the Treasurer, exclusive of the Reserve Fund, the Council recommend that it be expended in the publication of a small pamphlet of Transactions—the expense of which shall not exceed the balance aforesaid: and that a copy be supplied to each Member. The Council believe that this step will be conducive to the prosperity of the Society in the coming Session.

In conclusion, the Council beg to congratulate the Society upon the undoubted success of their first Session. The numbers, and the standing, of those who have joined your ranks, distinctly prove that some such association was a *desideratum*; and the fact that the Membership has been sought for, even at the closing weeks of the Session, likewise proves the high appreciation in which it is held. Though the original objects of the Society are manifestly unattainable by the work of a single Session, the Council trust that a sure foundation has been laid, and that it is not too much to expect that it will eventually assume considerable importance among the Societies of Ireland, towards the promotion of Medical Science.

LIST OF SIXTY-EIGHT PATHOLOGICAL
SPECIMENS EXHIBITED.

Recent Parts, 35.	Patients, 13.
Plaster Casts, 12.	Wax Casts, 5.
Dried Preparations, 7.	Wet Preparations, 3.
Daguerreotypes, 3.	Drawings, 3
	= 81. ¹

I. - NERVOUS SYSTEM.

1853.	
Oct. 15,	Facial Paralysis, in a Patient, exh. by Mr. HANNA,
" 22,	Capillary Apoplexy, Two Coloured Casts, exh. by Dr. MALCOLM.
" "	Ossified Falx Cerebri, Dried prep. exh. by Dr. MURNEY.
Nov. 12,	Hydrocephalus in an Idiot, Recent parts, exh. by Dr. MURNEY.
Dec. 17,	Facial Paralysis, Cast and Daguerreotype, exh. by Dr. MALCOLM.
1854.	
March 11,	Ramollissement of Spinal Cord, Wax Cast, exh. by Dr. MALCOLM,
April 1,	Infantile Paralysis in a Patient, exh. by Mr. H. M. JOHNSTON.
May 13,	Meningitis—10oz. effusion, Recent parts, exh. by Dr. LYNCH,

II - CIRCULATORY ORGANS.

1853.	
Oct. 8,	Diseased Aortal Valves, Dried prep. exh. by Mr. JOHNSTON
Oct. 22,	Ossified Pericardium, Dried prep. exh. by Dr. MURNEY.
Dec. 26,	Aneurism of Arch of Aorta, Recent parts, exh. by Dr. MURNEY.
1854.	
Jan. 21,	Aneurism of Abdominal Aorta, Recent parts, exh. by Dr. MALCOLM.
Feb. 11,	Pericarditis in a case of Phthisis, Recent parts, exh. by Dr. PIRRIE.
" "	Do. in a case of Fever, do. exh. by Dr. MALCOLM.
" 18,	Do. Recent parts, exh. by Dr. MACLAUGHLIN.
Mar. 4,	Excessive Varicose state of upper extremity in a Patient, exh. by Dr. MALCOLM.
" 11,	Aneurism of the Brachial Artery in a Patient, exh. by Dr. MACLAUGHLIN.
" 18,	Valvular disease of Heart after Syphilitic Rheumatism, in a Patient, exh. by Dr. ROSS.
Apr. 22,	Hypertrophy of the Heart, Recent parts, exh. by Dr. MACLAUGHLIN.
May 6,	Naevus of Lip, Drawing exh. by Dr. J. MOORE.

III. - RESPIRATORY ORGANS.

1853.	
Oct. 15,	Pulmonary Apoplexy, Coloured Cast, exh. by Dr. MALCOLM.
Nov. 5,	Foreign body in Trachea, Recent parts, exh. by Dr. FERGUSON.
1854.	
Jan. 7,	Varieties of Pulmonary Induration, Recent parts exh. by Dr. MALCOLM.
" 14,	Empyema, Cast of Thoracic wall, taken Ten years after cure by Thoracentesis, exh. by Dr. MALCOLM.
Feb. 11,	Plueritis, fatal from cerebral effusion, Recent parts, exh. by Dr. PIRRIE.

¹ 13 of these were Supplementary Illustrations

" 25,	Ulceration of the Trachea in Phthisis, Recent parts, exh. by Dr. MURNEY.
Apr. 1,	Bronchial polypoid deposit, Recent parts, exh. by Dr. FERGUSON.
May 20,	Cystic nasal polypus, Recent parts, exh. by Mr. AICKIN.

IV. - DIGESTIVE ORGANS.

1853.	
Oct. 8,	Farre's Tubercle of the Liver, Recent parts, exh. by Dr. MALCOLM.
Nov. 14,	Ulcerated Intestine in Fever, Recent parts, exh. by Mr. H. M. JOHNSTON.
Nov. 26,	Farre's Tubercle of Liver, Recent parts, exh. by Dr. LYNCH.
Dec. 5,	Ulceration of (Esophagus, do. exh. by Dr. LYNCH.
" 10,	Cirrhosis of the Liver, do. exh. by Dr. MALCOLM.
1854.	
Mar. 18,	Extensive Ulceration of the Tongue, Patient, exh. by Dr. MALCOLM.
May 20,	Carcinoma of Stomach, Recent parts, exh. by Dr. MACLAUGHLIN.

V. - URINARY AND GENITAL ORGANS.

1853.	
Oct. 8,	Bright's Kidney, Two Wax Casts, exh. by Dr. MALCOLM.
Nov. 19,	Carcinoma of the Breast, Patient, exh. by Dr. HALLIDAY.
" 26,	Carcinoma of the Breast, Recent parts, exh. by Dr. HALLIDAY.
1854.	
Jan. 28,	Peculiar mammary tumour, Patient exh. by Dr. HALLIDAY.
Feb. 25,	Pendulous Tumour of the Labium, Recent parts, and Drawing, exh. by Dr. W. MOORE, Ballymoney.
Mar. 18,	Peculiar Stricture of the Urethra, Patient, exh. by Dr. LYNCH.
" "	Bright's Kidney, with Disease of the Aorta, Recent parts, exh. by Dr. MACLAUGHLIN.
Apr. 22,	Carcinomatous Tumour of Mamma, Recent parts, exh. by Dr. W. MOORE, Ballymoney.
May 20,	Warty Tumour of Penis, Recent parts, exh. by Dr. J. MOORE.

VI. - JOINTS AND BONES.

1853.	
Oct. 8,	Foot and Leg extraordinarily deformed by a Burn Cicatrix, Cast, exh. by Dr. ROSS.
" 29,	Carcinomatous disease of Ilium, Two Plaster Casts, and Two Drawings, exh. by Dr. MALCOLM.
Nov. 12,	Peculiar Exostosis of the Tibia, Dried prep. exh. by Dr. STRONGE.
" "	Elbow with obscure fracture of Condyle, Cast, exh. by Mr. HANNA.
" 26,	Osteo-sarcoma of Lower Maxilla, Dried prep. exh. by Dr. J. MOORE.
1854.	
Feb. 25,	Osteo-sarcoma of Lower Maxilla, Dried prep. exh. by Dr. J. MOORE.
Apr. 15,	Carcinomatous Tumour of Femur, Recent parts, exh. by Dr. J. MOORE.
" 22,	Distorted Union, after fracture of Femur and Tibia, Dried prep. exh. by Dr. LYNCH.
May 20,	Disease of Lower Maxilla, Patient, after operation, exh. by Dr. J. MOORE.

VII. - THE SKIN, AND SUBCUTANEOUS TEXTURES.

1853.	
Oct. 29,	Congenital Tumour of Scalp, Patient exh. by Mr. HANNA.
Nov. 5,	Cancroid Tumour of Leg, Recent parts, exh. by Dr. MURNEY.
" 12,	Enormous Hypertrophy of Leg, do., exh. for Dr. A. KIDD, Ballymena.

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" "	Cancroid Tumour of Leg, Recent parts, exh. by Dr. ROSS.
" 26,	Fibro-cartilaginous Tumour of Neck, Cast and Daguerreotypes, exh. by Mr. ARMSTRONG.
" "	Extensive Ulceration of Leg, Recent parts, (after amputation) exh. by Dr. H. STEWART.
Dec. 17,	Encysted Tumour of the Neck, Recent parts, (after excision) exh. by Dr. J. MOORE.
1854.	
Mar. 4,	Enormous enlargement of Arm, from Carcinoma of Breast, and axillary glands, cast exh. for Dr. THOMAS THOMPSON.
" 18,	Indurated Lymphatic Glands of neck, which, by the passage of the clavicle over them, produced a peculiar crepitation upon movement, Patient exh. by Mr. WALES.
Apr. 15,	Encysted Tumour of Neck, Recent parts, exh. by Dr. J. MOORE.
May 6,	Excessive (Edema of Scrotum, &c, in a case of Anasarca, Drawing, exh. by Dr. J. MOORE.
" 20,	Encysted Submental Tumour, Recent parts, exh. by Dr. MALCOLM.

MISCELLANEOUS.

1853.	
Dec. 3,	Monster-foetus, exh. by Mr. DALY.
" 10,	Dissection of same, by Professor CARLILE.
1854.	
Apr. 22,	Gonorrhœal Ophthalmia, Patient exh. by Mr. J. S. ARMSTRONG.

LIST OF TWENTY-EIGHT CASES READ.

THE NERVOUS SYSTEM.

1853.	
Oct. 22,	Coma simulating Apoplexy; by Dr. LYNCH.
1854.	
Jan. 21,	Congenital Hydrocephalus, Two Cases; by Dr. HALLIDAY.
" 28,	Chorea supervening on Rheumatic Endocarditis; by Mr. JOHNSTON.

THE LUNGS.

1853.	
Nov. 5,	Phthisis and chronic Cystitis co-existing; by Dr. MALCOLM.
1854.	
Mar. 10,	Bronchitis with Pneumonic-like Sputa, in a Muslin Gas-singer; by Mr. WALES.

THE DIGESTIVE ORGANS.

1853.	
Oct. 15,	Perforation of the Stomach; Dr. T. H. PURDON.
" 15,	Blue tinging of the Skin from Pleuritis; on record.
" 22,	Ruptured Intestine; by Mr. WALES.
Nov. 5,	Protrusion and enlargement of the Tongue, continuing Four years in a case of Scrofula; on record.
" 19,	Hepatic Disease; by Dr. JAMIESON, Newtowndars.
1854.	
Feb. 4,	Ulceration and Perforation of the small Intestines; by Dr. ROSS.

THE BLOOD VESSELS.

1853.	
Nov. 19,	Aneurism of the Innominate, for which the common Carotid was tied; M. S., of the late Dr. SAUNDERS, read by Dr. H. A. STEWART.
" 19,	Aneurism of the Thoracic Aorta; by Dr. T. H. PURDON.
Dec. 24,	Aneurism of the Thoracic Aorta, long undiscovered read by Dr. MALCOLM.

CASES IN MIDWIFERY.

1854.	
Feb. 4,	Uterine Hydatids, mistaken for pregnancy; by Mr. MADDEN, Portglenone.
" 11,	Laceration of Abdomen and protrusion of Intestines, in a new-born child from strain on Funis; by Mr. REA.
Feb. 25,	Dropsy of the Amnion; by Dr. W. F. ROGAN, London-derry.
Mar. 4,	Two Placentæ to one Birth; by Mr. AICKIN.

ABSCESS.

1853.	
Oct. 22,	Lumbar abscess bursting into Intestine; by Dr. HALLIDAY.
1854.	
Jan. 27,	Cervical abscess communicating with the lungs; by Mr. HANNA.

MEDICAL JURISPRUDENCE.

1853.	
Nov. 5,	Malingering in Medical Practice; by Mr. H. M. JOHNSTON.
1854.	
Feb. 25,	Case, illustrating a source of error in medico-legal examinations for suspected arsenical poisoning; by Mr. AICKIN.
Apr. 29,	Punctured wound in the Thorax, involving a difficult point in Medical Jurisprudence; Dr. T. H. PURDON.

DROPSY.

1853.	
Oct. 22,	Hydatids mistaken for Ascites; on record.
Dec. 10,	Ascites for which Paracentesis was performed Sixty-two times; by Dr. LYNCH.

HÆMORRHAGE.

1854.	
Jan. 14,	Fatal Hæmorrhage from extraction of a tooth; by Mr. ARMSTRONG.

FEVERS.

1854.	
Jan. 22,	Measles with unusual complications; by Dr. J. C. FERGUSON.

MISCELLANEOUS.

1854.	
Feb. 11,	Case, illustrating the use of Chloroform in injuries of the eye in children; by Dr. PIRRIE.

NEW INSTRUMENTS AND MEDICINES EXHIBITED.

1853.	
Oct. 15,	Sibson's Spring Percutor, exh. by Dr. MALCOLM.
" "	A new Larynx Syringe for injecting Nitrate of Silver Solution, exh. by Dr. MALCOLM.
" "	Œsophageal Bougies, and Sweepers, exh. by Dr. PURDON.
Oct. 22,	A new Tracheotome, exh. by Dr. STRONGE.
" "	An improved "Porte Caustique," for cases of Spermatorrhœa, exh. by Dr. MALCOLM.
" 29,	Hardy's apparatus for the local application of Chloroform, exh. by Dr. PURDON.
Nov. 12,	Koussò: its History, and the result of recorded trials, by Dr. MALCOLM.
1854.	
Mar. 4,	Instrument for supporting Prolapsed Funis, exh. by Mr. AICKIN.

"	11,	Tourniquet for applying compression in Aneurism, exh. by Dr. H. STEWART.
Apr.	22,	Hardy's Instrument for injecting the Uterus, exh. by Dr. PURDON.

CLINICAL FACTS AND STATISTICS.

1854.		
Apr.	15,	Quinine in Sciatica; by Dr. J. C. FERGUSON.
"	"	Opium in Acute Rheumatism; by Dr. J. C. FERGUSON.
"	29,	Statistics to shew the tendency to Phthisis in Diabetes Mellitus; by Dr. MALCOLM.
"	"	Notes of Peculiarities in cases of Eczema; by Dr. MALCOLM.

PAPERS ON NEW MODES OF TREATMENT.

1853.		
Nov.	26,	Sulphuric Acid in Diarrhoea and Cholera; by Dr. YOUNG, Holywood.
Dec.	24,	Muriated Tincture of Iron in Erysipelas; by Dr. MALCOLM.
1854.		
Jan.	21,	Chloroform in Delirium Tremens; by Dr. LYNCH.
Feb.	18,	Large doses of Quinine in continued Fever; by Dr. MALCOLM.
Mar.	4,	Lemon juice in acute Rheumatism; by Dr. MALCOLM.
Apr.	22,	Small doses of Mercury in Infantile Pneumonia; by Dr. MALCOLM.

QUERIES DISCUSSED.

1854.		
Apr.	8,	"Is organic Cardiac disease a frequent effect of Bright's lesion?" Introduced by Dr. LYNCH.
"	15,	"What is the proximate cause of the Anasarca after Scarlatina?" Introduced by Dr. MALCOLM.
May	13,	"What should be the basis of our Treatment of Asiatic Cholera?" Introduced by Dr. MALCOLM.

ANALYSIS OF SIXTY SPECIMENS SUBMITTED TO
MICROSCOPICAL AND CHEMICAL EXAMINATION.

Specimens of Morbid Urine and Urinary deposit,	9
Tumours of Bone, ...	2
" External Organs, ...	5
" Internal Organs, ...	4
Crust in Cutaneous Disease, ...	1
Gastric Fluids, ...	4
Mammary Secretion, ...	1
Matter expectorated, ...	3
Calculus, ...	1

Report of Council

LIST OF SPECIMENS SUBMITTED TO MICROSCOPICAL AND CHEMICAL EXAMINATION.					
No.	Date.	Specimens.	Forwarded from.	Result of Examination.	Remarks.
1853.					
1.	Oct. 5,	Crust of Scald Head,	Town,	The Achorion Schœnleinii	
2.	" "	Urinary deposit,	"	Lithate of Ammonia	
3.	25	Abdominal Tumour,	Country,	A Cancroid growth	Was mistaken for an abscess.
,					
4.	" "	Urinary deposit,	Town,	Lithate of Ammonia	
5.	" "	" "	"	Pus-cells	
6.	29	Tumour of left Ilium,	"	Gelatiniform Cancer	The left leg and thigh were enormously swollen.
,					
7.	" "	Urinary deposit,	"	Lithic Acid and Lithates	
8.	" "	" "	Country,	Albumen, Renal Epithelium, Blood-cells	
9.	31	" "	Town,	Lithic Acid, Lithates, and Pus-cells	Case of Typhoid Fever.
,					
10.	" "	" "	"	Vesical Epithelium, and Lithates	
11.	Nov. 1,	" "	"	Blood and Mucus-cells	
12.	" "	" "	"	Lithate of Ammonia	
13.	" "	Urine,	"	Saccharine, Diabetic	
14.	" 3,	Urinary deposit,	Country,	Purpurate of Ammonia	
15.	" "	" "	"	Renal Epithelium & Granular tube-casts	
16.	" 5,	" "	Town,	Blood & mucus-cells, Lithic acid, Renal Epithelium and tube-casts	
17.	" 1,	Tumour of Leg,	"	A Cancroid growth	
18.	" 9,	Tumour of Finger,	"	Fibro-cartilage and Bone	
19.	" "	Tumour of Lip,	"	A Cancroid growth	
20.	" 11	Urine,	"	Albumen and Lithates	
,					
21.	" 12	Urinary deposit,	"	Lithic acid, Lithates, and oxalate of lime	
,					
22.	" "	Urine,	Country,	Albumen, Granular tube casts	
23.	" "	Urinary deposit,	"	Vesical epithelium & mucus, lithate of ammonia	
24.	" 16	" "	Town,	Prismatic Phosphates and Lithates	Case of Herpes zoster. " Syphilitic Paralysis.
,					
25.	" "	Matter expectorated,	"	Tubercle, Pus and oil cells	
26.	" 17	Urinary deposit,	Country,	Oil cells, (Milk ?)	" Phthisis.
,					
27.	" 21	Diseased Liver,	Town,	Farre's Tubercle, cancer cells	
,					
28.	" 24	Urine,	"	Saccharine, diabetic	
,					
29.	" 26	Urinary deposit,	Country,	Phosphates, Lithic acid and super-urates	
,					
30.	" "	" "	Town,	Lithic acid, Lithates and pus cells	Chronic Hip joint disease, suppurative.
31.	" "	Urine,	Town,	Albumen and Lithates	Bright's Disease, and Pneumonia.
32.	" "	Tumour of Mamma,	"	Cancer cells and Epithelioma	
33.	" 29	Ulcerated œsophagus,	"	Cancroid	
,					
34.	Dec. 2,	Disease of external Ear,	"	Cancer cells and fibrous circles	Two years' duration.
35.	" 5,	Cholera discharge,	"	"Cholera bodies" of Swayne, &c.	Asiatic Cholera.
36.	" 14	" "	"	" and Phosphates & Oil	Ditto.
,					
37.	" "	Urinary deposit,	"	Pus cells	
38.	" 25	" "	Country,	Blood and pus cells	Chronic Cystitis.
,					
39.	" 30	" "	Town,	Mucus, phosphates	Symptoms of acute Nephritis.
,					
1854.					
40.	Jan. 12,	Matter expectorated,	"	Pus cells, striped muscular tissue	
41.	" 15	Urine from pelvis of kidney,	"	Albumen, epithelial cells and tube casts	Aneurism of Abd. Aorta pressing upon Kidney.
,					
42.	" 20	Gastric fluid,	"	Starch grains, oil cells and pigment	Supposed to be Cancer of the Stomach.
,					
43.	" 29	Urinary deposit,	"	Lithate of Ammonia	
,					
44.	" "	" "	Country,	Blood, mucus, epithelium and tube casts	
43.	" "	" "	Town,	Blood, pus cells and lymph	
48.	Feb. 8,	Mammary secretion,	"	Normal	
47.	" "	Urinary deposit,	"	Phosphates, mucus & granular tube casts	Inflammation of Breast.

Transactions of The Belfast Clinical and Pathological Society

LIST OF SPECIMENS SUBMITTED TO MICROSCOPICAL AND CHEMICAL EXAMINATION. [Continued]					
No.	Date.	Specimens.	Forwarded from.	Result of Examination.	Remarks.
48.	" 9,	Tumour of cervix uteri,	"	Compound fusiform and caudate cells	
49.	" 10	Urine,	"	Saccharine, diabetic	
50.	" 16	Urinary deposit,	Country,	Lithate of Ammonia	Diffuse Inflammation of the Neck.
,					
51.	" "	Urine,	"	Albumen	Bronchitis in a Muslin Gas-singer.
52.	Mar. 10	Matter expectorated,	Town,	Oil, & mucus cells & charcoal fragments	Ulceration of Stomach.
,					
53.	April 4,	Gastric fluid,	"	Oil & blood cells & vegetable epidermis	
54.	" "	Urinary deposit,	"	Prismatic phosphates	
55.	" 22	Urine,	Country,	Normal	
,					
56.	" 21	Urinary deposit,	Town,	Lithates, prismatic phosphates & oil cells	Valvular Disease of Heart.
,					
57.	" 22	" "	"	Prismatic phosphates	
,					
58.	" "	Mammary tumour,	Country,	Oil cells, aggregated nucleated cells and fibrous stroma	
59.	" 29	Calculus, (sub-lingual)	"	Phosphate of Lime; oxalate, a trace	
,					
60.	May 9,	Urine,	Town,	Saccharine, diabetic	

CATALOGUE OF MUSEUM.

1. Two PLASTER CASTS of extraordinarily deformed feet and legs, caused by a Burn-cicatrix in infancy. A donation from Dr. J.S. Reid, Belfast.
2. Two WAX CASTS of Kidney in Bright's Disease. A donation from Dr. Malcolm, Belfast.
3. DRAWING: The Achorion Schoenleinii (after Robin). A donation from Dr. Malcolm.
4. COLOURED FRENCH CAST illustrative of Pulmonary Apoplexy. A donation from Dr. Malcolm.
- 5 and 6. Two COLOURED FRENCH CASTS illustrative of Capillary Apoplexy of the BRAIN (after Cruveilhier). A donation from Dr. Malcolm.
- 7 and 8. Two PLASTER CASTS: Carcinomatous Tumour of the Ilium; Cancelli were enlarged and charged with cancerous matter (gelatiniform). A donation from Dr. Malcolm.
9. PLASTER CAST illustrative of Hypertrophy of the Leg: the original was forwarded by Dr. Kidd, Ballymena. A donation from Dr. Malcolm.
10. DRY PREPARATION: Remarkable specimen of Exostosis of the Tibia, to which was originally attached a fungoid Tumour. A donation from Mr. C. Mulholland, M.R.C.S. (Eng.), Belfast.
11. PLASTER CAST of part of arm and fore-arm in which Fracture of the Humerus simulated Dislocation. A donation from Mr. H.H. Hanna, M.R.C.S. (Eng.) Belfast.
12. Two DAGUERREOTYPES presenting views of a Fibro-cartilaginous Tumour of the Neck, removed by Surgeon Browne, R.N., Belfast. A donation from Dr. Malcolm.
13. WAX CAST of a recent specimen of Cirrhosis of the Liver. A donation from Dr. Malcolm.
14. PLASTER CAST of Face, presenting Hemiplegia from disease of the External Ear. A donation from Dr. Malcolm.
15. PLASTER CAST presenting the appearance of the Thorax ten years after an attack of Empyema, for which paracentesis was performed. A donation from Dr. Malcolm.
16. WAX CAST illustrative of Recent Pericarditis which occurred during the progress of Phthisis; original by Dr. Pirrie, Belfast. A donation from Dr. Malcolm.
17. DRAWING: Pendulous Tumour of the Labium in Situ. A donation from Dr. W. Moore, Ballymoney.
18. PLASTER CAST: Enlargement of upper extremity, which occurred during the progress of carcinoma of the Breast; original by Dr. T. Thompson, Belfast. A donation from Dr. Malcolm.
19. PLASTER CAST: Extraordinary varicosity of upper extremity. A donation from Dr. Malcolm.
20. WAX CAST presenting the Spinal Cord in a case of Myelitis and recent congestion. A donation from Dr. Malcolm.
21. WAX CAST of a Bronchial Polypus expectorated. The original exh. by Dr. Ferguson. A donation from Dr. Malcolm.
22. CALCULI; Calarious bodies expectorated in a case of supposed Phthisis. A donation from Dr. Malcolm.
23. DRAWING representing Nævus of the Lip. A donation from Dr. James Moore, Belfast.
24. DRAWING representing a malignant Tumour of the Ilium in Situ. A donation from Dr. James Moore, Belfast.
25. PLASTER CAST of diseased Thumb, caries of the last phalanx. A donation from Dr. Malcolm.
26. PLASTER CAST of fore-arm, representing Scrofulous ulcers and abscess. A donation from Dr. Malcolm.
27. PAINTING representing Lipoma of the Nose. A donation from Dr. Malcolm.
28. PAINTING representing Carcinomatous Tumour of the Neck. A donation from Dr. Malcolm.
29. PLASTER CAST of Abdomen in a case of Ovarian Dropsy. A donation from Dr. Malcolm.
30. DRAWING representing enormous Carcinomatous Tumour of the Neck. A donation from Dr. James Moore, Belfast.
31. Two PLASTER CASTS of Nates, representing Morbus Coxa. A donation from Dr. Malcolm.
32. PAINTING representing Encephalocele in the Accipital Region. A donation from Dr. Malcolm.
33. PAINTING representing Epulis. A donation from Dr. Malcolm.
34. PAINTING representing Polypus Nasi. A donation from Dr. Malcolm.

BALANCE SHEET.

The Treasurer in Account with the BELFAST CLINICAL and PATHOLOGICAL SOCIETY, for the Session, 1853-54.

Dr.	Cr.
	£ s. d.
To Amount of Subscriptions	
By Printing Laws, Circulars, Case-papers, Tickets, &c.	14 17 2
By Postage,	3 6 6
By Advertising,	1 15 9
By Society's Books,	1 12 11
By Ballot-box,	7 6
By Gratuity to Porter,	5 0
	22 4 10
Balance in Treasurer's hands	13 1 2
	£ 35 6 0
N.B.—Of this sum, £8 15s was set apart as a "Reserve Fund" for this Session, agreeably to LAW XVII.	

NOTICE TO MEMBERS.

THE ANNUAL SUBSCRIPTION is due on the last Saturday in October. Defaulters will be noticed according to Rule XX.

MEMBERS, desirous of exhibiting PATHOLOGICAL SPECIMENS, or otherwise contributing their quota of information, will please communicate with the Secretaries some time before they submit their Contributions to the Society; and Country Members, who may not find it convenient to attend, are reminded that all communications intended to be read at the Meetings of the Society, should be forwarded to the Secretaries, or some Member resident in town whom they may depute.

ANY Member who may be apprised of the desire of any Medical Practitioner to join the ranks of the Society, is requested to intimate the same to the Secretaries.

SPECIMENS for MICROSCOPICAL EXAMINATION, from Country Members, may be conveniently forwarded by Post, enclosed in gutta percha or oiled silk; and RECENT PARTS for EXHIBITION, by Rail direct, or the "Parcels Delivery Company" who have agents in several provincial towns.

REVIEW¹

Transactions of the Belfast Clinical and Pathological Society, for the Session 1853-54; with List of Members, Laws of the Society, and Report of the Council; to which is added a Catalogue of the Pathological Museum. Belfast: Alexander Mayne; 1854.

The desire for a knowledge of the causes of disease, and its effects on the textures and fluids of the body, is spreading fast; nor need we go farther for proof of this than the volume which now lies before us. We are glad to meet it, for it is the first in this country which has been issued; and, as might almost have been expected, it has come from that city whose rapid increase and progress is behind none other in the British empire. Belfast is fast going ahead, and as it is the first in mercantile pursuits, so has it been the first to send forth a volume of Transactions like the present. We know the Dublin Pathological Society existed for years before there was any other of the kind in Europe; we know, too, that its proceedings are reported in scraps, and, if we be rightly informed, are supplied to its members; but we have been looking, and for so far in vain, for any volume of Transactions, and now precedence has been taken not only by London but also by Belfast, on this important point.

How is this? How is it that the Belfast Society, whose numbers are ninety-six, and the subscription only half what it is said to be in Dublin, has been able to publish its proceedings? We presume it cannot be from want of thought. Have its funds anything to say to it? how have they been managed? or will anyone be kind enough to inform us? Whilst we see some of its business details, we have never seen an account of its income, and how it is expended. The volume before us gives ample details on these points, and we think every society should do so.

But to come to what is more in hand. The Belfast Society was founded in September, 1853, its first president being Dr. Purdon, and its second Dr. J. C. Ferguson, now Professor of the Practice of Medicine in the Queen's College. We think it a high honour that a gentleman who left Dublin within the last six years, should have been placed in such an honourable position, and we congratulate him on it. The objects of the Society are thus set forth, and we copy them verbatim, as they seem to us to embrace a wider range than those of any other similar society:—

"The Society shall be called 'The Belfast Clinical and Pathological Society,' whose objects shall be the cultivation of practical pathology, diagnosis, and therapeutics, by means of the accumulation and analysis of appropriate cases, and pathological reports and public discussion thereon; the establishment of a pathological museum, and the keeping of records to indicate the progress of discovery in medical science."

This is a most comprehensive scheme, and so far

seems to have been carried out with great energy and exactness. Including specimens, as recent, dried, casts, &c., we have a total of eighty-one brought forward in the first session. All these, too, are classified, and admit of easy reference; and in addition to all this, we have valuable remarks—debates, in fact—on many of the subjects brought forward.

One of the fundamental rules of the Society, we observe, is that every member shall be a qualified physician or surgeon. This is as it ought to be: there never was a time when such a rule was more necessary. No man can be either physician or surgeon without a knowledge of the various changes which disease causes in our frames; and this knowledge belongs especially to physicians and surgeons. We are great advocates for the division of labour; we believe it is the only plan by which science can be advanced, and every year, more particularly in London, we know is adding to what are known as the specialities. Thus we have special hospitals for the study of consumption, cancer, diseases of the skin, diseases of children, deformities, affections of the eyes, mental maladies, &c. We have men who devote themselves solely to the use of the microscope, and we have every kind of societies for the cultivation of medical science; amongst the rest we have a Pharmaceutical Society, which publishes its Transactions. This latter subject—we mean pharmacy—has, we regret to say it, been allowed to die out in Dublin. We do hope, however, that the body entrusted with the special management of this important branch will bestir themselves. In Dublin, medicine and surgery are being now pursued with a zeal which we believe to be behind none other in Europe. We trust we may soon have the same to say of pharmacy. We notice that in the Society there is both a microscopical and a chemical committee; this we regard as a very decided improvement. Without having any reasons for doubting the truth of the observations of any one individual, we do think these investigations, and more particularly those connected with the microscope, demand all the weight which numbers can give. We have long been of opinion that too much importance has been attached, in the investigation of structure, to what the microscope discloses; and that the existence of caudate and other cells has been spoken of in a way that is anything but conducive to the advancement of science. We are firm believers in the great advantages the microscope is capable of affording; but we believe its use is attended with difficulties which seem to be made light of, and owing to which erroneous conclusions are certain to have been arrived at.

Lastly, and as a subject of general interest, we would notice the fact of the considerable number of what we may call country members who contributed to the proceedings of the Society by sending specimens to be exhibited or papers to be read. This augurs well for its future life, as well as for the zeal of its members.

Our limits forbid us to do more than glance at the contents of the volume. Where all is valuable, it is no easy matter to select; we may, however, direct special attention to a few of the more interesting cases brought forward. At page 35-6 are the details of two cases of abdominal tumours, each in its way of much

¹ Review and Notices of Books: *Transactions of the Belfast Clinical and Pathological Society*. Dublin Medical Press 1853; 33:151-152

interest. The first, sent by Dr. Philip Russell of Bangor, was an instance of a tumour of rapid growth, first detected in the left hypochondrium. It occurred in a man of 33 years of age, caused much suffering, and death in a few months. On examination with the microscope, it is stated no cancer cells were found. Now this is exactly one of those cases we have alluded to above. We believe that in many such the naked eye is a surer criterion to go by than the microscope. We incline to the opinion that though it detected no cancer cells, yet still that the tumour was malignant. We have seen no cases of abdominal tumours of such rapid growth and intense suffering that were not malignant; besides, too, brain-like structure is described as being found in one of the testes—a strong proof, we take it, of the view we hold of the case. The second case is given by Dr. Malcolm. It was the case of a woman, aged 50, married. She was attacked with severe pain, which was at first supposed to be rheumatism of the left hip. On admission into hospital, however, a tumour was detected in the left iliac region; this being attended with inflammatory symptoms, caused a difficulty in its diagnosis, which was only cleared up after some time, when its rapid growth and the constitutional symptoms attending it showed that, it was most probably of a malignant character, which it proved to be. It was an example of gelatiniform cancer, taking its origin in the ilium itself, the cancelli of the latter being very much hypertrophied.

No. 26 is an interesting case, also given by Dr. Malcolm, of a boy of 5 years, in whom the tongue, when he was about one year old, began to protrude from the mouth. This increased to such an extent, that the point reached below the chin, and so continued out of the mouth for 4 years; when, by pushing it back, and keeping the jaws closed by main force, the organ gradually resumed its normal size, and the boy was cured. His constitution was, in a marked degree, strumous. At the sixth meeting, the Society was chiefly engaged by hearing an account of the history and effects of the koussou, from Dr. Malcolm. This led to an interesting discussion on this important drug. At the eighth meeting, Mr. Armstrong exhibited casts with Daguerreotypes of a fibro-cartilaginous tumour of the neck. From the powers of this latter, we are sure it may be used to delineate disease with great effect, though we have not ourselves seen anything of the kind. At the same meeting, Dr. Young of Holywood read a paper on the utility of dilute sulphuric acid in diarrhoea and vomiting. This is one of those remedies which has passed through various phases like so many others. Though much used formerly it fell into disrepute, but only to be employed again, and as now asserted with the greatest benefit. We know it to be a valuable remedy, but, like too many others, we have found it fail. The great mistake about every remedy seems to us to be, in expecting that it will cure every case; and when we hear persons state that such a remedy has never once failed in their hands, we are sure that their experience is but very limited.

At the ninth meeting, Dr. Murney exhibited an example of aneurism of the arch of the aorta; the patient, however, died of sanguineous apoplexy. At the

tenth meeting, Dr. Ferguson made some observations on the difficulty of diagnosis between ascites and ovarian dropsy. Several very interesting cases and practical points are detailed in connexion with this subject, and we can recommend it to the special notice of our readers. At the twelfth meeting we have an interesting discussion on the use of muriate of iron in erysipelas. One gentleman, Mr. George Hamilton Bell, stated in Edinburgh, in 1851, that in a quarter of a century he had not lost a single case, and all due to this medicine! Truly, this must be the long-looked for elixir of life. How we are to explain such an astounding success—unless by supposing that this gentleman had few or no patients—we are at a loss to say. Once for all, we must repudiate the idea of any single medicine being invariably successful in any single disease, as this is asserted to have been. Such an assertion has with ourselves always the contrary effect. We believe that no such success attends medicine under any circumstances, and that it never will do so. As to the medicine itself, we would make one remark, that it is not iron alone which is given, but also a powerful acid, which has long enough been known as a valuable agent in some fevers, and to which we would be inclined to give some of the credit which the iron has got. At this meeting, likewise, Dr. Malcolm detailed a case of aneurism of the thoracic aorta. We know not that in the whole volume, a more valuable case is given. We cannot refer to it at length; but merely state that, literally, for years the, case was mistaken for rheumatism; and this by a number of gentlemen, including the names of Carmichael and Graves. Its whole detail will amply repay perusal. At the thirteenth meeting, an interesting case of cervical abscess, which communicated with the right lung, is given by Mr. Hanna; the abscess formed above the clavicle. The patient was in a marked degree of strumous constitution. We have seen exactly similar cases; and in one haemorrhage from the transversalis colli artery occurred, which proved fatal. At this same meeting, Dr. Malcolm made some valuable remarks on the varieties of chronic induration of the lung. At the sixteenth meeting, after the details of an interesting case of measles by Dr. Ferguson, we observe a very interesting, and ultimately fatal, case of chorea, complicated with endocarditis. The case is very well given by Mr. H. M. Johnston, and will amply repay perusal.

At the eighteenth meeting a case is given where a mother was delivered in such a way that her child fell forcibly toward the floor; this caused a large rent in the abdominal parietes of the child, from which, however, it recovered completely. It only lived five weeks subsequent to this. This curious case was sent by Mr. Samuel Ray. The nineteenth meeting was occupied with a very elaborate statement from Dr. Malcolm on the use of Quinine in continued fever. This, like so many other points in practical medicine, seems to be still anything but settled. Our own experience is against it, at least till the height of the disease be over. We know that it may then be used, and much sooner than is generally done. The late Dr. O'Brien, who was for many years connected with the Cork-street Hospital of Dublin, used it in this way, and published a

very able paper on it. At the twenty-first meeting, Dr. Malcolm detailed a case of varicose veins of the upper extremity. There were signs of this state at birth, and this had gradually increased till the patient reached 21, when he was liable to attacks of severe pain, and the movements of the limb were much impeded, apparently by the weight of the tumours which the veins had then formed. Phlebolites could be distinctly felt. Then we have a notice on the treatment of acute rheumatism by lemon juice, and a notice of the several writers who have used it. We have used it ourselves, and with benefit; but not in every instance, and we are not sure that other treatment is not equally successful.

At the twenty-fourth meeting an example of bronchial polypus was exhibited by Dr. Ferguson, being sent by Dr. Patten of Tanderagee. The case was remarkable in this respect, that there does not appear to have been any haemoptysis whatever; the appearance of the patient was, however, delicate. At the thirtieth meeting we have a very full discussion on the treatment of cholera, which has prevailed in Belfast since then—very much longer than, we believe, occurred in any other town in Ireland. We do not observe that anything was advanced which throws new light on this much disputed question. The general opinion seems to be, that the mercurial treatment holds out the best prospect of success. At the thirty-first meeting a patient was introduced by Dr. James Moore. The patient had suffered, during an attack of fever, from sloughing of the cheek, which had gone on to such an extent as to cause great deformity from loss of substance, and subsequently total inability of opening the jaw from the process of healing which had taken place. The patient was operated on by Dr. Moore on three different occasions, chloroform being used in each, and the result was that he left very much benefited, and the deformity greatly lessened. It is worthy of notice that, on one of the occasions, the chloroform caused very threatening symptoms; which, however, were promptly met, and the patient shortly recovered. This case on the whole, surgeons will read with much interest.

This concludes our necessarily hasty sketch of some of the contents of this valuable volume. We congratulate the members of the Society on so soon being able to publish such a volume, and we trust they will continue to do so each year. It must have a material influence on the medical school of Belfast, and on the status of its members amongst the profession at large. One point, and only one, we would venture to suggest—we think it is due to such a Society that the next volume should appear in somewhat of a different garb. When the present volume was put into our hands, we really thought it was a "Reading Made Easy," or, at the worst, a National School-book. But we were pleasantly deceived. We do think, however, that valuable contents should have a good outside. First impressions are not always easily effaced. We feel, however, that the point has only to be noticed, and that it will be remedied in the next volume, the appearance of which, we must say, we look forward to with pleasure.

BELFAST CLINICAL AND PATHOLOGICAL
SOCIETY

SECOND SESSION
1854 – 1855

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Belfast.

* Members of the Pathological Museum Committee.

† Members of the Microscopical Committee.

The ordinary Meetings of the COUNCIL are held every Wednesday, at Half-past Two o'clock, during the Session.

The SOCIETY meets every Saturday, at Three o'clock, during the Session, which commences on last Saturday in October, and ends on the first Saturday in May.

Place of Meeting.—The GENERAL HOSPITAL, Belfast.

THE FIRST ORDINARY MEETING.

28th October, 1854.

The President in the Chair.

THE PRESIDENT opened the Session with an Inaugural address:-

GENTLEMEN,—I would wish to preface the few observations I shall to-day trouble you with by an attempt to give expression, however faint, to the feeling of gratification with which I am impressed. First, by that mark of confidence and kindness which your placing me in my present position has conferred; and next, by that which I feel must be a mutual pleasure to us all—our meeting to-day to inaugurate our Second Session of the Belfast Clinical and Pathological Society.

And whether we estimate our circumstances and position by a retrospective or a prospective process, I feel we have nothing to offer each other save congratulations on the past, and in the prospect pleasure and improvement. Who of us that served in the past winter's campaign does not look back upon its weekly forays with reminiscences as pleasurable as profitable? and, moreover, replete with this very satisfactory feeling, that, though we were engaged in what might be truly designated "war to the knife," yet that we could "fight and run away," and are here "to fight another day." We are now, gentlemen, but in the second session of a career which I trust will outlive us all, and yet I am happy in being able to report that our numbers reach ninety-six—a success which I may truly say was hardly anticipated by the few who constituted the first meeting of this Society, convened now only twelve months since by our indefatigable secretary, to whom is due not only its very nativity but in a great measure its now full-grown maturity. Nor do I recognize a more pleasing feature in its constitution than that it includes so large a proportion of non-resident members, whose contributions to our transactions, and frequent attendances during the past session, give ample assurance for the future. I may here state that, with a view to their convenience, our weekly meetings on Saturdays open at three and close at four o'clock precisely.

The objects we propose to ourselves, gentlemen, are by the very name of our Society sufficiently indicated. I may, however, briefly state that they include the consideration of every topic which the term *pathology*, in its most comprehensive sense, embraces. And here assuredly we have a most extensive—an almost unbounded flight! Matters, however, of practical import, and such as are of every day's occurrence, constitute the more ordinary topics. A glance at the "Transactions" of the past session (which I hope will soon be in the hands of every member), or at the headings and order of precedence of the various subjects, as arranged in the weekly notice, will perhaps convey the best idea upon this point, and, I may add, dispel the erroneous notion wherever it may have been entertained that mere specimens of morbid anatomy formed the staple of our subject-matter. Disorganization of tissue, no doubt, occupies its proper place, but we must be ever careful to discriminate between morbid anatomy and pathology; the former referring merely to appreciable disorganization of

tissue or organ, the latter including not only these but far more important still—every phenomenon that differs from what is considered the standard of health, or that may be viewed in the light of disease, whether it be functional or organic.

Whatever the subject-matter brought forward here, expression of opinion and discussion are sought, and by the interchange of ideas and facts, information is mutually imparted, and knowledge necessarily elicited. This much at least I may assert of our experience of the working of our Society during the past winter, that few indeed were the weekly meetings from which its members departed without the pleasing feeling of having learned something. For myself I must say, that the opportunity of meeting my brethren, and interchanging professional courtesies at the Pathological, was looked forward to and enjoyed more than any other hour of my professional work; and I feel that I may confidently predict of the session on which we are to-day entering, that it will not fall short of its predecessor, nor disappoint the hopes of those who are sanguine in their anticipations of its success and their gratification.

Truth to say, on this point, I have but one doubt—but one misgiving, and that arises irrepressibly when I reflect on the so successful occupancy during the past session of that chair which I now so unworthily fill. Were this the place, or the time, for indulging in panegyric, I might easily, in gratifying my own wishes, strike a chord that would but echo your feelings; but I must forbear and content myself with giving expression to the hope that while I emulate my predecessor's example, my efforts may not be altogether fruitless, and that at least they may obtain for me your kind and indulgent consideration. Success in our object, gentlemen, and gratification in obtaining it, I do confidently anticipate. To secure this "consummation most devoutly to be wished," we must admit, that much, nay all, depends upon ourselves. We must, one and all, work; we must each, senior and junior, bring before the Society his facts, nay, even his theories; we must be prepared, as best we can, to establish our facts and to maintain our opinions, ever with a view and desire to impart or obtain knowledge—the grand object which this Society proposes to its members; and I need scarcely add, with that delicate feeling and gentlemanlike demeanour which I hope will ever characterize medical discussion. Differences of opinion, wide as the poles, may and will rise. Happily we may each hold, and fearlessly express his own, making it our boast that:

" Nullius addictus jurare in verba magistri."

We around this table at least may

" Agree to differ."

The sneers that had too often and too long been cast at the indefatigable labours of the pathologist, as well of the Continent as of our own country, have long since subsided, and the question of "Cui Bono," so foolish in connexion with this subject, has been even hooted out of medical society. If it were true, and we believe it to have been, that by some physicians too much attention has been devoted to the effects or products of diseases, and too little to the causes and treatment, is that a reason why we should run into the opposite error, and

neglect or despise one of the only two means we possess of investigating the nature, and subsequently the more successful treatment of diseases? To say that it is no use to determine whether disease exists in the pleura or in the parenchyma of the lung, because in both cases we must employ similar or analogous treatment, is a melancholy specimen of ignorance or laziness, or of both. Ignorance, for the seat of diseased action must ever make a difference, save to the routinist, in both the nature and amount of treatment; laziness, because accuracy of diagnosis must always be gratifying to the inquiring mind, ever useful in practice, and highly conducive to a habit of accurate observation. What but a knowledge of pathology can fortify us against errors as well of diagnosis as of prognosis?—errors which are far more disgraceful to him that commits them—far more than the "opprobria medicorum," than mere failures in treatment. Simply because a knowledge of the former is within most men's reach, whilst the latter too often baffle human power. In fact, the pathologist's grand object should be to combine the phenomena of disease presented in the living, and collate them with the physical alterations detected in the dead body. Hence alone can we deduce certain data for rational treatment. In this pursuit the warping influence of theory must be carefully guarded against. For example, whilst we admit the influence of the solids in the production of morbid phenomena, let us accord also its due importance to the alteration of the fluids. Whilst we admit that *local* disease is capable of producing constitutional disturbance, we would also maintain that those more general agents, the blood and nervous system, may be, and often are, primarily affected, and that thus *general* disease may precede the existence of any *local* affection. In short, we should select what is of real value from every theory that may be presented to us, wedding ourselves to none, but profiting when we can by it all—in matters medical being pure eclectics.

If ever there was a time, gentlemen, in the history of medicine which loudly called for a close investigation into the truth or falsity of opinions and facts, daily promulgated, it is the present; and for such inquiries our society offers a fair field, where I hope all such analyses will be candidly conducted, and the dross separated from the genuine ore. And here, if I might offer counsel without seeming to lecture, which, gentlemen, whilst I occupy this chair it shall be my study to avoid, I would caution all, especially my younger friends, to guard against a blind and indiscriminating incredulity on the one hand, and on the other against that credulity which receives too easily as facts, without sufficient careful investigation of them, what may have been the workings of a wandering and disordered imagination. We must steer well our bark, equally remote each vortex of ignorance—from this Scylla and that Charybdis. Both are alike pernicious in their effects, and unless men endeavour to free their minds from their baneful influence, in vain will they attempt to store them with knowledge which may serve themselves individually or advance the interests of science. The history of the researches and discoveries of the true friends and labourers in the field of

medical science, affords us numberless examples of how, by the exercise of industry the most labourious and indefatigable, of learning and talents possessed by few of his confreres, how by observing certain facts with precision and accuracy, a man may have established a new truth, or may have thrown light on points previously obscure, when forthwith the pen of rancorous criticism or the tongue of envious incredulity have been roused to all their ill-directed energy, deprecating the worth, too oft even the motives, of the man, bringing into doubt and discredit his most brilliant discoveries. Hence a powerful obstacle to the more rapid advancement of knowledge, not only clogging the revolving wheel of improvement, but too often turning it from its progressive to a retrograde course. "I have always remarked (writes one of the brightest ornaments of modern medicine) that they who were the most ignorant of any science were the those who believed the least in it." Nor could it be otherwise, for it is not the man who has observed a number of facts, who has attentively examined and, as far as it is given to man, verified them, who will deny their truth or validity, but far more probably *he* who may never have given himself the trouble of ascertaining even their existence.

And if incredulity arising, as it often does, in presumptuous ignorance, checks the advance of science, an unbounded credulity, or placing implicit belief in all one hears or reads, thus making us adopt, without sufficient inquiry into their truth, errors often the most absurd, is certainly productive of no less pernicious or less lamentable consequences. He who acts so is not only not likely to advance a single pace in the improvement of the science he may be cultivating, but he retards its progress by all the wandering dreams of his own fertile imagination, and by the adoption of every phantom that meets him in his erratic career. These two extremes, then—a blinded confidence or an unmeaning distrust in the opinions of others—are, I conceive, alike tests of mediocrity of intellect; in reality the effect of ignorance, and undoubtedly the cause of still more. Doubt, or that rational hesitation, which consists in neither implicitly believing nor positively denying anything before we shall have satisfied our better judgement of its rationality and truth, or actually applied some one of our senses to its investigation. This cautious *doubt* I take to be the characteristic of a truly philosophical mind—the source of knowledge and the mainspring of improvement. In illustration of this I would instance the immortal Laennec, who with industry the most indefatigable, with talents for observation and induction granted to but few men, worked during a period of full ten years before he ventured to put before the world his theories and facts. And in vivid contrast with this truly philosophic spirit, would I point to the baseless unmeaning phantasies which the late epidemic has elicited from too many of our profession—theories opposed to reason and to knowledge, facts unsustained by experience or truth, affording grounds occasionally, alas! but too well founded, for the boldly expressed doubt whether medicine had actually benefited the human family or not.

Pardon me, then, gentlemen, if I forcibly impress upon all the necessity of examining with care everything, especially theoretical, that may be proposed at the meetings of our Society. Let us not submit too hastily, nor bow too implicitly to

"The paltry jargon of the schools, where Pedantry gulls Folly,
We have eyes—."

Yes, and I may add, other senses too; and let us use them, ever holding in mind that though our science be not a physical one, yet that we should make every effort to reduce it as nearly as may be to physical certainty. Would that this great desideratum could be more frequently attained! would that our knowledge of this universally admitted difficulty, made no less dogmatic in our acceptance or rejection of problems emanating either from ourselves or others!

I have thus, gentlemen, briefly and faintly touched upon a few topics, allusion to which our present meeting seemed to me to justify. These, however, have had reference solely to our professional pursuits and our relations to each other. Now, some may think, and it may be wisely, that I should here, frank and mindful of "Ne sutor ultra crepidam," make my bow and sit down. Nevertheless, I feel strongly impelled, and perhaps unwisely, if I trespass not too much on your time and patience, to crave the privilege of making one or two observations not altogether irrelevant I hope, nor unsuited to our present circumstances; and I shall confine myself to such as bear upon our relations to, and intercourse with, the public.

If there be a profession, gentlemen, whether we view it in the abstract or its daily, hourly applicability to man's wants and circumstances, which should secure for its votaries the esteem and respect of their fellow men, assuredly that profession is ours. In what quarter of the globe, civilized or savage, from the eternal snows and crushing icebergs of the polar regions, to the burning plains and deadly jungles of sunny India, does our country not ask and have our willing service? Where nations have been menaced by, or are suffering from, the fearful scourges, pestilence and war, has medicine ever shrunk from her perilous post, or deserted the hallowed path of duty? To whom when "the noisome pestilence" stalks through the land, dealing dismay and death around, to whom have the people turned and looked "for safety and for succour?" Mid the carnage of the deadly sea-fight, and the slaughter of the ensanguined battle-field but yesterday at Bomarsund, on the banks and heights of the Alma, and around the bastions (and I trust ere now in our hospitals) of Sebastopol, has she not done her part? Has she not been deservedly praised and honoured? Do not passing events well illustrate the truth of old Homer's panegyric –

"The learn'd physician, skilled our wounds to heal,
Is more than armies to the public weal."

Or, to view our position in another light, will it be denied that a just estimate of the extent and importance of the knowledge which medicine requires and imparts, would have the effect of elevating our profession to the very highest rank in the world's estimation? What department of mental philosophy is

there that medicine has not availed herself of, or that medical men have not successfully cultivated? And yet we cannot, we must not, close our eyes to the fact that, as a profession, medicine is not held in that high estimation to which she is entitled, at least by the general public, whom we may well regard as -

"Monstrum horrendum, informe, ingeus, cui lumen ademptum."

That public -

"Whose pleasure is as great,
In being cheated as to cheat."

Although medicine, as a science, has made rapid and extensive progress, her sons have never reaped rewards proportionate to their labours and to their sacrifices in behalf of the community. Whilst the sister professions of law and divinity are upheld and defended in their rights and privileges by the strong arm of the legislature, and by codes of ethics and of etiquette, no doubt self-imposed by their members, medicine, which surely is inferior to neither in the extent and variety of its studies, or in the grandeur of its aims and objects, has been left to struggle as best it may against apathy, too often even contumely from without, and unhappily (and this, gentlemen, is our great reproach) against angry dissensions and jealous bickerings from within. This state of affairs, as unfortunate as notorious, has been long admitted and deplored, and numberless have been the remedies proposed to palliate or remove the canker. Yet, though their name be "Legion," an antidote supplied through them seems still remote and problematical.

For my own part, without entering at length into this difficult and vexed question, I would expect that benefits greater than from any other source would accrue to our profession from a good understanding and perfect union amongst ourselves—from self-reliance and from self-esteem. Let there be no mysterious assumption of superiority, nor affected air of condescension on the part of any; but on the contrary, let there ever subsist amongst us the most amicable relations, the most cordial coöperation, the most punctilious observance of the dictates of unflinching probity and honour, and the strictest attention to the requirements of decorum and professional etiquette, our ruling principle being "to do as we would be done by." May we never forget, for we never can with honour, that "Good name in man and woman is the immediate jewel of their souls; who steals my purse steals trash; 'tis something, nothing; 'twas mine, 'tis his, and has been slave to thousands; but he that filches from me my good name, robs me of that which not enriches him, but makes me poor indeed."

Should we ever find cause to be dissatisfied with, or openly to prefer a charge against, a professional brother, be it ours, prompted by the "still, small voice of conscience," whispering "humanum est errare," to try and have our differences arranged, and amity restored, if not by the interposition of mutual friends, at least within the pale of the profession. But, above all, be it ours religiously to avoid, as well in word as deed, as well in look as gesture, the insidious innuendo, the crafty, base insinuation; these let us shun even more scrupulously than we would open accusation. The

solemn oath imposed by "my Lord Hamlet" on his "good friends," would not be very inappropriate, me thinks, to us:-"Never with arms encumbered thus, or this headshake, or by pronouncing of some doubtful phrase, as 'well, well, we know,' or 'we could, an' if we would,' or 'if we list to speak,' or 'there be, an' if they might,' or such ambiguous giving out to note that you know aught." Oh! gentlemen, many be the ways of doing the vile, the noxious deed, but to us let them be anathema. Mutual confidence, respect, courtesy, and good feeling should characterize the intercourse of all the members of our profession.

Such conduct on our parts will lay the firmest foundation for that esprit de corps, that close bond of union, which we see with such beneficial effects pervade other professions so very much more spiritedly than our own; the want of which in our body, I firmly believe, in point of fact, to lie at the root of many of the evils we complain of. Doubt there can be none, gentlemen, that that man will ever secure for himself the most lasting and sincere respect who contemns every word and deed that has even the semblance of littleness or meanness, and who eschews every act that is unworthy of an honourable, manly, and exalted mind. Let us, then, laying aside our petty, selfish jealousies, our paltry, party struggles for ephemeral preëminence, evidence our self-esteem and self-respect by union amongst ourselves, and by proper esprit de corps. Let us establish our claims on the high consideration of the public, as well individually as collectively, by adopting a lofty standard of education, both literary and medical; and, above all, making it our pride and boast, "nil conscire sibi, nullà pallescere cupâ;" let our professional morality be without taint, above suspicion, and strong am I in the conviction that, though we may not accomplish all we may desire, yet that then, and not till then, we shall have put ourselves in a position most likely to promote and secure our individual good, and advance the best interests of our noble profession.

Following this the ordinary business was commenced.

I. Dr. MALCOLM exhibited two plaster casts, each representing the anterior thoracic wall, in a case of *aneurism of the ascending aorta*. The tumour had, by pressure, produced absorption of a portion of the sternum, and a considerable protrusion of the remainder, causing a considerable elevation. (See Plate I., figs. 1 and 2.) Dr. M. supplied the following particulars of the case:-M. A.

M'C_____, aged 58, resident at Belfast, of sallow and worn aspect, and looking older than her actual age would indicate; stated that she enjoyed good health until about three years ago, when she first noticed a *prolapsus uteri*, which was occasionally attended with difficult micturition. Her general health did not, however, become seriously affected till one year afterwards, when she began to complain of unusual debility, palpitation, and some degree of pectoral oppression, and fleeting thoracic pains. About one year subsequently (that is a year since), she first noticed a swelling at the upper part of the sternum, which gave her little or no uneasiness. Gradually, dyspnœa set in,

latterly attended with dysphagia, and pains of the neck and shoulders, and, at times, when attempting to lie on the left side, she suffers much from cough, and a choking sensation. The pains of the neck extend along the left arm. On the 15th ult. I examined her. The tumour then presented the appearance represented in the cast, No. 1. The impulse is great, and the pulsations are synchronous with the heart's action. Last week, a secondary tumour, between the sterno-mastoid muscles at their inferior attachment, appeared. There is no bruit. The pulse is regular. The respiration is quick and easily accelerated; palpitation frequently distressing, and her nights are sleepless. On 19th inst., (after the lapse of thirty-four days), I re-examined her. The tumour, in size and appearance, is represented by the cast, No. 2. The semi-circumference is about four inches, and it has a firm but elastic and pulsating feel. The dyspnœa is increasing in direct proportion to the increasing size of the tumour. Over the base of the heart there is well heard a systolic murmur, but this is not properly due to the tumour itself; it is rather to direct aortal disease. The impulse of the heart is heaving and forcible, while the sounds are dull and muffled. The pulse is regular, and eighty four.

II. Dr. MURNEY exhibited a specimen (wet preparation) of *caries of the vertebræ* attended with tubercular deposit in the bodies of the same. The patient was a man aged 27, who having complained of persistent pain in the dorsal region, and other symptoms evidencing inflammatory action, was treated in the usual way, and the gums touched with mercury. There co-existed, however, tubercular deposit in the lung. Dr. M. remarked upon the infrequency of this deposit in the spinal osseous structure, and observed that Louis, Nelaton, and most writers, are silent on this head.

III. Mr. BROWNE, R.N., reported the particulars of a case of *exostosis of the malar bone*, in which he had performed the operation of excision, the patient being under the influence of chloroform. The bone was found to be extremely vascular, and the actual cautery was required.

IV. Mr. BROWNE exhibited and explained an improved *Eye-douche*, recently recommended by Haynes Walton, Esq., London.

SECOND MEETING.

4th November, 1854.

The President in the Chair.

V. Mr. BROWNE, R.N., presented a patient affording a good example of *congenital cataract*, and read the history and particulars of the case, as follows:—

The patient, Margaret P., aged 10, was admitted on the 9th of August last for operation. The history is, that when about a month or six weeks old, her mother observed that there was something wrong with her eyes, and perceived that the pupil presented a dull whitish appearance, and that as the child grew up she was evidently blind. When admitted it was clear that

her amount of vision only enabled her to distinguish light from darkness, or the illuminated from the darkened part of a room. As is usual in such cases, her eyes were unsteady in their movements, evidently seeking for the natural and grateful impression of light, while the pupils were very active under its stimulus. When dilated by dropping one or two drops of a solution of sulphate of atropia—four grains to the ounce of water—the pupils presented, immediately behind them and occupying the posterior chamber, completely opaque greyish lenses, the anterior capsule in each being streaked and dotted with pure white striæ and points, depending upon calcareous deposition—a very common occurrence in cases of congenital cataract, when the eyes have not been interfered with till the sixth or seventh year of age. The operation I perform in congenital cataract, at first, is gently breaking up the anterior surface of the lens, through a pretty extensive laceration of the anterior capsule. The instrument I use is a fine straight needle, and I invariably operate through the cornea; of course in this, as in all needle operations, the pupil is fully dilated by means of extract of Belladonna applied around the eyes, or a drop or two of the solution of atropia placed upon the conjunctiva. This case was again operated on at the end of three weeks, to hasten the absorption, and the progress is now visible after a lapse of eight weeks.

REMARKS.—Now, as regards the cause of congenital, or indeed any spontaneous cataract, we are still in the dark; were we to judge of the effect we witness in cases of wounds of the capsule of the lens, we would infer that inflammation is the exciting cause; and it is likely that in every species the change in the structure of the lens, or of its transparency, is preceded by some inflammatory action of an asthenic type. In some cases of congenital cataract it has been observed that the pupillary membrane had become adherent to the face of the anterior capsule, remaining there after the other portions had been absorbed before birth, and if so, adhesion must have followed inflammation in utero; I have seen this central additional membrane on the centre of the capsule, but I am not prepared to say that such was the remains of the pupillary membrane. It might be a deposit of lymph; but if so, that is evidence of inter-uterine inflammation. However, as we have many cases in which something of the kind is presented, either deposition of lymph or pupillary remains, the question of the cause of congenital cataract remains to be proved. With respect to the best period of life for operation, the recorded experience of authors is in favour of an early one; if it be deferred to the age of eight or ten years, some imagine that the eyes not only acquire a rolling, unsteady motion in their search for their natural and most grateful stimulus, but lose sensibility from the want of that stimulus. There are cases that such arguments apply to; but again there are others, in which no such doctrine holds good, and some of my best cures have been in cases of complete congenital cataract existing up till the twelfth or thirteenth year.

I have heard it lately asserted that the very early operation is likely to be followed by injurious waste of the eye, the absorptive process having once been set

up. I believe the assertion to be incorrect.

VI. Mr. BROWNE, R.N., exhibited the recent parts of an excised *tumour of the breast* which occurred in a patient under 30, and which he considered to be of a scirrhous character. The operation had been early, and therefore presented a most favourable case.

VII. Dr. MALCOLM exhibited a cast of an upper extremity, affected with extraordinary varicose condition of the veins. (*See plate.*) The tumours gave little uneasiness, save from their weight and size interfering with the ordinary use of the limb. Sometimes, when any part of the skin became abraded, he has observed a difficulty in arresting the bleeding. The subject of this case is at present about 45 years of age, and in perfect health. He has noticed this varicose condition as long as he can remember. It is not increasing.

VIII. Dr. ROGAN, Londonderry, forwarded the following successful case of *vesico-vaginal fistula*:—

M. B., aged 20, applied for advice, in consequence of not being able to retain her urine, which was constantly dribbling away. A vaginal examination discovered a fistulous opening between the bladder and vagina, about an inch within the vaginal orifice; the point of the forefinger could be passed into the bladder. She stated that about a month previously she had been confined; her labour was a very bad one, and the child had to be destroyed before delivery. About a week after, she first perceived that her water came away without effort, and that she was constantly wet. A trial of the actual cautery was decided on. The patient was placed on her back, and a three-bladed speculum being introduced, the opening became apparent, and a silver catheter passed into the bladder through the urethra was easily seen. The cautery was applied by means of an iron rod, bent towards the end, with a button on the extremity, the patient being placed on her back, with the knees drawn up. Ten days after, no improvement being manifest, the cautery was again applied, and, in the course of another fortnight, there still being no improvement, it was decided to give the cautery another trial. On this occasion the patient was placed on her hands and knees—this position gave much greater facilities for the application of the heated iron, and the part was carefully cauterised. In about five days after, she complained that she was much worse; but in about a fortnight the flow of urine through the fistula was much diminished, and in about a month from the last application of the cautery she was quite recovered. An examination showed a firm cicatrix on the site of the former opening.

THIRD MEETING.

11th November, 1854.

The President in the Chair.

IX. Dr. MALCOLM read the notes of a case which was under the care of Dr. PIRRIE, in the General Hospital, of *gangrene of the foot, in connexion with diseased heart*.

J. W., aged 17, a mill-worker, of lymphatic constitu-

tion, was admitted into the General Hospital on the 7th of August, 1850. He never suffered from rheumatism, but occasionally for the last two winters has been annoyed with cough, which was so severe last winter as to be accompanied by expectoration of blood. He has latterly complained of palpitation on using more than the most ordinary exertion. On admission, his principal complaints were troublesome cough, and a painful tumour situated at the lower part of the left ham. This tumour, which obliges him to keep the leg closely flexed, was hard and tender and without pulsation, and its external appearance red and inflamed. After a few days the tumour completely disappeared, and nothing remained for complaint, save the slight cough, which soon also ceased without any particular treatment. He was now about to leave the hospital, when, at the physician's (Dr. Pirrie's) visit on the 15th, he directed attention to the toes of his left foot which were exceedingly painful. On examination the little toe was found to be quite black, while the others, and the dorsum of the foot, presented a mottled appearance. Lesion of the organs of circulation was now suspected, and, on examination, there were discovered extended dulness over the cardiac region, feeble pulse, a distinct murmur with the first sound, increasing in intensity towards the carotids; the pulse was 100, and soft. Opium, stimulants, and nourishing diet were administered, but on the 21st it was evident that a portion of the foot must be lost. The gangrene, however, seemed to have stopped, sloughs were being detached, and the surfaces underneath began to assume a healthy aspect, when, one evening, while sitting up at his supper, he suddenly expired.

P. M. EXAMINATION.—Unfortunately the heart and lungs were the only organs examined, so that the condition of the arteries in the left leg cannot be positively declared. The lungs were healthy. The left ventricle of the heart may be seen in the specimen to be extremely dilated, without hypertrophy of the substance of the walls, while the aortic valves are completely covered with small lymphy vegetations, the evident result of chronic inflammation.

(For particulars of cases showing the effects resulting from detached fibrinous deposit from interior of heart blocking up arteries, see the following references:—Edin. Monthly, for March, 1854 (Prof. Simpson); Trans. of Lond. Path. Society, vol. iv. (Dr. Crawford, and Mr. Shaw, Middlesex Hospital); Trans. of Medico-Chirur. Society, vol. xxxv. (Dr. Kirker); Medical Times and Gazette, vol. v., p. 412.)

X. Professor STEWART read the notes of a successful case of *traumatic tetanus*. The principal treatment was mercurialization, and the repeated use of chloroform by inhalation, and a stimulant regimen. The symptoms lasted five weeks.

FOURTH MEETING.

18th November, 1854.

The President in the Chair.

XI. Dr. YOUNG, Holywood, introduced the subject of the

treatment of Pertussis by dilute nitric acid.

In consequence of a very extensive epidemic of Hooping Cough in Holywood and the surrounding district, I have had a favourable opportunity of trying the effects of the new remedy, nitric acid, in that disease. As to its nature, I entirely agree with Dr. Todd, who pronounces it a disease depending on some peculiar irritation of the vagus nerve, the irritation being quite as complete as when the nerve is mechanically stimulated; and that, as far as present knowledge enables us to speak, it is a disease which runs a certain course, can be communicated from one person to another, and is probably due to the influence of a poison which gets into the system, and produces its local manifestations on the vagus nerve. It is not an inflammatory affection of any part, being simply dependent on a morbid state of the blood, caused by the introduction into it of some poison from without, and whatever inflammation may occur in the course of it must be regarded in the light of a complication of the disease.

It appears that the mortality from Hooping Cough is greater than any of the eruptive diseases that occur under five years of age, and it is supposed that in the sixteen years ending in 1853, there were not fewer than 130,662 deaths. Now, a remedy that would successfully combat such ravages as these must certainly be a great boon to the whole human race, and the assertion that at last such a specific has been found, deserves our most serious consideration.

Hooping Cough seldom attacks very young infants, yet I have seen a child three weeks old ill with it, and escaping too, when another child of the same family died. But I am not equal to Dr. Watson in experience of this kind, who says in his lecture, that a woman came under his notice who, while in the last week of her pregnancy, lived in a house where the disease was prevalent, and whose infant hooped the very day it was born. It is also rare in advanced life, though Dr. Todd has seen it in an old couple of 80 and 72 respectively, who did well and got safely over it; and a friend of mine recently informed me of a case occurring in an old gentleman of 75, who, when taking his daily exercise, used to astonish the public by running to a lamp-post when the fit came on, and holding tight till the attack had subsided.

As to the average duration of hooping cough, Dr. West, a high authority in diseases of children, says, that out of 25 cases watched from the time the cough first assumed a paroxysmal character, until the final cessation of all cough, he should be disposed to estimate the average duration of hooping cough to be ten weeks; two for the first stage, four for the second, and four for the third.

Since the commencement of the present epidemic of hooping cough in my neighbourhood, I have had abundant opportunities of putting the new treatment to the test. I have notes of cases in all stages, and they were all cured in less than a month. In the cases treated from the commencement of the attack, before the characteristic hoop was heard, I found that the acid reduced the violence of the paroxysm to a minimum, if I may so speak. In one of these cases, unless I had

heard the whoop, I might have supposed I was dealing with a simple bronchitis, although I am aware pertussis, like scarlatina or rubeola, may run its course without the presence of some of the important symptoms which usually mark the disease. Of one case I may give a few particulars. A gentleman's child, aged 9 years, coughed mildly for a week, and not being supposed to have anything but a common cold, got merely a little simple pectoral mixture. At the beginning of the second week it was evident she had hooping cough, and I then prescribed the nitric acid. I gradually increased the dose from five minims every third hour to fifteen minims every second hour, of the dilute acid. Here the disease was divided into three distinct stages, each stage occupying about a week; the first week catarrhal, the second spasmodic, and the third the period of decline. By the end of the third week the disease had entirely disappeared, with the exception of an isolated cough now and then for two or three days. I need hardly add that in this case, and in every other, where practicable, I employed every adjuvant that I considered useful, such as regulation of temperature, bowels, diet, and clothing; and strict confinement to bed when the cough was at the worst, gave very decided relief.

From having had the charge of a Poorhouse where hooping cough was prevalent some years ago, I took a great interest in this hitherto intractable disorder, and used varied and numerous methods of treatment, viz.—prussic acid, counter-irritants, laurel water, touching the pharynx with a solution of lunar caustic; alum as recommended by the late eminent Dr. Golding Bird, for checking the copious secretion from the bronchi, and the cochineal potash mixture, which last, I must confess, I never found to fail in alleviating the urgent symptoms. The cochineal is believed to be anodyne, and the carbonate potash counteracts the supposed tendency to acidity in the stomach and bowels. I have not tried chloroform, as lately recommended and insisted on by Dr. Churchill, but I think that moderate inhalations in conjunction with the nitric acid would be of great service.

The *ratio medendi* of the new remedy, as given by its author, Dr. Arnold, of Montreal, is supposed to be "to introduce the elements of the atmosphere into the blood by the process of gastric digestion, so as to enable the lungs to outstand the stage of temporary asphyxia which is induced during a severe paroxysm." Dr. Gibb believes that an antidote has been discovered in nitric acid. My own view is similar. I believe that nitric acid is almost as effectual a remedy in pertussis, as quinine in ague. The therapeutical properties of the remedy are admirably fitted to counteract the pathological effects of the disease. It is anti-spasmodic in its nature, a powerful tonic, antiseptic in a high degree, and it allays the dyspepsia and the usual tendency to sickness and vomiting. Dr. Gibb says he has no doubt that its chief use is in supplying the blood with an element, *nitrogen*, which neutralizes the excess of fibrine that exists in the blood in hooping cough.

I shall merely add Dr. Gibb's formula for a child under two:—Acid nit. dil., 12 drs. Tinct. card. co., 3 drs. Syrup. simpl., 3½ oz. Aqua, 1 oz.

Of this a teaspoonful every hour or every second hour. Children from two to five, and so on, may take increased quantities. It is of some importance to bear in mind the necessity for a soda gargle immediately after taking the medicine.

XII. Dr. HALLIDAY read the particulars of a successful case of *recto-vaginal fistula*.

XIII. Dr. MOORE exhibited a specimen of diseased scrotum and tunica vaginalis, and a drawing of the part before excision, which was required. The testis, though only atrophied, could not have been saved. The scrotal tumour was composed altogether of inflammatory products, as ascertained by microscopical examination. The tunica had been tapped twice; the last time the fluid removed resembled that of hæmatocoele.

XIV. Dr. MALCOLM read the following notes of a case of *inflammatory cystic formations of the gall-bladder*:—

The subject of this case was a woman, aged 50, who had suffered for the last ten or twelve years from dyspepsia, which, during the last two, was greatly aggravated and characterized by repeated paroxysms of pain, referred to the epigastrium, and—the constitution having been unaffected—were ascribed to the passage of gall-stones, which, however, were never observed in her stools. During the last four months she was constantly confined to bed, and was reduced to a state of great debility, from the increasing irritability of the stomach. Two months ago she became slightly jaundiced, and then the pains became more settled in the region of the liver. Latterly the pain and irritability were so persistent, that scirrhus of the pylorus was diagnosed. During the presence of the paroxysms, the occurrence of large tumours in the curve of the colon was remarkably deceptive, their size and dense hardness indicated retained and hardened faeces so perfectly. They were always, however, dispersed by the administration of enemata of turpentine and assafœtida, which frequently brought away scybalous masses. The tumours, however, were constantly co-existent with the paroxysms. The adhesions of the colon may account for the hardness felt when this gut was inordinately distended.

P. M. EXAMINATION.—The liver is greatly enlarged and very friable, and has contracted adhesions to the colon, which is diminished in calibre. The gall-bladder is greatly contracted, and its walls thickened to such an extent as to occupy a considerable space, are converted into a cartilaginous structure, containing cysts filled with gall-stones of large size. These cysts had no communication with the ductus choledochus. In the immediate neighbourhood of this mass a small portion of the liver had supplicated. The stomach and intestines, and other abdominal organs, were healthy.

XV. Mr. MADDEN, Portglenone, submitted (per Secretaries) the following case of *protracted amenorrhœa*:—

Mrs. C ___, now aged 50, was married about the age of 20. Ten years afterwards, she fancied and hoped she was in that state in which "ladies like to be who love their lords;" and so confident was she of this being the

case, that she had procured the baby things, and all other requisites generally had by farmers' wives on such blissful occasions. At last, labour pains apparently coming on, I was hastily summoned, and found her calling out most lustily; in fact, she had every appearance of a person likely soon to give birth to a child. On making an examination I was a little surprised at not finding the os uteri, the vagina being totally closed up. The abdomen presented no enlargement, more than might be expected in a person of her appearance, being rather enbonpoint at the time. On making inquiry into her history, I found she had never menstruated. For some time after her marriage, she suffered the embraces of her husband with great pain; but through time, the roof of the vagina got stretched by the long-continued attempts at coition, and matters afterwards got on as well as if no malformation existed. A few years after I had discovered this state of affairs, she removed from this place, and again fancied she was enciente. A neighbouring professional gentleman was called on to attend her; but he observed nothing different from what I had experienced on the former occasion. What makes this case remarkable, are the facts, that up to this period she never menstruated, never had any vicarious discharge, and always enjoyed excellent health, with a tendency to obesity. The mammae are perfectly developed: her face is rather florid, and presents a small moustache.

FIFTH MEETING.
25th November, 1854.
The President in the Chair.

XVI. Dr. MALCOLM exhibited the recent parts, in a case of *scirrhoid thickening of the pylorus and colon*; and observed as follows:—

The recent parts here exhibited are portions of the colon and stomach. The pylorus is thickened considerably, and its calibre much diminished. On section of the mass, the structure seems to consist of white fibro-cartilaginous tissue having the appearance of scirrhus; there is distinct thickening of the short curvature in the sub-mucous tissue. The stomach, generally, was contracted; the transverse colon is observed adherent at one end to the pylorus, and at the other contracted, with thickening of its coats at the inner margin; besides these changes, there was considerable amount of fluid in the peritoneum, turbid, and of a brownish tint, amounting to 24 ounces. The cæcum and the ascending colon were enormously distended, with natural discharges. The subject of this examination was a man, aged 37, who was seen by Dr. MALCOLM, in consultation with Dr. BRYCE. He had laboured under symptoms of indigestion for a period of 14 years; these symptoms were vomiting, pyrosis, acidity, flatulence, and torpor of bowels. He never complained of pain until last six months. This pain was first felt in right side and shoulder, and afterwards at various points over the abdomen; the vomiting generally occurred about six hours after a meal, and it was always preceded by a peculiar taste like oatmeal cake. He never observed a sensible perspiration, and the skin

appeared always dry and scaly. The matters vomited were of varying colour and consistence; when not the ingesta, they were sometimes of a greenish tint, sometimes white, and effervesced; and at others, exactly similar to strong black tea. The constipation was latterly a source of great misery, as to it were due the shifting abdominal pains and obstinate flatulence, which gave him so much distress on some occasions. The intestine would remain obstinately obstructed for a period of two to three weeks, and frequently repeated enemata were absolutely necessary, to produce the slightest relief.

Medicine of various kinds had been unsuccessfully administered by different practitioners, and he gradually became more and more exhausted till the period of his death.

XVII. Dr. M'CORMAC exhibited portions of a tuberculous lung, in the advanced stage. A discussion originated as to the treatment of phthisis, and the alleged efficacy of ol. je. aselli. It was resolved to hold a formal debate thereon at some future meeting, to be fixed by the Council.

XVIII. Mr. BROWNE introduced a patient affected with goitre, and read the following paper thereon:—

The subject of the following brief remarks, and whom I have had the pleasure of exhibiting to the Society, is a native of the County Down; has resided for many years in the neighbourhood of Whiteabbey, and has never been out of this country, save for a few months in Glasgow, three years ago. She first observed the swelling of the thyroid gland some six years since, and considers that the increase was not great after it had attained to about half its present size, until within a few months back, when it attained its present dimensions. The tumour measures, semi-circumferentially, four inches by four; and is more especially marked on the right side, occupying the position of that portion of the thyroid gland. The tumour is evidently composed of thin lobes, or cysts; it is soft, elastic, and smooth; and the lobular character can only be detected by close examination. The cause of this growth the patient cannot account for, as her health and functions have always been good and regular.

The only discomfort she has suffered is, latterly, that she has felt occasionally some difficulty of breathing, and on exercise or excitement, some pain, or rather a sensation of fulness and uneasiness, in the head. From the number of cases of simple goitre that have been reported as cured (so many as 75 per cent.), by treatment, I was induced to take this patient into the hospital; and I have put her under the following system of medicine:—She took for some six days, three-fourths of a grain of the protoiodide of mercury, night and morning, in the form of a pill, made up with extract of hyoscyamus; this quantity was reduced to one pill daily, when the gums exhibited the first trace of the system coming under the influence of the mercury. She has also taken, for the last twelve days, five grains of the iodide of potassium three times a day; and since this day week the tumour has been painted every second morning with a concentrated solution of iodine. The

medicine, hitherto, has not in any way disagreed with her, and I can perceive a decided diminution in the volume of the tumour, of which the patient herself is quite sensible. My intention now is to omit the iodide of mercury, and to substitute half grain or grain doses of iodide, with the iodide of potassium, continuing either the painting with solution of iodide, or substituting for it the ointment of the iodide of lead, to be applied by repeated frictions, the method that, has been very useful in promoting absorption of this species of tumour.

The question that I now wish to put to this Society is—What would the members recommend, provided the treatment I have adopted fail? Would they advise puncture and injection of the tissues of the tumour, or the passing of a seton through its substance? For my own part, seeing that I believe the tumour to be composed of a complete cyst, or cysts, communicating freely, I would be disposed to puncture and throw in a solution of iodine, not so strong as to run the risk of much irritation, or any tendency to sloughing of the part. Of course, the step of puncturing would be a guide for further proceedings; for if I found that the cyst, or separate cysts, if they exist, could not be emptied by the opening, or openings, I would not think of forcing any fluid into the cells of a hypertrophied gland. For if the tumour in question be not of the cystic character, I think the attempt at injection would be wrong.

XIX. Dr. MALCOLM exhibited a new *uterine compressor* which he had found useful in some cases of post partum haemorrhage. It is simple, and easy of instant application. (*Sold by Pratt, London.*)

SIXTH MEETING.

2nd December, 1854.

The President in the Chair.

XX. Dr. MOORE exhibited a dried specimen of malignant disease of the femur.

XXI. Dr. MALCOLM exhibited a recent specimen of a placenta charged with calcareous deposit, and adverted to the views lately published on diseased placentæ by Professor Simpson, Rokitanski, Drs. O. Ward, H. Jones, Burnes, Druitt, Ollivier, &c.

An interesting discussion ensued as to the alleged influence such changes might induce on the nutrition of the foetus; as to their cause; and, lastly, as to the connection of "fatty degeneration," atheromatous and calcareous deposits, and such like states of the placenta, and the "cessation of function"—a relation strongly advocated in the *Medico-Chirurg. Trans.*, for 1851.

XXII. Dr. ROSS opened the debate on the query—"What has the experience of the recent epidemic (Asiatic cholera) contributed to our knowledge of its pathology and treatment?" as follows:—

As there is every reason to fear that cholera may eventually become an endemic disease of this country,

I am sure you will approve of the query proposed for discussion to-day—"What has the experience of the recent epidemic contributed to our knowledge of its pathology and treatment?"

This epidemic commenced in Belfast about March, 1854, and ended about the following October, during which time there were 1,025 dispensary cases, and I calculate that private cases, and those not reported, would make the total number about 1,100. The disease was almost confined to the poorer classes, and was much less severe in point of numbers than in the epidemics of 1832 and 1849, but not in virulence, as far as I know.

The filthy parts of the town suffered most, and in those districts in which the cases were most numerous, there also, generally speaking, the fatality and the severity of the cases was greatest.

I have been confirmed in the opinion that cholera, like typhus fever, is the effect of some poisonous agent received into the system, and that diarrhoea, exhaustion, bad drainage, situation, &c, merely act as predisposing causes.

From what I have seen, I am satisfied that cholera is propagable by infection, but that as malaria develops ague, so the choleraic poison derived from the earth or the atmosphere develops cholera, and that it is in this latter way the disease generally spreads.

I consider the vomiting and diarrhoea efforts made by nature to get rid of the *materies morbi*; why it should seek egress by the alimentary canal is nothing more remarkable than the fact that tartar emetic injected into the veins seeks elimination in a similar way.

But we must take a proper view of this eliminative action, and certainly not, in order to promote it, purge our patient to death by full and frequently repeated doses of castor oil; recollecting that, although by the efforts of nature we get rid of the poison partly or entirely, unfortunately it is not it alone that is poured out; the blood is almost drained of its aqueous constituents, producing extreme depression of the vital powers, and rendering the blood almost incapable of circulation.

What is the cause of death in hanging or drowning? The entrance of air into the lungs is prevented, the chemical changes cease to take place, the blood becomes loaded with carbonic acid; in this unnatural state it will not pass through the capillaries, and, consequently, it stagnates in the lungs, the heart's pulsations becoming weaker, until they cease altogether. So in cholera—though from a different cause, viz., the non-fluidity of the blood—the circulation flags, and, finally, too often ceases.

I think, then, that to consider cholera the effect of a poison introduced into the blood, will best account for the immense gastro-intestinal evacuations, these, in turn, causing the extreme depression, the craving for fluids, and the interruption of the circulation. The blueness, the loss of temperature, and the cramps are direct consequence of the non-arterialization of the blood.

In the consecutive fever there is real weakness from the loss of albumen in the previous stages, and the depurating organs are more or less paralysed, probably

because the blood is so much deficient in serum.

As to the portion of the query relative to treatment, still further evidence has been obtained of the importance of arresting diarrhoea when cholera is epidemic, and of the utility of house to house visitation. The astringents I prefer for this purpose are opium (with calomel if there be vomiting), sulphuric acid, tincture of krameria, and acetate of lead, with opium.

The free use of opium in the fully developed choleraic seizure, I consider highly injurious. I think this epidemic will impress this opinion still more strongly on the members of our profession.

In this stage I put most confidence in small doses of calomel, 2 grains every hour, or if the vomiting be urgent 5 grains of calomel and one of opium every hour until bilious evacuations appear; in astringents (and the mixture I prefer is composed of sulphuric acid, tincture of krameria, chloroform, capsicum, and Hoffman's anodyne); in the free use of fluids; and in turpentine epithems and bandages.

The more general use of frequently-repeated small doses of calomel, instead of the very large ones formerly used, is a very great improvement.

The removal of patients in collapse to hospital at a distance, has, to say the least, in many cases, hastened the fatal termination, and should, if possible, be avoided.

In the consecutive fever, the system having been weakened by the loss of albumen, etc., in the previous stages, and the blood being in a very unhealthy state, the indications are, to support our patients' strength, to administer fluids freely (which is in all stages necessary, but more particularly so in this), and to depurate the blood through the lungs, liver, skin, and kidneys.

I have used the sulphuric acid mixture as a prophylactic with much success, but I have experienced no benefit from quinine or silver in any stage of the disease.

When, Mr. President, I see around me some who have treated cholera in three epidemics, and so many who have, like myself, in two, I do hope that we shall be mutually benefitted by the discussion on "What has the experience of the recent epidemic contributed to our knowledge of its pathology and treatment?"

The PRESIDENT—The choleraic diarrhoea washes away the constituents of the blood, hence our duty is to arrest it. Diarrhoea is a predisposing cause.

Dr. McCORMAC did not think Asiatic cholera would become endemic. It is brought here by infection. Seasoned individuals are not very liable. The constitution of the individual is the cause of variety in the case, as regards severity. Treatment advised:—Opium and sulphuric acid at first; vomiting relieved by iced water, prussic acid and creosote, sinapisms. In collapse all means uncertain.

Mr. GELSTON, Comber, submitted the result of his experience at Ballymacarrett, in 1849, as follows:—

In the early stages, when the patient has not been exhausted by profuse serous evacuations, the disease may be arrested by a purgative of the bitter class, as

Tinc. Rhei., 1 oz.

Tinct. Aloet., 2 drs.

Aqua Menthae, 2oz., M.; or,

Pulv. Gregorii, 2 drs.
Aqua Menthae, 2 oz.
Tinct. opii, 20 guttæ, M.
Ad effectum.

An emetic of hippo, previously exhibited, if tongue foul, as in drinkers. When much prostration, and evacuations profuse and watery, by tinct. opii, 1 dr., in raw spirits or strong hot brandy and water, repeated if necessary, with tinct. catechu, sinapisms, &c. If the discharges persistent, large doses of tinct. kino, catechu, or tannin; or if these be inefficient, by strong solution of alum. In collapse, reaction may be procured by warm bath, the emetic system as before-mentioned, &c.

The object, in the first instance, being to assist nature in discharging the poison from the stomach and bowels, by means calculated to counteract the disordered action therein, this may be attained by such agents as arrest fermentation and expel it from the system; to this end are applicable bitter purgatives, absorbents, and aromatics. In the second case, the disordered action having induced a relaxation of the exhalents, powerful astringents are indicated; the process of exosmose may be arrested by preparations of opium, astringents, &c. In the third case, the patient must be plunged immediately in a hot bath or enveloped in hot air or vapour, taken out and wrapped undried in blankets. An emetic of half a drachm carb. ammon., and two tea-spoonfuls of mustard administered in hot water or chamomile-tea; this produced active vomiting and profuse perspiration succeeded. In a few cases, vomiting was not induced, but notwithstanding, sweating was produced. Beef-tea or meal-tea occasionally; the thirst allayed by a saline drink of nit. potass., carb. soda, and tart. acid in solution; diluents were plentifully allowed. If the watery purging returned, a strong solution of alum was found the most prompt means of arresting it; the vomiting combated by large sinapisms. The reaction, and consecutive fever soon became violent, especially in those who had taken large quantities of stimulants; leeches to the head, and venæsection frequently required; the bowels obstinately constipated, for which calomel and ext. coloc, followed by inf. senna, was found the best purgative; the milder aperients, as castor oil and rhubarb inefficient. In cases out of hospital, where a bath cannot be procured, jars of hot water to the feet, hot bricks, wrapped in wet cloths, to the body, and the emetic as above, produced the same good effects.

Mr. BROWNE believed in the preponderating operation of local causes, and advocated chiefly the mercurial treatment.

Dr. THOMAS THOMPSON drew an analogy to yellow fever of the West Indies, and referred to his experience there as to the influence of season, quoting the following pithy distich:—

"July stand by,
August you must;
September, remember
October, all over."

He believed that there was a great tendency here every July and August to choleraic disorders. In his treatment he relied chiefly on opium and stimulants.

Dr. BECK had seen much of cholera in 1832, and lately. He considered the cholera poison was imported here. Sanitary defects may spread, but cannot produce it. The discharges, though common, he did not deem essential. The spasms observed are the result of a vitiated or poisoned state of the blood. As to treatment, calomel is the chief, though he was not favourable to it in 1832. Opium in the early stages.

Dr. PATTERSON's experience in several epidemics led him to believe that it was not contagious.

Dr. MALCOLM advocated the sanitary view of the cause of cholera. No doubt there is a certain condition of the atmosphere favourable to the propagation of Asiatic cholera, but local agencies determined its presence in particular localities. It was a poison of the most virulent description, which manifested itself principally on the intestinal tract, and afterwards on the nervous and circulatory systems. Arrest the diarrhoea and debility of the early stage by full doses of opium, or, if this fail, calomel and opium; and, in general, collapse will be prevented. Save temporarily to raise the temperature, stimulants are hurtful, as also ordinary astringents. Fluids, especially saline drinks, are of great service. In reaction, a small cupping over the loins will be found useful in restoring the renal secretion.

The PRESIDENT believed that the pathology of Asiatic cholera was yet a desideratum; morbid anatomy threw no light. He considered its influence bore most heavily on the ganglionic system.

Mr. JOHN THOMSON had seen many cases in the Union Hospital, last epidemic. He related the case of a hemiplegic patient, who was attacked, and passed into collapse, in whom the paralysed limb was decidedly warmer than the other. All the cases had premonitory diarrhoea; a few only, the "rice-water stool." Opium in the early stage, and opium and calomel afterwards, was the usual treatment adopted by the physician, Dr. Seaton Reid.

Mr. HANNA suggested (having found utility in) the application of ice to the throat, to relieve the inordinate thirst; and cupping the epigastrium for the vomiting. He also recommended the administration of iod. pot. internally.

Dr. HALLIDAY advocated large and full opiates at the commencement; calomel only in reaction. Found in almost hopeless cases, the greatest benefit from half drachm doses of turpentine every half hour.

Mr. ARMSTRONG employed calomel and stimulants.

Dr. DILL spoke of the inhalation of oxygen; a proceeding, however, which received a fair trial at Sunderland in 1832, and was found wanting.

Mr. CROKER, Hillsborough, had seen benefit from use of tinct. cantharides in restoring the renal secretion; but not having seen much of the epidemic, did not like to give an opinion.

SEVENTH MEETING. 9th December, 1854.

XXIII. Mr. BROWNE presented a patient affected with malignant disease of the eye and orbit, also engaging

lymphatics of neck. (Particulars of origin and progress, as given in subsequent reports,—to save repetition—are here given, though the case did not terminate till 21st instant.)

R. D., aged 38, was admitted into the Hospital, 9th December, 1854. States that about eighteen weeks ago a small tumour appeared in front of the ramus of the lower jaw, on the right side. About a fortnight afterwards there was a slight protrusion of the right eye occurred, with an imperfection of vision. There was also a difficulty in the closing of the eye.

During the fourteen subsequent weeks the tumour increased but slightly in size. About a fortnight before admission, both the tumour and protrusion of the eye became much greater, and appeared increasing rapidly.

On admission, the swelling includes the whole of the parotid gland on right side, together with the submaxillary and cervical glands, and extends from the clavicle below, to the mastoid above.

The eye appears much protruded, the eyelids are red and swelled, with effusion of serum. Pupil rather dilated, irregular, also insensible to light.

He was ordered the proto iod. hyd., also leeching and poultices to the eye and tumour.

On the 16th an incision was made into the tumour, from which a small quantity of pus and blood exuded.

From this time he gradually grew worse, and died on the 21st December.

P.M. EXAMINATION.—Upon removing the cranium, the membranes and surface of the brain presented a natural appearance. The brain substance was of a natural consistence.

After raising the anterior lobe of the right hemisphere of the cerebrum from its seat upon the anterior fossa of base of the skull, it was observed that the orbital plate of the os frontis was in a state of caries, and that the diseased action had extended through the roof of the orbit. The tissues about were evidently infiltrated with the morbid brain-like matter.

In the substance of the anterior lobe of the right cerebral hemisphere, we found the cavity of an abscess. In respect to size, it might contain a walnut. The brain substance in its neighbourhood was healthy in appearance and consistence. The walls of the abscess presented a dotted bloody appearance, and one could scrape off portions of the same morbid product as that mentioned above.

Upon reflecting the integuments from off the tumour in the neck, we found the sterno mastoid expanded over its surface. The tumour occupied the greater portion of the posterior, superior, and anterior triangles of the right side of the neck. The tissues in its neighbourhood were very much involved in it. It had no distinct cyst. It seemed to take its starting point from the glands about the angle of the jaw, and did not appear to have any intimate connection with the parotid, as healthy portions of this gland could be dissected out. Upon making a section of the diseased mass, it presented an appearance very similar to semi-purified brain, and the outline of the different lymphatic glands presenting this appearance were plainly visible, as forming portions of the tumour. Different points of suppuration had occurred, chiefly

near its surface. Upon tracing its extent and ramifications, we found it to extend downwards to a point upon a level with the circoid cartilage, inwards to the sides of the cervical vertebræ, larynx, and pharynx, and upwards to the base of the skull, where it seemed to be connected with the diseased orbital mass. (See plate and Museum Catal.)

XXIV. Mr. BROWNE exhibited the recent parts (larynx) in a case of fatal scald from drinking boiling water.

The case was most urgent: laryngotomy was performed, and there was a respite for the space of one week. Indeed, until the seventh day, no bad symptom occurred. The epiglottis was much congested.

EIGHTH MEETING.
16th December, 1854.

The CHOLERA DISCUSSION was resumed and concluded. [The report is included in the transactions of the sixth meeting.]

NINTH MEETING.
6th January, 1855.

XXV. Dr. MALCOLM exhibited the recent parts in a case of *apoplexy supervening upon a paralytic seizure some four months previously*.

The patient was a female, aged 45, and had had dropsy one year ago, from which she perfectly recovered. In this case there were found an organized cyst on the left hemisphere, and a recent extravasation of blood in the substance of the medulla oblongata. The vessels were diseased—atheromatous and calcareous deposit here and there. Rokitanski considers the occurrence of rupture in the medulla "quite exceptional;" and observes that "there is no single cause that will account for the frequent repetition of attacks of apoplexy in many individuals, and its simultaneous appearance at several spots in the brain, but the presence of disease of the vessels."

XXVI. Dr. HALLIDAY presented a patient whose right upper extremity afforded an extraordinary example of varicosity of the veins.

XXVII. Mr. H. M. JOHNSTON read a paper upon a case of pertussis, complicated with convulsions, coma, and paralysis, and followed by dementia. The patient was presented to the Society.

TENTH MEETING.
13th January, 1855.
The President in the Chair.

XXVIII. Dr. BECK read the following paper, being analysis of 900 cases of midwifery attended by himself personally:—

I have been more or less actively engaged in the practice of midwifery since 1835. Since 1840 I have on

the average attended 100 cases each year. In 1835 I commenced to register the particulars of each case I attended, but, as it had been imperfectly kept, I destroyed it, and in January, 1845, commenced a new register, which has been correctly kept, and contains every case I had charge of since that period. They amounted to 900 on the 11th December, 1854, and were attended during the last eight years of active practice. The register contains the following particulars of each case, with a very few omissions—The number, the name, the date, the residence, the sex, the number of hours ill, the treatment, if any, the hour when delivery took place, the day of the week, the number and sex of the previous family, if any, and anything considered at the time worthy of remark, in relation to either the mother, the foetus, the labour, or its effects, &c.

Sex.—The children born amount to 917, of these there are males 474; females, 423, and not marked, 20, showing a preponderance of males over females of 51, or nearly one-seventeenth of the whole number. I may also remark that the number of males is greater than that of females in every complete year of the register, with one exception, and that was last year, 1853, in which the males were 53 and the females 55, showing a bare majority of 2.

Cases in which the full term of gestation was not accomplished.—There are 55 cases in which the contents of the uterus were expelled before the full time, i.e., little less than one sixteenth of the whole number. **Causes**—Some occurred from no traceable cause, others from a variety of causes, among which are mentioned fever, fright, muscular exertion, falls, and last, though not least, a syphilitic taint. With regard to the periods at which the miscarriage, abortion, or premature labour took place, we have, from a few weeks to 3 months, 14 cases; above 3 months, and up till 6 months, 18 cases; above 6 months, but under the full time, 23 cases. With regard to the sex in these cases, there were 26 males and 17 females, which seems to favour an opinion very popular among old women, that males are more frequently lost in this way than females. As to treatment, there is little worthy of remark. Secale was given in three cases, and the plug was used once for haemorrhage. Two had peritonitis. They were treated in the usual way, and recovered. One child at 7 months (No. 271) was born *alive*, and lived 9 days. The same occurred in only another of these cases, twins, at 4 months (No. 303). They were both born *alive*, and one lived 20 minutes. Three of the mothers died. The first (No. 136) was seized with a fit of convulsions at 8 months and a quarter; was bled, blistered, &c, became comatose, and in that state had three energetic pains, which brought the child's head to the perineum; the forceps were then applied; she was very easily delivered; the placenta came away readily; no haemorrhage; she died the same evening, having been 3 days ill altogether. I had not seen her till after she had become insensible, but I learned she had complained much of head-ache before the convulsive fits set in. The second death (No. 173) was from haemorrhage. She had the spots of typhus fever on her, when I first saw her, and was lying with a bed-pan

under the pelvis, which some thoughtful attendant had placed there to catch the haemorrhage. This I saw, at a glance, was so large as to be, under the circumstances, fatal. I emptied the uterus as soon as was possible, and applied a bandage, which proceeding completely arrested the haemorrhage—but the work was already done, and she sank 20 hours afterwards. The third and last death (No. 770) has already been mentioned to the Society, by Dr. LYNCH, who had tapped her for ascites a few days previously. In fact she was in *articulo mortis* at the time I was sent for; was easily delivered of a 7 months' foetus; had remarkably little, indeed I may say, no haemorrhage; expressed herself greatly relieved at getting rid of her burden, and yet breathed her last in less than 2 hours afterwards. I may remark that 8, or one in 7 of these cases, must have been dead some time, as they are marked "putrid." With regard to the presentations, one is marked "face to pubes," one "foot," and one "hips."

Twins.—The number of twin cases is 17, or about 2 per cent, of the whole number; of these nearly a half, or 8 in the 17 cases, were unusual presentations. The first twin "head," and second "foot," 1. The first twin, "foot," and second "face," 2. First twin "foot," and second "face to pubes," 1. The first twin, "hips," and second "arm," 1. The first twin, "feet and hand," and second "head," 1. Both "head," 9. Not marked, 2. Three in the 17 were premature—2 at six months and 1 at four. Secale was used once for a "face" presentation for the second twin, and the forceps once in a like case, for the same reason. These cases were the ninth and eleventh births respectively, and consequently there was a want of energy in the uterine action. The arm case was of course turned, and then all did well. With regard to sex in the twins, there were two males, 8 times; a male with a female, 5 times; and two females, 4 times—in all 21 males and 13 females, or 3 males to 2 females nearly. In one case at the full period the twins were dead. The mother had had three dead born children before. In one case at 4 months, they were both born *alive*, and the last one lived 20 minutes. Indeed the old woman in attendance unwittingly killed the first by filling its mouth full of salt, for some inscrutable reason of her own. I interfered just in time to save the second one from a like fate, and had it rolled up in cotton wool and kept in a warm place, just to see how long it would live. The mothers all did well.

Presentations.—With regard to presentations, though I made it a point of first importance in every case, to ascertain, as soon as possible, and as accurately as circumstances would permit, the exact position, not only of the foetus as a whole, but of the presenting part in particular; yet I have not registered, nor do I see any utility in registering, the head as being in the 1st, 2nd, 3rd, 4th, or 5th position. Indeed, while it is one of the most necessary, it is one of the most puzzling things, in some cases, to make out what you have under the *tactus eruditus*. In turning I have had exceeding difficulty to assure myself I was in contact with a foot, and not a hand. In two cases of hydrocephalic head, I was for a long time at a loss, owing to the pressure, to know whether I was touching the head or some other part of the body through the unruptured membranes. I was

twice completely nonplussed to make out the presenting part, while carefully examining the place where the cranium should have been in, in each case an acephalous foetus. In another case (No. 884) which occurred on the 18th of October last, I was very near making a fatal blunder, by permitting a tumour to descend before the child's head. It was a first case; the mother aged at least 40; and I can assure you that it was no easy matter to keep the tumour above the brim of the pelvis, until what I knew to be a foetal head had entered. The patient told me afterwards she wondered what I was about, but submitted, as she supposed what I was doing was necessary. In fact I was not sure, until after the child was born, that it was not the hips of another foetus I held back. Still, I had determined, if it had been a Pharez, he should neither have an arm nor a leg out until his brother Zarath had fully come forth. I have registered the following peculiarities of presentation: The face towards the pubes, 20 times, or 1 in 45; the hips, 8 times; the knee, feet, or foot, 9 times; the cord, 7 times; the face, 5 times; the arm, 3 times; the placenta, twice; the back, once; the arm and leg, once; the feet and hand, once; the side of abdomen, once; and lastly, one born double. The presentation had been the shoulder; an officious attendant had pulled out the arm, and, when I first saw the case, the process of spontaneous evolution, which was going on, had brought the child's lumbar region to near the os externum; and, as the pelvis was roomy, and the pains energetic, it was expelled exactly double, with the feet on the face, in about five minutes. Of course it was dead.

With regard to the 20 cases of face to pubes, they were, as is usual, more difficult than when the head was in the ordinary position. Six required the forceps, and one secale. One child was dead. It was one of the forceps' cases. The mother had hepatitis and jaundice afterwards. The mothers all did well in these cases.

Of the hips, foot, feet, and knee presentations, they are all together 17, of which nearly a fourth—four—were dead. One a "leg and an arm out for some hours" before seen; the second was "feet and hand," a twin; the third was a hip, and the fourth required the forceps for the head. Had I had the instruments at hand at the moment, it would have been saved. It died struggling for breath before me, while the messenger was away for them, notwithstanding all my efforts; first, to accomplish the delivery without breaking its neck, and second, to make a communication between its mouth and the external air, but I could neither bring Mahomet to the mountain, nor the mountain to Mahomet till it was too late. I may remark that I had delivered this mother of her previous child with the forceps.

The cord presentations are 7 in number, and two of the children were dead, one (No. 801) in which the cord was out 4 hours, and pulseless before I saw it. In the other, I used every effort in vain to expedite the labour. It was too slow. I had no room to turn, and the child perished during the few minutes necessary to free the os externum. In these cases there is no possibility of effectually returning the cord, or keeping it above the brim of the pelvis. The best chance of having a living child is to expedite the labour by secale,

or terminate it by turning, if there is room, or the forceps, if not.

The five face presentations all did well; vesications formed on the cheeks, nose, and lips of one of the children (No. 277) when it was a day or so old, from the effects of the pressure, and though the face looked frightful for two days, they healed without any scar; this one, a first, and another, required secale, and one the forceps. The two last were each the last of two twin cases noticed before.

The 3 arm cases were turned. These were cases in which the arm had been out some hours before my having charge of the case, and were perhaps shoulder presentations at first; the officiating midwife thinking she had done very cleverly in getting the arm down. I remember one case in which this feat was told as a boast. The back presentation and the abdomen, with cord out, were turned. The feet were brought down in all 8 times, for various reasons.

There is one case in which the placenta was the presenting part. I remember having charge of another, not in the present list. There is also a case in the present list, in which it presented its detached edge along with the head. In all, the mother was saved; in the last the child was saved. I made a note in the register at the time, which I shall read:—"No. 46, 20th Dec., 1845.—Mrs. Q.; 11 A.M.; haemorrhage all night; no pains; edge of placenta (detached) and head presenting; let 16 oz. liq. amnii escape and plugged; gave 1½ dr. secale at three doses. Eleven P.M.—Withdrew plug, when the umbilical cord fell out pulsating; unable to return it; thought of the forceps; but child still-born in five minutes, and revived in ten minutes afterwards, with hard work; both did well. P.S.—Plug arrested haemorrhage completely." The treatment I adopted in cases of *placenta previa*, was to plug the vagina so as effectually to arrest the haemorrhage, and give secale to excite uterine action, until matters were so far advanced that I could either turn or apply the forceps—the turning preferred, though I have done both successfully.

Hæmorrhage.—There are 6 cases marked "haemorrhage," after parturition, and 4 cases of the same unpleasant accompaniment before it was accomplished. These were at the full time, as I exclude the premature cases, in which more or less haemorrhage, of course, always occurred. The only means found effectual for arresting haemorrhage, after parturition, was to cause the uterus to empty itself by contracting; and there is no machine that will accomplish this like a good pair of strong hands and arms, judiciously applied; both to compress the uterus and to arrest the flow of blood in the aorta, by pressing it against the spinal column. That this last is a very effectual means—particularly in severe cases—I know. Its *modus operandi* I leave to be discussed; but I practised it, and had my own reasons for so doing, long before I had seen it recommended by anybody. I have been warned by patients that they flooded violently at every previous confinement, and have surprised them by using no cold water, and no spirits, or other stimulant, and by having no flooding. One patient, delivered on the 17th October last of her sixth child, had always

flooded violently. As soon as the child was born she cried—"Now, Doctor, I'm over—get the whiskey—Doctor so and so had always to feed me with it for two days, to keep the life in me with the flooding." I countermanded her order—gave her no spirits—removed the placenta, bandaged her up, and left her perfectly well; and perfectly astonished that there was no flooding. Nor had she more than the average discharge afterwards, and this, by the judicious use of a pair of hands. In no case but one, was there such haemorrhage, after parturition, as to put the patient's life in any danger; and in the case which forms the exception, I was called solely on account of the haemorrhage. The patient's mother had pulled the cord off the placenta, which was partially separated from, though still entirely within, the flaccid uterus. When I arrived she appeared to be dead. I threw the window up to its full height—pulled all the coverings off the bed—and at once introduced the hand, through a large quantity of clots, into the uterus. I then, for the first time, knew she was not dead, by feeling a very faint pulsation in the abdominal aorta. The circulation through this vessel I immediately arrested with the very best effect. I got the uterus empty and contracted, in a short time, and she gradually recovered her usual health and strength—a few moments longer, and it would have been all over. To illustrate its fearfully rapid fatal effects, I may mention another case, attended by pupils of the class of Midwifery many years since, whom I promised to assist if sent for. As the patient was advanced in life and feeble, I was summoned, but was not at home. The woman died about five minutes after the delivery, of a violent haemorrhage. The labour had not been severe. One of the pupils told me afterwards the details of the case, and of a well-meant attempt he had made to arrest the haemorrhage by grasping, with his hands, the labia, so as to close the os externum. In no case of uterine haemorrhage, connected with the parturient state, are you safe until you have obtained an empty and contracted uterus. Before leaving the subject of haemorrhage, I will mention another rather remarkable case. I was called hurriedly, in the evening, to see Mrs ___, who had just been seized with uterine haemorrhage. When the haemorrhage occurred, she sat down on an ordinary sized chamber-vessel. In about five minutes she fainted, and fell on the floor; she was laid in bed, and I was sent for. I found about two quarts of florid, coagulated blood in the pot, which had come away during the five minutes she sat, and produced the syncope. She had now rallied, and informed me she was between five and six months pregnant. The haemorrhage had ceased. I prescribed acids, opium, &c. The haemorrhage did not return. She went to the full time, and was delivered in her ordinary easy way.

Convulsions.—There are 5 cases of convulsions mentioned. The greater number of these cases I had not seen until after the convulsions had set in. 3 of these cases recovered, and 2 died. I have more than once been called to a patient, working in strong convulsions, requiring three or four to hold her in bed, and prevent her from injuring herself. I have bled her, conversed with her, delivered her with forceps, partly with her consent, partly without—given her medicine,

which she swallowed—given her directions, which she promised to follow—and left her. A day or two afterwards I found her perfectly herself again, but with no recollection of having seen me so lately, or of how she obtained the child, which, on the evidence of her friends, she accepted as her own. This is the happy termination of this fearful affection. In fatal cases, the patient sinks into coma and dies rapidly. There is one case, in which, though the only remark made is, that the "head threatened," yet I remember she told me next day that she had no recollection of the birth of the child, nor of anything that occurred for some time before it.

Secale.—Secale was administered 99 times, and generally with good effect. In a few cases it was of little or no use; and these were cases in which the labour had passed its height, and was on the decline, before it was administered. In such cases, I would not expect any benefit from it. The uterus, in its efforts to expel the foetus at the full time, appears to be capable of a certain amount of action, and of keeping it up for a certain length of time, when, if it has not accomplished its task, the pains become irregular in regard to their strength, and uncertain as to the length of the intervals of rest. Now, this average amount of muscular effort may be called *par*; and when the labour has made some progress, and the muscular efforts of the uterus keep below *par*, I would say, as a general rule, secale is indicated; on the contrary, if the uterine action is up to, or above *par*, and no progress made, or if it has passed its acme, and is in a state of decline, and even then, little or no progress has been made, I consider secale not only to be not indicated, in either case, but it will do harm in the former, and produce no effect in the latter case. I have given secale in the latter case, when I have been deceived as to the duration of the labour, from a fear that I would not take charge of the case, if informed beforehand that it had been tedious, and was likely to be a bad one; but it produced no effect, except to delay the application of the forceps another hour. There is another method adopted in these tedious cases, where energetic labour is long in setting in, and that is to give opiates, to keep away the pains when they are trifling, and comparatively worthless, in the hope that they will ultimately become strong and fit for their work. This method does very well if no progress has been made; but if any progress has been made, and particularly if the membranes are ruptured and the "waters" away, I disapprove of it altogether. In one case (No. 891) this plan was followed for three days. She was kept under the influence of opium. She gave me the box of opium pills given her by her dismissed attendant, who was not qualified. I never thought of giving secale in this case, but applied the forceps. The child's head was swollen and oedematous, and formed a very pretty mould of the cavity of the pelvis. In this case, I consider that the child would have had a very fair chance of life, had either the forceps been applied about the time the first opium pill was given, or secale given instead of opium.

With regard to the effects of secale on the child. I have seen nothing that would lead me to believe that it had any injurious effects on the child, farther than that

which may be, or rather must be, produced by the increased pressure arising from the increased muscular action induced by its use. In no case but one, where only secale was used—and these cases amount to 71—was the child dead; and in that case, the first born, a boy, the heart beat for half an hour after birth. I exclude two cases in which the children were dead; because in the one (No. 700) it was given after turning, and delivering an arm presentation, and could, consequently, have had no effect on the child; and, in the other, the child was born putrid, after being, as the mother most positively asserted, carried by her ten and a half months.(?) She should have known something about it as it was her seventh child. 50 of these cases, or more than the half, were cases of first labour. The sex of the child does not seem to have much influence in rendering the use of secale necessary. 54 were males and 42 females. In 3 cases the sex of the child is not marked. In 28 cases, the forceps were used after the secale; of these 16 were males and 12 females; 8 of them dead—5 males and 3 females. In two other cases, perforation was had recourse to afterwards. In all, these 99 cases, where secale was given, with one exception, which will be mentioned hereafter, the mothers did well; though pneumonia, peritonitis, and hepatitis, followed in 3 different cases.

Instrumental cases.—The forceps were used successfully in 58 cases, the perforator (after failing with the forceps) in 3 cases, and the crochet in 1. 19 of them, however, I had not in charge from the commencement of the labour, and few or any of which I would have seen, had some instrumental interference not been necessary. 7 of these are marked "face" or "face to pubes" presentations. In 6, the mothers were old, with their first children; the ages, in these cases, (marked only when confessed,) were from 36 to 43 years. There are others, I know, equally old, who did not confess it. 3 were cases of convulsions. In 3, the children were enormously large, and these cases were, respectively, the 10th, the 13th, and the 18th births. One of these was fifteen pounds weight. The forceps were used once when the placenta was the presenting part, and once for the head in a hip presentation, mentioned before. They were tried three times before perforation, without success. In the other cases, the reasons for the application are not particularly mentioned. It may be remarked that 29, or nearly a half of these cases, were first cases. In 8 cases the forceps had been applied more than once to the same patient. There were 13 of the children, 7 males and 6 females, *dead*—nearly a fourth, excluding the two perforated. There were 2 mothers dead; one (No. 136) mentioned before among the premature cases, from convulsions, &c, for three days before their application. The other (No. 649) was above forty years of age with her first child. She was delivered by the forceps, with great difficulty, of a putrid child, and sunk in four days from phlebitis and the absorption of the purulent or putrid matter, into the circulation. She had control of the bladder and rectum. The lochia was much as usual, except its putridity. The symptoms were febrile, with rigors, anxiety, vomiting, extreme prostration, typhoid symptoms, coma, death. In some cases the forceps slipped over

the head—so often, in one case, as six times, and succeeding the seventh. In this case (No. 140) the child was dead. In one other case (No. 848) though they slipped four times, and nearly ruffled the ears off one of the enormously large children mentioned before, it lived, though animation was suspended for fifteen minutes after its birth.

With regard to the perforation cases little need be said. Secale and forceps were tried previously. They were the 6th, 7th, and 12th births; and they had forceps applied or children perforated before, in, as far as I remember, all their previous confinements. The mothers recovered well. I believe all these cases might have been delivered by the long, heavy, powerful forceps, generally used in France, as they are capable of reducing the size of the head by pressure, from the length and strength of their blades, giving a powerful, and, in ordinary cases, I would say a dangerous, leverage.

In one case (No. 280) was the crochet used. It occurred two miles out of town. The head was born easy. I expected the body to follow next pain; several smart pains produced no effect. I got out the arms, pains continued, but no effect; I pulled, gradually increasing the force, until it was as great as I supposed the child could bear with safety, still no effect. Made a more careful examination. Found a hole in the cranium, surrounded by a translucent membrane; this was evidently the remains of a tumour, or bag, which had contained fluid—the arachnoid secretion—and had been ruptured during the progress of the labour. Its internal surface was continuous, with the arachnoid through the foramen, into the cranium. On examining the child, as well as I could in the capacious and well-formed pelvis, I came to the conclusion that it had ascites, or some other tumour in the abdomen. Acting on the former supposition, I endeavoured to make an opening into its abdominal cavity, unsuccessfully with a sharp-pointed pair of scissors, but successfully with a small blade of a knife, guided on the finger; still, not the slightest effect, though the labour in the meantime continued good. I next pulled on the child as much as I could, without breaking or dislocating bones, still no effect. I then informed the mother that the child would have to be brought away piecemeal, and sent her husband to town, on the car, for a medical man. The labour now flagged through fear, though she said her chief fear was that we would do something that would prevent her having any more family. After the arrival of the late Dr. J. W. BRYSON, with fair, steady, constant pulling with the hands, I separated and brought away the head, and arms, and thorax. I then introduced the crochet, and brought away, from the child's abdomen, what Dr. B., the moment he saw it, very naturally called the placenta. I introduced the crochet again, and another just such tumour was brought away. The crochet was now fastened on the pelvis, and it, with the lower extremities passed easily, and she was delivered; the placenta, &c, soon followed, and she recovered rapidly in the usual way. With regard to the two tumours, they somewhat resembled placentæ; but when freed from blood on the surface, and laid with their flat sides together—for they had pressed each

other flat—they exactly resembled, in size, shape, and colour, the two hemispheres of a large adult brain. They were a pair of hypertrophied, lobulated kidneys.

Removed Placenta.—The placenta is noticed as having to be removed twelve times, and marked "fatty degeneration" twice. In these cases a portion of the placenta was converted into a solid, a most cartilaginous yellow substance, resembling adipose tissue, and this portion was particularly adherent to the uterine surface, though its solidity enabled it to be cleanly peeled off. In one case (No. 561) the child (it was the 12th) was dead; the placenta was enormously large and very soft, almost as soft, in all its parts, as a clot of blood, and resembled more, when I succeeded in getting it scooped out, a ragged mass of hydatids than anything else. It all but filled a very large chamber vessel.

Deformities and Monstrosities.—One of the children had one foot inverted by talipes varus; one had harelip, with cleft palate, the mouth and left nostril forming one cavity; two were acephalous; and three had those tumors called "spinal bifida."

In one case (No. 828) the umbilical cord was wanting; the placenta was adherent to the abdomen over the hypogastric region, from which up to the centre, and including the half of the sternum, the parietes of both abdomen and thorax were wanting. Their place was supplied by a transparent membrane, which formed a kind of hernial tumour, in which I saw the stomach, spleen, liver, colon and small intestines. There appeared to be no diaphragm. In the second case, (No. 828,) the brain and spinal cord were wanting. The bones of the cranium, and spinous processes of all the vertebrae, were also absent. From the top of the face, and extending in a sulcus down the back, over the place the brain and spinal cord should have been, was observed a dark purple integument, resembling mucous membrane, injected, or rather ecchymosed, through its substance. The foetus was in other respects perfect.

Deaths.—With regard to the number of children born dead, at the full period, there were 37 single children and twins, in all 39,—15 male, and 24 females. 13 of these, or about a third, was the produce of first labours. As to the causes of death, 6 were born putrid; 2 with hydrocephalus; 2 acephalous; 1 from diseased placenta; and 1 from haemorrhage from the placenta; in all 12; leaving 27 cases in which death appeared to have been caused by pressure during the labour, or instrumental or other interference. In 17 cases were instruments used—the forceps 13 times, perforation three times, and the crotchet once. In one case (No. 300) the 6th child, a female, was born easy, breathed about 30 times, and died without any obvious reason. In all, except No. 649, referred to before, the mothers did well.

Mothers, deaths of.—There were 3 deaths of the mothers, in the premature cases (Nos. 136, 173, and 770, referred to before), and 4 in the cases at the full time. The first, (No. 649,) the only one in which instruments were used, has already been referred to. The second (No. 187) had an "easy" labour—she had had typhus, when 6 months pregnant, was very low, and gradually sunk till the 5th day, when she died. In the

third case, (No. 294,) though the labour was "easy," convulsions, and coma, and death, followed each other rapidly; she died 58 hours after delivery. The last case (No. 655) was "very easy" in the labour; she fell into coma, suddenly and unexpectedly, on the fourth day, and died the same night.

There were many cases in which the perineum was more or less torn, during the passage of the head, but in no case but one, as far as I know, was the slightest inconvenience produced afterwards. The exception was one in which the perineum was not at all torn during the passage of the first child, at the full time: but the second, and not a larger one, caused the perineum to be torn; the commissure, however, keeping entire, and causing the left labium to tear a piece out of the right one. It formed a disagreeable appendix which, at the urgent request of the patient, I afterwards removed with the scalpel, much to her comfort, and with no inconvenience to the subsequent births.

Length of labour.—With regard to the length of the labour, they are marked all lengths, from a few minutes to some days. I have been astonished at the rapidity of some cases, and at the tedious slowness of others.

Number of each labour.—As to the number of each birth, I have taken the trouble of counting them. They are as follows:—251 first; 159 second; 112 third; 93 fourth; 66 fifth; 67 sixth; 44 seventh; 33 eighth; 25 ninth; 23 tenth; 11 eleventh; 6 twelfth; 3 thirteenth; 4 fourteenth; 1 sixteenth; and 1 twentieth. (An error of 3.)

Days of Week.—I long fancied that there were more children born on some days of the week than on others. However, there is very little difference. After counting, we have Monday, 122; Tuesday, 128; Wednesday, 120; Thursday, 138; Friday, 119; Saturday, 131; and Sunday, 140. (Error of 2.)

At the suggestion of a Member of the Society, I counted the number born each month; they are as follow:—January, 78; February, 70; March, 70; April, 78; May, 79; June, 84; July, 67; August, 83; September, 73; October, 73; November, 74; December, 71.

Two children had each a knot very neatly tied on the umbilical cord. The joint of the cox was ankylosed in two cases, (not first ones;—one was the ninth,) and was fractured with a crack that alarmed, from its loudness, all who heard it.

The following remarks have a medico-legal bearing. In two cases the child would have been strangled, so tight was the cord about the neck, which became more so as the child advanced. In one of them the cord was but once round the neck, and very short. I had the greatest difficulty in getting it over the shoulders. I had written this remark, when I discovered that I had written the same thing five years before with regard to another child born of the same mother, the only difference being, that the cord was five times round the neck in that case. In both it was impossible for the child to have been born unless the cord had been either broken, or turned over the shoulder. In two other cases would the children have been drowned, one from an immense flood of liq. amnii, which followed the child, though only about 1 drachm came before it; the other,

still more remarkable, from being born in the amnion, whole and entire, and it took some strength of fingers to break and tear it open.

There is little more I see worthy of remark. I remember one case, when an abscess formed in one labium, from inflammation, consequent on engorgement, and perhaps rupture of a small vessel. There have been cases in which the bladder required the catheter for a time or two after the delivery; but no case of sloughing, or of recto-vaginal or vesico-vaginal fistula, as far as I know. Chloroform was not used in any case I met with; but of two patients who had used it, one told me she had breathed it—I suppose only for the purpose of amusing herself—as she not only felt every pain as acutely as usual, but it made her "feel her head as if a coach and six were going through it, and nearly put her deranged." She would not try it again for any consideration during her labour. She had been told that there was no danger in breathing it, and that she would not feel her labour pains, or know when the child was born, if she used it. She was afterwards greatly surprised, when told by a friend that patients had died from breathing it. The other had been made insensible by it, and was unconscious of the delivery, but complained of head symptoms, occasionally alarming, ever since, and is fully persuaded it did her much permanent harm.

ELEVENTH MEETING.

20th January, 1855.

Dr. R. Stewart, V.P., in the Chair.

XXIX. Dr. M'CORMAC made some remarks upon the generation and propagation of the cystocercus in man; and exhibited some specimens from the flesh of a "measled pig."

XXX. Dr. M'CORMAC read the following case, illustrative of the use of electro-magnetism in ileus:—

The subject of this case was a native of Scotland, a man of about 50 years of age, and of a spare astute temperament. His bowels were generally costive, but the arrest of the alvine discharge, with the consequent pain and suffering, seemed more immediately consequent on the adoption of a drier sparer regimen than usual. The symptoms were of the ordinary character, only that there was no vomiting. The accumulation, which was obvious to both sight and touch, was in the ileo-caecal region.

Most of the remedies usual in such cases, were resorted to. Castor oil and turpentine, by the mouth and rectum, were exhibited in repeated and energetic doses, alternated with, calomel, croton oil, black draught, and the ordinary saline aperients. Towards the fourth day, injections, repeated several times, were thrown up through a tube introduced about two feet into the gut.

The patient's condition becoming rather alarming, I had recourse to the ordinary electro-magnetic apparatus. I passed the current, alternately, from the belly to the back, and from one side to the other, at various points of the dorsal and abdominal surfaces.

The apparatus was in excellent order. Hardly had it been resorted to, when smart contractions of the abdominal muscles could be observed, along with deeper seated undulations, which I ascribed to active peristaltic movements. I had recourse to the apparatus twice, allowing the patient respite at short intervals. When I had done enough, as I conceived, I administered a moderate black draught, perhaps unnecessary, and in the course of the afternoon and night, the patient was completely relieved by the passage of a copious, repeated, feculent discharge, of various degrees of consistency. I gave him many charges as to the regulation of his bowels, and directed the compound decoction of aloes, along with the wine of aloes, whenever he observed any tendency to returning costiveness.

XXXI. Dr. BECK read the following case of *placenta prævia*, which illustrated his mode of management in such circumstances:—

As I did not make myself clearly understood at the last meeting with regard to the treatment I adopted in the cases of *placenta prævia*, I give you the following new case, (No. 917 on my register,) which will illustrate my views on that subject.

At 7 P.M. on Monday last (15th January, 1855), I was called to visit Mrs. M___. I found a surgeon in attendance, who informed me that she had flooded for many hours, that the placenta was the presenting part, and that he had introduced a plug. On entering the room I was struck with the death-like pallor of the patient's countenance. On addressing her, I found, that from the loss of blood, she had dulness of hearing, and was unable to speak above a whisper. She said the haemorrhage had come on suddenly and without pain, and had continued, sometimes in gushes and sometimes in a regular flow, for the previous twenty-four hours. During all this time she had no pains, though there was a slight bearing down. On examination I found the quantity of blood lost immense—her attendant said "gallons." The bed and a large heap of clothes had been completely saturated with it. The first thing the hand encountered was the plug, lying between the patient's thighs. It had come away without her knowledge. On introducing the fingers through a very moderately dilated, but very soft, os uteri, I found the placenta presenting, but, owing to its thickness, could not ascertain what part of the foetus was above. As the patient was *in extremis*, I advised immediate delivery by turning. The os uteri was not sufficiently dilated to admit the hand, but was very soft, and, in the then state of the patient, I judged very dilatable. As this advice was deemed good, I was requested to proceed to put it into practice. I introduced the hand, with the intention of separating and bringing away the placenta entire, but finding that this was very difficult to do, and that I could not reach its edge from any point of the os uteri, I changed my determination, and went through the centre of the placenta, when the head was discovered to be the presenting part. I passed the hand (right) gradually up through the os uteri, which, as I had anticipated, dilated easily, seized the left foot and brought it down through the placenta to the os

externum. I then gave it up to my confrere, who pulled lustily at it for about two or three minutes, when he gave it up to me again. I now endeavoured to reach the other foot, but being unable to do so, I fastened the blunt hook over the right groin, or rather round it, and by a little steady pulling at the hook and leg together, delivered the hips and legs. The arms were over the head, and gave me very considerable trouble to extricate; but, after they were extricated, the rest was easy. The placenta followed immediately. The uterus was contracted well, and there was no more discharge afterwards than was expected. The whole process did not occupy more than from five to ten minutes, and when it was finished, a dose of secale was given. It is unnecessary to remark that the child was dead. The mother is, so far, progressing favourably.

This case will illustrate very well my ideas on the use of the plug. It was not used here. The thing applied was no plug. It was laid in the vagina, not plugged in; and, as a matter of course, it fell out; I should perhaps rather say it floated out unperceived. The plug I would apply would not be thus easily removed; and, lest it should be removed by coughing or any other muscular effort, I would apply a T bandage.

With regard to the use of the plug, I use it only when the os uteri is so undilated and undilatable as to prevent me doing anything else. In this case, as in every other, it would, if properly applied, have saved the loss of perhaps three-fourths of the "gallons" of blood lost, and this would have been no small matter for the ultimate safety of the patient. I think it is a matter of convenience more than anything else, whether you remove the placenta first, or go through it. I would recommend whichever the hand found on trial to be easiest done.

XXXII. Dr. MACLAUGHLIN, V.P., Lurgan, forwarded for exhibition the recent parts in a case of *hypertrophy of the heart, and cardiac murmurs without valvular disease*, and related the following history:

W. M., aged 21, a weaver by trade, was in perfect health in June last; in the latter end of that month he was seized with feelings of oppression, weight, and distension of the abdomen, considerable uneasiness over the liver, and complete loss of appetite. He was awakened early in the morning with an inclination to go to stool; he passed an immense quantity of dark-coloured blood—nearly the full of a chamber vessel. The next day all his symptoms were much improved. He was then removed to the infirmary of the Lurgan workhouse. His appearance was pale and sallow, just like a case of chlorosis. The only thing he complained of was violent action of the heart, which prevented him sleeping. He said that in other respects he was quite well. On examining the heart, distinct murmurs were heard over the aortic and mitral valves, and similar sounds in the vessels of the neck. With the exception of the heart, all the other organs appeared healthy. At first I was disposed to think that the bruit was owing to his anemic condition, but latterly I had reason to suspect the existence of organic disease. I gave him different preparations of iron, and with considerable benefit. He improved very much up to last Thursday, when he was

seized with convulsions, which continued the greater part of the day. Towards evening he became comatose, and died the next day. He never had any but the one attack of melæna, yet he was as completely blanched as if he had lost every drop of blood in his body.

The following quotations from two esteemed authorities are in point:—

Dr. Latham (Clin. Med. ii. 338). "The heart, by the simple vehemence of its action, has the power to kill, through cephalic insomnia, delirium, mania, convulsions, and nervous exhaustion."

Dr. Walshe (p. 468). "A systolic blowing murmur, basic, and audible at the second right cartilage, is sometimes heard in cases of *pure hypertrophy*, nor can it be positively ascribed in all instances to co-existent spæmæmia." "Hence excess of force of propulsion of naturally constituted blood would seem capable of generating *direct murmurs*."

XXXIII. Mr. BROWNE read the report of the post-mortem examination held in the case of the patient presented at the meeting of the 9th of December ult., for which see proceedings of that date.

XXXIV. Mr. BROWNE exhibited and explained "*Smee's optometer*," and "*an improved eye-douche, by Cooper*."

TWELFTH MEETING.

27th January, 1855.

The President in the Chair.

XXXV. Dr. MALCOLM reviewed the subject of the *topical medicament of the larynx, as practised by Troussseau and Belloch, H. Green, and Watson*.

He adverted to the ancient origin of topical medication, by means of the insufflation of powdery substances and vapour, which, it appears, had been practised in the time of Aretæus.

MM. Troussseau and Belloch in their work on "*Laryngeal Phthisis*," speak of the result of a long experience of such medication. They used, in powder, bismuth, calomel, zinc, copper, lead, alum, and silver; in vapour, chlorine, iodine, and sulphuret of mercury; and in solution, nitrate of silver, corrosive sublimate, sulphate of copper, and nitrate of mercury.

Of all these they preferred the *nitr. arg.* (strength, dr. ii. ad oz. i.), and they employed it thus:—1. By expressing the solution into the larynx; 2. By means of a syringe; and, 3. By the direct application of a sponge filled with the solution to the interior of the larynx.

Sir C. Bell used the nitrate solution in cases of laryngitis by means of a sponge.

Dr. Horace Green had experimented with the same, years before MM. Troussseau and Belloch, and employed a strength of scr. ii., scr. iv., ad oz. i. He used a curved piece of whalebone, with sponge fastened to its extremity. He has tried this method successfully—1. In follicular disease of the larynx and pharynx; 2. In chronic laryngitis (concentrated solution); and, 3. In croup. In this last disease it has been strongly recommended by M. Bretonneau, MM. Dupuytren, Guiet (1843), Bouchut (1845), and Guersent (1843). In the early stage of croup

(before exudation) it has been more useful. 4. The bronchial and laryngeal complications of phthisis.

Dr. E. Watson, of Glasgow, has lately written a work in advocacy of this form of treatment. He has largely employed it in acute and chronic laryngitis (strength, grs. xxx. ad l.); aphonia (do., grs. xx ad xl.); pertussis (grs. xv.); spasmodic asthma (grs. xx.); stomach and hysterical cough, laryngismus, epilepsy, and laryngeal complication of phthisis.

Dr. Watson has given some idea of its *modus operandi*, as thus:—1. It protects eroded surfaces. 2. It stimulates the capillary circulation. 3. It produces osmotic currents. 4. It removes nervous excitability.

In the discussion which ensued, the merits of this special treatment were generally considered by the members limited, and none endorsed the enthusiastic views of Green or Watson.

XXXVI. Dr. M'CORMAC exhibited a *tape worm*, which came away after the exhibition of a dose of turpentine; the kousso having been previously unsuccessfully tried.

THIRTEENTH MEETING.

3rd February, 1856.

The President in the Chair.

XXXVII. Dr. MALCOLM exhibited a recent specimen of tuberculous lung with intercurrent pneumonia.

XXXVIII. Professor STEWART exhibited a recent specimen of diseased ankle joint, shewing degeneration of synovial membrane, and ulceration of cartilages.

XXXIX. Also, an encysted tumour of the scalp, or wen. Upon section it was found to contain about 8oz. of a milky fluid.

XL. Dr. HALLIDAY opened the discussion as to the treatment of diabetes, especially by rennet, as recommended by Dr. Gray.

Professor STEWART had used barm with some benefit, and carb. ferri (administered before meals) with much more.

Dr. BRYCE found some utility in the employment of quinine in one case, which was, however, complicated with mucous catarrh of the bronchi and intestines. The quantity of sugar in this case was so great that a single drop of the urine falling accidentally upon the dress would leave a hard saccharine crust. Dr. B. considered that the cases of diabetes should be viewed as simple or complicated acute, or chronic, as nothing definite regarding treatment can be predicated when such analysis is not made.

FOURTEENTH MEETING.

10th February, 1855.

The President in the Chair.

XLI. Dr. M'CORMAC submitted the chief points of a case illustrative of the state, termed *euthanasia*.

The paper was as follows:—

Medical men seldom describe the manner of death, unless incidentally. When death arrives, the medical man considers his business at an end. Few are required to witness the last moments of life. Nevertheless, there is in the manner of dying very much of deep interest to us all. Many, I conceive the great majority, leave this life without much apparent, and I believe real, pain or suffering, while to some, the last agony is long and painful. There may be a euthanasia of the mind as well as of the body. It is most desirable doubtless, when body and mind are alike at ease. The causes which determine a painless death or the opposite, are very imperfectly known. One sees the strongest men perhaps, die easily; while delicate, weak women endure long suffering.

The occasion of these remarks was a young girl. She had experienced protracted general indisposition. She had suffered much both in body and mind. Her final indisposition, if not entirely occasioned, had been greatly aggravated by a long journey during cold, inclement weather. There had been bronchitis, and to some extent pneumonia, as I learned on consultation with the medical attendant. Her indisposition, however, did not prevent her from sitting up to the last. At the very last indeed, she was sitting up leaning on her attendant, the sick girl's languid head supported on the nurse's breast. This attitude was maintained for a protracted interval. No one moved, neither the sufferer nor her attendant. At length, a sister of the sufferer came in. She spoke to her sick sister, asked her how she did, but there was no reply. Looking closer, she perceived that the sufferer was dead, quite dead, without the slightest plaint or struggle to signify the change, or even to derange the position she had assumed.

XLII. Mr. H. M. JOHNSTON adverted to a case of dislocation of the inferior maxilla, occurring during the progress of fever.

XLIII. Dr. YOUNG exhibited a detached foetus with membranes and placenta, supposed to have reached the seventh week.

XLIV. Dr. MALCOLM presented a patient who afforded an exquisite specimen of the mature favus dispersus.

XLV. Dr. MALCOLM exhibited the recent parts of a case of gangrene of the lung, and submitted the following particulars:—

Thomas W., aged 52, a porter, was admitted into the hospital on 15th January, ult., having then been ill five weeks. His habits were intemperate, and he was habitually exposed to much privation. He ascribed his illness to a severe cold. On admission his chief symptoms were bronchitic, but soon "fine crepitus" was detected at the right base, and the other indications (rusty expectoration, etc.) followed. On the 20th, the tinging of the expectoration had disappeared, but the pulse continued frequent (104). He was now troubled with diarrhoea, and almost immediately afterwards symptoms of sinking set in, which resulted in his death on the 23rd.

At no time was there any indication of a cavity, much less of a gangrenous one, and the sputa were not even foetid.

On a post-mortem examination, a large irregular ragged broken down mass of sphacelated lung tissue was found occupying the base of the right lung, bounded superiorly by a stratum of consolidated lung; and beyond this, a congested portion.

The absence of the gangrenous foetor in gangrene of the lung has been noticed by several authors, though its presence is generally laid down as the most characteristic sign. Craigie says: "A peculiar gangrenous inflammation may exist, and have proceeded to a considerable extent, yet without giving rise to foetor of the breath and expectoration."

Then as to the insidious character of the incipient symptoms, most authors are agreed. Thus, Walshe—"The evidences of this affection of the lung at first are commonly extremely obscure.

Skoda (Trans.)—"An examination of the thorax is rarely made in the first stage of the disease, on account of its insidious nature." Laennec (Forbes' Trans.)—"Nothing but the general debility strikes the attention of the physician, and nothing seems to announce a severe affection of the chest."

FIFTEENTH MEETING.

17th February, 1855.

The President in the Chair.

XLVI. Dr. BECK exhibited a recent specimen of a *fœtus with membranes, &c.*, of the seventh week.

XLVII. Dr. MALCOLM exhibited a *lung presenting several pneumonic encysted abscesses, having no communication with the bronchi*, and gave particulars of the history. Hope and Sieveking consider this form of abscess extremely rare; and Walshe remarks that "in consequence of want of ready communication with the bronchi, the signs are of necessity extremely obscure."

XLVIII. Dr. MALCOLM exhibited a *dense fibro-calcareous body which was found lying loose in the pleural cavity*; and explained the origin of such, as given by Rokitanski, thus:—

These "fibroid and cartilaginous tissues are developed without inflammation. We first observe a whitish circumscribed opacity and condensation of the serous tissue—a development of tissue resulting in the formation of a smooth, or nodular, elastic plate; or a group of granulations of fibrous and fibro-cartilaginous tissue, or of irregularly shaped masses, which vary from the size of a pea to a nut, and finally ossify. They sometimes become liberated, and are found free in the cavity of the thorax, in the form of round nodular masses."

XLIX. Mr. BROWNE exhibited an osseous specimen, showing the excavation in a case of *abscess of the tibia*, and detailed particulars:—

J. A., aged 50, had suffered for six years. The knee-joint was supposed disorganized, as there was no

distinct evidence of abscess. He walked about till very lately. The bone was sound all around the cavity. Pain, deep-seated, was the chief and constant symptom. The limb was removed.

SIXTEENTH MEETING.

24th February, 1855.

Dr. R. Stewart in the Chair.

L. Dr. LYNCH read the notes of a case of *masked typhus*, presenting, at one stage, strongly marked *apoplectic symptoms*. This case is reported at length in the *Dublin Hosp. Gaz*, 1855.

LI. Mr. HANNA read a paper, illustrated by cases, confirmatory of the existence of *syphilitic bronchitis* as a distinct disease.

Among the various bronchitic affections there is one species which seems to depend upon pulmonary irritation, connected with a venereal taint of the system. Drs. Graves and Stokes were of opinion that syphilis may attack the pulmonary mucous membrane as well as the cutaneous, osseous, or mucous tissues of other parts of the body. Pathologists have investigated accurately the various morbid changes to which the pulmonary tissue is subject, but they have withheld the inquiry of examining into states of constitution which may originate these changes. Systematic authors have indeed investigated scrofula with attention, but how silent they seem about rheumatism, syphilis, and scurvy, the prolific sources of many chest affections. The most important point in this disease is the diagnosis, as on this all depends. The importance attached to it arises from the circumstance of this disease being frequently considered phthisis. A patient comes to consult you, and you find he has cough; is pale, feeble, and emaciated; he sleeps badly, and is disposed to sweat at night. If this case were phthisis, would he be benefitted by mercury? all must acknowledge, the result would be fearfully bad. I hope I shall be able to prove that the cases I intend to bring before your notice had almost all the symptoms of phthisis, and that one of them was pronounced phthisis by a practitioner who has obtained some celebrity. We can only recognise this disease by its history. If a patient's sufferings have commenced after sores on the genitals, and when secondary symptoms generally make their appearance, along with emaciation, night sweats, debility, disturbed nocturnal rest, accompanied with sore throat, and an eruption over the skin, or any other marked secondary symptoms, we may then consider that his constitution is saturated with the venereal poison, the lungs as well as other parts.

First case.—J. M., aged 28, of a slender conformation, and of moderately temperate habits, had gonorrhœa on two occasions, and had suffered a great deal of fatigue and privations a few years before, having been one of the unfortunate followers of Lopez, at the invasion of Cuba, and was there taken prisoner by the Spaniards, who treated him cruelly. Last March, three weeks after connection, a bubo formed without any previous sore (which is not very rare) in the left groin, below

Poupart's ligament, for which he was treated by some practitioner. I saw him for the first time in the latter end of June, 1854. He was then affected with sore throat and rupial ulcers; one situated on right thigh, and two on outer surface of left leg, for which I gave him four grains of blue pill and one of quinine, night and morning, till the sores assumed a healthy appearance. With some tonic treatment, he became apparently convalescent. I again saw him in the month of September; he was now affected with pain in right shoulder and knee; his body all covered over by a lichenous eruption; and a harassing cough annoyed him so much as to prevent rest at night. Examination of the chest elicited nothing posteriorly, excepting a few bronchial rales; but under the right clavicle there was dulness of percussion, suppressed respiratory, prolonged expiratory, and evident bronchophony; respiratory murmur all over the left lung free, excepting a few scattered bronchial rales. My attention was principally directed to the chest affection, for which I directed him to use ung. iod. cum ol. crotin, to be rubbed anteriorly and posteriorly over the right side of chest; of 8 oz. ol. morrhœa, with two grains of iodine suspended in it, a dessert-spoonful three times a day; with soothing cough mixture, and country air. My reason for uniting the iodine with the oil was, that it might have some effect on the systemic syphilis. Having gone to the country, I did not again see him until Nov. His cough was then no better; had expectoration, was losing flesh, and had night sweats. The lichen disappeared after he was about a fortnight in the country. Living but a short distance from Lisburn, he consulted a practitioner there, who considered his case to be incipient phthisis.

I now began to think that he might be labouring under systemic syphilis, for which I gave him ten grains of iod. potassii three times a day, in an infusion of chireta, with the cod liver oil, and to stop in the country. I have seen him once a fortnight since. The cough and pains have all disappeared, and he has improved very much in flesh, and expresses himself never to have enjoyed better health than the last time I saw him, and that was yesterday. Some dulness still remaining under right clavicle, with prolonged expiration. But might not the pain he complained of in the right shoulder, proceed from thickening of the periostium of the internal surface of the first rib or clavicle? and would not that account for the dulness and prolonged expiratory murmur?

Second case.—J. F., mechanic, aged 22, of a stout athletic form, and of irregular habits. From his own account, he contracted syphilis in summer, 1852, became better after a period of three weeks' treatment of himself, which consisted in the use of black wash, and red precipitate ointment.

About four months after the primary symptoms had disappeared, he was attacked with sore throat, pains, and a severe cough, for which he consulted me. On examination of the throat, there were two excoriations, one on the side of the palatine-arch and one at the back of the pharynx. The cough was very severe for about an hour or two after lying down at night, and in the morning, before and after rising, accompanied by

profuse expectoration. Examination of the chest elicited nothing of any importance more than the ordinary signs of bronchitis. The chest affection became so very severe that he was unable to attend, after treating him for about five weeks. He was gradually losing flesh, his hair began to come out, and a papular eruption appeared over the body. Since this eruption began to come out, the cough seemed to be alleviated. Having considered that he might be labouring under a syphilitic cachexia, and that the bronchial mucous membrane might be as liable to the poison as any of the other mucous membranes, I gave him small doses of calomel and opium and tart. emetic, three times a day, for about a week, until the mouth became tender, and kept up the irritation by rubbing half drachm doses of strong blue ointment along the course of the femoral artery, night and morning, every other day, until cough and other symptoms disappeared. His health began to improve rapidly under tonic treatment, and he has had no return of any secondary affection for a year, as I had an opportunity of knowing. He has since gone to America.

SEVENTEENTH MEETING.

3rd March, 1855.

Dr. Moore, V.P., in the Chair.

LII. Mr. GELSTON, Comber, submitted the history of a case of (alleged) aneurism of the abdominal aorta.

LIII. Dr. MALCOLM related the particulars of a case of pulmonary disease, in the course of which the expectoration assumed all the appearance of ink.

W. J. M'K., aged 20, a sawyer; ill since Christmas; began to expectorate blood on 29th; ascribes attack to over work; admitted 30th Jan. Pulse, 108; respiration hurried a little; anorexia; thirst; skin dry; bowels regular; tongue clean; weak. Illness commenced with influenza at Christmas. On admission had a saline purgative, and following day an infusion of ipecacuanha to act as emetic and nauseant. Return of haemoptysis during night of 30th. Continued the mixture till Feb. 2, when it was omitted, as all bleeding had ceased. On 4th, there was a relapse, and I then put him under the gall, acid, gr. v. bi-horio. This was continued regularly on 5th, 6th, and 7th, and on 8th reduced to gr. v. ter in dies. The expectoration became inky on or about 7th and 8th. On 9th, was ordered pil. plum. gr. iii., ter in dies., which was continued till about 16th, when bleeding ceased; and on 20th, ol. jec. as.; and 24th discharged.

In commenting upon this case, Dr. M. alluded to the following records, which notice a similar phenomenon:—On November 3, 1853, at the Med. Chir. Soc. of Brighton and Sussex, Dr. W. Bayes, of the Brighton Dispensary, read a paper on "Gallic Acid and its Remedial Power in the Haemorrhagic Diathesis, &c," and in the course of his remarks stated that, while pushing the remedy in a case of haemorrhage, he observed that the colour of the blood poured out "becomes darker and darker, until it is often perfectly inky. When this occurs it shows a complete saturation with the acid

which may then be given at much longer," &c. On February 7th, ult., at the Med. Chur. Soc. of Edin., Dr. W. T. Gairdner read a paper on "the Administration of Gallic Acid in Hæmoptysis and Albuminaria," and remarked, in reference to Dr. Bayes' observations, that, in one case, hæmoptysis repeatedly occurred after the sputum became inky. "The inky tinge he thought was due to an alteration of the mucus, and not the blood." (See p. 180.)

LIV. Dr. MURNEY exhibited the recent excised parts from a case in which he had performed resection of the elbow joint.

The joint, when examined, presented pulpy degeneration of the synovial membrane. The patient was 30 years of age, not scrofulous, and 11 months ill.

LV. Dr. MOORE exhibited an arm most terribly mangled at a hackling mill in the neighbourhood. During the amputation, but a single vessel required ligature. Chloroform was used, as usual.

It was generally admitted by the members that cases of severe injury, with depression from haemorrhage or shock, bore chloroform well, in corroboration of Mr. Guthrie's view.

EIGHTEENTH MEETING.

10th March, 1855.

The President in the Chair.

LVI. Dr. YOUNG, Holywood, related the history of a case of retro version of the uterus.

The female was three months pregnant, and had complained but two weeks. The chief symptom was retention of urine. Six and a-half pints were drawn off by the catheter. He reduced it effectually by firm pressure and manipulation.

LVII. PROFESSOR STEWART introduced the subject of discussion, viz.: under what conditions in syphilis should mercury be proscribed?

In his remarks, Dr. S. dwelt upon the following conditions as being contra-indicatory of mercurialization: Peculiar idiosyncracy; a decidedly scrofulous diathesis; debilitated constitution; peculiar phase of the disease, as the inflammatory form, gangrene, &c.

Under other circumstances, mercury is our sheet-anchor. The poison should be, if possible, expelled. Mercury increases all the secretions, and hence is rationally indicated. But it should be remembered that, unless persisted in for a lengthened period, the full elimination cannot be expected.

Mr. BROWNE considered that mercury may be much more frequently used with benefit by attending to the form of administration. So far from the bichl. hyd. being a depressing agent, it is in small doses a most admirable tonic.

Dr. BRYCE did not think that secondary syphilis could be cured without the use of mercury. There is no greater mistake, in his opinion, than that mercury is injurious in scrofula; but he condemned the old system of administration, and argued that the mere touching

the gums was sufficient. He confessed he had unlearnt much of what he was taught at the schools concerning mercury.

Dr. MALCOLM referred to the effects, as laid down by therapeutic authors, as some guide in coming to a decision. Christison, for example, considers it capable of producing or predisposing to the following long list of maladies, viz: Hysteria, gangrene, tremors, serous inflammations, eczema, impetigo, erythema (Pearson), chlorosis, dysentery, dropsy, sloughing ulcers of the throat, diseases of the bones. Further, Dr. S. Wright believes that mercury renders the blood watery and septic, and diminishes fibrine, albumen, and the colouring matter. Then, as to its effects on the syphilitic constitution, Christison thinks "in no circumstances does mercury so often give rise to troublesome and severe disease of the glands, and bones, and skin, as when it is administered in a strumous constitution, tainted also by the venereal poison."

Almost all writers are agreed as to the injurious consequences of mercury, under the following circumstances in syphilis, viz:-violent local inflammation, pustular, rupial, and tubercular forms. Notwithstanding the bold opinion of Pearson, who having administered mercury in 20,000 cases, felt himself "authorized to assert that it is a remedy always to be confided in under every form of lues venerea," the foregoing facts are conclusive as to the necessity for care in the exhibition of this drug. Dr. Malcolm concluded by expressing his concurrence with the views of the late eminent Liston: "In any case, I would never think of ordering it, unless the progress were tedious, the ulcer being indolent and contumacious."

Dr. ROSS argued that the kind of primary sore gave definite indications: and if this be "indurated," mercury was indispensable. He considered the remedy as much a specific as any other medicine of this class.

Dr. YOUNG, Holywood, spoke in favour of mercury under the limitations advised by Acton and Ricord.

Mr. WARWICK mentioned two instances of indurated chancre, in whom he excised the hardened part without any bad consequences, all other treatment (including mercury) having failed.

Mr. H. M. JOHNSTON stated, that the non-mercurial plan had been fairly tested in the Dublin Hospitals, and completely failed. The character of the sore is not a true guide. The mode of administration is all-important. The drug should be insinuated (as it were) into the system. He concluded his remarks by asking whether we should mercurialize a case of secondary syphilis, in a pregnant female.

Professor STEWART observed that almost every such case in the Lock wards aborted.

Dr. HALLIDAY considered that there was scarcely any syphilitic case in which mercury might not be beneficially employed.

Dr. DILL also advocated the mercurial treatment.

The PRESIDENT was strongly convinced that the tubercular diathesis contra-indicated the use of mercury. We should also not employ it, when we cannot command the proper adjuncts in the administration of the mineral.

NINETEENTH MEETING.

17th March, 1855.

The President in the Chair.

LVIII. Dr. MOORE exhibited a recent specimen of diseased knee-joint, of 14 years' duration. The patient was aged 30. There were sinuses communicating with the joint, and evidence of caries of the articulating surfaces, whose cartilages had ulcerated. There was partial ankylosis, and slight displacement of the tibial head backwards, which increased the deformity. The limb was removed by the flap operation, during which 11 arteries were secured.

LIX. Dr. YOUNG, Holywood, mentioned the case of a child, aged 2 years, who had, it was alleged by the parents, swallowed a cube of wood two-thirds inch on the square, without injury.

A discussion ensued as to the capacity of the oesophagus at such an age, and the best means to be adopted when such an accident occurs. Repeated doses of *ol. ric.* and the ingestion of a large meal of wheaten porridge, were recommended.

LX. Mr. HANNA read the notes of two cases of *purpura*—one in which phthisis had supervened, and the other associated with cerebral disease—after premising the following observations:—

Among the various forms of purpura there is one which has been termed *purpura haemorrhagica*, which is specially worthy of attention, as there is always something in disease, accompanied by loss of blood, calculated to arouse our sympathies.

Hæmorrhage, besides its immediate effects, is likely to produce changes which are long felt by the system. Persons having had profuse loss of blood are liable to suffer long after the occurrence; although the functions go on as before and the loss repaired, a certain debility generally remains. Almost the same may be said about chlorosis, in which the blood is in a depraved condition, and is formed slowly. This condition differs from the former, for it can be rectified by the ferruginous part of the liquid being restored to its natural element. But a person who remains some time pale from the loss of that fluid, we are told, seldom or never attains the hue of health. And where there is any predisposition to specific disease, there is nothing more calculated to awaken the lurking latency than its after results.

In *purpura haemorrhagica*, the petechiæ are pretty large, and are mingled with livid stripes resembling marks left by violent bruises. They generally appear on the extremities first, and trunk secondarily: their first appearance is of a florid hue; they then become of a livid, and, lastly, yellow, when they disappear altogether. The cuticle appears smooth, and is not generally elevated; in some cases the cutis has been raised into a sort of vesicle with its blood contents; the gentlest pressure will produce an ecchymosis.

Rayer, on dissection, has found that the ecchymoses do not confine themselves to the same texture of the skin; some are situated on the surface of the rete mucosum, others occupy the areolæ of the cutis, and the largest have generally their seat in the cellular

tissues, in which the blood is coagulated; but in the smaller it remains semi-fluid.

There is one alarming symptom in this affection, viz.:—hæmorrhage, from mostly all the mucous outlets, or sometimes from serous surfaces, which is enough to make us fearful of the consequences. This symptom is often preceded for some time by weakness and pains in the limbs, which incapacitates the patient for any exertion, who not unfrequently *appears* in robust health; in some there are deep-seated pains about the præcordia, chest, loins, and abdomen; in other cases, previous to the eruption, syncope has occurred. Although all these are alarming features, experience has not proved it very often a fatal disease.

Dr. Watson asserts in the *Medical Gazette*, vol. x. p. 599, that in all cases where the blood has been chemically analysed, as well as its qualities which are sensible to the eye examined, it has undergone a change. On post-mortem examinations, the meninges of the brain have been found spotted; ecchymosed and extravasated blood has been found on the convolutions, and in the substances and ventricles of the brain, from the size of a pin head to a pigeon's egg, and also on and in the cerebellum. In all patients where this has occurred, they have generally died comatose, after headache. In the chest, Rayer has observed the following appearances:—The outer-surface of the lungs spotted; beneath each of these spots the lung is firmer in its texture than the healthy lung, and presents a circular engorgement, from which, on pressure, black blood excretes a morbid hæmoptysical engorgement, such as has been described by Laennec. Some have been also found on the heart, pleura, pericardium, and tissue of the lungs. In the abdomen, similar spots have been found scattered over all the hollow viscera, with enlargement of the liver, spleen, and softening of those organs, the kidneys not excepted.

The predisposing and exciting causes of purpura are mere hypothesis, but Williams, Bateman, and Bayer, seem to think that it chiefly occurs in persons of delicate habit, or enfeebled by their occupations or mode of life; they also think that confinement, low and damp habitations, scanty food, hard labour, anxiety, grief, or fatigue may produce it. Still, purpura does occur where no causes of a debilitating or depressing nature can be supposed to have existed—as in persons in the vigour of youth, and the prime of life, and in easy and comfortable circumstances, breathing a pure air, enjoying all comforts. Of the pathology of purpura very little also is known, but it is considered to arise:—First, from an attenuated state of the blood, allowing it to escape from the extremities of the capillaries. Secondly, dilatation of these vessels. Thirdly, tenderness of the coats of the vessels, giving way from the ordinary impetus of the blood. Fourthly, obstruction of the vessels, causing rupture. Fifthly, two or more of these causes acting simultaneously or successively. The most striking peculiarity of purpura is its universal hæmorrhagic tendency, whereby blood is poured out not only from the various mucous surfaces, but is effused into the texture of the skin, cellular membrane, serous cavities, and solid viscera, or hollow viscera. It is therefore probable that the immediate cause of these

phenomena is one affecting the whole system, and none seems so well to accord with that phenomena, as an alteration in the composition and vital properties of the blood. When we take into consideration the analogy which subsists between the phenomena of purpura, and of maculated fever on the one hand, and the cachexia of passive haemorrhage on the other, it is highly probable that a similar cause is in operation in all these cases. In scrobutus, it is admitted that the composition of the blood is vitiated. That a change in its properties is intimately concerned in the production of fever is now generally admitted. We have, therefore, strong reason for believing that a like cause is productive in some cases of that assemblage of symptoms to which is given the name of purpura.

Case 1. H. K., aged 19, of a bilious temperament, a printer by trade, very temperate in his habits, subject from childhood to neuralgic headache. His appetite never would continue any length of time good. His principal diet was tea, which he took three times a-day. His bowels were always loose. His residence might be termed unhealthy, having to sleep in a small damp room, the floor being unboarded. At three years old, the cervical glands suppurred, but though they healed up after discharging one year, they have still remained more or less indurated. Had three attacks of purpura. First commenced at 11 years; got better in a week by treatment. Second time at 17; recovered at the end of a fortnight.

At about the beginning of last June, he complained of a chilliness and trembling of cold, great weakness and feebleness, so much so as to have to discontinue his work.

About the 13th of June I first saw him; the extremities were covered, as well as the trunk, tongue, and mucous membrane of the mouth, with purpuric spots; some on the arms were evidently elevated, the gums were swelled, and he said his mouth was full of blood this morning. I saw him on 17th. He was lying in bed. Pulse 60; small and weak. All around him was saturated with blood. His mother told me that, for the last two days, he had bleeding from the nose and mouth. The bowels had been twice moved, and each time was filled a large chamber-pot with dark blood. She thought he had lost about seven quarts altogether. I then ordered him the following:—R. sulph, quinæ, gr. xii.; tinct. ferr. mur., dr. ii.; aq. font. oz. ii. M.;½ oz. ter die. Also, thirty drops of turpentine every third hour, and cold beef tea for a drink.

After the 18th, the bleeding began to cease from nose and mouth, the spots to fade, and the secretions in the course of a week afterwards to present a natural appearance, when he slowly recovered from the purpuric disease.

In the month of July, he took ill with cough, difficulty of breathing, and shivering, which occurred every day at irregular times. Examination discovered dulness under both clavicles and in right axilla, the vesicular murmur suppressed in the apices of both lungs, prolonged expiratory, and sub-crepitating rale. He continued to grow worse, dying with all the symptoms of hectic in the month of November.

Case 2. C. R., aged 13 months, an apparently healthy

child, took ill on the 6th March, with vomiting, hot skin, and general irritability, tossing of the head, pulse very quick. I then gave him a quarter of a grain of calomel every two hours, a blister to the nape of the neck, and applied a leech to each of the mastoid processes of the temporal bone.

He became worse that evening. I was awakened about twelve o'clock, when I visited him; vomiting had continued, pulse still quick, pupils contracted, and cornea buried in the underlids; extremities cold, and the surface covered over with large purpura patches which had come out since I had last seen him but a few hours before. He continued still worse, when he went off in convulsions at three o'clock in the morning.

LXI. Dr. MOORE presented a patient with pharyngeal abscess, and related some particulars of the case.

TWENTIETH MEETING.

24th March, 1855.

The President in the Chair.

LXII. Dr. MALCOLM exhibited a patient aged 19, presenting *an extraordinary mass of indurated enlarged glands at the side of the neck*. The patient was of the scrofulous diathesis. A discussion ensued as to the treatment, and especially as to the utility of setons or issues in such cases. (See plate.)

LXIII. Mr. BROWNE, R.N., presented a patient who had suffered *great loss of the scalp from injury*. In the healing, considerable exfoliation of the bone had taken place, yet such was the restoration, that eventually there would be no appearance of such destruction.

LXIV. Dr. MALCOLM exhibited a child aged two and a-half years, presenting a slight appearance of cyanosis, with peculiar cardiac signs.

This child had been partially cyanosed (with dyspnoea), since birth, and complained constantly of cold. About one year ago, he was ill three months with bronchitis. On now examining the cardiac region, the "dull space" was considerably increased, as also the "impulse." The pulsations were but 48 in the minute, and the heart-sounds resembled a rough pronunciation of "durrr rup."

Dr. M. made some remarks regarding the pathology of cyanosis in general, and this case in particular. The following tabular statement he submitted in proof of the prevalence of narrowing or obstruction of the pulmonary artery as a cause.

Author.	Cases of Cyanosis	No. due to the Cause assigned.
M. Guitrac,	50	26
M. Bouillaud,	15	10
M. Louis,	19	10
M. Stillé, U.S.	62	53
	---	---
	146	99

LXV. Mr. M'GOWAN, Warrenpoint, submitted (per Secretaries) a recent specimen of uterine mole, with some particulars as to the origin of these formations, which, according to Dr. Ashwell, includes the following varieties:—

1. Ovum blighted.
2. Part of retained placenta.
3. Dysmenorrhoeal clots.
4. Polypus uteri.
5. Fibrine of coagulated blood.
6. Hardened mucus.

LXVI. Mr. BROWNE, R.N., exhibited a recent specimen of a chronic tonsillitic tumour, which he had removed, after a protracted treatment by medicine had been ineffectually tried. He explained the plan of the operation.

LXVII. Mr. BROWNE also exhibited a patient with contracted fingers, supervening upon injury of the palmar tendons, and explained the mode of procedure in the treatment.

TWENTY-FIRST MEETING.

31st March, 1855.

Dr. Pirrie, V.P., in the Chair.

LXVIII. Dr. MOORE presented some specimens of hydrocele fluid, which was highly charged with the usual "cholesterine," with a little blood. In one case there was double hydrocele and double hernia. There had been previous injury.

LXIX. Dr. MURNEY submitted the particulars of a case of stricture of the urethra, treated successfully by Syme's operation of perineal section. There were three false passages, and no catheter was passable. The wound closed up in two days, and the cure was complete, though the false passages still remain an obstacle.

LXX. Dr. MURNEY exhibited the excised portions of the articulating bones removed by the operation of resection of the elbow-joint. The original disease was chronic pulpy degeneration of the synovial membrane.

LXXI. Dr. MOORE presented a patient who had been the subject of popliteal aneurism, for which he had used Carte's clamp apparatus. The patient was altogether six months in hospital. The clamp was applied for twenty minutes or so at a time; but the application was not well borne, and, in fact, was given up in consequence of the suffering. However, the tumour gradually hardened, and after some time disappeared. Dr. MOORE expressed some doubts as to the alleged superiority of the pressure plan.

Dr. GRAVES, Cookstown, had seen four cases treated thus, in Steevens' Hospital, Dublin. It was noticed that the solidification took place more completely when the circulation was not entirely arrested. He noticed one fatal case under Dr. Cusack's care. The tumour disappeared in about 14 days, but the patient died suddenly, having had "mitral disease."

LXXII. Dr. TAYLOR, Ballymoney, submitted (per Secretaries,) an interesting case of "very protracted (40

minutes suspended animation from hanging, during a maniacal suicidal attempt," as follows:—

"I was called on to see a young man, now under the care of our excellent friend, Dr. Robert Stewart, of the Hospital for the Insane.

"On Tuesday morning, the 27th of February last, he had laboured under the idea that he was the victim of a conspiracy to kill him and his friends.

"A party of the 15th Regiment of Foot passing through, made an excitement here which attracted his relations' attention, when he ran up to a dark garret, cast his handkerchief over a beam, and suspended himself for 5 or 6 minutes, when he was discovered by his brother. He was taken down, supposed to be quite dead.

"A young medical man, resident about one eighth of an English mile from the place, was sent for, who pronounced him dead, and said his neck was dislocated, and the spinal marrow injured.

"About 15 minutes after the accident, I was called in, and found him extended on the floor, apparently dead; no pulse; no apparent respiration; and a deep mark round the neck, above the os hyoides.

"I had his head raised, the window thrown open, strong stimulants held to his nose; friction used; attempted bleeding, but failed; but in about 5 to 10 minutes could see a motion in the neck; in 10 minutes more, breathing, and in a short time he was able to swallow. After this, violent reaction—the patient requiring three stout men to prevent him from leaping out of the window; power of speech not properly restored for 10 or 12 hours afterwards."

LXXIII. Mr. BROWNE, R.N., exhibited a lime-cast of a patient's head and neck, presenting an unusual example of scirrhous tumour of the neck and orbit.

The disease was of one year's duration; the patient had been sent into hospital to be treated for "eversion of the lower eyelid", and "polypus of the nose."

LXIV. Dr. GRAVES, Cookstown, exhibited an intestinal concretion, one of several which had been passed by an old woman (aged 70) whose chief complaints were constipation (two to ten days at a time) and constant tenesmus. Ol. ric. gave most relief; she passed "lumps" similar to one exhibited, for several months. He (Dr. G.) had carefully examined the abdomen, but could detect nothing morbid. Dr. Graves referred to Monro's cases in the *Edinburgh Quarterly Journal*, and made some remarks upon the kind of nucleus most frequently discovered. (See plate.)

LXXV. Mr. FERRES, Larne, submitted (per the Secretaries) the notes of some cases of severe injury, in which capital operations had to be performed. There was very marked prostration in both instances, and in both the utility of chloroform, under such circumstances, was well illustrated.

The following are the examples referred to. The one from a severe gunshot wound, the other from a similar wound, viz. that produced by a quarry-blast:—

1. On the 23rd ultimo, a lad, aged 18, whilst carelessly lifting down from a hook in a wall, a gun

loaded with duck shot, received the contents in his left knee-joint, fracturing the patella, and opening up the joint, part of the charge having passed into the tibia. There was considerable haemorrhage, and the shock to the system was necessarily great. I amputated above the knee, whilst the patient was under the influence of chloroform, with the happiest effects, the pulse improving considerably during the anaesthesia.

2. On the 6th inst., whilst a lad, aged 19, was ramming a charge for blasting limestone at the Whitehead limeworks, the explosion took place prematurely, lacerating his right hand frightfully, and shattering the bones into many fragments: the radius was also fractured between its lower and middle third. He was brought to the Union Hospital at Larne much prostrated. From the close contact of the hand and arm with the gunpowder, the integuments were so blackened they presented the appearance of gangrene in its last stage. I amputated at the middle of the forearm. The patient, under chloroform, improved amazingly, the pulse becoming quiet, round, and full. The chloroform acted as a good diffusible stimulus. The lad became jolly, singing and whistling at the close of the operation.

These cases are adduced as adding to the many proofs that the objections urged by Dr. Hall, of the Army Medical Department, against the use of chloroform, in operations after gunshot wounds, are not tenable.

TWENTY-SECOND MEETING.

7th April, 1855.

The President in the Chair.

LXXVI. Mr. H. M. JOHNSTON introduced a patient with *necrosis of the acromion*.

There was an abscess in the neighbourhood of the joint, and sinuses existed down along the arm at the posterior region of the axilla.

LXXVII. The PRESIDENT introduced a patient having evidence of *regurgitant aortal disease*.

He was a shoemaker, and had been ill 18 months. He had had syphilis, and was mercurialized 18 years ago. The peculiarities in the case were the replacement of the usual signs by two distinct "bruits," systolic, and diastolic, heard best at the base. He has pain in the upper part of the back, which prevents him lying down at night. There was no dyspnoea. A discussion ensued as to the cause of the sounds of the heart, as deduced from clinical observation.

LXXVIII. Dr. MALCOLM exhibited a series of *daguerreotypes of disease*, taken at the General Hospital, and remarked upon the utility of the photographic art in facilitating the study of morbid physiognomy.

LXXIX. The PRESIDENT exhibited a new form of *perineal crutch*, the invention of the late Lord Antrim, which he had found useful while suffering from fractured femur. The instrument was considered by the members very ingenious, and suitable for the purpose aimed at.

TWENTY-THIRD MEETING.

14th April, 1855.

The President in the Chair.

LXXX. Dr. MOORE presented a fatty tumour of the shoulder, which he had just removed from the person of a female, aged 17. The tumour was about 3 inches square, and 1 inch in depth, and had existed one year.

LXXXI. Dr. MOORE also exhibited a hand and wrist removed in consequence of *disease of the wrist joint*. The bones were also engaged, and the synovial membrane presented the usual pulpy degeneration. The case was of three years' duration, and the muscles had already assumed a pale gelatinous appearance.

LXXXII. Dr. YOUNG, Holywood, read a paper upon the treatment of an asthenic form of *dysentery* by the exhibition of a combination of quinine, opium, and hyd. c. cretā.

The typhoid and haemorrhagic phases were particularly amenable to this mode of management, which he had not found elsewhere recommended.

[This paper is published in full in the Dublin Quarterly, for August, 1855.]¹

LXXXIII. Mr. BROWNE, R.N., introduced the subject of the query—What is the best treatment for bursal swellings?—and advocated the puncturing and injecting the sac in chronic cases. He recommended a trial of a saturated solution of muriate of ammonia, and lime water as a discutient, as he had had experience of its efficacy.

TWENTY-FOURTH MEETING.

21st April, 1855.

Dr. Young, V.P., in the Chair.

LXXXIV. Dr. JAMISON, Newtownards, exhibited (per Secretaries) portions of the bones from a case of "fracture of the neck of the thigh-bone," and submitted the following notes:—

The head of the femur was taken from a woman called Margaret M'C., aged 76. She fell off her feet on the 12th March, 1855, and was admitted to the Workhouse Hospital nine days afterwards; on admission she was in a state of semi-starvation and dotage, and gradually sank on the 6th April. There was no constitutional fever: the foot was never everted: crepitus could be felt. She was permitted to place the limb as she pleased, and she generally kept it semiflexed, with a pillow under the knee. She inclined the knee inwards at all times, and the position of the limbs resembled that in luxation on the dorsum of the ilium. On opening the capsular ligament, no adhesive matter was found in it, nor any increase of synovia; there was a very little coagulated blood between the head and the socket. The other end of the fracture was in precisely the same state as this.

¹

[See Added Appendix A at end of Second Session]

LXXXV. Mr. BROWNE, R.N., exhibited a recent specimen of scirrhous mammary tumour, which he had removed. The patient was aged 44, and had suffered from the tumour about three years.

LXXXVI. Dr. M'CORMAC introduced the subject of the query—

Under what conditions in phthisis is cod liver oil most beneficial? Dr. M'C. considered that its utility, under any condition, was problematical. The mortality had not diminished since the oil was introduced.

In the discussion which followed, the great majority advocated the free use of the oil, and appeal was made to the authority of Dr. Bennett, Edinburgh, and the decided statistical results of the Brompton Hospital, London.

TWENTY-FIFTH MEETING.

28th April, 1855.

The President in the Chair.

LXXXVII. Dr. MOORE exhibited a portion of necrosed tibia, taken from a child aged 13, who had suffered several years.

Also similar specimen of necrosed scapula, removed from the person of the patient presented to the meeting of 7th April.

LXXXVIII. Dr. MOORE also exhibited *an encysted tumour of the neck*.

The tumour felt hard, firm, and moveable. It was easily turned out, being free of the great vessels. There was no haemorrhage after the first artery was tied. The contents resembled Indian meal porridge. The tumour had resisted numerous applications for discurtient purposes.

LXXXIX. Dr. JAMISON, Newtownards, submitted (per Secretaries) the notes of a case of *dislocation of the femur into the ischiatic notch*.

W. M'K., aged 14, large and strong for his years, was driving a horse and cart on the 19th December, 1854. The horse took fright and ran away with him; the cart was upset and fell on him, dislocating his left hip, and otherwise injuring him. He was received into the Newtownards Union Hospital on the 28th December, 1854, late in the evening, nine days after the accident. I saw him soon after his admission, and found he had sustained a dislocation of the femur into the ischiatic notch. The leg was about one inch shorter than the other, the foot was a very little inverted, the knee was a little advanced. The position of the trochanter major, the limited mobility of the limb, &c, sufficiently indicated the character of the accident. But the symptom, which Mr. Syme says, is diagnostic of this accident, was also present—the lumbar vertebrae were drawn forward, and the abdomen prominent in every position in which the patient was put. He could neither lie nor stand straight, though the abnormal position of the spine was most perceptible when he was standing. In standing on the right leg, the great toe of the left foot toward the ground, was indeed, neither turned out

nor in, but kept straight, (the right foot was naturally turned out a little), the hollow state of the lumbar vertebrae was very remarkable when he was on his feet, and he could not stand without help.

On the morning after his admission, I gave him two grains of emetic tartar, and in half an hour, upon applying the pulleys, and while traction was going on, I endeavoured to lift the head of the bone from its position by a handkerchief put under the upper part of the thigh: the first application of the pulleys did not succeed. Ten minutes after they were removed, my patient got very sick, and I put them on again, and this time I put my hand on the trochanter major, to aid and observe the operation. (I applied the pulleys in the same way merely as for dislocation on the *dorsum of ilium*.) In about fifteen minutes the bone was reduced with a snap, and at the same time I was quite conscious of feeling a *double succession* with the hand on the trochanter. I deem this fact worth notice.

About a week after, I was called to aid Dr. Whitlaw of this town, to reduce a luxation on the *dorsum of the ilium*; Dr. Whitlaw, during the operation, kept his hand on the trochanter major, and on the snap accompanying the reduction, he felt quite distinctly the *double succession*.

Perhaps double succession is not the term I should use. What I mean to describe, is the slight double slide from the hand, produced by the contractility of the muscles in replacing the head of the bone. I have not seen this fact noticed before. As there are cases of hip dislocation where reduction is effected without a snap or shock, might it not be well for the surgeon in all cases where it is practicable for him to do so, to keep his hand on the trochanter major, and watch for this double feeling communicated by the head of the bone passing over the edge of, and into, the socket, as this is a distinct matter from the snap?

My patient, M'K., was able to walk a little on a crutch on the third day after the reduction, and he left the hospital on the 27th January, 1855, well able to walk without a stick, and believing himself competent to resume his occupations of labouring on a farm.

XC. Also, a case of *dislocation of the humerus into the axilla*, for which he suggested a novel mode of procedure, as follows:—

David M., a labourer, and muscular, about 50 years of age, was admitted to the hospital a fortnight ago. Eight days before his admission, he received a number of injuries while drunk. On examining him I found his right humerus dislocated into the axilla. I applied the pulleys in the way recommended by Mr. Skey, but did not succeed in reducing it. Next day I tried twice to reduce it by using traction at a right angle to the body, and failed. On removing the bandages the last time, for the purpose of applying the pulleys in a new direction, I put the fingers of my left hand into the axilla, and pressed a little up with them, while I brought the elbow down to the side rather quickly. I used no force in this manoeuvre, which was done merely to learn the position of the head of the humerus, when, to my surprise, the head of the bone bounced into the socket—a force not more than adequate to lift a dead

humerus effected the reduction, the muscles being so fatigued, and I suppose the head of the bone being partly dislodged. As the best way to reduce dislocation into the axilla is yet undetermined, it has occurred to me that a mode of applying the pulleys similar to that used in dislocation of the femur into the foramen ovale might be worth consideration—i.e., to apply the pulleys close up to the head of the bone, and to use traction at a right angle to the body, the elbow being fixed to the side by a bandage. There is no mention of any such plan in any work I have looked at. There is, certainly, some analogy in the dislocations. I very respectfully mention the suggestion for the opinion of the Society.

I should have stated that while the traction by the pulleys was last being used in M.—'s case, I put a bandage of calico under the upper part of the arm, and endeavoured by lifting at the head of the humerus to dislodge it from the axilla with no perceptible effect.

THE ANNUAL MEETING.

5th May, 1855.

The President in the Chair.

After reading the Minutes of the last Annual Meeting, Secretary submitted the "Report of the Outgoing COUNCIL," (see p. 12.) and the "Report of the AUDITORS," (see p. 76,) which were unanimously adopted.

It was then resolved, "That the Transactions of the Society for the past Session, be published, provided the funds (in ordinary) in the hands of the Treasurer permit."

THE PRESIDENT next announced the "Office-Bearers for 1855–56," as ascertained by an examination (by the Council and Auditors) of the ballot-papers. (See p. 3.)

Professors STOKES and SMITH, of Dublin, were elected Honorary Members.

The following six members of the NEW COUNCIL were then elected by the ballot of the members present:—

Dr. MURNEY.	Dr. DILL.
Dr. PIRRIE.	Dr. LYNCH.
Dr. R. STEWART.	Dr. PATTERSON.

Dr. ROSS was unanimously elected (by vote) Joint Secretary, in room of Dr. MALCOLM, elected PRESIDENT.

Thanks were cordially voted to the Treasurer, Dr. HALIDAY, and the Secretaries, and their continued services for another year solicited.

The PRESIDENT elect having now assumed the chair, the warm thanks of the meeting were passed by acclamation to the retiring President, Professor FERGUSON. Votes of thanks were also passed to the retiring Council.

CONVERSAZIONE¹

A conversazione was afterwards held in the spacious rooms of the Corn Exchange in the evening, and was attended by upwards of one hundred gentlemen. The proceedings were very interesting, and the display of objects connected with medical science exceedingly valuable and extensive. Refreshments were supplied by Mr. Thompson, Donegall-place, in a manner well calculated to uphold the high character of the establishment.

The members of the society present were:—Professor Ferguson, president; Dr. H. Purdon, Profs. Andrews, Carlile, and H. Stewart; Dr. M'Gee, Surgeon Browne, R.N., Dr. Malcolm, Dr. Moore, Dr. Pirrie, Dr. Halliday, Dr. R. Ross, Mr. H. M. Johnston, Dr. Dill, Dr. Patterson, Dr. Lynch, Dr. M'Mechan, Whitehouse; Dr. Bryce, Dr. Wheeler, Mr. M'Mullan, Mr. John Smyth, Mr. John Thomson. The guests and others invited were:^{2*} The Bishop of Down, Right Rev. Dr. Denvir, *The Mayor, *R. Davison, Esq., M.P., Rev. Dr. Henry, President of the Queen's College, Revs. J. S. Porter, *Dr. Cooke, Dr. Edgar, W. Bruce, John Porter, Wm. M'Ilwaine, J. C. Flood, W. Johnston, D. M'Afee, Dr. Bryce, I. Steen, Professors M'Cosh, Tait, Stevelly, Hodges, & Dickie, *W. S. Tracy, Esq., R.M., Robert Patterson, Esq., Robert M'Adam, Esq., G. C. Hyndman, Esq., *J. Grainger, Esq., Jas. MacAdam, Esq., F.G.S., *S. G. Fenton, Esq., J.P., J. Clarke, Esq., J.P., C. Lanyon, Esq., C.E., J. J. Murphy, Esq., the Editors of the Local Press, *W. H. Malcolm, Esq., Geo. K. Smith, Esq., Alexander Mitchell, Esq., C.E., *Dr Gaußen and N. Hunter, Esq., Royal Antrim Militia Regiment, T. H. B. Crosse, Esq., 15th. Regiment; Gordon Thomson, Esq., James Alexander, Esq., W. Dunville, Esq., J. Godwin, Esq., C.E., J. G. Smith, Esq., G. H. Strype, Esq., C.E., R. Wilson, Esq., *J. Grattan, Esq., S. Brace, Esq., J. A. Henderson, Esq., Jas. M'Intyre, Esq., James Macnamara, Esq., J.P., Newton Williams, Esq. C.E., D. Shannon, Esq., C. Davis, Esq., R. Hook, Esq., T. Pring, Esq., D. Ferguson, Esq., W. M'Iwrath, Esq., W. Young, Esq., J. Simms, Esq.

1. Among the articles exhibited were an extensive series of pathological models and wax casts, by Dr. Malcolm. These beautiful models are from the factory of Madame Bourgery, Paris, the relict of the celebrated modellist, Dr. Thibers. Their composition is not known in this country. They are much superior to ordinary plaster casts, and possess great advantages over the wax, as they can be freely handled and washed, when soiled, without injury. The wax models were made by Mr. H. Tuson, London, the chief in this line in England. They are the most faithfully executed specimens we have ever seen.

2. A series of Anatomical and Pathological Drawings. A considerable number of these were original drawings, by Dr. James Moore, characterized by vigour of touch and graphic delineation. Others were from the splendid portfolios of such Pathologists as Albers, Gluge, and Lebert abroad, and Quain's and Wilson, Bell, Morton,

¹ Report extracted from "The Belfast Daily Mercury" May 8, 1855

^{2*} These gentlemen forwarded letters of apology.

Lawrence, &c., at home.

3. Models of papier mache, illustrative of the anatomy of the eye, with accompanying diagram, supplied by our local Ophthalmologist, Surgeon Browne.

4. A series of crania and casts illustrative of one type of Irish head, procured by Mr. Grattan, from ancient sepulchral mounds at King's County, Armagh Cathedral, Buttevant, County Cork, and Aghadoe, County Kerry; and 3 casts from crania, found in and among several ancient canoes embedded in the Blackwater, County Armagh, when that river was being deepened in September, 1852.

5. Messrs. Dyas & Cantrell, Ulster Medical Hall, Castle-place, contributed a unique and tasteful collection of chemicals, pharmaceuticals, medical and surgical accessories, selected with much judgment, and many of which were quite novel in the profession. The collection comprised probably the most select assortment of Dispensatory rarities ever exhibited in Ireland.

6. A collection of surgical instruments, furnished by Mr. Bell, which presented a varied and choice selection of highly-finished articles in the extensive department of medical and surgical appliances.

7. A complete assortment of *utilia*, manufactured in gutta percha and vulcanized caoutchouc, sent by Mr. MacIntosh, Bridge-street. This collection attracted considerable notice, in consequence of its novelty, and the numberless applications of this material to domestic and scientific use.

8. Several magneto-electric machines and galvanic batteries, by Mr. G. H. Strype, C.E., and Mr. Pring. The application of these instruments in the process of electro-typing and the working of Morse's (American) telegraph, was fully demonstrated during the evening to a large circle of admiring spectators.

A very ingenious application of clock-work we noticed as the original design of Mr. Strype, C.E.

The object of this is to regulate the duration of the exposure in photographic operations. It performs with unerring accuracy the closing of the camera to any time it may be previously set to. It will also open the camera as well as close it, so as to enable an operator to take his own portrait after having set the instrument.

9. A portable field photographic apparatus was exhibited by Mr. Pring; and several excellent drawings, taken by the wax paper process, were also on view; as, also, some excellent stereoscopic drawings, which attracted much attention.

10. A number of articles more or less bearing on medicine, were supplied by the Council of the Natural History Society, from their admirable museum, at the request of the Society. These included objects from the three kingdoms of nature which furnish our materia

medica. Amongst these we noticed two beautiful specimens of virgin gold, one from Australia, and the other from the mines of Peru.

11. On the President's table, we noticed a few microscopes, whose surprising powers were fully tested during the evening under the superintendence of Dr. Purdon.

12. A collection of rare and ancient medical works of the most distinguished authors of the past ages.—The most of this collection was kindly granted by the Council of the Belfast Medical Society, who possess an excellent and select medical library. The volumes exhibited represented the principal epochs in medical science. Some rare works we also noticed, sent by Dr. McGee, Dr. Jamieson, Newtowndrds, and Mr. Ferris, Larne. In connexion with this, we noticed a small but valuable assortment of modern medical works, supplied by Mr. Henry Greer, of High-street.

A few sanitary mechanical appliances, including Arnott's ventilating valves, patent traps for sewers, Gribben's window sash &c., were on view from the establishment of Messrs Riddell and Co. Besides the above, which formed the bulk of the vast collection—which occupied twelve long tables placed in three rows—we observed some very handsome tableaux indicative of Mexican manners and customs, kindly granted for the occasion by Gordon Thomson, Esq., of Bedeque House. One of these groups of figures represented the process of extracting the aloe gum from the plant.

We also noticed a large number of portraits of distinguished members of the profession, both ancient and modern, which added not a little to the interest of the scene; but of the objects not strictly professional which came under our eye, a volume of autograph letters, the property of William H. Malcolm, Esq., seemed to us decidedly the most valuable and recherche. We observed many of the distinguished guests particularly noticing the unique volume, which contained the letters of many celebrated, remarkable and eminent persons, and formed altogether a highly valuable and interesting collection. We subjoin a list of the principal portion: David Garrick—letter; General Washington—long letter, dated Mount Vernon, to Sir Thomas Newenham; Duke of Marlborough—letter; Robert Burns—the poem “The bonnie lad that's far awa,” all in the poet's own handwriting; Lord Nelson—letter dated from on board the San Josef, 1801; Napoleon I.—signature; Empress Josephine—letter; Edmund Kean—do; Right Hon. W. Pitt—do; Right Hon. Sir Robert Peel—do; Mr. Wilberforce—do; Daniel O'Connell—do; Richard Brinsley Sheridan—do; George Frederick Cooke—do; Mrs. Charles Kean—do; Lord Byron—promissory note; Mrs. Billington—letter; Cherubini—do; Weber—do; Paganini—a few bars of music; Thomas Moore—letter; Sir John Moore—do; Marshal Ney—do; Marshal Desaix—do; Duke of Wellington—letter to Right Hon. Robert Peel, 1823; Thomas Campbell—poem (all in the poet's handwriting);

Barry Cornwall—love song, do; Canova—letter; L. E. Landon—do; Jane Porter—do; Sir Thomas Lawrence—do; &c., &c. But it were totally impossible to even allude to all the varied objects which the society exhibited on this interesting occasion. We have only presumed to give a bare outline of the principal, leaving it to our readers' imagination to fill up a great deal of the real scene, which, we only echo the general voice by saying, elicited the unqualified admiration of every one who had the privilege of being present.

After tea and coffee, Dr. MALCOLM, president elect, called attention, and Dr. FERGUSON, outgoing president, having taken the chair, proceeded to deliver the following address, which was heard throughout with the greatest attention, and occasionally elicited general applause: –

Gentlemen, guests, and members of the Belfast Clinico-Pathological Society, on me has devolved to-night an onerous and a double duty; in one respect the most gratifying and pleasing that could be imposed, bidding you, our guests on the present occasion, a sincere and hearty welcome to this our closing reunion of the session; and in another, exciting feelings not less intense, though of an opposite tendency, and calling on me imperatively, though reluctantly, to say to you, my fellow-members, in vacating your presidential chair, a respectful and grateful farewell. And though in good truth I could have wished that this duty had fallen to the lot of one more capable of doing justice to such a theme, and more eloquent in conveying the thanks of the society for the honour conferred on us by the presence of our guests, yet to none will I yield in the warmth and sincerity of feeling that prompts both greeting.

We have to-day, gentlemen, reached the close of the second session of the Belfast Clinico-Pathological Society, and in accordance with one of its laws, I necessarily vacate the office of president, I avow it not without feelings of regret, no doubt greatly modified by the conviction that in my successor the society will discover many qualifications for the office in which I am fully conscious of my own deficiency. Yet the uniformly kind consideration and support which I have received from every member of the society, the actual amount of information I have gained, and the pleasing interchange of professional courtesies which the possession of it secured me, naturally make me happy and proud of having been the occupant of this chair, and proportionably engender regrets at my retiring from it. The few remarks with which I am about to trouble you, gentlemen, were intended for the annual meeting held this morning for the transaction of the society's more immediate business, but at the eleventh hour it has been deemed expedient that they be inflicted on you here; consequently, they will possess, I fear, but few attractions and little interest for an audience not strictly professional.

One subject, however, I hope to effect—be not startled at the announcement—I mean to extend the sphere of your knowledge; for I am persuaded that many who hear me will leave this room informed on

what they were before ignorant. It is more than probable that many of my audience date their knowledge of the very existence of the Clinico-Pathological Society from the hour of their entering this room; and I would wish to lay before the meeting a general outline of its objects and machinery, with a view to inform our non-professional visitors on a subject with which they could scarcely be expected to be familiar. If I but succeed in this I shall deem myself as *functus officio*. For we all know that the public interest themselves but little about matters connected with our profession; or when they do, are too apt to associate the idea with the ills and disagreeables of life. Now, assuredly, this should not be so. On the contrary, I feel satisfied that from more frequent opportunities of meeting, as on the present occasion, for the interchange of ideas and courtesies, between those within and those without the pale of the profession, great mutual advantages would accrue to each, and much prejudice and ignorance would be dispelled.

For what is there interesting or important in the whole sphere of natural knowledge which directly or indirectly the science of medicine does not embrace? What can be a more worthy or more lofty theme than her first and more immediate object, to study and learn the construction of that noblest work of the all-wise Creator, man?—man for whom this teeming world was called into being; for whom such wonders have been lavishly spread out by the great first cause. What more intellectual occupation than to contemplate the means by which we “live and move, and have our being?” Is it not ours to investigate the nature and operation of the various influences by which health is interrupted and restored—to apply the means by which, to the honour of medicine be it told, disease, suffering, and even death itself may be averted? The study of nature, and the search after the truth which she teaches, are the leading objects of our pursuits. Is there not here much neutral ground where all can meet and profit by each other's labour? We, of this society, hold this opinion strongly, and feel that we have sufficient ground for it in the great variety of matters of value and interest by which we are to-night surrounded, all more or less intimately connected with medicine. We therefore seek a closer and more intimate alliance with our fellows, labouring though they be in a different field. We believe that reunions such as, I hope, the present may prove, are well calculated to promote this

“Consummation most devoutly to be wished” –

And we trust that they may be as frequent, as mutually instructive and interesting. When I addressed the society at the opening of the session, it was in terms congratulatory of our success. First—on what is and should be its paramount object—the endeavour to elicit and diffuse professional knowledge; and secondly—on the number of our members. In both these respects it gives me sincere pleasure to state that our present position is equally if not more satisfactory. As regards the former point, I would appeal to the abstracts of our proceedings, lithographed and distributed to our members after each weekly meeting, in which even a cursory glance will discover evidence of the society having, during the past Winter,

addressed itself to many of the most interesting and novel points of clinical medicine and surgery, of pathology, therapeutics, physiology, histology, new and improved mechanical appliances connected with our art, &c.; nor have the specialities been overlooked. I may particularize midwifery, ophthalmia and aural surgery; and I might add the many individual cases illustrative of various and anomalous forms of disease which have been supplied either from the private practice of members, and kindly communicated, or selected from the prolific wards of our hospital. I feel I may safely assert that such consultations as these cases have given rise to have ever been productive of instruction to ourselves and suggestive of good to our patients.

And as regards the second point, our numbers—that far from despicable test of progress and success—I am happy to say they are most cheering and satisfactory. In the first session of our infancy—the Winter of 1853 and 1854—we boasted, and with reason, our 96 members—43 resident and 53 non-resident in Belfast; whilst in the closing session of 1854 and 1855 our numbers have risen to 105—45 resident and 60 non-resident members. It is not for me to enter into an analysis of the composition of this society—a subject I feel satisfied better understood by many of those whom I address than by myself; but I will hazard the expression of my individual opinion, that neither in professional erudition, intellectual endowments, nor social position, are its members surpassed by their brethren of this great community, whence is supplied one of its constituent parts, not of the Province of broad Ulster, which chiefly, though not exclusively, supplies the other.

As may be readily inferred from a mere glance at the objects by which I find myself surrounded, the almost endless variety of topics that have presented themselves to my mind as worthy of being brought before the notice of the society on the present occasion, has rendered selection as well as omission a necessary, though not an easy, task. In fact, my difficulty has been *l'embarras des richesses*. But the fast failing sand in old Time's hourglass reminds me that I must be brief: and for only one or two points, connected with the working of our society, would I for a moment claim your indulgent attention.

It seems by common consent to have been admitted that the facts brought forward at our meetings merited something more than a mere ephemeral existence, and that our theatre should not be alike their cradle as their mausoleum. We have the recognition of this principle in the publication of our "Transactions" of the former session, and its flattering reception by the profession. The same idea has suggested during the late session the publication of the weekly "Abstract," which, I have reason to think, has given very general satisfaction and pleasure, but, for obvious reasons, to non-resident members more especially. The "Abstract," I should hope, however, will not interfere with our volume of Transactions. In fact, I feel that in this matter we have committed ourselves; that the profession expect it from us; and I confidently trust they shall not be in any way disappointed. Nor can I leave this subject without

giving expression, however faint and inadequate, to what I, in common I am sure with every member of our society, so strongly feel—our deep sense of the obligations in the accomplishment of these objects that we all have incurred to our zealous, our indefatigable hon. secretary, whose presence alone checks my indulging in eulogy farther than what, in candour, must be admitted, nay proclaimed, that his is the master mind that not only projects, but works the most of our machinery.

But besides the press, there is another means by which much that is interesting in our labours may be rendered useful and available for our purposes—I allude to our museum. This, I think, is a subject well worthy the serious consideration and attention of the society. Morbid specimens, dried or preserved in spirits, or—what I am inclined to consider better still—those exquisitely beautiful and truthful models which we have seen occasionally through the session, and of which specimens are in the room, together with casts and drawings, as each individual case may require, should be eagerly sought for and carefully collected, with a view to the formation of a museum, which, I have little doubt, would in a short space of time prove not only most instructive and interesting, but actually of intrinsic value, and highly creditable to our society. Few will deny the great value of both these means in rescuing from oblivion our weekly labours. Therefore would I anxiously solicit from all their aid and assistance in achieving these objects, as also impress upon members the importance of each of us communicating cases and facts of particular interest, in order that thus a record of them, accessible to all, may be obtained and preserved. Such a volume, and such a museum, by placing the experience of the profession before individuals, must prove almost invaluable. Which of us does not often feel the want of such a guide amidst the doubts and difficulties of practice? But to our professional brother of the rural district, who may not enjoy the daily or hourly interchange of thought and converse with his peer, must not the possession of such a record on practical points be a "*decus et tutamen?*" Hence do I indulge the hope, that not only will every hospital and dispensary attendant in the province join our ranks, but that each will aid us by his practical contributions.

I would next direct attention to a source of information in our art, becoming daily more interesting and important. I mean the microscopic investigation, and the chemical analysis of morbid tissues and secretions. For such investigations our society presents many facilities. Nor during the past Winter have instances been wanting illustrative of the great value of such inquiries.—For example—the practitioner in a remote district wishes for assistance to determine whether or not an excised tumour be malignant; or he may desire a chemical analysis to ascertain the morbid condition of any of the secretions. He corresponds with our committees and his doubts are at once dispelled. I know that already many have availed themselves of this privilege, and that it has proved a very great boon.

Nor should I omit to mention that, in accurately portraying morbid appearances, as well as those

remarkable alterations in the expression of “the human face divine,” given by disease, not only the artist’s pencil, but in the wondrous products of photography, the very sun’s rays have been made subservient to our purposes; many interesting illustrations of which you will have an opportunity this evening of inspecting.

And to what, gentlemen, do all these different objects tend? And perchance the reply, though it may not alike interest, yet equally concerns my non-professional as my professional hearers. Obviously they are but means to an end; that end accuracy of diagnosis, or, in other words, the means of ascertaining the presence or absence and the nature of any morbid affection. Is there a quality in the medical practitioner more deservedly prized, or by the enlightened and educated medical mind more anxiously and laboriously sought for than the capability of forming an accurate diagnosis? If he possess not the means of determining the seat, nature, extent, and intensity of the disease he may be called on to treat, how can he be qualified to direct such curative means as may be best calculated to counteract or remove it?—Would that we could boast that the days were gone by when, in utter disregard, perhaps ignorance, of the change of structure or derangement of function which gave rise to them, mere symptoms were regarded as diseases, and treatment directed solely against them.

We all know how much in our profession what is called *experience* is prized and vaunted. But what, gentlemen, are the proofs, what are the tests of its value? If, as I fear is often the case, it can be measured by or inferred from a man’s years, heterodox though the opinion to some may seem, for my part I reject the standard, and I ignore the validity of the inference.—If it be founded on a close observance of symptoms at the bed-side, whilst I appreciate the value and importance of such knowledge, I deny its sufficiency for the object; and I maintain that *post-mortem* investigations, and the results there obtained, collected and compared with living signs and symptoms (in other words, pathology) constitute the only safe and valid foundation for the great superstructure of accurate diagnosis. If time permitted, it might be interesting to inquire how some of the more modern and vaunted (misnamed) systems of medicine would bear the application of this test. But of most of them, I fear, may be said that “what is new is not true, and what is true is not new.” What force and point we recognise in that pithy exclamation of Rostan, “All medicine consists in diagnosis.” Nor does he stop there; but so great stress does he lay on the worthlessness of that practice which is based on symptoms, irrespective of pathology, that he adds, “The medicine of symptoms is the worst of all medicines.”

Let us then, gentlemen, members of the Pathological Society, persevere in our efforts to spread a taste for and knowledge of pathology. The field is yet an open and a widely spread one. The labourers no doubt are many and fully equipped for their work. We must not lag behind, but rather spiritedly, and I hope successfully, keep our place in the van. A mere feather thrown up clearly enough shows how the wind blows. “*Verbum sat sapienti.*” A “pathologist” to the hospitals of Scutari has been sent out by the Government—an ample

though a tardy recognition of the vast importance of this subject. Nor could a better or more judicious selection have been made than my former distinguished pupil, Dr. Lyons. On his appointment I would together congratulate him and the profession of which he is an ornament. Are we to accept this as an omen of better days? Are the errors, the horrors, and fatalities of routine and *red-tapeism* in the medical department of our Government at an end?

Are the snows of age ever to be a necessary qualification for the onerous and important duties of office? Loth though I should be to found an objection on their possession, yet holding with the prisoner of Chillon, that

“My hair is grey, but not with years;
Nor grew it white
In a single night,
As men’s have grown from sudden fears.”

I must take leave to question their being indispensable. Are “three score years and ten” the greatest recommendation of a public servant? The truth and force of “*Solve senescentem maturè sanus equum*” were never more displayed, though, perhaps, never more overlooked in certain quarters than at the present moment. Hence that dismal “cloud” that just now “lowers upon our house;” but let us remember “*aide toi et le ciel t'aidera*,” and soon shall it be “in the deep bosom of the ocean buried.”

But I fear I have trespassed on your patience; and though the theme be one on which I might dwell at greater length, yet must I restrain the *cacoethes*, however impulsive, I hasten to a close. But before doing so, I would again tender you, gentlemen, who have favoured us with your presence this evening, our best thanks and grateful recognition of your kindness. We pray you overlook the many defects and imperfections of our “youth and inexperience,” but two years’ old, and this is our first essay! We deprecate hypercriticism, and we promise to improve. And, gentlemen of the Pathological Society, deeply impressed as I am with the utility, the intrinsic value, the growing importance of our undertaking, satisfied with its present, and secure of its future, success, with feelings sincerely and deeply grateful for all the kind assistance and support I have ever received from the office-bearers and members of this society, I now restore to you, I hope unsullied, the honours with the chair of your president. (Loud cheering.)

After the conclusion of the learned president’s address, the company resumed conversation and inspection of the various objects of interest, in which, and in discussing the characteristics of each collection, a considerable time was spent profitably and agreeably. Few reunions have ever taken place in Belfast that gave more gratification to those who had the pleasure of being present.

APPENDIX No. 1.

Further particulars respecting the case of BRONCHIAL POLYPUS mentioned in Transactions for 1853-54, page 101 {39}.

The patient was aged 30; tall, thin, but not unhealthy-looking; clear skin; light sandy hair and whiskers; a farmer, who was formerly very active, fond of athletic exercises, and dissipated.

Two years since he had a smart inflammatory fever, for which he was bled three times, (he says,) but had no pain in his side, rusty sputa, or cough. Six weeks he was ill from this attack, and as he recovered he began to cough and spit up pieces of plastic-lymph. His chest is broad and well expanded; perfectly resonant, except in the inferior posterior left, where there is slight dulness, but the respiration is in no point morbid or marked by morbid rales; it is only weak, the murmurs faint. He says, however, that he has always lain more comfortably on his right side, and if on the left he was wheezy and oppressed. He coughs violently when the masses of lymph are coming off, one or two each day; and at night if he awake, he spits a piece, and falls asleep again. He expectorates occasionally a tough mucus, which rises when the plastic pieces are removed for a few hours.

Once, in Liverpool, he spat up masses for a week or ten days, and there again lately, after a feverish cold for which he was bled. He was a good deal relieved by the bleeding, and had no return of the expectoration for some days. He had some for several days lately, during an attack of spontaneous diarrhoea, which lasted for some days, and which came on when he was taking iod. potass.

His pulse is ordinarily quick, upwards of 80: urine, scanty always; bowels generally regular; appetite good; no thirst of any consequence; general aspect rather strumous. He is a very intelligent fellow, and can give a wonderfully good description of his case, more clear and lucid than the foregoing, as from his various conversations with members of the faculty, it is presumed, he has picked up the medical terms, and uses them with great propriety.—

(Extract from a letter from Dr. PATTON, Tandragee.)

APPENDIX No. 2.

History of the case of PERTUSSIS read by Mr. H. M. JOHNSTON, at the Ninth Meeting, on 6th January, 1855.

CASE of hooping-cough, complicated with convulsions, followed by a state of coma, from which the patient did not recover for a period of six weeks; after recovery, a very imperfect re-establishment of the mental faculties.

Sunday, January 15th, 1854, I was requested to visit J. P., a child aged three years and four months. About three weeks before my seeing him, he had an attack of measles, and the cough, from which he then suffered, had gradually assumed the character of hooping-cough. He had always been a fine, healthy, smart child. When I saw him, he was passing through the inflammatory stage of pertussis, being feverish, cross, oppressed with sickness, and disinclined to take part in any amusement. The paroxysms of coughing were very frequent, prolonged, and severe; the expectoration scanty; and there were bronchitic rales heard over both lungs. He was treated with emetics, and repeated small doses of chloroform, to allay the spasms; for a little the child seemed to improve, and obtained some sleep. About the 28th January, he became more feverish, the paroxysms being very frequent and prolonged, and he was occasionally delirious after an attack. The secretion of urine was scanty, and his face, eyelids, and lower extremities were oedematous. One night, about this period, he seemed to his parents to be slightly convulsed after a paroxysm, the eyes being turned up under the eyelids.

I saw him upon Friday, February 3rd. He was then about one month ill with the hooping-cough; and, so far as regarded the bronchitic complication, a decided improvement had taken place; his breathing was, however, still very quick; he was inclined to lie, in a half drowsy state, upon his mother's knee during the intervals between the attacks of coughing; and these latter were now not only very frequent and prolonged, but they were of a suffocative character, the hoop not being so distinct. About three o'clock on the morning of the 4th February, he was seized with an attack of convulsions, after a very severe and very prolonged paroxysm. I saw him at nine o'clock, a.m., and found him almost constantly labouring in convulsions. The left side was specially affected, the thumbs of both hands were bent in upon the palms, and there was a degree of rigidity of some of the muscles of the left upper extremity. He was quite unconscious, the pupils were widely dilated, and did not contract, the eyelids being kept wide open; his pulse was about 130, and his respiration rapid. I saw him again in the evening; the convulsions had continued to recur during the entire day; he frothed at the mouth, and there was no return of consciousness. At intervals of half an hour, there was an attempt at coughing, but the hoop was suppressed. Heart's action was rapid and tumultuous, pulse being about 150, and much smaller than in the morning; there was a clammy perspiration over the body, and exhaustion of the vital powers seemed rapidly approaching. My prognosis was unfavourable, more

especially as his sister, a child nine months old, who was teething, and had been suffering from hooping cough, was also, upon the 1st February, seized with convulsions, after a paroxysm of coughing, and died in a few hours. In her case, prior to the convulsive seizure, the hoop had become quite indistinct, and for two days, there were frequent attempts at vomiting.

J. continued in the state described above for a period of forty-eight hours from the first seizure. The convulsions then abated, recurring only slightly, and at much longer intervals; the pupils were less dilated, and more sensible to the stimulus of light. There was, however, no return of consciousness, and I now discovered that there was a paralysed condition of almost the entire body. There were slight movements of the right foot and hand, but the left side was completely paralysed, both as regarded motion and sensation. The cerebral lesion seemed to be of such an extensive nature as completely to cut off all cognizance of the brain over the bodily functions or the world without. He lay in his cradle in whatever position he was placed, passing his motions and his urine without giving the least notice. He did not seem at all annoyed when the soles of his feet were tickled. He neither asked for food nor showed any desire for it, until the spoon was brought into actual contact with his lips, when they were immediately opened, the food admitted, masticated, and swallowed. There was a constant automatic motion of the lips; the eyelids were kept widely open, the pupils being much more dilated than natural, and the expression vacant. In fact, he seemed neither to see, nor bear, nor feel; his intercourse with the external world, through the medium of the senses, being thus entirely closed. His pulse continued high, ranging from 130 to 150 in the minute; his respiration was rapid; tongue clean and moist; bowels rather confined. As regarded treatment—after the convulsive seizure, his temples were leeched, and he was freely purged with calomel and scammony; when the convulsions abated, his head was shaved and blistered, and he was put upon mercury, the blistered surface being dressed with mercurial ointment.

Upon Saturday, February 11th, he was ordered powders with calomel and antimony, instead of grey powder, and, in addition, a diuretic mixture, with tincture of digitalis. Sunday, February 12th, he continued to lie in much the same state as described; the attacks of coughing were more frequent, and the hoop more distinct; skin cooler, pulse quieter, and the secretion of urine more copious; there were slight convulsive seizures, after the paroxysms the face becoming congested and swollen.

Saturday, February 18th. Some days since I had to omit the digitalis, as it caused intermission of the pulse. The evacuations are greenish coloured. He is becoming very much emaciated, and bed sores are forming. Pulse has come down to 123, and has lost its intermittent character. Dr. Seaton Reid saw him with me to-day. He considered the case as one of a very peculiar nature, and in respect to its pathology, he believes that an effusion of blood took place from the violence of the paroxysms at the time of the convulsive seizure. He advised me to persevere in the steady use of mercury.

Already there seems a slight improvement in the power of motion, especially in the right upper extremity. He still lies in the same comatose state. It would be tedious to detail at much greater length the progress of this case.

Upon February 26th, his gums were somewhat red and swollen; he was ordered a mixture with iodide of potassium. From about this period a very gradual, but very steady, improvement began to take place; he first regained complete power over his right upper extremity, and in a little time he kept up a constant motion of his right hand to his mouth and face.

March 22d. The improvement in his state is very marked. He has now acquired complete power over the right side, and in great part over the left also, there being but a slight degree of weakness; and sensation is also re-established. The paroxysms of coughing are diminished in frequency and severity. He eats well, and is rapidly gaining flesh; as yet, however, he does not appear either to see or hear. If any object is placed in his hand, he immediately brings it to his mouth; he frequently utters an incoherent cry, but cannot be said to speak. About the end of March, there was some evidence that a gradual, but slow, recovery of the functions of the special senses was taking place, and that his mental powers were being in part regained. It was observed that he was attracted by the glare of the candle, and that when his attention was strongly roused, he could answer a question, or finish a sentence. Previous to his illness, his parents had taught him to repeat hymns; and, much to their delight, one evening about this time, he repeated the greater part of a favourite one.

He continued to improve; by degrees he quite recovered, so far as regarded his physical powers and bodily health. He regained his flesh, and is now (October 1850) a fine, healthy, robust child. During his recovery, he was frequently seized with peculiar convulsive fits, during which his face would flush, his breathing become hurried, and his left side slightly convulsed. Such attacks would continue for about one minute and a half, and when they ceased the child would fall, if not supported. These occurred more frequently on the approach of wet weather, or about the change of the moon. He still occasionally has such attacks.

Had there been an equal improvement in his mental as in his physical powers, it would have been indeed well; but here there still exists a sad blank. It is now (October 1856) above two years and a half since his illness. All his organic functions are duly performed, but the mental are far from perfect. He gives no notice either when evacuating the contents of the rectum or bladder. If allowed to go out he would continue to run on, and on, and if not stopped, he would not think of returning, nor would he avoid danger. However, if forbidden to do anything, he will obey for the moment, and dread punishment, but he will almost immediately return again, and do what he was desired not to do. He cannot be made to fix his attention for any length of time; and though, previous to his illness, he was quick in learning, it is now impossible to teach him anything, he so soon forgets. When lying upon the floor, he will

occasionally repeat portions of hymns he had formerly been taught.

There seems of late to be no improvement in the state of his intellectual powers. His memory, his judgment, and his power of associating ideas, being all very imperfect. His is therefore almost an idiotic existence, but he seems perfectly contented, expressing his happiness by clapping his hands, kissing his parents, and uttering unmeaning cries. He is not passionate, and never becomes angry. Before concluding, I may mention that during his recovery, he frequently passed large numbers of lumbrici. Anthelmintics were administered; but there did not seem to me to be any connexion between the existence of the worms and the illness of the patient, as no improvement was consequent upon their expulsion.

by his own personal exertions, a large field of practice. He always sustained a high character for uprightness and honour in his intercourse with his brethren, and his sudden removal in the mid-day of his professional career, cannot but be deeply regretted both by the Profession and the public.

In accordance with Law XVI., Medical Students of at least one year's standing, have been admitted to the Meetings of your Society after the transaction of private business. The Council have been gratified in observing that such opportunity of improvement seems to be prized by the Students, as manifested by the increase in the number of those who attend, and by their attention and gentlemanly conduct when present. Forty-three have availed themselves of the privilege of attending, and certificates have been granted to twenty-five, showing a considerable increase upon last Session.

The business of the Society, during the past Session, has continued as before to embrace the following subjects, viz.:—The Exhibition and Explanation of 49 Pathological Specimens: four new Instruments have been brought before the notice of the Society: twenty interesting and original cases have been read: the results of thirty Microscopical Examinations have been submitted, the Specimens having been forwarded by Members: some peculiar and rare Clinical facts and Statistics have been noted: five papers upon new modes of treatment were read: and three discussions upon particular subjects for debate have taken place.

The Council would congratulate the Society upon the good feeling and order which have pervaded all the meetings and discussions of the Session. The mutual improvement and gratification of each Member, being the desire of all.

A considerable number of additions of interest have been made to the Museum.

Some changes in the Laws, suggested by Members as beneficial, have been adopted.

The Reserve Fund continues to increase satisfactorily, and at present amounts to about £18.

The first volume of the Transactions was issued in January, and has been favourably reviewed by different Medical Journals.

Two hundred copies were printed, and it was resolved to dispose of extra copies to Members of the profession, not in connexion with your Society. Twelve copies have been already thus sold at 3s. each; and if the remainder of the copies were disposed of, the expense of the publication would be defrayed without any cost to the general funds of the Society.

The Council would recommend the Society to continue to issue a volume of Transactions, for the following reasons:—First, because you are thereby enabled to place upon record many interesting, and rare Pathological facts and Clinical observations. Secondly,—they consider that such publication adds weight to your body, and cements the union of its Members, resident and non-resident; and, lastly, other Societies adopt with benefit a similar plan; and, as previously mentioned, your first volume has met the approval of the profession.

With a view to encourage the adhesion of country

REPORT OF THE COUNCIL, AT THE CLOSE OF THE SESSION, 1854-55.

In closing the Second Session of the "Belfast Clinical and Pathological Society," the Council feel it an agreeable duty to present to its members the following Report.

In accordance with Law XIII., the Annual General Meeting of the present Session was held upon Saturday, October the 28th, the President, Professor Ferguson, in the Chair.

The Society have continued to meet regularly every Saturday, except during the Christmas recess.

Twenty-six meetings in all have been held.

Of the enrolled members, 53 have, upon one occasion or other, been present; 13 of this number being Country Members.

The average attendance has been 19.

Our Members upon the roll at the opening of the Session numbered 95. Thirty have been since admitted, viz.:—In Nov., 13; in Dec., 7; in Jan., 2; in Feb., 1; in March, 2; in April, 3; six have tendered their resignation; five have retired by default; six have gone abroad, and one has been removed by death. There now remain, therefore, 107 Members: of these, 45 are resident and 62 non-resident. Of the non-resident, 16 reside in County Antrim; 5 in County Armagh; 1 in County Donegal; 26 in County Down; 1 in County Dublin; 4 in Londonderry; 4 in County Louth; 3 in County Tyrone; 1 in County Waterford, and 1 in England.

Our Society have to record its sincere sorrow at the sudden removal of one of its original Members, in the person of Dr. Bryson. He took a deep interest in the success of the Society. About the year 1833, he was appointed to fill the situation of House Surgeon in the Belfast General Hospital. He was therefore engaged in the practice of his profession in Belfast for a period of above 22 years. Possessed of a considerable amount of original talent, untiring energy of mind and body, combined with great perseverance, he soon acquired,

Report of Council

Members, it was resolved on the 8th of February, to publish weekly an Abstract of the proceedings. This has been highly approved of; twenty-three Members have taken it, besides Students. It is worthy of note that if forty Members subscribe for the Abstract, the expense of its publication would be covered.

According to rule sixth, two Members of the Dublin Pathological Society have been nominated for Honorary Membership, viz., DR. STOKES, distinguished for the zeal, energy, and success, with which he has pursued his Clinical researches in connexion with, and based upon, sound Pathological principles; and PROFESSOR SMITH, whose eminence as a Pathologist is world-wide, and who still continues to pursue his investigations with unremitting care. These candidates for Honorary Membership, are now to be balloted for.

It has been considered desirable to close the present Session with a Conversazione, for two reasons specially:—1st. To give greater publicity to the Society; and to afford our President an opportunity of placing more prominently before the profession, its claims to their support.

2ndly. With a view to bring us into closer communication with the other learned bodies, whereby scientific objects in general may be advanced and promoted.

Having thus placed before the Society a short report of its progress and business during the past Session, the Council feel warranted in believing that the objects of the originators of the Belfast Clinical and Pathological Society have been largely realized, and that the study of Pathology in connexion with Clinical Medicine and Surgery has been advanced.

Our Pathological Museum has received many interesting and valuable contributions, and promises soon to attain an extent worthy of the status of the Society, and of the notice of the profession at large. The interests and position of Medical Science, and of the Medical Profession in the North, have been promoted. Good feeling amongst the Members of your body has been uninterrupted; and our Weekly Meetings have been anticipated with pleasure, and enjoyed, both as a relaxation after the anxious and laborious duties of our profession, and as an agreeable, and profitable opportunity for the interchange of our views upon Medical topics, and discoveries. The Council would therefore urge upon all the Members to continue their support to the Society, and to seek to advance its objects, elevate its position, and extend its beneficial influence, by

enlisting new supporters, and by each individually carrying out, and promoting the objects and aims of the Belfast Clinical and Pathological Society.

NOTICE TO MEMBERS.

THE ANNUAL SUBSCRIPTION IS due on the last Saturday in October.

MEMBERS, desirous of exhibiting PATHOLOGICAL SPECIMENS, or otherwise contributing their quota of information, are requested to communicate with the Secretaries, and Country Members who may not be able to attend, are reminded that all communications intended to be read at the Meetings of the Society, should be forwarded to the Secretaries, or some Member resident in town whom they may depute.

ANY member who may be aware of the desire of any qualified Medical Practitioner to join the ranks of the Society, is requested to intimate the information to the Secretaries or other Office Bearers.

A weekly abstract of proceedings (lithographed) is regularly issued, principally for the advantage of Country Members who are generally prevented by distance from attending the Meetings of the Society. Prepayment of the entire postage for the Session (viz, 2s. 6d.) secures this privilege, which has, by a recent regulation, been extended to other Members, and Students of Medicine, as visitors.

SPECIMENS of morbid fluids and solids forwarded by members are examined and reported on by the Microscopical Committee without delay or charge. Reports are furnished to non members on prepayment of half a crown per specimen to the Society.

THE new regulations of the Post Office afford great facilities to Country Members for the transmission of morbid specimens for exhibition at the Meetings of the Society.

ALL Members are entitled to admit (once only for each visitor during the Session), by written orders, qualified Practitioners to any of the Meetings.

THE Secretaries are authorized to dispose of copies of the Transactions already published, to any qualified Practitioner, on prepayment of Three Shillings.

THE Pathological Museum of the Society is open every Saturday during the Session, between the hours of Two and Three o'clock, and at other times on application to the Secretaries.

The Treasurer in Account with the Belfast Clinical and Pathological Society, for the Session, 1854-55.

	Dr.	£	s.	d.		Cr.	£	s.	d.	
To Balance in Treasurer's hands,	4	6	2		By Unpaid Subscription,		0	10	0	
" Reserve Fund,	8	15	0		" Printing Transactions, Reports, Circulars, &c, Binding, and Advertising.		26	16	8	
" Members' Subscriptions,	38	0	0		" Postage,		3	11	9	
" Cash for "Transactions" 1853-54, sold,	1	16	0		" Messenger,		2	2	0	
	<hr/>	<hr/>	<hr/>	<hr/>	" Reserve Fund in Bank,		18	2	6	
	<hr/>	<hr/>	<hr/>	<hr/>	" Balance in hand,		1	14	3	
	<hr/>	<hr/>	<hr/>	<hr/>			<hr/>	<hr/>	<hr/>	
		£52	17	2				£52	17	2

Audited and found correct,

ROBERT STEWART.
R. F. DILL.

May, 1855.

LAWS OF THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

I. NAME AND OBJECTS.—The Society shall be called "The Belfast Clinical and Pathological Society," whose objects shall be the cultivation of Practical Pathology, Diagnosis and Therapeutics, by means of the accumulation and analysis of appropriate Cases and Pathological Reports, and public discussion thereon; the establishment of a Pathological Museum; and the keeping of records, to indicate the progress of discovery in Medical Science.

II. MEMBERS.—The Society shall consist of Ordinary Resident and Non Resident, and Honorary Members—number unlimited.

III. QUALIFICATION.—The Candidates for Membership shall be regularly qualified Physicians or Surgeons.

IV. ANNUAL SUBSCRIPTIONS.—The Annual Subscription shall be *Ten Shillings* to Resident, and *Five Shillings* to Non-Resident Members, payable on the first day of Session, or, if a new Member, on the day of his election.

V. ELECTION.—The Candidate for Membership shall be proposed by two members at one meeting, and balloted for at the next; one black bean in five to exclude, and prior to ballot, the legality of his qualification shall be duly certified, and his subscription paid.

VI. HONORARY MEMBERS.—Honorary Members shall be elected only at the stated annual meeting; the names of candidates to be entered on the Minutes at least one month previously, and proposed by four members. When elected, they shall be free to all the privileges of membership, except share in the property, without subscription; and in the ballot for honorary members, one black bean shall exclude.

VII. OFFICERS.—The officers of the Society shall consist of a President, to be elected annually by a majority of votes, not re-eligible for three successive years after expiration of office, but entitled, as Ex-President, to be placed on the Vice-President list; five Vice-Presidents (two of whom shall be chosen from the Non-Resident Members), exclusive of Ex-Presidents, two General Secretaries, and a Treasurer, all to be elected annually by a majority of votes, and after expiration of office, eligible for re-election.

VIII. THE COUNCIL—ITS FORMATION AND DUTIES.—The Council shall consist of the Office Bearers, and six other members, the latter of whom shall be elected by ballot at the annual meeting, by such Members as may then be present.

The duties of the Council shall be to make all the necessary preparations for the ordinary weekly meetings, to examine the contributions of members, and select for reading such as may be eligible; to report, by the aid of sub-committees, upon any morbid specimen which may be forwarded by members, or examination of which may be specially requested by a vote of the Society; to conduct the financial and ordinary business of the Society; to make bye-laws and other regulations not provided for in the stated laws of the Society; to report at the annual meeting upon all the proceedings of the session, and draw up the annual transactions.

IX. DUTIES OF THE GENERAL SECRETARIES.—The General Secretaries shall keep a record of minutes, enter the cases and notices received, or remarks furnished, in their respective books, and summon and attend all meetings of the Council and Society.

X. DUTIES OF THE TREASURER.—The Treasurer shall keep an account of all receipts and disbursements, and furnish his financial statement twice during the session, also at the close, and whenever required by a vote of the Society.

XI. CASE PAPERS.—Each member shall be supplied with forms of "Case Papers," having the annexed heading to guide him in drawing up the contributions which he may furnish. "The reporter is requested to note particularly the following points, in the reading of his case, viz.:—If from any author, the particular volume and page; if original, the place and date; in any case, the age, history, management, impressions regarding same at different periods, the termination, and P. M. examination, if any."

XII. MEMBERS' CONTRIBUTIONS.—The contributions shall be of the following description:—

- 1.—Cases showing unusual sequence or co-existence of diseases.
- 2.—Do. showing any practical lesson, point, or caution, useful in practice.
- 3.—Do. exhibiting any rare form, complication, exception to the laws of Diagnosis, Pathology, or Therapeutics; or unusual interpretation.
- 4.—Summaries of Medical Statistics to prove frequency of type, average of age and mortality, and effects of remedies in any disease, or other point susceptible of proof by statistics.
- 5.—Reports on novel modes of practice in any disease.
- 6.—Morbid Specimens of Pathological or general interest, with or without case, or for Microscopic or Chemical examination.
- 7.—Replies to Medical Queries proposed by members.
- 8.—Brief Clinical facts of practical interest.

All contributions to be original, or original translations from authentic foreign records, not generally accessible to members.

XIII. THE SESSION.—The Session shall commence on the last Saturday in October, and terminate the first in May; and the ordinary meetings shall be held every Saturday, at three o'clock, afternoon; and the annual meeting the first Saturday in May.

XIV. BUSINESS OF THE ANNUAL MEETING.—The business of the annual meeting shall embrace the following subjects, viz.:—1. The Report of the Council. 2. The Report of the Auditors. 3. The announcement of the New Office-bearers. 4. The Election of the New Council. 5. The Closing Address of the retiring President. 6. Installation of the President elect.

XV. BUSINESS OF THE ORDINARY WEEKLY MEETINGS.—The ordinary sittings shall be limited to one hour but, at the discretion of the President, may be extended to one hour and a-half: five Members to form a quorum. The following shall be the order of proceeding:—

1. The chair to be taken by the President: if he be absent, by one of the Vice-Presidents present, if possible in rotation.
2. The Minutes of the previous meeting read and

signed.

3. Announcements from the Council.
4. The proposal of Candidates and Election of New Members, &c. For the rest, see old Rule. TRANS. Vol. I.

XVI. VISITORS.—Medical Students shall be admitted as visitors by official orders of Members only. Any Medical practitioner, not being a member, may be admitted as a visitor once only during a session, on being introduced by a member, who shall write the name of the visitor in the Proposal Book of the Society.

Surgeons and Assistant Surgeons of the Garrison, also of the Militia and Navy on active service, may be admitted to any meeting on Members' orders.

XVII. RESERVE FUND: TRANSACTIONS.—One-fourth of the subscription money shall be set aside as a reserve fund, and deposited in bank in the names of the President and Treasurer for the time being, to the credit of the Society, and shall not be drawn thence except by a vote of the Society at the annual meeting.

During the recess, if the state of the ordinary finances permit, a volume of Annual Transactions shall be prepared and published for free distribution among members of the previous session only.

XVIII. BOOKS OF THE SOCIETY.—The books of the Society shall consist of the following:—General Minute Book; Council's do.; General Proposal Book; Treasurer's Account Book; Treasurer's Receipt Book; General Case Book; General Note Book for Record of Discoveries, Inventions, and interesting Medical Notes; Pathological Museum Record; Microscopical Reports; Document Book.

XIX. PROPERTY OF THE SOCIETY.—The property of the Society shall not be disposed of except by the unanimous vote of a special meeting. Due notice of intention to take such a vote shall be given in a special circular to all members, one month previously.

XX. DEFAULTERS.—No fines whatsoever shall be imposed on members; but in case of Subscriptions more than two months due, and after two successive notices from the Treasurer, the names of the defaulters shall be struck of the Roll of Members, and they shall be ineligible for re-election during the remainder of the current session. The last day allowed for payment of subscriptions for old members shall be NEW YEAR'S DAY each Session.

XXI. EXPULSION OF MEMBERS.—Members may be expelled for unprofessional conduct, by a vote of the Society, provided that such vote be carried by three-fourths of a meeting of at least twelve resident members, and that due notice of the intention to take such a vote, with grounds of the charge, be given to each member eight clear days before meeting.

XXII. PRIVILEGES.—It shall be a privilege exclusively granted to Members, to receive at any time reports from the Microscopical Sub-Committee upon any morbid specimens which they may furnish for examination.

Non-Resident Members shall be also entitled to receive a brief Abstract of the Proceedings of each meeting weekly during the session, on payment of the requisite postage. All other Members may enjoy a like privilege, on payment of the same amount.

XXIII. NOMINATION AND ELECTION OF THE OFFICE-BEARERS AND COUNCIL.—All members to be nominated for Office-Bearers and Council shall be proposed eight clear days before election; and every member shall receive due notice thereof, that he may be enabled to forward names for nomination.

The Election of Office-Bearers shall take place thus:—Each Member shall send forward to the Secretaries his Ballot paper, properly filled with the names he shall select from the list of nominees which will be furnished to him. These names, so returned, shall be examined by the Council and Auditors, who shall determine, by the highest number of votes, who are to fill the vacant Offices.

The Election of COUNCIL Members shall take place according to the mode laid down in Law VIII., and none but Nominees shall be eligible in either case.

LIST OF PATHOLOGICAL SPECIMENS
EXHIBITED DURING THE SESSION 1854-55.

Recent Parts, 29.	Drawings, 4.
Lime Casts, 5.	Daguerreotypes, 16.
Wax Casts, 3.	Collodions, 2.
Dried Preparations, 4.	Patients, 10=76 ¹
Wet Ditto, 3.	

I. - NERVOUS SYSTEM.

1855.
Jan. 6, Apoplexy, Recent parts, exh. by Dr. MALCOLM.

II. - CIRCULATORY ORGANS.

1854.
Oct. 28, Aneurism of the Thoracic Aorta, Two Plaster Casts of the Thoracic Parietes, exh. by Dr. MALCOLM. (See plate.)
Nov. 4, Remarkable Varicose Tumours of the Upper Extremity, a Plaster Cast, exh. by Dr. MALCOLM. (See plate.)
" 11, Dilatation of the Left Ventricle, with Diseased Aortic Valves, Recent parts, exh. by Dr. MALCOLM.
1855.
Jan. 6, Varicose Veins of the Arm, Patient exh. by Dr. HALLIDAY.
" 20, Hypertrophy of the Heart, Recent parts, exh. by Dr. M'LAUGHLIN, Lurgan.
Mar. 31, Popliteal Aneurism, cure by compression, Patient exh. by Dr. J. MOORE.

III. - RESPIRATORY ORGANS.

1854.
Nov. 25, Tubercular Lung, very large cavity, Recent parts, exh. by Dr. M'CORMAC.
1855.
Feb. 3, Pneumo-phthisis, or inter-current Pneumonia, Recent parts, exh. by Dr. MALCOLM.
" " Emphysema, with Diseased Tri-cuspid Valves, Recent parts, exh. by Dr. MALCOLM.
" 10, Gangrene of the Lung, Recent parts, exh. by Dr. MALCOLM. (See Catalogue of Museum.)
" 17, Encysted Abscesses of the Lung, Recent parts, exh. by Dr. MALCOLM. (See Catalogue of Museum.)
" " Loose Calcareous Bodies in the Pleura, exh. by Dr. MALCOLM.
Mar. 24, Congenital Cardiac Disease, with Peculiar Physical Signs, Patient exh. by Dr. MALCOLM.
Apr. 7, Regurgitant Disease of Aortal Valves, Patient exh. by Professor FERGUSON.

IV. - DIGESTIVE ORGANS.

1854.
Nov. 18, Diseased Gall Bladder, wet preparation, exh. by Dr. MALCOLM.
" 25, Scirrhus of the Pylorus, and of the Colon, a wet preparation, exh. by Dr. MALCOLM.
Mar. 31, Intestinal Concretion, exh. by Dr. GRAVES, Cookstown. (See Plate and Catalogue of Museum.)

V. - URINARY AND GENITAL ORGANS.

1854.
Nov. 18, Inflammation of the Scrotum and Tunica Vaginalis, Recent parts and Drawing, exh. by Dr. J. MOORE.
Dec. 2, Calcareous Degeneration of the Placenta, Recent parts, exh. by Dr. MALCOLM.
1855.

- Feb. 10, Foetus, with Membranes and Placenta at the seventh week, exh. by Dr. YOUNG, Holywood.
Feb. 17, Foetus of six weeks, exh. by Dr. BECK.
Mar. 24, Uterine Cyst, Recent parts, exh. by Mr. M'GOWAN, Warrenpoint.
" 31, Hydrocele, the fluid removed, exh. by Dr. J. MOORE.
Apr. 2, Cancer of the Mamma, Recent parts, exh. by Mr. BROWNE
Nov. 4, Scirrrous tumour of the Breast, Recent parts, exh. by Mr. BROWNE.

VI. - JOINTS AND BONES.

1854.
Oct. 28, Caries of the Vertebrae, Wet preparation, exh. by Dr. MURNEY.
Dec. 2, Malignant disease of Femur, Recent parts, exh. by Dr. J. MOORE.
1855.
Feb. 3, Disease of Ankle Joint, Recent parts, exh. by Professor STEWART.
" 17, Abscess in the Tibia, Dry preparation, exh. by Mr. BROWNE. (See Catalogue of Museum.)
Mar. 3, Excised Elbow Joint, Recent parts, exh. by Dr. MURNEY.
" " Shattered Forearm, Recent parts, exh. by Dr. J. MOORE.
" 17, Disease of Wrist Joint, Recent parts, exh. by Dr. J. MOORE.
" 31, Disease of Elbow Joint, Excised parts, exh. by Dr. MURNEY.
Apr. 7, Necrosis of the Acromion, Patient exh. by Mr. H. M. JOHNSTON.
" 14, Disease of the Knee Joint, Recent parts, exh. by Dr. J. MOORE.
" 21, Fracture of the Cervix Femoris within the Capsule, Dry preparation, exh. by Dr. JAMISON, Newtowndrds. (See Catalogue of Museum.)
" 28, Necrosis of the Tibia, Dry preparation, exh. by Dr. J. MOORE.

VII. - THE SKIN, AND SUB-CUTANEOUS TEXTURES.

1855.
Feb. 3, Encysted Tumour of the Scalp, Recent parts, exh. by Professor STEWART.
" 10, Favus, in a Patient, exh. by Dr. MALCOLM.
Mar. 24, Glandular Tumours of the Neck, of remarkable size, Patient exh. by Dr. MALCOLM. (See plate.)
" " An instance of Scalping, Patient exh. by Mr. BROWNE.
Apr. 14, Fatty Tumour of the Shoulder, Recent parts, exh. by Dr. J. MOORE.
" 28, Encysted Tumour of the Neck, Recent parts, exh. by Dr. J. MOORE.

MISCELLANEOUS.

1854.
Nov. 4, Congenital Cataract, Patient exh. by Mr. BROWNE.
" 25, Goitre, a Plaster Cast, exh. by Mr. BROWNE. (See Catalogue of Museum.)
Dec. 9, Malignant Tumour of Orbit, Patient exh. by Mr. BROWNE. (See Catalogue of Museum.)
1855.
Jan. 20, Cystocerci in the Muscles, diseased parts, exh. by Dr. M'CORMAC.
Mar. 24, Chronic Tonsillitis, Excised part, exh. by Mr. BROWNE.
" 31, Malignant Tumour of the Orbit, Plaster Cast, exh. by Mr. BROWNE. (See Catalogue of Museum.)
Apr. 7, The Physiognomy of Disease, a series of Daguerreotypes, exh. by Dr. MALCOLM.

¹ 11 of these were Supplementary Illustrations.

Report of Council

LIST OF CASES READ DURING THE SESSION 1854-55.

THE NERVOUS SYSTEM.

1854.
Nov. 11, Traumatic Tetanus, successful under the exhibition of Mercury; by Professor H. STEWART.

THE LUNGS.

1855.
Jan. 6, Pertussis complicated with Convulsions, Paralysis, and coma, followed by Dementia; by Mr. H. M. JOHNSTON.
Feb. 24, Syphilitic Bronchitis, two examples; by Mr. H. HANNA.
Mar. 3, Inky Expectoration; by A. G. MALCOLM, M.D.

THE DIGESTIVE ORGANS.

1855.
Mar. 17, Foreign Bodies swallowed; by G. F. YOUNG, M.D., Holywood.

THE BLOOD VESSELS.

1855.
Mar. 3, Aneurism of the Abdominal Aorta; by Mr. GELSTON, Comber.
" 17, Purpura, with Phthisis supervening; by Mr. H. H. HANNA.

CASES IN MIDWIFERY, &c

1854.
Nov. 4, Vesico-vaginal Fistula, cured by the application of the actual Cautery; by W. F. ROGAN, A.M., M.B., Derry.
" 18, Recto-vaginal Fistula, treated successfully by J. H. HALLIDAY, M.D.
" " Amenorrhoea protracted to the age of 56; by Mr. T. MADDEN, Portglenone.

1855.
Jan. 20, Placenta prævia; by J. W. BECK, M.D.
Mar. 10, Retroversion of the Uterus; by G. F. YOUNG, M.D., Holywood.

THE URINARY ORGANS.

1855.
Mar. 31, Stricture of the Urethra, cured by Syme's operation; by H. MURNEY, M.D.

FEVERS.

1855.
Feb. 24, Masked Typhus simulating Apoplexy; by P. LYNCH, M.D.

MISCELLANEOUS.

1855.
Feb. 10, Euthanasia; by H. M'CORMAC, M.D.
Mar. 31, Suspended Animation 40 minutes after attempted suicide; by Mr. TAYLOR, Ballymoney.
" Capital operations successfully performed with the aid of chloroform, in cases of marked prostration; Mr. FERRES, Larne.
Apr. 28, Dislocation of the Femur into the Ischiatic notch; by D. JAMISON, M.D., Newtownards.

NEW INSTRUMENTS EXHIBITED.

1854.
Oct. 28, Walton's Eye-Douche, exh. by Mr. BROWNE.
Nov. 25, Uterine Compressor, exh. by A. G. MALCOLM, M.D.
1855.
Jan. 20, Smee's Optometer, exh. by Mr. BROWNE.

- " " Cooper's Eye Douche, exh. by Mr. BROWNE.
Mar. 31, Cartes' Compression Apparatus for Aneurism, exh. by J. MOORE, M.D.
Apr. 7, A Perineal Crutch, the invention of the late Earl of Antrim, exh. by Professor FERGUSON.

CLINICAL FACTS AND STATISTICS.

1855.
Jan. 13, An Analysis of 900 Obstetric Cases occurring in private practice; by J. W. BECK, M.D.
" Peculiar Nervous Phenomenon, resulting from the exhibition of chloroform; by Mr. H. M. JOHNSTON.
Feb. 10, Dislocation of the Jaw, occurring in fever during violent delirium; by Mr. H. M. JOHNSTON.
Apr. 28, A suggestion on the mode of reducing Dislocations into the Axilla; by D. JAMISON, M.D., Newtownards.

PAPERS ON NEW MODES OF TREATMENT.

1854.
Nov. 18, The Use of Nitric Acid in Pertussis; by G. F. YOUNG, M.D., Holywood.
1855.
Jan. 27, The Topical Medication of the Larynx, as practised by Rousseau, Green, and Watson; by A. MALCOLM, M.D.
Feb. 3, The Employment of Rennet as a Curative Agent in Diabetes; by J. H. HALLIDAY, M.D.
Apr. 14, A combination of Quinine, Opium, and Grey Powder in Asthenic Dysentery; by G. F. YOUNG, M.D., Holywood.

QUERIES FOR DISCUSSION.

1854.
Dec. 2, "What has the experience of the cholera epidemic contributed to our knowledge of its Pathology and treatment?" Introduced by R. ROSS, M.D.
1855.
Mar. 10, "Under what conditions in syphilis should mercury be proscribed?" Introduced by Professor STEWART.
Apr. 14, "What is the best treatment for bursal swellings?" Introduced by Mr. BROWNE, R.N.
Apr. 21, "Under what conditions in Phthisis is Cod Liver Oil most beneficial?" Introduced by H. M'CORMAC, M.D.

DONATIONS TO MUSEUM, 1854-55.

- Two Plaster Casts, Bronchocele, Mr. Browne.
Two Plaster Casts, Aneurism of Aorta, Parietes of Chest, Dr. Malcolm.
One Coloured Cast, Elephantiasis of Arm, Dr. Malcolm.
Two Coloured Casts, Elephantiasis of Leg, Dr. Malcolm.
One Coloured Cast, Chronic Erysipelas of Leg, Dr. Malcolm.
One Plaster Cast, Scrofulous Lupus of Leg, at heel, Dr. Malcolm.
One Plaster Cast, Contracted Fingers, after injury of wrist, Dr. Malcolm.
One Model in Wood, Perineal Crutch, Earl of Antrim.
Two Poisoned Arrows, from South Sea Islands, Dr. M'Gee.
One Plaster Cast, Exostosis of Malar Bone, Mr. Browne.
One Coloured Cast, Herpes of Labia, Dr. Malcolm.
One Coloured Cast, Psoriasis Inveterata, Dr. Malcolm.
One Dry Preparation, Tibia, Cavity of Abscess, Mr. Browne.
One Plaster Cast, Cancer of Orbit, &c, Mr. Browne.
One Plaster Cast, Fibro-Cartilaginous Tumour of Neck, Mr. Browne.
One Wax Cast, Gangrene of Lungs, Dr. Malcolm.
One Wax Cast, Abscess of Lungs, Dr. Malcolm.
One Wax Cast, Pleuro-Pneumo Thorax, Dr. Malcolm.
One Coloured Cast, Pleuritis, Dr. Malcolm.
One Coloured Cast, Pneumonic Congestion, Dr. Malcolm.
One Coloured Cast, Favus of Scalp, Dr. Malcolm.
One Gutta Percha Cast, Arteries, Veins, and Nerves of Face and Scalp, Dr. Malcolm.
One Coloured Cast, Hyperæmia of Brain, Dr. Malcolm.
One Coloured Cast, Hæmorrhage at Base of Brain, Dr. Malcolm.
One Coloured Cast, Retro-Laryngeal Abscess, Dr. Malcolm.
One Plaster Cast, Head and Neck, shewing Muscles, Dr. Malcolm.
Four Coloured Casts, Muco-enteritis, Dr. Malcolm. One Coloured Cast, Ulceration of Os Uteri, Dr. Malcolm.
One Coloured Cast, Aneurism of Aorta, Dr. Malcolm.
Forty-four Photographs and Daguerreotypes. Dr. Malcolm, viz.:—
 One Emphysema.
 Three Heart Diseases.
 Two Phthisis.
 Two Bright's Disease.
 Three Favus.
 One Cicatrix of Burn of Cheek.
 One Scrofulous Abscess of Forehead.
 One Scrofulous Abscess and Sores of Neck and Cheek
 Two Diagrams of Viscera, anterior view.
 One Scrofulous Tumour of Neck (enormous size).
 One Scrofulous Abscess of Foot.
 One Ichthyosis.

- Two Facial Paralysis.
One Tuberculosis (Mesenteric).
One Melanosis of Eyeball.
One Stearhœa Nigricans (from a drawing).
One Cicatrix of Burn of Neck.
Two Lupus non-exedens of Face.
One Erysipelas of Cheek.
One Uric Acid Crystals.
One Rheumatic Endocarditis.
Two Gastritis Chronicus.
One Scrofulous Lupus of the Face and Neck.
One Psoriasis Guttata.
One Anthrax of Nape.
One Appearance of Elbow after excision of Joint.
One Morbus Genu (white swelling).
One Sycosis.
One Morbus Coxæ.
One Malignant Tumour of Ilium (from a cast).

Report of Council

ANALYSIS OF THIRTY SPECIMENS OF MORBID FLUIDS AND SOLIDS SUBMITTED TO MICROSCOPICAL AND CHEMICAL EXAMINATION.

Morbid Urine and Urinary deposit, ...	...	...	...	...	21
Tumours, ...	...	...	...	...	3
Calculi and Concretions, ...	...	...	...	...	2
Fluid of Tunica Vaginalis, ...	...	...	...	...	2
Gastric Fluid, ...	...	...	...	...	1
Ulcerous Discharge, ...	...	...	...	...	1
					30

LIST OF SPECIMENS SUBMITTED TO MICROSCOPICAL AND CHEMICAL EXAMINATION.

No.	Date.	Specimen.	Forwarded from.	Result of Examination.	Remarks.
	1854.				
1.	May 18,	Gastric Fluid,	Country	Cells, simple and compound, pris. Phosphates, Oil, on a Granular base	Cancer of the stomach.
2.	June 7,	Urine,	"	Albuminous, Oil Tube-casts, Epithelium	Bright's Disease.
3.	" 9,	"	Town,	Do. Deposit contains Phosphates	Ditto
4.	" 9,	"	"	Uric Acid and Urates	Spermatorrhœa & spinal disease
5.	" 9,	Fluid in Tunica Vaginalis	"	Pus, Oil, Exudation Granules	Inflammation of Tunica Vaginalis
6.	" 13,	Urine,	"	Specific Gravity, 1006; no Sugar	?
7.	Aug. 3,	Morbid Discharge,	Country	Granular Base, Vessels, Fibres	Carbunculoid Affection.
8.	" 3,	Tumour	Town,	Large Granular Dark Bodies, Oil, Blood, and compound cells	Disease of Mamma.
9.	" 31,	Urine,	"	Mucus, Oil, Oxalates, Spermatozoa	Spermatorrhœa.
10.	Sept. 1,	"	"	Slightly Albuminous	?
11.	" 8,	"	"	Uric Acid, Oxalates, Granular Flakes	Gouty Cerebral Affection.
12.	" 11,	"	"	Uric Acid, in cylinders and lozenges	?
13.	Oct. 11,	"	"	Lithates only	?
14.	Nov. 14,	"	Country	Spe. gra. 1009, Amorphous Granular Lithates, Epithelium	?
15.	" "	Tumour,	"	Numerous Lymph Cells, or imperfect pus	Malignant (?) Furunculoid dis.
16.	" 21,	Urine,	Town,	Blood, Granular tube-casts, vesical Epithelium	Bright's Disease.
17.	" 29,	" No 1.	"	Specific Gravity 1018, Lithates	
18.	Dec 2,	" No. 2.	"	" " 1026, Oxalates	
19.	Nov. 30,	"	"	" " 1025, Deposit, Lithates	
20.	Dec. 4,	"	"	Prismatic Phosphates	
21.	" 9.	"	Country	Lithates	

LIST OF SPECIMENS SUBMITTED TO MICROSCOPICAL AND CHEMICAL EXAMINATION. [Continued]					
No.	Date.	Specimen.	Forwarded from.	Result of Examination.	Remarks.
22.	" 9,	"	Town,	Lithates, Pus, Epithelium	
23.	Nov. 29,	"	"	Thick Lithates	
24.	Dec. 16,	Calculus,	"	Albuminous Matter, (Salivary.)	
25.	" 18,	Urine, 1855.	"	Specific Gravity 1025, pale Lithates	
23.	Feb. 1,	"	Country	Alkaline, Oxalates, Phosphates	
27.	" 4,	"	"	Specific Gravity 1026, Lithates, Milk?	Milk, accidental addition.
28.	April 3,	Fluid of Hæmatocoele,	Town,	Blood, Cholesterine, Oil, Coloured Granular-cells	
29.	" 3,	Tumour,	"	Granular (gravelled) base, circles with Nuclei and Fibrous Tissue	Epithelioma of Lip
30.	" 7,	Intestinal Concretion,	Country	Alternate layers of Phosphates and Vegetable Fibre	

SCROFULOUS TUMOUR.



Plate I
SCROFULOUS TUMOUR.

ANEURISMAL TUMOUR.

Fig. 1.

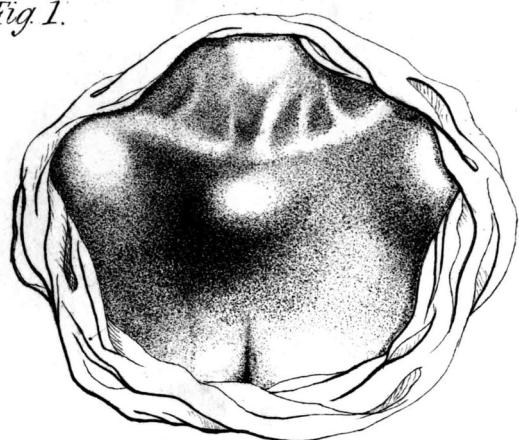


Fig. 2.

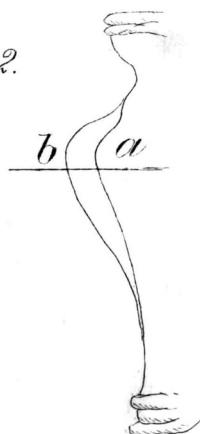


Plate II
ANEURISMAL TUMOUR.

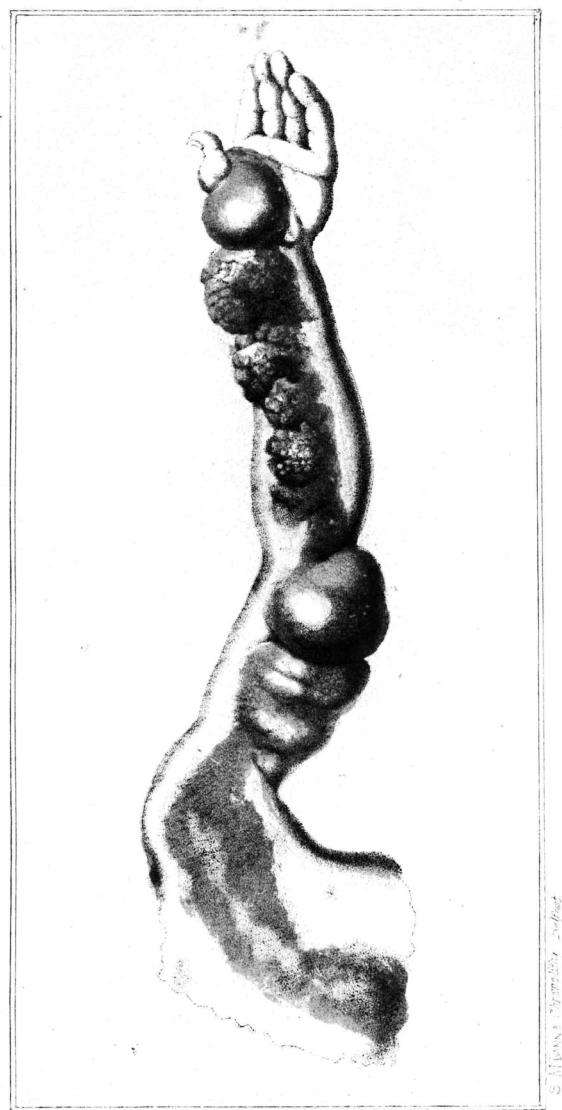


Plate 3
VARICOSE TUMOURS

ADDED APPENDIX A

ART. VI.—On Asthenic Dysentery, By G. H. YOUNG, M.D.,
L.R.C.S.I., Surgeon to the Holywood Dispensary, Co.
Down.¹

THE discussion of a subject like dysentery has peculiar interest at the present moment, when the fearful mortality of our troops in the East is so fresh in our recollection. It has ever been the scourge of armies, and a necessary accompaniment of war, and generally counts more victims than the most ingenious method of slaughter practised by man. In the Peninsular campaign, during thirty-one months, there were 23,000 cases of dysentery and diarrhoea, and we have it on the authority of Sir James Macgrigor, that dysentery was the disease which produced the greatest mortality in the army. However skilfully conducted modern warfare may be, dysentery will be sure to take its part in the campaign. There must be fatigue, cold, and wet, or burning and sultry heat; we must sometimes march through pestiferous jungles, and pitch our camps in a malarious atmosphere; we cannot always have pure water and the most wholesome food:—these are often unavoidable circumstances; and however well clothed and temperate the men may be, there will still be a long sick list and a high mortality.

Now, to my mind, it does not require a very vivid imagination to see that the dysentery which we sometimes meet is in all essential respects a similar disease to that of a besieging army in winter time. Do our poor not suffer from a scanty and unwholesome supply of food? Are they always warmly and comfortably clad? and do they not often pine away and die from exposure to the inclemencies of the weather? In fact, there are few conditions of an epidemic like this, in any army, that may not find their parallel among the poor at home; but I will go farther than this, and express my conviction, that the identity of dysentery, in every quarter of the globe, is much greater than is generally supposed, and my belief that (with some rare exceptions) the mode of treatment found successful here would be, *ceteris paribus*, equally so everywhere else.

It is true that abscess in the liver is a more common complication in India than in this country, but it would be a mistake to suppose that it is present in every case; thus Dr. Morehead states, that of 30 fatal cases (of chronic dysentery), 12 were attended with hepatic abscess; Dr. Paries, that out of 25 cases at Moulmein, in 7 there were abscesses; Dr. Innes, 84th Regiment, mentions 7 out of 39 fatal cases;—but although reasons of a climatic and dietetic nature would sufficiently account for the liver being so often and so seriously affected in India, yet we need not suppose that the same organ entirely escapes in our climate. Abscess is certainly a rare complication, but not so softening and congestion. Speaking of postmortem appearances in chronic dysentery, Dr. Mayne says:—"The liver alone, of all the glandular organs, was invariably diseased."

¹ Dublin Quarterly Journal of Medical Science August 1855 pp70. Downloaded from Google Books.

In the seventh and tenth volumes of the present series of this Journal may be found two papers on acute and chronic dysentery, which, conjoined, form the best essay on the subject that I know. I have carried out the treatment there recommended, and having had peculiar opportunities for testing its efficacy, I can truly say that I have seldom been disappointed, and that in simple sthenic dysentery the mercurial plan, as advised by the author of these papers, is the safest mode of treatment with which I am acquainted. However, at page 370, vol. x., he says:—"Some cases, undoubtedly, there are, where the disease, from the very outset, is of so bad a type that the most judicious management fails to be of the slightest avail." Now I presume he refers to that class of cases characterized by the asthenic, typhoid, or malignant type (a less violent amount of pain, more copious evacuations, of a less viscid and tenacious description, are generally present in asthenic dysentery); it is to this description of dysentery that my present remarks have particular reference. The two plainest divisions of dysentery are, undoubtedly, the sthenic and asthenic, both of which have many and various degrees of severity. I believe dysentery is infectious in exact proportion to its virulence; and though this is opposed to the views of some of our best writers, Harty among the rest, I feel justified in recording my decided opinion of its infectious nature. That simple sthenic dysentery may not only propagate itself in one case, but also give rise to asthenic dysentery in an unhealthy subject in another, is not more extraordinary than that a mild attack of typhus should in one man be followed by, perhaps, a milder case than itself, and in another by a most deadly and malignant affection; and the cause of the apparent anomaly in this, as in every other infectious disease, is too evident to acquire elucidation.

Asthenic dysentery may, as I have often seen, give rise to sthenic dysentery; and as to the complication with typhus or continued fever, I cannot do better than quote Dr. Copeland's observations:—"Many writers conceive that the asthenic varieties described above are complications of simple dysentery, with different kinds of fever, and that when they are infectious, it is not the dysentery, but the fever, which possesses this property. Some authors suppose that the typhoid variety, especially, is a complication of this description; but if such be the case, wherefore should the disorder which is communicated be always dysentery, and not fever? Moreover, this form of dysentery is often present where a case of typhus cannot be found. The fact is incontrovertible, that the asthenic forms, some of which are considered as complications by many writers, are direct and necessary, and uniform results of certain diversified but concurrent causes, and not contingent associations of two diseases capable of separate existences." These causes are: "Cold and moisture, unclean, unwholesome food and water, or emanations contaminating the fluids." With regard to the opinion held by many, that dysentery *always* arises from a specific malarious origin, I may say that three-fourths of all my cases are unquestionably of this nature, and the symptoms are very frequently remittent in their tendency. Over a large part of the

district under my care, the noxious exhalations from a mud bank, several miles in extent, covered by the tide for only a few hours out of every twenty-four, extend their dangerous influence; and the westerly winds which prevail saturate the atmosphere for miles with poisonous emanations. The dysentery that arises under these circumstances is, for the most part, simple and easy of cure; but, owing to extreme poverty and filthy habits, or a cachectic state of body, very bad cases now and then occur.

In the early part of the winter of 1853 I was attending a poor but respectable family, consisting of three sisters and a maid-servant, living in a damp and malarious locality. The first sister had a very severe attack of simple sthenic dysentery; the second sister died of a most malignant form of the disease, being only ill for three days; the third escaped altogether, and the servant had a very mild attack, hardly requiring treatment. On the 1st of November, 1854, at 11 P. M., I was sent for suddenly, to see a member of this family, who was described to me as being in a dying state¹. On my arrival I was greatly concerned to find the third sister, who had escaped on a former occasion, in precisely the same condition as that in which I found the one who had died so rapidly, in spite of the most energetic treatment. Her bowels had been slightly disturbed and pained two or three times during the previous twenty-four hours, but she had gone about minding her usual business until the evening, when she was suddenly seized with vertigo, a violent pain in the lower part of the abdomen, and a desire to evacuate the bowels. On examination, the stool was found to consist of pure blood, dark in colour, and about a pint in quantity. The face was livid, and covered with cold sweat; pulse 140, weak and small; tongue whitish and clammy; some tenderness on pressure in the hypogastric region, great nausea and anxiety about the praecordia, and a remarkable degree of apathy and tendency to stupor. Having seen many examples of this form of dysentery, both in this country and in India, I believed, if the ordinary routine treatment were pursued here, the result would be fatal; accordingly, I began to reflect seriously whether a new and rational method might not be tried in this apparently hopeless case:—Gallic acid to allay the hemorrhage, quina to support the sinking powers of life, and opium as the *sine qua non* in any treatment of dysentery.

The following medicine was then ordered to be taken every third hour, with a little weak brandy and water to wash it down:—Sulphate of quina and gallic acid, of each two grains, with one grain of opium. Having desired a bran poultice to be applied over the abdomen, I left her, with directions to be sent for, if any change for the worse took place during the night.

15th. 9 A. M. Bowels only twice disturbed through the night; the contents were grumous and muddy-looking, and fearfully fetid; pain on pressure increased; vomits everything swallowed; pulse firmer, 130; tongue with a deeper fur, urine scanty, and thirst great. A marked change had commenced: the countenance, from being

listless and apathetic, was becoming more clear and lively. As I had no longer the same dread of the hemorrhage (which, if it had returned, might have terminated the case at once), I substituted gray powder for the gallic acid.

9, P. M. Says if she had a sleep she might awaken quite well; bowels five times disturbed, with great tenesmus; a blister to be applied over the seat of pain, and effervescing saline draughts to check the nausea and allay the thirst.

16th. Tenesmus less; streaks of bile in the evacuations; had some, but not refreshing sleep; pulse 120; tongue more loaded; ordered the powders to be given every six hours.

17th. A wonderful improvement; nausea entirely gone; pain abated; pulse 120; tongue moist; evacuations not nearly so offensive, though their characters are various. Four different motions were shown me today; the first something like gruel in colour and consistency; the second reddish; the third greenish; and the fourth gelatinous and bilious; all more or less fetid.

18th. No motion from the bowels since yesterday; she was ordered one drachm of castor-oil, which was followed by a healthy stool; the powders to be discontinued, and quina and laudanum to be given in their place, in doses of one grain of the former and ten minimis of the latter, three times daily, in water acidulated with muriatic acid: she continued taking this medicine for ten days, when she was quite convalescent, though several months elapsed before the system entirely recovered from the debilitating effects of this very formidable malady.

Such is a meagre outline of the first case in which I used the threefold combination given above, and since then I have employed it in thirty cases of asthenic dysentery, of various degrees of severity, but all presenting symptoms of an adynamic type. However, out of these thirty cases there were only six as severely affected as that I have just narrated. In no instance was there a fatal result. This will not appear very extraordinary to those who remember what Reid (one of the earliest advocates for the treatment of dysentery by bark) says. He informs us that out of nearly 300 cases of dysentery treated by himself during his residence in the West Indies, there was but one fatal, and that one where bark was not employed. I would not be understood as wishing to claim the title of a specific for the mode of treatment I now advocate; I publish it with the simple intention of pointing out a method which, to say the least of it, has been, in my hands, more successful than any other. I have no doubt, however, that, sanguine as I may be about the matter, fatal cases will take place even under my own eye; but I can hardly think that the principles involved in the application of these remedies to dysentery characterized by decided asthenic symptoms can ever be called in question. Dysentery is, for the most part, of a remittent and often of an intermittent type. I have already stated that the great majority of my cases partook of the former symptom. That it is also most frequently of a malarious origin my own experience, as well as that of the highest authorities, abundantly confirms. On this point Dr. Baly says:—"I infer that dysentery is always produced by a

¹ This case was read at a meeting of the Belfast Clinical and Pathological Society.

poison introduced into the system from without, and that in most instances this poison is venerated by the decomposition of matters contained in the soil."

Dr. Watson says:—"The remarkable decline of dysentery in this metropolis has been contemporary with that of other serious disorders, and is due to the same combination of causes." "To the better construction of houses in the rebuilt city, to the increased means of ventilation, to the more general formation of drains and sewers, to the more copious supply of water, and to the more temperate and cleanly habits of the people, we may fairly ascribe our present exemption from dysentery, from ague, and continued fever, which are often the parents of dysentery, and from the plague itself."

That the form of the disease of which I am now speaking is attended with a dangerously low set of symptoms, in which all the powers of life are withered and depressed, needs no illustration here. What remedy, may I ask, is so well adapted to fulfil the indications so plainly set forth in such a complaint, as bark? This question might fairly arise, supposing there was no precedent for the use of bark in dysentery; out the names of those who have employed it are legion, and may be seen in the pages of Copeland or Harty. As to the use of opium to subdue the pain and soothe the shattered nervous system, procure sleep, and counteract the tendency to inflammation or irritation,—what so likely to serve the end, in conjunction with a mercurial preparation? what remedy so powerful and efficacious in so many disorders? Harty says that the obvious effects of opium, when employed to an adequate extent in dysentery, are the temporary alleviation or cessation of its most distressing symptoms, and the production of costiveness. Could, he says, the former object be attained without the latter, no medicine could be more valuable; but as that cannot be, few articles in the *Materia Medica* have done more mischief than the intemperate or untimely use of opium in dysentery. Now that opium is uniformly followed by such effects, I deny, and I beg to refer the reader to the published observations of Drs. Graves and Stokes in confirmation of my views on this point. It is true that they were writing principally on inflammation of the external coats of the bowels, and that I am now speaking of a disease attended with inflammation of the internal coats; but, from what I have seen, there can be no doubt that opium plays very nearly the same part in one affection as the other. Gallic acid I have only given in those rare cases of asthenic dysentery attended with profuse hemorrhage, of which I have already related an example, and a continuance of which I would dread so much. Cheyne says that it is surprising the relief that is sometimes afforded to the dysenteric patient by profuse hemorrhage from the bowels, and this, as illustrating the value of venesection, which he says was certainly the remedy the least equivocal in its effects, the most uniformly useful of any which we employed. This was, no doubt, quite true of the disorder as it manifested itself in that period; but could the same be said of the form of the disease we see now? For my part I look upon every variety of hemorrhage from the bowels in

the most serious light, except when its source is due to piles. The advantages of exhibiting gallic acid in melaena and hematuria are forcibly pointed out by more than one writer in the pages of this Journal.

I come now to the use of mercury, a medicine which, more than any other, has been relied on for the cure of dysentery in every part of the world. I have already said that, as the main element in the treatment of the disease in its acute or sthenic aspect, it is our mainstay, but to rely on it as the chief agent in the low or typhoid forms would be attended with disappointment and vexation. But there can be no objection to its taking a secondary part in the performance, and employing it in its mildest and safest shape. *Hydrargyrum cum cretâ*, by its alterative and sedative properties, and given till healthy bilious evacuations are brought down, in conjunction with quina and opium, will, I am sure, stand the test better than any other preparation of mercury. I do not think it necessary to carry the administration of any of these remedies to the extent of showing their specific action, such as cinchonism, narcotism, or salivation. With regard to salivation I may here express my opinion, that it is a state to be avoided, if possible, in any variety of the affection, particularly the typhoid¹.

I do not claim any more novelty for this mode of treatment, than prominently bringing forward a combination of remedies, any two of which have been long known to the profession; and though, as a general rule, I prescribe quina and opium in large doses, and gray powder in a moderate dose, as two grains of quina, one of opium, and two of the latter, every third hour, I can easily believe that it might be desirable to change these proportions from time to time. It is also important that I should observe, I was led to adopt this treatment from the extreme urgency of a particular case, and not from any preconceived theory or notion derived from the experience of others; it was only when examining the recorded opinions of those who had the most enlarged and extended knowledge, that I find so remarkable a verification of my own ideas and thoughts, based on the pathology and etiology of the disease. It struck me that quina was likely to meet one set of symptoms, opium a second, and mercury a third; and if, in addition to the success I met with, I add the fact, that each of the remedies has got its own powerful advocate, it will not seem extraordinary that I should with some confidence propose the combination of all three, as the most likely means we yet possess of conducting asthenic dysentery to a favourable termination. Blisters, hot stypes, bran poultices, effervescing draughts, suppositories, and anodyne injections, suitable diet, &c., &c., will be required, and a continual effort will be needed to guard against a relapse from indiscretion in getting up too soon, or

¹ The combination of quina and opium, and occasionally gallic acid, was used by me in the epidemic of 1862; and Dr. Playne of Dunmurry says:—"As regards treatment, when great prostration existed, and that was the stage in which I found nearly all my cases, I gave opium, quina, and camphor, together with mercurials and astringents, at the same time applying counter-irritants. My opinion is strongly in favour of mercurial preparations." See the Number of this Journal for August, 1853.

overloading the stomach.

I append the notes of a few cases to show more clearly the form of dysentery to which this treatment is applicable, and to illustrate some of the preceding observations.

Martha Huxley, aged 40, a delicate woman, had been ailing for a few days with chilliness, loss of appetite, pain and slight disturbance in the bowels, when she was suddenly seized with excessive prostration, and inclination to go frequently to stool, with little or no relief. When I visited her, the tongue was only slightly furred, but the pulse was 160, and weak, though steady; there was great thirst, but the stomach rejected everything that was swallowed; pain on pressure not great; the evacuations were rather copious, reddish, gruel-like, and floating on the top were a great number of lymphy-looking matters, not unlike burst barley. I ordered a blister to the epigastrium, to diminish the nausea and irritability of the stomach, and quina, opium, and gray powder, in the usual way. On my second visit, next day, every symptom was improved, but the tongue looked as if covered with wet clay. She was ordered to continue the powders thrice daily, this woman was quite well in a week.

Henry Montgomery, aged 45, a labourer, a few days after visiting his sister (whose case has just been mentioned, and who lived at a distance of a mile from her brother), had a smart attack of acute dysentery, for which he took castor-oil, but this having failed to give relief, in four days after he applied to me. He was now greatly prostrated, had a brown, dry tongue, a quick and feeble pulse, and a burning skin; urine very scanty, and dark red; great nausea and thirst; evacuations in colour and smell not unlike the expectoration which I have seen from fetid abscess of the lung. This man felt relief from the first powder, and after using them every third hour for the first day, and three times daily for the next three days, he was quite convalescent.

The third case was the best-marked example of the intermittent variety of the affection which I have seen. A policeman, with symptoms of ordinary sthenic dysentery, took three powders of calomel and Dover's powder, when he reported himself as quite well. Next day, however, he said that he had a sharp attack at 3 o'clock in the morning, and that he felt very weak, having passed a great deal of blood, and been up twenty times, he supposed, at the night-chair. I ordered him three more powders, and on my visit next day he informed me that he had experienced great ease from the powder, and slept until 4 o'clock in the morning, when he became as bad as ever. I ordered a turpentine stupe, and the quina powder every third hour. Next day I found that the attack had returned, but in a very slight degree; the powders were continued every eighth hour. Convalescence followed almost immediately.

It will thus be seen that on four successive mornings this man had a severe paroxysm of dysentery, while during the day he was quite free from pain or uneasiness, with a pulse at 90, and a tongue rather brownish.

The fourth case I will bring forward was one that I treated for a week as acute sthenic dysentery, on the

ordinary principles, namely, leeches, fomentations, calomel, and Dover's powder, &c., until the tongue became absolutely black, and the pulse 140. Having prescribed the quina, opium, and gray powder, she soon showed signs of improvement: her eye became clear, her aspect more lively, the black coating came off in patches from her tongue, and the pulse fell. In four days I omitted the opium and the gray powder, and gave her quina alone; this she took for a few days longer, when she was able to resume her usual avocations.

BELFAST CLINICAL AND PATHOLOGICAL
SOCIETY

THIRD SESSION
1855 – 1856

The third Session of this Society was inaugurated, on Saturday, October 27th, 1855, in the Library-room of the Medical Society, upon which occasion a very large and influential muster of members and others was present, by an animated and eloquent address from the President, Dr. Malcolm:

GENTLEMEN,

It is with some diffidence that I proceed to execute the task which my position enjoins. Called to the important office of President by your, I must say, too flattering suffrages, it becomes my duty, according to official custom, to inaugurate the labours of a new Session. I do with some misgivings as to how far my address may become the importance of the occasion, or the credit of our Society.

This feeling is not diminished, I assure you, when I recall to memory the previous occasions, when you were addressed from this Chair, by men so deservedly eminent and accomplished as my predecessors. I rely, however, notwithstanding these influences, upon your forbearance and a hope that any imperfections which you may observe will be kindly pardoned.

Gentlemen, it is with no small feeling of pride, that I have it in my power to congratulate you on the prosperity of this young Society. We are but in our third year, and we number the respectable number of 107 members and I believe I may add with every prospect of a considerable increase. This undoubted success can only be explained in one way, that is, simply the insufficiency of previously existing institutions to satisfy the wants of the profession in this locality.

The *desideratum*, referred to, your Society has been the means of affording; and you will remember, as a complete confirmation of what I now state, that, on the very first day when our standard was raised, upwards of fifty adherents were enrolled as original members.

To you amongst this audience who are in membership it is of course unnecessary for me to go over beaten ground, and point out the different objects at which we aim, or to explain the means by which we hope to attain them; but, for the sake of those strangers who have honored us with their presence and who are not so informed, I would beg to premise the expression of the few thoughts with which I intend to trouble you on this occasion, by advertising for a moment to the principles of our Society.

The cultivation of pathology in connection with clinical observation constitutes the grand basis of our operations. Pathology in its widest sense, as a theoretical science of disease based on physical, chemical and anatomical facts and a clinical observation, which shall ever associate the morbid indications in life, with the traces which are detected in death. But further, in our view of the domain of clinical study, we include all

therapeutic data, which may tend to throw light on pathology, restore the normal conditions of the system under disease or arrest the tendency to death.

In this wide field there are several departments which more especially attract our attention. Such are the study of Pathological Anatomy, Pathological Chemistry, Pathological Histology, the study of rare and difficult Cases noted at the bedside and the examination of them in the person of actual patients introduced to our meetings for inspection, the observation of interesting, though they may be isolated, Clinical facts,—the results of medical statistics—the history and results of new and special modes of treatment, including the exhibition of new instruments, and new articles of the *Materia Medica*,—and lastly, the open discussion of debated points in practice.

Such is the scope of our transactions, and none can doubt, that in it, we possess “ample room and verge enough” to satisfy almost every form of professional predilection.

It may be worthy of more particular mention, as a distinguishing feature of this, in comparison with the metropolitan Pathological Society, that we encourage free discussion after the introduction of every subject and we do this on the good old fashioned principle that in numbers there is wisdom. For it does not unfrequently happen, that “as all looks yellow to the jaundiced eye”, so the perverted apprehension of one, may lead to an erroneous view of a subject, which can only be satisfactorily be corrected by an appeal to the common sense of many.

I am quite aware that some have made material objection to discussion, on account of their tendency to overstimulate the forward and ready speaker and discourage the diffident and slow, though it may be superior, member. *A posteriori*, however, we have found this objection to be groundless. Hitherto our debates have been generally conducted in a temperate and gentlemanlike manner, though I must say, much of this happy result is to be ascribed to the Steadfastness and Adroitness in handling the reins, for which my predecessor was so happily distinguished. Besides it must not be overlooked that the friction of mind with mind, like the flint and steel, is calculated to elicit scintillations of genius, which unimpassioned occasions would ever fail to produce. Indeed discussion when tempered by reason cannot but have a suggestive influence fraught with valuable results. It is only thus, that many fallacies especially those coming from a warped judgement can be cleared away, and the virgin ore of truth be separated from the surrounding mass of error. I consider that in this respect our own particular department of Knowledge more imperatively calls for some such winnowing process than perhaps any other. So much is taken for granted—so easily are we apt to be content with half proofs—so entangled are our minds by foregone conclusions—so defective is our science in solid first principles and the true nature of the most elementary of our foundations that it is little wonder that almost any enquiry undertaken to advance our Art is beset with innumerable difficulties: and it is only by looking at the subject from different points of view by a variety of minds, that anything like a clear method for

arriving at true solutions can be ever gained.

Gentlemen, were it in my power I should desire that one and all on this the opening of a new session should be inspired with feelings akin to my own, which I need not say, are ardent and zealous for the welfare of our Society.

When deeply impressed with the importance of a particular pursuit we enter upon it with a buoyancy with removes half the burthen incident to the prosecution. We got forward with an unfading trust that good and nothing but good to ourselves individually and the body at large, can result from every step we take; and we feel stirred up to a capacity for increased exertion, exactly in proportion to the amount of enthusiasm we experience. Now, is there anything in the nature of our Society which can supply this desired zeal? I think there is. I think, if we reflect upon the great objects we all have in view, upon the important fact so well put by Stokes of Dublin, whom we are proud to call our honorary member,—that every new fact in pathology or pathological anatomy may be regarded without exception as either immediately or ultimately fruitful in its application to practical Medicine. Nothing can be observed in vain. Even the very treatment of diseases is, as Latham in [support]¹ of a truth so well known to Hippocrates himself (another name dear to every scientific physician) so justly writes, a part of their pathology. "What they need and what they can bear, the kind and strength of the remedy and the changes which follow its application are among the surest tests of their nature and tendency."

Westl, the great histologist of Vienna, has well remarked that the method of research at present followed in the cultivation of pathology has opened out a rich mine of results. And in an excellent remark of (Simion?) we find it laid down that Pathology has been the referring and rationalizing principle of Medicine and not the least of its immense advantages has been its invaluable tendency to counteracting mischievous practice, teaching us to refrain from doing harm and I will venture to add as the unanimous impression of the present time its capability in numerous cases of pointing out the only rational and safe mode of conducting a case to a happy termination. I need only mention the present management of diseases of the organs of the Lungs and Heart, and ask you to compare it with the treatment of the same maladies but three years ago, to prove the inestimable value of the aid which pathological science has afforded.

Now I say gentlemen that that mind which is not improved and stimulated into fresh energy by participating in the information and reflection which our meetings here from week to week so abundantly afford, and which pertains to topics such as those I have alluded to, cannot be other than insusceptible of improvement.

Ours, gentlemen, is a noble aim. While we are directly benefitting ourselves, we are not the less advancing the causes of our profession. Though none of us may attain the glory of a great discovery or an invention, still the materials we are gathering with

patience and assiduity from the countless stores of nature must undoubtedly tend to hasten the period when accumulated experience will have placed the practice of our art upon an irrefragable basis. Let but nature be our only guide, whether speaking to us from the pallet, the deadhouse or the laboratory—

"Unerring Nature, still divinely bright,
One clear, unchang'd, and universal light
Each motion guides, and every nerve sustains
Itself unseen, but in the effects remains"

And here, gentlemen, I would bring to your recollection the important advances which Medicine has made by the introduction of the pathological element as affording data for improved medical reasoning without which no hope of real progress in our science can be entertained.

In the pre-scientific age of the profession, medical knowledge was limited to the limited results of unguarded experience on the one hand, or groundless hypotheses on the other. In point of fact it is only of late years that a truly scientific era has commenced. Though for upwards of 250 years the domain of pathological anatomy has to a certain extent been cultivated, yet we find that not till 1767 when Mogagni's "De sedibus et causis morborum" appeared, can we say that its culture was conducted upon anything like scientific or rational method.

Our own Baillie followed and laid the foundations of British Pathology. But for the unfortunate want of a correct idea of the intimate structure of the human body physically and chemically, which has only been supplied within the last 15 or 16 years, the advance of the study referred to could not be else than imperfect and unsatisfactory.

We cannot it is true but acknowledge with the deepest gratitude the great services which discoverers in anatomy, both healthy and morbid have rendered the profession from time to time. Need I particularly allude to the undying names of Harvey, Hunter, Bell, Hall, Laennec, Hole, Cooper and many others which will at once spring to your attention. But the observations which these were enabled to make must be deemed comparatively isolated and fragmentary, when we look forward to the brilliant field, rich in mental wealth, which lies before the vision of the present generation.

It is impossible that it could have been otherwise. Indeed until lately the very data on which any practical conclusions could have been founded were in great part a mystery. The pioneers of medical science may be divided into three classes,—those who brought to light new facts, those who facilitated the discovery of new facts by improving the methods of observation and lastly those who, perceiving the hidden chain that binds these facts in indissoluble union, can exhibit to the world one or more of the laws of the Great Physician Himself. Now until the present age the discoverers in scientific Medicine have been perhaps without exception limited to the two former classes, and consequently the proper materials for generalization have only now sufficiently accumulated; and it is reserved for succeeding time to reveal those great and doubtless simple laws (not theories) which

¹ gap in original copy of the address.

truly regulate the morbid phenomena of animal organisation. "In point of factual knowledge" says Osterlein of Heidelberg—"even a Celsus or Hippocrates, a Boerhaave or a Sydenham would be as ? in comparison with any practical physician or physiologist of the present day."

Since the days of the father of our art then, there has existed no more favourable opportunity for realizing the advances of medicine than the present and we should esteem it a privilege of no common kind to be enabled to take our part in contributing even in a small degree to this momentous result. Why, even the simple accurate observation of a single remarkable case at the present day may command an important influence on future medicine, while parts of similar reports in writings anterior to the present age will necessarily pass into oblivion. The reason is obvious. The observations of the past age may be compared to the perceptions of a youth while those of modern times are the experience of the man.

Is it not therefore a wise step for individuals of the present generation to bind themselves together in societies such as ours? For it is only by such means that we can hope for the full value of the resources within our reach and which as I have mentioned transcend all the boasted appliances of former times can be attained.

Individual exertions may it is true occasionally be attended with invaluable advantage to the profession at large; but this is rare compared with what a number of minds in council have it in their power to bestow. Individuals are frequently prejudiced—they cannot divest themselves of the slowly formed but inveterated influences of education and especially educational authority. Their capacity, their skill, their inclinations vary so indefinitely that most probably no two could separately conduct the same enquiry or make the same observations in the same manner or with the same result.

When however the many are brought together as one assembly with definite objects in view, their varied powers are found to radiate towards the one centre and the happy result is the discovery of truth. Not that I deem truth always lies in numbers but I believe that where difficulties exist in the search for truth they can be best overcome by the varying influences of a multitude of educated minds.

There is yet another point of view in which I would desire the operation of this society to be viewed. In our prospectus issued in 1853 amongst the inducements held out to the profession, was one which I deem of great moment namely the collection and analysis of semeiological phenomena, more especially the recording for future reference of all unusual interpretations of the signs and symptoms of disease.

In our every day practice we meet with some case, which from some peculiarity arrests our attention. We cannot on the moment give a true signification of, interpret or solve the mystery. It is an unusual, let us say and as far as we know a unique circumstance. On reference we do not find it noticed in our accustomed authors. We perhaps hold a consultation. Still the mystery remains and nought but surmises or hypothetical reasonings is our resource. Now, it may be in our present condition most probable indeed that a similar

case and with this interpretation too lies buried in some corner of one of that vast multitude of reports which are scattered up and down the literature of our profession in every conceivable shape, monograph, compilation, cyclopaedia, dictionary, essay, lecture or other work to be found on the shelves of medical libraries.

Members of a sister profession can, with the greatest facility, refer to the counterpart of any given case that may come before them in the legal archives of the Kingdom and thus render the experience of the past at once available for almost any emergencies. Now we in numerous instances have no such command. The information we want to arrive at may be accessible to one perhaps among ten thousand; but for the mass of the profession it is practically sealed. To accomplish this *desideratum* the powers of association is necessary. Doubtless in any circumstances it would be a work of time and entail considerable labour, but I see nothing insurmountable in it. A body such as ours, in the course of a few years might form such a nucleus as would be easy of future development. Let us but continue to accumulate case after case in our general note-books, always keeping in view the semeiological element to which I have adverted, and the most obtuse amongst us would soon perceive the value of the undertaking.

In bringing these few remarks to a conclusion I would desire briefly to epitomise the advantages which members of this Society derive from their connection with it. 1st—Our meetings at this board tend to refresh our already acquired knowledge upon every variety of disease, New ideas, New facts, New analogies, are thrown up in the interchange of thought. Suggestions often for immediate practice are offered from hand to hand and that good feeling which inspires mutual confidence and respect and without which there can exist no real union of interest, becomes gradually strengthened amongst us. 2nd—Our country friends of whom I am happy to see so many here to-day are for the most part debarred from attending our meetings. Nevertheless they are not forgotten. The "Abstract" of our weekly proceedings informs them of the principal subjects brought before us; and in our annual volume of "Transactions" we supply the additional information derivable from papers published *in extenso*, and members' remarks. 3rd—Further it is a privilege to which every member is entitled, to receive an authorized report of the result of chemical, microscopical examination of any morbid specimen he may choose to forward; and in our pathological museum which is being gradually formed he has the opportunity of referring at his leisure to many objects of great pathological interest and value. It not infrequently happens that the recent specimens exhibited at our meetings are reproduced by the artist in a permanent form on the shelves of our museum, as for example during the very last session there were exhibited some morbid remains of remarkable interest and rarely modelled which are in the specimens now lying before you in a state completely imitative of vivid freshness and reality.

The examination of such specimens when taken in

connection with the detail of their respective cases in our "Transactions" supplies everything that can reasonably be desired from such a source; while in other instances again we employ the unerring pencil of the photographic process to stamp with lifelike accuracy the passing features of an important case.

And last though not least amongst the advantages must I mention the smallness of the annual subscription which places them at once within the reach of every member of the profession who may desire to avail himself of them.

And now, Gentlemen, I have only to add that the success of this Society depends much upon your cooperation, not simply as subscribers, but as working members. I would, therefore, urge you to contribute each your quota of information, either by forwarding objects of pathological interest, or reports of cases of clinical value, or personally imparting such information as you may have from time to time collected from your valuable experience. I conceive that every member of the profession is in some measure conscientiously bound to advance the interest of the body; but members of this Society established for the very purpose of gathering and disseminating the knowledge which constitutes true experience are still more imperatively called on to improve their opportunities for its benefit.

Much good is also in our power individually by using our influence in our respective localities to induce every hospital and dispensary attendant to join our banner. It is such men that are calculated to promote our objects in the highest degree, and I would further express a hope that the senior members of our body in particular would attend the meetings as often as practicable, not so much perhaps for the sake of deriving as of supplying information to the less experienced brethren. May I indeed ask this on my own behalf as well as that of the Society, for I am well aware of the difficulties with which the office I have the honour to hold is surrounded.

At the same time while I would feel grateful for the countenance of my seniors I shall yield to none in zeal and interest for the prosperity of the Belfast Clinical and Pathological Society.

* * *

The address having terminated, the following candidates for membership were proposed for election, by ballot, at the next meeting, viz.:—Dr. Leathem, Ballymoney; Dr. Robert Herd, Dr. Forsythe, Dr. Fras. M'Minn, Dr. Sheal, Killyleagh; Dr. Murray, Ballymacarrett; Mr. Weir, Dromore; and Dr. Seaton Reid.

Dr. M'CORMAC then read a paper, on an anomalous case in practice, which having elicited remarks, from its unusual nature, from Drs. Ferguson, Pirrie, M'Mechan, &c, was postponed for further discussion at the next meeting of the Society.

Dr. ROSS, one of the Secretaries, next read a very interesting paper on "The best and safest Mode of

administering Hydrocyanic Acid," which was well received, from its practical value; after which the meeting separated.

ORDINARY MEETING

January 5th, 1856.

The President, A. G. Malcolm, in the Chair.

Mr. WARWICK presented a uterine mole. Occasionally, during three months previous to its expulsion, the patient had abdominal pains, but the catamenia recurred regularly until three weeks before it was thrown off by the uterus. On opening the mole the membranes were seen, and a clot of blood, but no ovum.

Dr. LYNCH presented a patient affected with pneumothorax with effusion. The patient had, for nine months, been conscious of a splashing sound on giving a jerk to the upper part of his body. He repeated this jerk before the members, and the splashing sound was heard distinctly by those about him. He had been in bad health for two or three years, but his history shows no hereditary taint; his age is twenty-seven; his aspect phthisical; he is emaciated; there are the signs of a cavity in the apex of the left lung, and amphoric respiration with metallic tinkling, and the signs of effusion in the right side. An interesting discussion followed the reading of this paper, in which Prof. Ferguson, the President, Dr. Lynch, Dr. Heeny, and Dr. Ross took part.

ORDINARY MEETING

January 12, 1856

Mr. H. M. JOHNSTON introduced a patient who had that morning presented himself at the Dispensary, with a well-marked partial dislocation of the shoulder forwards, complicated with fracture of the acromial extremity of the clavicle, and rupture of the acromio-clavicular ligament. He was a bricklayer, and eight days previously had fallen from a scaffold. Upon rising, he found that he had completely lost the power of raising the right arm; but hoping that he would gradually recover its use, he had delayed applying for advice. The features of the accident were well marked, and after being examined, the patient was admitted into hospital, where the reduction was effected, but not without considerable difficulty and the aid of chloroform.

The PRESIDENT presented specimens of diseased lungs taken from A. K., aged eighteen, a printer, admitted into hospital 4th. January, 1856, moribund; and ill for three months with pulmonary symptoms. He had been suddenly attacked on 2nd. January, 1856, with extreme dyspnoea, and died on the 4th. The post-mortem examination revealed a very large cavity in the left pulmonary apex, in other parts of the left lung there were hepatization, suppuration, and grey miliary tubercles. The right lung was emphysematous, had a

small cavity in apex, contained tubercles, and was congested. The body was oedematous throughout, and the pericardial sac contained a considerable quantity of fluid. The chief points of interest were the great amount and extent of disease in so short an interval, and the co-existence of emphysema and tubercle. An interesting discussion followed.

The PRESIDENT also read notes of a case of ulcer over the right temple, which had resisted many modes of treatment. The patient was a pensioner, æt 37; received a blow on the site of the ulcer seven years ago, and had contracted syphilis eight years previously. The pain was intermittent at first, but for the last twelve months it has been constant, and of a dull, aching character. The President considered that the persistence and character of the ulcer were due to syphilitic disease engaging the periosteum.

Mr. Browne considered the ulcer malignant; Dr. Dill thought that the chronicity of the case showed that the disease was not so; Dr. Murney concurred in the latter view.

Dr. ROSS presented the central portion of the frontal bone, weighing upwards of an ounce and a-half, and measuring four and a-half inches by three and three-quarters, taken from a woman, aged about 39, who had got syphilis from her husband ten years previously; the ulcer healed after the removal of the bone, but a cicatrix and a deep depression still remain. Dr. Ross had no doubt that this was a case of syphilitic necrosis. The principal treatment consisted in the prolonged use of hydriodate of potass, with sarsaparilla, linseed meal poultices, and nitric acid, and solution of chloride of soda lotions.

ORDINARY MEETING

January 19.

Mr. BROWNE presented a patient with fibrocystic disease of the right breast.

The PRESIDENT introduced a patient presenting a large pulsating tumour, situated in the right mammary region. He was æt. 46, pale and emaciated; the right arm was oedematous. The tumour measured, in semi-circumference, eleven inches by nine and a-quarter, its longest diameter being transverse. The semi-circumference of right side, including the tumour, measured twenty-one and a-half inches; of the left, sixteen and a-half; immediately underneath the tumour, the corresponding measurements were eighteen and three-quarters, and sixteen. The veins of the abdomen and left shoulder were distended and tortuous. There was dulness on percussion, with absence of respiratory murmur over every part of left side of thorax, save the scapular region, where bronchial respiration was heard. The impulse of tumour was heaving and uniform at all points, and the diastolic pulsation marked; but there is no bruit. A murmur is heard, however, at midsternum and along the spine.

The history of this case was briefly thus:—He had become a pensioner seven years ago, having served the full time—twenty-three years; and had experienced no serious illness till two years ago, when he was seized with cough and dyspnoea, which have ever since affected him. Two months ago, for the first time, he observed a swelling in the region of the tumour commencing, which has, particularly of late, rapidly progressed, and within the last eight or ten days the right arm has swollen and the axillary glands enlarged. After examination by several members, a very animated discussion arose as to the exact nature of the tumour, about which it was felt there was some obscurity.

The President gave it as his opinion that the evidence afforded indications of an aneurism of the ascending aorta, but there were signs and symptoms in the case, which also showed that this was complicated either with malignant disease or extensive pleuritic effusion in the right side of the thorax.

Professor Ferguson reviewed the chief points in the case, and brought forward some objections against the idea of aneurism, but was unwilling to give a decided opinion until he had an opportunity of a careful examination.

Dr. Young was inclined to view the case as one of malignant tumour of the thorax.

Some other members addressed the Chair, but seemed unwilling to diagnose; all, however, admitting the very great interest and value of the case.

The President stated that he would, at some future meeting, report further on the case.

Mr. WALES presented a child, aged eight months, the subject of spina bifida; the tumour was quite translucent, situated between the dorsal and lumbar vertebræ, and about the size of a melon.

Dr. J. W. T. SMITH presented a man, aged about 26, affected with a serpiginous syphilitic ulcer of the right groin, extending towards the ilium, and of a horse-shoe outline. The patient had syphilis twelve months ago, for which he was mercurialised; while under the influence of the mercury an abscess formed in the fold of the groin, which was the starting point of this remarkable ulcer. Dr. Smith had found no benefit result from the use of iodide of potassium in 10-grain doses three times a-day; and he was now treating him with small doses of mercury, as recommended by Ricord, who, in his work on syphilis, gives a case corresponding to the above.

The case of dislocation of the right shoulder, referred to in last week's abstract, was reported on by Mr. Johnston, having been reduced under the influence of chloroform.

ORDINARY MEETING

January 26th, 1856

Dr. HALLIDAY introduced a person with a supernumerary thumb. His father, grand-aunts, and sisters had either supernumerary fingers, or were

web-footed.

Dr. J. MOORE exhibited a lower extremity removed above the knee-joint this morning. The patient's history was this:—He had for some years a loose cartilage in the joint, which gave him so great uneasiness as to prevent him following his business. About six weeks ago, Dr. Moore removed this cartilage, and the patient went on very well for a week, when he was seized with erysipelatous inflammation of the joint, which ended in abscess, dislocation of the head of the tibia backwards, and ulceration of the cartilages. Dr. Moore had now operated upon three cases of loose cartilages of the knee joint; the first two were successful, and the third was the case now given.

Mr. BROWNE exhibited a limb amputated above the knee, for disease of the knee-joint, of two years' standing; the cartilages were ulcerated. He also exhibited a mammary tumour, recently removed, of a conical form, presenting a fungous ulcer at apex.

Dr. Malcolm made a microscopical examination of this tumour and considered it fibro-cystic.

Professor STEWART presented to the Society a knee-joint, removed for acute ulceration of the cartilages, of six weeks' duration, following an attack of erysipelas.

The PRESIDENT introduced for discussion, "The best local treatment for severe scarlatinal sore-throat," and advocated the local use of nitrate of silver solution, strength, 3*i.* to 3*ss.* to the ounce of water, by injection through the nares, as well as directly to fauces. This treatment, which was specially applicable to the diphtheritic forms, he advocated on the principle of preventing the (secondary) absorption of the morbid secretions and facilitating respiration, by the clearing of the passages, in addition to the well known effects of the nitrate in this particular kind of inflammation.

Professor Ferguson varied his local treatment in each case, and thought that we should rely chiefly on the constitutional treatment of the disease. Professor Stewart, Dr. Patterson, and Mr. Browne confirmed the value of the strong solution of nitrate of silver, as recommended by the President. Dr. Moore preferred a dilute solution of nitric acid; Dr. Lynch used a syrup made with lemon juice and sugar; Dr. Young preferred a linctus of muriatic acid and honey; Dr. Pirrie had successfully used the tincture of iodine, but he had not much faith in local applications.

ORDINARY MEETING
February 2nd, 1856.
Professor Ferguson in the Chair.

Surgeon BROWNE read a case of fatal injury of the cervical vertebrae. The patient, a man aged 40, was struck by a beam over the lower cervical vertebrae, while driving a bread cart through a gateway, on the evening of 22nd. December, 1855. He immediately fell from his seat, but did not think himself seriously

injured, until he attempted to rise, when he found himself much paralysed, and unable to do so.

On the 23rd. December, 1855, he was admitted into hospital, and presented the following symptoms: partial anaesthesia, and complete paralysis of motion of all parts supplied with nerves from the spinal cord below the sixth cervical vertebra; pulse 86; respirations 30, and diaphragmatic; constant inclination to cough, but inability to do so; mucous râles over the chest, much swelling on the seat of injury, and a prickling sensation all over the body.

The catheter was passed, and three ounces of turbid urine were drawn off. A turpentine enema, which was administered, brought off a large quantity of faeces, but without the consciousness of the patient.

24th. December.—Pulse 100; respiration 38; attempts to cough frequent and distressing; thirteen ounces of urine were drawn off by the catheter.

25th.—Worse; anaesthesia increased; ten ounces of urine were drawn off, sp. gr. 1,037, and loaded with phosphates; respiration laboured; deglutition perfect.

26th.—Pulse 160; respiration 48; delirium followed by coma, tracheal rale, and death at 2 p.m., ninety hours after the injury.

The treatment was leeching on the seat of injury, two grains of calomel every third hour, and a blister to nape of neck. No post-mortem examination could be obtained.

Surgeon BROWNE also presented a part of the petrous portion of the temporal bone which had been broken by a blow, which left but a slight contusion externally. The case was of course fatal. A discussion followed the reading of these papers.

Dr. LYNCH presented the recent parts of the case of pneumothorax, with effusion, referred to in the abstract of the 5th. of January, 1856. The post-mortem appearances confirmed Dr. Lynch's diagnosis. There was a tubercular cavity in the apex of the left lung.

The right lung was compressed against the vertebral column to about the size of the kidney. There were about two or three quarts of seropurulent pleuritic effusion; a large fistula connected the bronchial tube with the pleural cavity. A small collection of softening tubercles was detected in the apex of the compressed lung.

ORDINARY MEETING
February 9th, 1856.

Mr. JOHNSTON introduced a patient, aet. 23 years, with enlargement of the lower end of the tibia. Thirteen years since he received a blow upon the leg, from which period he dates the commencement of the disease. The circumference of the extremity of the tibia is fully three times that of the other leg. The shaft of the bone seems elongated, skin over the affected portions is of a dusky red appearance; but there are no fistulous openings. The ankle joint is perfectly free. The patient complains chiefly of pain of a very severe character, frequently depriving him entirely of sleep.

Taking into consideration the symptoms complained of, and the appearance of the part, Mr. Johnston was led to suspect the existence of an abscess in the cancellated structure, and believed the case to be a fair one for drilling the bone.

The PRESIDENT exhibited gastric fluid, containing the sarcinæ ventriculi, which occurred in a case of chronic disease of the stomach. The patient was a young girl, æt. 15. Her illness commenced gradually about eight months previously. The principal symptoms were periodic gastric pain after meals, followed by vomiting of frothy grey acid fluid to the amount of one pound and more, and great distention of the stomach. The appetite and the general state are unaffected. The President had used the bisulphite of soda with much temporary benefit; but he feared organic disease of the pyloric extremity. In his observations on this case, he referred to the history of this curious vegetable growth, and to the recorded cases of it, which proved that there was no necessary connexion between its appearance and any special disease, as it has been observed in very different lesions, and detected in various fluids and organs. The practical indications afforded by its presence in the gastric fluid, the President remarked, were, first, that pyloric contraction, or atony of the muscular coats, or fermentation is most probably present; and, second, that antiseptic remedies will be found of most service.

The PRESIDENT also exhibited the heart, lungs, and aorta of a patient affected with aneurism of the descending aorta. This was a case of a young man, æt. 28, who was admitted into the General Hospital on 29th. December, ult., labouring under well-marked pleuritic effusion of the left side, complicated with aortal obstructive disease. The systolic murmur was heard also all along the thoracic aorta. His illness commenced fourteen months previously, and the symptoms were those of ordinary pleuritis. The usual symptoms and signs of aneurism were wanting, excepting the evidence of aortitis. There was no murmur or impulse. Death ensued, suddenly, on February 1st, from the sudden bursting of the sac into the left bronchus. On a post-mortem examination two aneurisms were detected, both small, one connected with the bronchus, and another with the bodies of the eighth and ninth vertebra, the eroded part forming the posterior wall. The aorta itself presented the marks of chronic aortitis.

Dr. ROSS introduced for discussion: Should we bandage immediately after delivery? He supported the affirmative for the following reasons: –

1st. The abdominal vessels and viscera had been accustomed for months to the pressure of the enlarged uterus and its contents, and this pressure was suddenly removed by delivery. He would therefore apply the bandage immediately after delivery, upon the same principle that he would use it after the removal of the fluid by paracentesis abdominis in ascites.

2nd. The pressure on the womb, by the bandage, acts as a gentle stimulant to that organ, and so favours its

tonic contraction, which is so important in preventing post partum haemorrhage and the lodgment of clots in the uterus.

3rd. The abdominal walls having been so much distended during utero-gestation, they frequently do not recover their natural tension after delivery without proper treatment, and disfigurement from pendulous belly, and disorders of the abdominal viscera, from their being imperfectly supported by the parietes of the abdomen, result. These consequences are generally prevented by the immediate and somewhat prolonged use of the abdominal bandage.

ORDINARY MEETING

February 16th, 1856.

The President, A. G. Malcolm, M.D., in the Chair.

Surgeon CORRY presented a patient (a boy 5 years old) with congenital deficiency of three metacarpal bones of the right hand, the corresponding fingers existing in a mere rudimentary state. It appeared, on inquiry, that there had been no malformation in any other member of the family; and his mother attributed the deformity to a fright she had received from a lobster, when in the third month of pregnancy. The appearance of the hand certainly resembled that of a lobster's mandibles.

Surgeon ARMSTRONG, R.N.D. Rifles, exhibited specimens of the lung and spleen of a patient who was admitted into the Belfast Regimental Hospital, on the 17th. December, affected with measles. He was in good health previously to this attack. He appeared to be going on favourably through the disease until the 20th. January, when profuse sweating was noticed, and, shortly after, symptoms of general bronchitis supervened; he died on 15th. inst. The lungs, liver, and spleen were congested, and miliary tubercles were largely diffused through their substance. On the motion of Dr. Pirrie it was directed that a wax cast of the specimens be ordered for the Society's Museum.

ORDINARY MEETING

February 23rd. 1856.

Mr. JOHNSTON exhibited Acton's syringe for injecting a solution of nitrate of silver in cases of spermatorrhœa; the piston and tube were made of glass attached to a silver catheter, which is passed down to the membranous portion of the urethra. Mr. J. also showed an artificial boot, suited for cases upon whom Chopart's or Syme's operation had been performed. It was constructed by Mr. Biggs, of London, and had been presented personally, by the Queen, to a soldier who had lost both feet in consequence of frostbite. The boot is constructed so as to supply an artificial ankle joint, capable of flexion and extension, and also to bear off, to a great degree, the weight of the body from the stump.

Dr. MOORE exhibited a portion of the lower lip, removed from an old woman. The affection appeared to

be of a cancerous nature, and had been greatly aggravated by the applications of a quack. Dr. M. also exhibited the Prepuce of a man, aged 25 years, who had attempted mutilation.

Surgeon ARMSTRONG, R.N.D. Rifles, narrated the rare case of a patient having a third attack of measles, as follows:—The subject of the case was a lady, aged 35. The previous seizures had occurred at the ages of 4 and 18 years. During the first attack her brothers and sisters also took the complaint. At this time she was very ill, and, as far as I could learn from her friends, who saw her at that time, she had the usual catarrhal affection. When 18 years of age, this lady, who, while on a visit, was engaged in nursing a friend's child who had measles, on her return home became similarly affected; and, at the same time, two young friends, who had been staying at her father's, and who, when they ascertained that the complaint was measles, immediately left, soon afterwards sickened of the same. Prior to her present, third, attack, I attended her son in measles, and it was during his convalescence that she became ill; she is now herself convalescent, but another son and daughter are still suffering from the same disease. An interesting conversation followed.

Dr. HALLIDAY read a case of cirrhosis of the liver, communicated by Dr. Maxwell, Surgeon to the 2nd. Foot. The patient, a private in the 22nd. Regiment, of intemperate habits, on admission into hospital, laboured under general dropsy, for which it became necessary to resort to tapping. 156 pints were drawn off from 12th December to 5th. February. Death occurred on the 6th. On post-mortem examination being made, the thoracic viscera were all found to be healthy. In the abdominal cavity the entire peritoneum was considerably inflamed, and the liver was entirely granulated, having the appearance of a pine apple. The spleen was much enlarged, but healthy. The cause of the enlargement of this latter organ gave rise to an animated discussion.

ORDINARY MEETING
March 1st, 1856.

Mr. H. M. JOHNSTON exhibited a portion of the aorta, in Dr. Malcolm's case of thoracic aneurism, referred to in the "Abstract" of 22nd. January, 1856. The necroscopy was held on 27th. February, thirty-four hours after the patient's decease (which was sudden), and disclosed the following morbid appearances:—The body presented an anaemic condition, and the tumour had collapsed considerably. The latter was found to consist of a confused mass of coagulated blood, surrounded externally by the fibres of the great pectoral muscle (and partially by the integument alone) and cellular tissue, and communicating with a false sac in the middle mediastinum, which was composed in part of the cellular tissue of the region, and bound behind by the descending vena cava, and root of the right lung, externally and to the right, by the right mediastinal layer of the pleura, and in front by the right margin of

the sternum, and its junction with the cartilages of the second and third ribs. This immense false aneurism communicated with the ascending aorta (about 1½ inch above the valves), by a well-defined, smooth-edged opening of an oval form, and measuring about 2 inches by 1½ inch. There was partial absorption of the second third, and fourth ribs, at a point just external to their cartilages, and perforations existed in the corresponding intercostal spaces.

The aorta was dilated and diseased; plates of cartilaginous deposit were observed in several places. The aortic and mitral valves were indurated at their edges, but their bodies appeared healthy. The left ventricle was dilated and hypertrophied. The left lung was emphysematous; the right was much compressed against the vertebral column; and the corresponding pleural space was quite filled with serous effusion and coloured coagula. The former, probably passive, accounted for the dull percussion note, laterally and posteriorly, noted in the history of the examination of this interesting case, and the coagula were the result of rupture of the false sac into the pleural cavity immediately prior to death. There was no appearance of any regular deposit of fibrinous layers. An animated discussion followed the reading of the above, chiefly in regard to the diagnosis of the case, in which Dr. Thomas Reade, Professor Ferguson, the President, and others took a part.

Dr. LYNCH presented a patient, whose thumb had been almost cut off with a saw; a small strip of integument alone connected the divided ends. Though this case was so unpromising, he placed the parts in connexion, applied a small splint, and used the water-dressing; perfect union took place, and the man has now a very useful thumb.

ORDINARY MEETING
March 8th, 1856.

Mr. BROWNE presented a patient, fourteen months old, affected with hydrocephalus. The mother of this child had contracted syphilis four years before its birth; another child had been born in the interval, but died in a few days from the effects of the disease. She was kept under the influence of mercury for some months previous to her conception. This child, when born, had syphilitic eruptions on the body especially about the scrotum and nates, and on the mucous surfaces of throat and nostrils. Symptoms of hydrocephalus appeared when it was three months old, and general paralysis, deafness, and blindness shortly ensued. These symptoms have all nearly vanished, and the head has diminished in size. It had convulsions lately, but is better. Mercury, in the form of grey powder, one-fourth of a grain thrice daily, has been the treatment.

Mr. BROWNE also introduced a man, aged 80 years, on whom he had operated for cancer of the lip, two weeks ago; the union was quite perfect, and the cicatrix scarcely noticeable.

Mr. CORRY introduced a man, about 60 years old, in whom a hydrocele of long standing had been radically cured by the supervention of haematocele terminating in ulceration. The patient had frequently submitted to the operation of tapping, without, however, any attempt having been made to produce a permanent cure, by injection or otherwise. On the last occasion of the operation being performed, he suffered considerably more pain than usual, and, in about six days afterwards, applied to Surgeon Corry at Barrack-street Dispensary, in consequence of the tumour having increased to its former size. On examination, the scrotum (which was of a dark livid colour) was greatly distended, tender to the touch, but presented no sign of fluctuation. Leeches, evaporating lotions, and strict antiphlogistic regimen, were prescribed. A week afterwards, the patient was visited at his own house, when it was discovered that extensive ulceration had taken place, producing hernia of the testicle, which had completely escaped from the scrotum; it was reduced, the edges of the ulcer brought together by sutures, and dressing applied. The wound healed rapidly by granulation. Six months have now elapsed without return of the hydrocele.

Dr. MURNEY presented a portion of the jejunum, ileum, and descending colon, which had been lacerated by shot accidentally discharged from a gun. The man died seven hours after the injury. The haemorrhage from branches of the mesenteric artery was considerable, but the shock seemed to be the immediate cause of death. The external wound was on the left side, midway between the crest of the ilium and the last rib.

Dr. STRONGE exhibited a cast of a cranium presenting a remarkable symmetrical depression on each side of the sagittal suture. The depressions commenced, he believed, ten years before death, and their development was not accompanied with any symptoms of cerebral disease. The patient was a female, who died about the age of 70 years.

The PRESIDENT presented a calculus, about the size of an almond, passed by a female child, aged three years, a patient of Dr. Russell's, Bangor. It consisted of the phosphate and carbonate of lime, with two centres and alternating rings of uric acid.

Mr. H. M. JOHNSTON exhibited an interesting specimen of a large aneurism of the ascending aorta, an account of which will appear in next week's abstract.

ORDINARY MEETING
March 15th, 1856.

The President, A. G. Malcolm, M.D., in the Chair.

Aneurism of the Thoracic Aorta.

Dr. LYNCH introduced a patient, æt. 45, affected with aneurism of the thoracic aorta near its origin. It commenced about twelve months ago with pain in the right side of the chest, extending through from above

the nipple to the back of the right shoulder, which persisted for above eleven months. He has lost flesh to the amount of three stone—there is a double pulsation with strong impulse, and a distinct bellows murmur, with considerable dulness on percussion over the right mammary region; some dyspnoea, but no pulmonary affection. He is pale and anaemic. His sufferings have been greatly mitigated by rest from his trade (a house carpenter) and the internal use of sesquicarbonate of ammonia, and ammonio-citrate of iron, with mild nourishing food.

Dr. L. saw him two weeks ago for the first time. At an earlier period mercury and blistering were employed.

The President, Professor Ferguson, and others, agreed in the view taken of the case, &c.

Puerperal Convulsions.

Surgeon HANNA read a paper on puerperal convulsions, basing his observations upon three cases in his own practice, which he detailed: —

1st. The first case, a primipara, was of a pale complexion, and had œdema of the ankles for two months before delivery, the urine being albuminous. The convulsions occurred suddenly on the removal of the placenta, and were attended with a partially comatose state. Timely bleeding, and the rapid introduction of mercury, were followed by complete recovery.

2nd. The second case was also a young plethoric primipara, who was seized half an hour after parturition. In this case, there was also œdema of the feet. The same treatment was adopted, but unsuccessfully—the patient having died on the fifth day.

3rd. The third case, also a primipara, æt. 28, had been long subject to headache, dysmenorrhœa, and hysteria. After the fourth month of pregnancy her legs began to swell. She was seized with convulsions just when the head was pressing on the perinæum; and, before the attack was over, the child and placenta were simultaneously expelled. The seizure was attended with partial coma. After the use of the lancet, and a brisk purgative of calomel and croton oil, consciousness was restored, and her health was soon re-established. Albuminous urine was observed in all the cases. Mr. H., in commenting upon these cases, referred to the fact first noticed by Drs. Simpson and Lever, that in a large proportion of the cases of puerperal convulsions, albuminuria holds a first causal rank. The latter authority especially insists on the connexion. The cases, Mr. H. considered, corroborated this view, and treatment calculated to remove congestion would therefore seem primarily indicated.

Aneurism of the Ascending Aorta.

Mr. H. M. JOHNSTON exhibited an interesting specimen of aneurism of the ascending aorta. He had seen the patient first, February 26th, and found a pulsating tumour situated between the cartilages of the third and fourth ribs of the right side. The pulsation was double, and there was a single murmur, less distinct as the heart was approached. There was also a rough, single murmur heard, extending from the epigastrum along the margin of the ribs upon the left side. The heart's pulsations were very low down. She stated that her

illness had commenced above one year since with cough, dyspnoea, and epigastric pulsation, and that she had some pains in her right arm, but none between the shoulders. There was no difficulty in swallowing, no stridor in breathing, no aphonia, nor any difference in the pupils. The pulse was ninety-six, equal in both wrists. There was marked dulness upon percussion over the right side of chest, laterally and posteriorly. The patient, when I saw her, presented an anaemic aspect, was extremely debilitated, and had slight anasarca. She gradually sank, and died in three days after her admission into the Belfast Union Hospital, without, however, any evidence of any rupture having taken place. Through the kindness of Dr. J. S. Reid, Physician to the hospital, I was permitted to make a post-mortem examination, and found the ascending aorta dilated to fully four times its normal size, its lining membrane very much diseased, and studded with small osseous plates. About one inch and a-half above the aortic valves, on the right side, there was a well-defined circular opening, considerably larger than a crown piece, forming the medium of communication with a false aneurismal sac, the latter about the size of a large sized orange, or a small melon, lying in the middle mediastinum, formed of the cellular tissue of that region, and of the muscular structure behind the sternum, and having deposited in its interior a series of layers of fibrine. Its direction was external and anteriorly. Absorption of the third rib, at its junction with its cartilage, had commenced, and the protrusion appeared between the third and fourth right intercostal spaces. The right ventricle was dilated, but the mitral and aortic valves were quite healthy, as was likewise the muscular structure of the heart. The lungs were emphysematous, and there was a large amount of serous effusion in the right pleural cavity.

ORDINARY MEETING

March 22nd, 1856.

The President in the Chair.

*Fistulous Communication between the Urinary Bladder
and the sigmoid Flexure of the Colon.*

The PRESIDENT presented the recent parts of a rare and very peculiar case of chronic disease of the bladder and colon, complicated with tubercular disease of the lungs, incipient cirrhosis of the liver, and recent fistula in ano. The patient had died with purpuric intestinal haemorrhage, supervening upon erysipelas of the nates, which occurred during the treatment (by operation, &c.) of the fistula. The cystitis was of old standing, the mucous membrane of the bladder presenting several ulcerative spots, and a fistulous communication between the bladder and the sigmoid flexure of the colon. This fistula was valvular at the vesical end, and hence, while it permitted of the escape of gas from the intestine into the bladder, it prevented any risk of extravasation of the urine; the intestinal extremity presented a wide aperture with sloughy edges. This portion of the colon was bound close to the posterior wall of the bladder by firm old adhesions. In the lung were found numerous small cavities at each apex,

surrounded by much tubercular "grey granulation;" the liver was uniformly pale, and in the state already mentioned. The President, in commenting upon this case, alluded especially to the rarity of the pathological lesion noticed, and to the difficulty, during life, of ascertaining the course of the gaseous excretion which escaped immediately after the urine, at almost every occasion of micturition, during upwards of three years.

Nature of Tuberclie.

The PRESIDENT opened the debate on the subject, "What is the nature of tubercle?" He first noticed its physical characters, as they pertain to:-1. The various forms of the semi-transparent grey granulations, nascent tubercle of Lænnec, or the simple fibrinous tubercle of Rokitanski; 2. The yellow, or crude tubercle; 3. The gelatiniform, infiltrative or albuminous tubercle, which is supposed to merge into the first form. The resemblances, phases, and changes, which these varieties present, were next stated. Then the chemical composition of tubercle, from which Dr. M. showed that tubercle could on no account be deemed a highly carbonaceous substance, as had been confidently alleged, as it really contained less of this element than other proteinous compounds. Dr. M. then noticed the usual site of the deposit in various organs, the nature of the softening process, the transformations and disappearance under favourable circumstances, and dwelt at considerable length on the results of microscopical examination, which he believed tended to prove that nascent tubercle was an organized substance, but that the cells and nuclei developed in the blastema were incapable of forming any definite tissue, and, consequently, that all ulterior changes in the tubercular mass were due to the vascular action of the original structure, in which it was first deposited. When considering the circumstances under which the deposit is most usually observed, Dr. M. referred to the chemical character of the blood at different stages, and showed how it materially differed in the proportion of haematosin, albumen, and fibrine, and that the variations of advanced tuberculosis were owing to the accompanying (secondary) morbid states of which tubercle became a cause. He especially noticed also the result of some chemical experiments, which he had made some years ago on the expired air, in cases of confirmed phthisis, with a view to ascertain the average amount of carbonic acid exhaled. These experiments went to prove that the decarbonizing function was in excess in tuberculosis. At this stage of the proceedings, in consequence of the lateness of the hour, the debate was adjourned.

ORDINARY MEETING

March 29th, 1856.

The President in the Chair.

Operation for Permanent Flexion of the Knee Joint.
Mr. BROWNE introduced a patient on whom he had operated for flexure of the knee-joint. This girl, now aged fourteen, when eight years' old received a severe injury of the knee, followed by acute inflammation, and

ending in permanently flexed joint. In November last, she came under Mr. Browne's care; the heel was then drawn up nearly to the hip, and the limb could be extended very slightly. She was put under the influence of chloroform, and subcutaneous section of the ham-string tendons was made; ten days after, the popliteal fascia was likewise divided. Forceable extension was then made, when the patella, which had been partially ankylosed to the head of the tibia, separated. The limb was then secured to a double-inclined-plane splint, and by means of an extension screw and graduated slide, very gradual extension was daily made. In the month of January she was discharged with a limb nearly straight, and very little shorter than the other, and she is now beginning to use it with some freedom. The knee is not quite stiff, though the motion is very limited; but a completely ankylosed joint is obviously the best and safest for the patient. Mr. Browne remarked that during the process of extension no inflammation had taken place.

On the Nature of Tubercl.

The PRESIDENT resumed the discussion on the nature of tubercle, by referring to the chemical composition of the blood in tuberculosis, and observed that the evidence of the first chemists showed, that, while the albumen and aqueous element were in excess, the fibrine, red globules, and salts were diminished; and as to the fatty element, its presence was very limited indeed, not amounting to more than 2.3 per 1,000, while in the lymph of the thoracic duct, according to L'Heritier, the proportion in health amounted to 5 per 1,000. He admitted that in ancient tubercle, fat, in the form of cholesterine, is in considerable quantity; but this occurred just as often in the curative process of tubercle as the destructive stage, and, besides, the presence of fat is by no means uncommon in the later changes of cysts and other benignant tumours. The President further objected to the carbon theory of tubercle, by referring to the well-known pathological influence of alcoholic diet. "A careful consideration of all the facts brought forward by the best-informed pathologists, and of all the direful effects of intemperance, leads to the conclusion, that tubercles, or other formation of tubercle, is not one of the effects of alcohol!" See Ancell., p.456. After noticing some other points, especially in reference to the prevailing seats of tubercle (concerning which he showed that the blood-forming organs were the chosen depositaries), he stated briefly the conclusions which a careful consideration of the whole evidence induced him to form: –

1. Tubercl is an organized substance when first deposited as tuberculous blastema, which, however, is incapable of forming any definite tissue.

2. Tubercl is produced from nascent blood.

3. This blood is charged with the extra waste of tissues (albumen modified) which supplies the requisite blastema; and is only influenced indirectly by the character of the supply or nourishment.

4. The treatment arising from this view would comprise all that would tend to purify the blood, especially in its incipient, forming stages, and

especially promote the formation of extra fibrine and hæmatoxin.

Professor Ferguson, Drs. Cumming and Ross took part in the debate that followed.

ORDINARY MEETING
April 8th, 1856.

Dr. MOORE exhibited a foot which he had removed by Chopart's operation, upon account of scrofulous disease of the tarsus, and gelatinous degeneration of the synovial tissues. He also exhibited a moveable fibrous tumour, in size about that of half an orange, which he had removed from the upper and outer part of a lady's breast. She went home, a distance of twenty-five miles, the day after the operation. In operating, he removed no portion of the skin. The wound healed by the first intention.

ORDINARY MEETING
April 12th, 1856.

Surgeon JOHNSTON introduced a child whom he had exhibited to the Society about twelve months since, in order that members might form a comparison between its state then and at present. The appearance of the patient was altogether fatuous. His mother stated, that he had frequent convulsions, and is disposed to be somewhat mischievous; the health was otherwise excellent. Professor Ferguson considered the case incurably epileptic. Drs. Stronge and Magee would recommend the employment of mercury, under the impression that a chronic inflammatory state of the meninges might exist. Dr. Bryce would suggest the ammoniuret of copper. Mr. Johnston, in reply, stated, that the recovery from the paralytic condition, in the early stage of the disease, occurred after the use of mercury for four or five weeks.

Dr. DILL reported a case of hysteria, which for a considerable period assumed a variety of phases, and simulated various diseases. At one time the patient would pass through an ordinary hysterical paroxysm; at another would be seized with a violent motion in the right hand and arm, as if using a hammer and knocking upon the knee; again, retention of urine, to such a extent as to demand the repeated use of the catheter, would be the chief feature; afterwards she would be found suffering from trismus, which has lasted for days; and again, attention would be exclusively directed to the occurrence of general and complete anaesthesia of the surface of the body. The symptoms in this Protean case yielded ultimately to a long-continued course of tonics, particularly steel, with small but frequently repeated doses of ext. belladonna, the cold bath, and out-door exercise.

Surgeon CORRY exhibited a boy, aged 7, affected with well-marked rachitis of the lower extremities. The deformity was very considerable in the tibial shafts, and altered position of the right patella.

Professor FERGUSON exhibited the heart taken from the body of a boy, aged 13, who was admitted into the General Hospital on 9th inst., and died on 11th. He was anasarcaous, and evidently labouring under cardiac disease, but the peculiarity of the physical signs was a source of peculiar attraction while he remained in hospital. There was a perfect absence of impulse, and all cardiac sounds were replaced by a distinct systolic bruit, heard best at the apex, and not continuous along the aorta. On examination (*post-mortem*) it was found that the aortal semilunar valves were one mass of induration, of irregular wart-like outline, which must have been a great obstacle to the flow of blood, and the aperture of the mitral was extremely contracted. The size of the organ was not changed.

Dr. MOORE presented three specimens of cholesterine fluid taken from the bodies of different patients. One from the neck, the contents of an encysted tumour; the others the fluid of ordinary hydrocele. The scales of cholesterine displayed a vivid brilliancy on agitating the fluid.

ORDINARY MEETING
April 19th, 1856.

Professor FERGUSON introduced a patient (on a litter), affording a remarkable example of the articular effects of chronic rheumatism. Almost every joint presents an apparent ankylosed condition. The patient (now aged nineteen) enjoyed good health till ten years of age, when he began to complain of pains, which were very acute at times, and it may be truly said, never left him since. He has been bed-ridden for the last four years. Dr. M'Mechan, Whitehouse, had seen him some five years ago, when he presented all the symptoms of acute rheumatic arthritis. Dr. Malcolm examined a specimen of the urine, which afforded an abundant precipitate of the lithate of soda. Dr. M. viewed the case pathologically as an instance of rheumatic gout. Professor Ferguson spoke rather against the idea of either gout or rheumatism. Mr. Browne, R. N., considered the joints in this case presented examples of true bony ankylosis. He had seen cases of such general ossific growths. Dr. M. objected to this last view, as in such circumstances we have osteal deposits more frequent on the shafts of the long bones, which in this patient were untouched. Dr. Ross concurred in Dr. Malcolm's view, and was doubtful of the existence of real ankylosis in this case.

The following case of variola in utero was contributed by Dr. R. CROTHERS, now stationed with his regiment at Downpatrick:—“Mrs. K., aged 24, has one child, and is again pregnant. When on the march hither, and passing through Portadown, on the 25th. November last, she was exposed to the contagion of variola. About the 8th. December she felt unwell. I saw her on the 11th., when the eruption was appearing. The following notes I made at the time:—‘Dec. 16. Face much swollen, particularly about the lips, where the pustules almost cohere. She complains much of soreness of the tongue.

The pustules on it are broken, and appear as round indurated spots, slightly elevated at the margin, and depressed in the centre.’ The disease ran the ordinary course. There was but slight consecutive fever. On the 20th. she sat up for a little, and in three or four days was convalescent. On the 23rd. January ult. she applied at the hospital, saying she thought herself nearly five months pregnant, and was now threatened with abortion, which occurred same evening. The foetus had evidently died from variola. There were numerous traces of pustules on it over the back and sides, also some on arms and legs, exactly resembling those on the mother's tongue. Dr. Brabazon, of the County Infirmary here, saw the case, and was satisfied as to its being variola. The disease had proceeded as far as the maturation of the pustules; and as the foetus appeared to be recently dead, I am inclined to think that the disease must have almost run its course with the mother before it suffered. The foetus was sent to the Inspector General, who intends forwarding it to the Army Museum at Chatham. Mrs. K. had been vaccinated when a child, but I think imperfectly. She is wife of a private of the Tyrone artillery.

An interesting conversation ensued as to the amount of immunity afforded by vaccination.

Dr. MOORE exhibited a portion of a corn which he removed, in the centre of which he found a strong hair with bulb complete. He had not seen any similar case mentioned.

ORDINARY MEETING
April 26th, 1856.

Dr. MOORE exhibited a recent specimen of *cancerous mamma* which he had excised from a patient aged 45. Professor Stewart also presented a similar tumour.

A discussion ensued as to the comparative utility of removal of such tumours, and the leading points which should guide us in deciding.

The PRESIDENT introduced a young girl aged nine, whose nasal organ was completely lost by *lupus*. It appeared that in 1851 this patient had scarlatina (her mother states two attacks), which was followed by a bronchitic affection, and ophthalmia of the scrofulous form. The latter malady was extremely obstinate, and for two years there was but little real improvement. In 1854, while in the country, she met with an accident which injured her face and nose slightly; after this she contracted small-pox, and had a mild seizure, but it was immediately followed by the appearance of an impetiginoid eruption all over face, for which she received various and prolonged treatment. It was at this time that the ulceration of *lupus* appeared, and committed the disfigurement referred to. The countenance is now very repulsive from the crusted state of the eruption and the loss of the nose.

Dr. MOORE gave a short account of an instance of *rupture of the perinæal tendon*. There was a distinct depression an inch and a-half between the ends. The

case was rare compared with division of the tendo achillis and plantaris due to injury.

* * *

CONVERSAZIONE.
April 30th, 1856.

The Second Conversazione of the Society was held on the 30th April in the Corn Exchange. The Members and Guests began to arrive at 7 p.m. The guests numbered 106 and included the Mayor, both bishops of Down and Connor, members of the academic staff of Queen's College, Chas. Lanyon the architect of the college, many clergymen, shipping and mercantile leaders, lawyers, military gentlemen, artists and schoolmasters. The members present numbered 45.

The room was decorated in an impressive and pleasing manner. From the ceiling several flags depended, the French tricolor and the Union Jack being appropriately placed together. The banners and flags of Turkey, Spain, Prussia, Russia, Greece, Mecklenburgh, and of the cities of Dantzig and Hamburgh were along the walls. The tables were conveniently disposed, so as to permit of promenading around each, and, altogether, the arrangements were excellent.

Stand I: Some admirable photographic views taken in the Crimea by Mr. Robertson were displayed. The clearness of outline and accuracy of these "sun-pictures" were the theme of universal commendation. A group of officers of the 19th Regiment before Sebastopol attracted much interest from the fidelity with which it represented Colonel McGee (he was present as a guest). Many who had known the gallant colonel recognised him at once. As illustrative of the advance of one of the collateral sciences, these pictures were well entitled to a place in the collection.

Table 1: There was a splendid array of Surgical and Philosophical Instruments from Young of Edinburgh, comprising all the latest inventions—a case of instruments which was specially fitted up for the French Exposition of 1855, including the designs of Professor Syme; a set of Syme's perineal instruments, of Simpson's instruments for gynaecological operations, lithotries, Dupuytren's bistoury for lithotomy, Spence's instruments for extracting musket balls, Dr. Alexander Wood's Opiaye Syringe for injecting Batteley's Liquor into the cellular tissue, Liston's double inclined plane splint etc.

Table II: A very good collection of similar instruments was exhibited by our townsman Mr. Thos. Bell whose work will bear favourable comparison with any specimens we have yet seen.

Table III: Mr. Wm. McKenna a veterinary surgeon (for the first time we believe in Belfast) exhibited a collection of surgical instruments and preparations illustrating hippo-pathology. Legs of horses with the

blood vessels injected and the nerves and ligaments were shown also preparations showing joints. The instruments on display included dental forceps and rasps, trocars and cannulae, lancets, catheters, instruments for neurotomy, improved castrating knife, bronchotomy tube, cupping instruments and a tobacco smoke enema apparatus.

Table IV: Mr. G. H. Strype exhibited an apparatus for controlling the duration of exposure in photography. This opened and closed the lens. An operator could take his own portrait without assistance. The time of exposure could be any length up to ten minutes. Mr. Strype also showed a magneto-electric machine capable of yielding shocks or carrying out electrolysis or electro-silvering.

Stand II: This stand was crowded with choice specimens of Mineral and Vegetable Materia Medica. Messrs Dyas and Cantrell had on show a great variety of medical appliances and medicinal extract of great rarity, some introduced for the first time to the medical profession. Scarce and costly alkaloids were on view. They also showed domestic and surgical appliances in India Rubber. Feeding bottles on a new and improved principle and respirators of a light and simple construction were also seen. Mr. Wakington "now the oldest druggist firm in town" exhibited a selected series of vegetable medicinal preparations with tickets explanatory of their nativity and circumstances attending their introduction into practice were appended to each article.

Table V: Messrs Grattan & Co. Apothecaries and Chemists displayed pure vegetable alkaloids and also cheap and expensive preparations which could not be told apart except by an expert. The cheap ones had been adulterated. Examples were: Scammonies from 5s. 6d per lb. to 50s.; Rhubarbs from 6d to 20s.; Musks from 24s. per oz. to 74s., Iodine and its Salts; Salts of Bismuth; Preparations of Sulphur etc., manufactured especially for the low priced market, and only to be distinguished from the genuine by the educated eye or chemical and microscopical examination, although occasionally containing so much as 75 per cent. of inert or foreign material.

Stand III: A collection of portraits of celebrated English and Irish physicians and surgeons; a volume of autograph letters the property of Wm. H. Malcolm (Dr. A. G. M.'s brother). It contained letters from David Garrick, George Washington, the Duke of Marlborough, a poem by Robert Burns in his own handwriting, and a letter from Lord Nelson of 1801, from Empress Josephine, Edmund Kean, Wm. Pitt, Robert Peel, Wilberforce, Dan. O'Connell, R. B. Sheridan, from Lord Byron a promissory note, Cherubini—letter, Weber do., Paganini—*a few bars of music*. Thomas Moore, Sir John Moore, Marshal Ney, Duke of Wellington—letters; Thomas Campbell—poem in his own writing, Edmund Burke and Wordsworth—letters, Joseph Haydn—2 leaves of music with his signature, signatures of Alexander Pope, Laurence Sterne, W. M. Thackeray, Charles Lever,

W. C. Macready, Joseph Hume, Charles Dickens, Mandelsohn, S. T. Coleridge and Lord Belfast. Lastly Oliver Cromwell's signature to a commission in the Parliamentary army dated Whitehall, 28th May, 1655.

Table VI: A number of trophies of travel, principally collected in Mexico, by the contribution of Gordon A. Thompson, Esq., of Bedeque House. Also some reminiscences of the late war, in the shape of Crimean trophies consisting of helmets, coat, sword, musket, bayonet, sabre boots spurs etc. which were secured as booty from the Russian slain, and kindly procured for the occasion by Mr. John Bell. Near this collection were a pair of stout boots (sent by Mr. H. M. Johnston, Secretary of the Society) adapted for the use of those who had lost the foot from frost-bite, and which, we were told, were manufactured by Her Majesty for the use of our disabled soldiers.

Stand V: A portable wheel barometer invented by Joseph Cappo, Chemical & Philosophican Instrument Maker, 145 Millfield, Belfast, also a "very neat rotatory steam engine of glass" which could be used in fumigating rooms etc. during sickness.

Stand VI: Modern articles of sanitary value—a full sized warm bath heated by gas, ventilators, plans for the drainage of Belfast by R. Young, Esq., C.E., plans of model dwellings for the poorer classes and illustrations from the Parliamentary Inquiry "The Health of Towns" (presented by Dr. A. G. Malcolm).

Table VII: Microscopic demonstrations by members of the Society, such as the polarization of light, and the circulation of the blood in a frog's foot; and in some novel experiments illustrating the physiological effects of strychnine by Dr Hall's frog-test. None of these could be viewed with indifference, even by those accustomed to such spectacles, while to the uninitiated they were productive of surprise and amazement.

At another part of the hall we observed spirometers adapted for measuring the "vital capacity" of the lungs.

Stand VII: A collection of models illustrating the various forma of Crysallography and pathological drawings and models in lime and wax were furnished from the private collection of the President (A. G. M.) and in part from the Society's museum.

Stand VIII: Dr. Moore, Belfast contributed from his collection a number of photograph portraits of the leading medical and surgical celebrities of Gt. Britain and Ireland and a series of pathological drawings "the production of his own truthful and powerful pencil."

Table IX: A selection of ancient works in medicine printed in the 16th. century and a number of splendidly illustrated folios from the library of the Belfast Medical Society. An assortment of modern medical treatises (1850 to 1856) were exhibited by Mr. H. Greer, Bookseller, Belfast.

Stand IX: Coloured drawings of botanical and zoological subjects (especially physiology and anatomy) by Professors Dickie and Stewart of Q.C.B.

Table X: Coloured and most life-like gutta-percha models of the heart and eye, and appendages by Dr. Murney, Demonstrator at Queen's College and Mr. Browne, R.N. "our able local ophthalmologist."

Stand XI: An array of botanical and other drawings by Mr. A. Nicholl "our accomplished townsman" made during his residence in Ceylon. The Palmyra palm represented possesses interest from the fact that its trunk is in the Belfast Museum, having been presented by Sir James Emerson Tennent.

Stand XII: Mr. Magill, Fine Arts Repository, Donegall Place exhibited a series of photographs—the majority stereoscopic. (The programme report contained a very full account of the marvels of stereoscopy. "Though but a discovery of yesterday, the stereoscope has already proved the means of prolific enjoyment to many.... Not only has it brought within the reach of all such treasures as those of the Crystal Palace but views from Paris, Vienna and Rome... and from Swiss Alpine scenery. By its agency all that is grand in nature may be collected from every quarter of the globe, and nationalized to sweeten leisure, to charm society, to educate youth, and to shed the most refined enjoyment around the domestic hearth.")

The beautiful appearance of the hall was enhanced by a number of objects of statuary from the studio of Messrs Venturelli, Corporation Street, consisting of casts of a suit of armour, "Bacchus", the Neapolitan Girl, Hebe, Prometheus chained to the rock, Helen & Paris, William Tell, Napoleon III and "a well executed Phrenological Head."

After completing the circuit of the room Members and Visitors stopped at a well-furnished refreshment table, where tea and coffee and confections were liberally dispensed by Mr. Thomson, Donegall Place.

ADDRESS DELIVERED BY DR MALCOLM
At the Second Conversazione

Shortly after nine o'clock Dr. Malcolm rose, amid general applause and proceeded to deliver his presidential address as follows: -

GENTLEMEN,—However much I might have wished to occupy, this evening, the position of a spectator or a listener, instead of the office which the partiality of my professional brethren has thrust upon me, I shall not shrink from fulfilling, to the best of my ability, the task which my situation, as retiring President of the Belfast Clinical and Pathological Society imposes; because I feel assured, that the same indulgence which has sustained me throughout the labours of the Session, which this evening terminates, will not be withheld on this—to me, at least—trying occasion.

I must say, that were my audience composed exclusively of my professional brethren, I should feel much more at ease, as the observations with which I would, under those circumstances, have occupied their attention, would naturally and genially flow, as from one medical mind to another, without the most distant risk of being misinterpreted or misunderstood. But, as it is, when I see around me gentlemen, eminently distinguished in other walks of knowledge—gentlemen, whom I may, in all truth, regard as the representatives of science and literature in this city, whose proudest boast was, and is, that it contained such men—I cannot conceal the difficulty of the position I hold. I would, however, trust, that in the remarks which I purpose to offer this evening, I shall steer clear of deserving the imputation that the medical element has been too strongly infused to render them palatable to a mixed audience.

Before proceeding to the principal subject of this address, I desire to express my feelings of heartfelt congratulation to the members of our Association on its past progress, its present position, and its future prospects. My non-medical friends will bear with me, when I tell you I am proud—confessedly proud, of the standing of the Belfast Clinical and Pathological Society amongst the Medical Associations of Ireland. But three short Sessions have passed over our heads, and we already number in our ranks upwards of one hundred and sixteen Members. When, three years ago, its foundations were laid, I little thought how far beyond my first anticipations would be the result of the work. In that little space of time our Society has extended its operations into all parts of the province of Ulster; and its most distant members feel its improving influences almost as vividly as if they were resident, and enabled to join directly in its proceedings. This pleasing result of our weekly lithographed "abstract" is but a slight indication of what I trust may yet be accomplished, in the way of placing the resident and non-resident members more on an equality. The time may come when we may have our medical reporters, who will give our brethren at Letterkenny or Culmore full reports weekly of the doings and sayings of our medical parliament in Belfast.

Gentlemen, I am happy in having it in my power to

state that, on last Saturday, we elected the thirtieth new member for this session—an evidence at once of our strength and of an evergrowing interest in the objects of the Society. However anxious and doubtful I might have felt as to the issue of its early struggles, the experience of each successive session has more and more confirmed me in my impression that the stability of our Society is real, inherent, and permanent; and that its existence has filled a vacuum which had been forming for many years past, especially in the midst of our local brethren. In the attainment of its present triumphant position, I would be doing an injustice were I to omit making the most honourable mention of the labours of my predecessors in this chair. The first volume of our "Transactions" is a sufficient index to the ability and zeal of the one;¹ and I have only to mention the name of Professor Ferguson to intimate to you the peculiar qualifications for the office which the other enjoys. (Hear, and cheers.) And need I add that, in your selection this day of my respected successor, there is afforded the best guarantee of a prosperous future. (Renewed applause.)

You will naturally suppose, gentlemen, that this language, in reference to our Society, savours rather much of the sanguine temperament. I confess I must yield to the soft impeachment. But I believe no new undertaking was ever yet projected into permanence without a large infusion of the element referred to amongst its promoters. And I know that those amongst my audience, who are acquainted with the incipient stage of this Society, will pardon me for any exuberance of feeling which the occasion has elicited.

Gentlemen, the guests of the Belfast Clinical and Pathological Society, permit me to wish you a hearty welcome to our second conversazione. Many of you will, doubtless, recognize amongst the various objects of interest which are this evening displayed before you, some which will remind you of a similar occasion this time last year; and, from what I know of the general impression which was expressed on the last occasion, I am not apprehensive as to the result of our present efforts to form a meeting which will be not altogether unattractive to the distinguished savans whom I see around me. On this occasion, however, it is my desire to draw your particular attention to the elements of advanced science, which may be gleaned by an inspection of the contents of this Hall. One impression which such examination must, I think, elicit in the minds of all, will be that of surprise; for you will meet with here, on almost every table, objects of scientific interest which do not seem, to a non-medical understanding, to be very intimately associated with medical practice. On the contrary, the devotee of pure science, who had never so much as opened a medical volume, would recognize in the great majority of the objects here presented, his most familiar acquaintances. Now, when I have shewn you that the medical mind considers all these same objects as equally interesting to him, it will not be too much to infer that there is an indissoluble connexion between science and true medicine. But I go further, and I state without any

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Dr. T. H. Purdon.

hesitation, that the progress of medicine has advanced, and will continue to advance, in a direct ratio with the advancing strides of science. We do not, therefore, consider ourselves as diverging from the path of strict professional duty, when we issue our annual invitations to many whose knowledge of medicine is limited to the painful experience of the *armamenta medicinæ*. On the contrary, in summoning you to our annual gathering, and in placing before you on these occasions objects of equal interest to us both, we do so with a view to impress upon one and all the grand presiding fact, that science, in all its divisions—in all its apparently varying characters—call it by what title you will—is one and the same—the discovery and interpretation of the laws of our common Creator.

Gentlemen, I deem the present a fitting occasion for illustrating this truth. The subject admits of endless amplification. It is not my intention, however, to do more than touch the salient points; for this will be quite sufficient to render manifest the validity of the proposition, that medical progress only became real when science became the pioneer and guide of medicine. Like to the benighted traveller, who walks on and on in the vain hope of reaching his destination, but who, in reality, has lost the true path, so medical knowledge, in the early times, endeavoured to advance by the changing light of *ignes fatui*, which successive hypotheses had engendered from time to time. It was reserved for science to light the traveller on his way, to dissipate the clouds which hovered o'er the road to truth, and to remove, with a single touch, obstacles to onward progress which seemed colossal to a prescientific age.

The progress of human knowledge, in any of its numerous departments, seems, in my view, to include three stages. In the earliest period, the mind of man was bewildered with the number, variety, and extent of the objects in nature submitted to his contemplation. Man, under such circumstances, may be compared to a child; his observing powers are over-taxed, and his perceptions are necessarily intermixed, and almost shrouded in the inward imaginings, which the objects suggest. He is at this time incapable of true observation. The immensity overwhelms his feeble understanding; and in the attempt to describe what comes within the range of his senses, he loses himself in the vain endeavour to grasp the entire phenomena presented to him. In no department of human knowledge is this more evidently manifested, than in that of medicine. Truly, may the first steps here be deemed, the impress of conjecture and superstition. It seems to us of the present day passing strange, that the early writers in medicine displayed such gross imperfection with regard to the structure and functions of the human frame. Is it not surprising that for a long period subsequent to the time of Hippocrates, the veins and arteries were undistinguishable; that nerves, and sinews, and ligaments, were designated indiscriminately by the same terms; that Aristotle's arteries contained only air, which the windpipe conveyed from the atmosphere to the heart, and at a later period, in the time of Galen, that the veins were supposed to originate in the liver, and the arteries in the heart, and

that that large muscle which separates the thoracic from the abdominal cavity was, in some way or other, connected with mental emotions? It does seem strange, indeed, that even up to the fourteenth century of the present era, the only movement which the blood was supposed to possess was that of flux and reflux, and it was only about this time that any rational ideas were beginning to be entertained as to the action and uses of the valves which are observed at the origin of the two great arterial trunks, those situated between the chambers of the heart and the delicate semivalves of the veins. Does it not, I say, strike us with amazement that Berengarius and Vesalius were the first to show the instability of the ancient doctrine, that the intermixture of the two kinds of blood, which the most ordinary ocular demonstration was sufficient to discriminate, was effected by means of a filtering process through the *septum ventriculorum*, or the partition between the right and left chambers of the heart? But it is, perhaps, still more curious to reflect, that the very first step towards a solution of the great problem of the circulation of the blood, sprung directly from the agitation on the question, at this time widely debated in the medical world, viz. if the *septum* (referred to) be, as was proved, impervious, where can the meeting of the arterial and venous blood be accomplished? And it is certainly a fact, of equal interest, that the individual who had the honour of proposing a clue to remove the difficulty, was no other than a theological writer, the unfortunate Servetus, who was the first to suggest the transit of the blood through the lungs from the right side of the heart to the left. Here I must diverge a little to state, that I am quite aware that Servetus' claims as a discoverer have been questioned, and that his views have been deemed, by some, as a mere hypothetical proposal for getting over a difficulty; but a reference to some passages from his work, entitled, "Christianismi Restitutio" (of which, by the bye, it appears only two copies have come down to us), abundantly proves that he had reasoned upon the facts presented to him, and inferred the truth therefrom. Some short time later, Andrew Cesalpinus, having observed the swelling of the veins below ligatures, bethought him that the blood must have a movement in these vessels, in a direction from the extremities towards the heart; and this idea was still further corroborated by Fabricius, who, having more carefully examined the disposition of the valves of the veins, which Sylvius had previously discovered, ascertained that they were all turned towards the heart, and thereby became obstacles to the return of the blood to the extremities. Here was the first light shed upon the nature of the general circulation; and it does seem an object of great wonder to us at the present day, that it was reserved for a later than Fabricius to unfold the true character. Reasoning upon the facts thus ascertained, and believing that the movement of the blood in its vessels was fully established, HARVEY, in the year 1616, conceived the happy idea of instituting a series of experiments to determine the exact course of the blood. He compared the different effects, when a ligature was thrown round a vein, and an artery; and he placed the results in conjunction with the known

direction of the valves, and, in a comparatively short time, was enabled to satisfy himself that the blood is impelled by the left side of the heart, in the arteries, to the extremities, and thence returns by the veins into the right side of the heart; and he further proved, that the pulmonic circulation is but a continuation of the larger. In this manner he gave a complete theory on the circulation.

Now, let us pause a moment to inquire how it was that this, the most important physiological discovery up to his day, was effected. It was impossible for Harvey to see the current in its entire course. It is, therefore, an inference—but an inference so based upon a series of acknowledged facts that the demonstration becomes complete. Harvey was asked, on one occasion, What induced him to think of the circulation? And he replied, that when he took notice that the valves in the veins, in so many parts of the body, were so placed that they gave a free passage to the blood towards the heart, but opposed the passage of the venal current the contrary way, he was incited to imagine that, so provident a cause as nature had not placed so many valves without design; and no design seemed more probable than that the blood should be sent through the arteries and return through the veins, whose valves did not oppose its course that way. Whewell, in commenting upon this discovery, states that Harvey must have possessed clear views of the motions and pressures of a fluid circulating in ramifying tubes to enable him to see how the position of valves, the pulsation of the heart, the effects of ligatures, of bleeding, and other circumstances, ought to manifest themselves in order to confirm his view; and that he had referred to a multiform and varied experience for the evidence that it was so confirmed. The simple fact is, the elements of this great discovery were previously well and generally known. Fabricius, as I have observed, was upon the very verge, yet missed it. He supplied, however, the last link in that chain of evidence which put Harvey upon the track. Harvey discovered the circulation, not in the manner that a new mineral or a new plant might be casually observed for the first time, but solely as an inductive truth. He had the same facts to deal with as many of his predecessors. In their hands they were isolated, unproductive, and non-suggestive. He was the first to place them in relation, harmony, and mutual dependence. And, in the true philosophic spirit of Baconian reasoning, he cast aside the unsupported imaginings of ancient medicine, seized the facts actually observed, constructed others with his own hands, and raised that immortal structure which the progress and the test of time have only tended to consolidate. Harvey was a true disciple of nature. Whatever, before his time, had had her sanction, he was satisfied with. He himself questioned her eagerly, and carefully noted her replies; and, though totally and necessarily unacquainted with the modern facts of natural philosophy or physiology, he unveiled to an astonished world the beauty and simplicity of the Creator's design.

This reference to one of the great eras in physiological history leads me to my second proposition, that the second stage in any department of knowledge is

distinguished by the prevalence of a rational observation, or, in other words, the acquisition of philosophic truth by a process of inductive reasoning.

Though Bacon was the first to insist upon this particular method of investigation, though he was the first to throw this yoke upon the ardent labourers of the mental world, still we find in the circumstances connected with the growth of the grand discovery to which I have just drawn your particular attention, there is abundant evidence to prove that Harvey had anticipated the very system with which the name of Bacon will be for ever associated.

As another memorable instance of the power of rational observation, I may here allude to the splendid discoveries of Sir C. Bell, and later still, of Dr. Marshall Hall. In this particular department of physiological research, the conjectural age seems to have been unusually protracted. Galen taught that the nerves are the channels of perception, but he, and for a long time his successors, not unfrequently confounded nerves and tendons. The division of the nerves according to their connexion with the nervous centres, the examination of the different ganglions or knots which occur upon them, and the unravelling of the brain according to its proper structure, was the work of Willis in 1664. But all this came far short of the views which Bell and Hall for the first time propounded to the world, and these, be it remarked, were simply the result of the most careful, but at the same time ordinary observation and experiment as a basis, and of a calm judgment upon the data thus laboriously established. It must be remembered, however, that there is a considerable difference in the character of these two discoveries. Sir C. Bell dissected the nervous ramifications, and at the conclusion of his work was enabled to say with the utmost confidence, this is a nerve of motion, and this other is a nerve of sensation.

On the other hand, Marshall Hall predicates certain functions of a portion of the nervous system, based chiefly if not entirely upon clinical observation, and the result of systematic experiment. The object of both, nevertheless, is ultimately attained in the same way. In this and the preceding example, it will be observed, that most important advances were made in medical knowledge without other aid than what a well-regulated observation was sufficient to impart. But even these, great undoubtedly as they are, were but a small portion of that knowledge of the circulation and the nervous system which even the merest tyro of the present day possesses. We are now cognizant of the most intimate nature of the vital fluid, and its actions in the minutest vessels, and also of the nervous substance wherever situated.

These considerations bring me to the last stage through which our own knowledge has passed, namely, that which is characterized by the result of rational observation, aided by scientific instruments. I allude especially to that vast increase of knowledge which is mainly due to the careful use of the MICROSCOPE, the employment of chemical analysis, and the result of electric agents, in health and disease. Wherever these agents have had the proper field to labour in, the yield has been unprecedented; though it must be admitted

that all are as yet in an infant condition, but such as promise for the future the brightest prospects. (Hear.)

It were totally impossible, in the brief space which I intend to occupy, to refer in a particular manner to these immense results. I shall, therefore, confine myself to a notice of that new world which the revelations of the microscope have unfolded to the medical practitioner. We are accustomed to speak of the immensity of space; and, indeed, the successive improvements in the means for discerning the countless worlds that surround us have even yet barely enabled us to possess the faintest idea of the infinity of Providence. When astronomers tell us that stars are visible, by means of instruments, whose light must have occupied a period of many hundred years in traversing that vast interval of space between them and us, we cannot but feel the awfulness and majestic sublimity of the "ways of the Almighty." But if such be our impression when contemplating nature upon her grandest scale, let us remember that there is another extreme wherein we have worlds, which, though invisible to unaided vision, present a perpetual succession of objects to excite our wonder, and teach us the great truth of the unfathomable depth of the wisdom of the Infinite. In the successive improvements from the time of Seneca, who, in the first century, wrote for the first time that small and indistinct objects become larger and clearer in form when seen through a globe of glass filled with water, down to the present year, when objects are magnified hundreds of thousands of times, a succession of improvements has enabled us to state, that as each step made towards the present perfection of the instrument has opened up new conditions of existence unknown to previous observation, so there is every reason to believe, that we are still far from being in possession of the highest capabilities which the instrument is calculated to afford. Just as the hazy nebulae in the time of Herschel have been clearly analysed by the six-feet parabolic speculum of Lord Rosse, so it is not unphilosophical to assume, that there are still wonders in the microscomic existence which some future microscopist will be yet enabled to discern. (Hear.)

In regard to the influence which has been felt, through the whole domain of physiology, by the use of the microscope, I believe I may say, without fear of contradiction, that it has been the means of completely revolutionizing the knowledge of animal structures which prevailed prior to its introduction. What modern chemistry has done in elucidating the composition of the materials concerned in secretion and nutrition; what the stethoscope has effected towards the detection of thoracic disease; what our knowledge of electricity has enabled us to predicate concerning the phenomena of the nervous system, have, I would say, been far excelled by the mass of facts in anatomical, physiological, and pathological knowledge, which is due to the scientific use of that queen of instruments, the microscope.

We may date the commencement of micro-anatomical study, in the year 1660, when the celebrated Marcello Malpighi commenced his inquiries upon the blood, which have been the foundation of all

subsequent knowledge upon this subject. It is recorded that he was the first individual who was favoured with that most wonderful sight—a view of the capillary circulation in the living animal; a spectacle which even at the present day, and though often observed, ever excites our greatest wonder. Indeed we can scarcely imagine the intensity of the emotion it must have originally called forth in the mind of the celebrated discoverer. It proved in him the strongest stimulus to extended research; and we find that on the nature of almost every tissue, in both the animal and vegetable world, he has thrown so much light, and by means of what would be now regarded as very imperfect instruments, as to have anticipated much of the boasted knowledge of many of his successors.

I must pass over the names of Leuwenhoeck, whose untiring industry in minute anatomy the Transactions of the Royal Society sufficiently establish; also the names of Ruysch, Sömering, Prochaska, and Lieberkun, all of whom have left imperishable names in the history of microscopic anatomy. I can also but merely mention the name of our celebrated countryman, William Hewson, in whose experimental inquiries, the results of his anatomical investigations were so accurate, notwithstanding the imperfection of the means at his command, that subsequent observers have been only enabled to confirm them.

The "observations" hitherto referred to, it must be remembered, were made by means of unachromatic instruments, and no steps were taken to remedy this great defect, till about thirty years ago, when the first compound achromatic was presented to the French Academy of Sciences, and shortly afterwards, in 1826, the first of this kind was constructed in this country. Amongst those to whom we are indebted for this highly important improvement, without which, indeed, the best compound instrument would give less perfect results than the commonest single lens, must be mentioned the names of Dr. Goring, Dr. Hodgkin, and Mr. Lister. This last-named gentleman is, perhaps, the most deserving of renown, for his combination of lenses, constructed in 1829, has, to use the words of Mr. Quckett, "tended more than any other to raise the compound microscope from its primitive and almost useless condition, to that of being the most important instrument ever yet bestowed by art upon the investigator." Now, who think you was this Mr. Lister? A London merchant, who, in the midst of a large and pressing business, was yet enabled, by his great talents and untiring energy, to lay the foundation of the true principles of achromatism, and in his spare moments to carry those principles into practical realization.

There have been many instances in the history of discovery of similar manifestations of genius in the persons of those who were never permitted to indulge in "learned leisure." Indeed, it seems to have been a favourite system which nature has ever adopted, to disclose her secrets to those who have laboured in the pursuit of truth amidst the greatest obstacles and difficulties; and this fact, for illustrations of which no one need be at a loss in the history of British science, should be an encouragement to all who enjoy the taste for scientific research in all the varied occupations of

the world. (Hear.) There is no business so engrossing as not to leave many valuable moments for calm reflection or experimental inquiry, and no one can predict what may be the result in any individual instance of a devotion to some particular branch, of these leisure hours.

The important improvement in the instrument to which I have just referred, it is to be presumed was not without its immediate practical results. Every object previously observed was subjected to the new test, and thus many of the errors of previous imperfect observations were corrected, and novel phenomena for the first time established. Amongst this latter class none has exceeded in importance the new facts due to the labours of Schleiden in the vegetable, and Schwann in the animal kingdom. Their researches have eventuated in the establishment of, probably, the greatest attempt at generalization ever made in physiological science: I allude to the "cell theory," a theory which owes its origin to the suggestions which sprung out of a contemplation of the cells of cartilage, and a comparison of this observation with what was previously noticed in the vegetable world. It is difficult to conceive what may be the result of further developments of this grand theory, but I have no hesitation in stating my belief, that if we are ever to possess any more distinct knowledge than we already enjoy as to the growth of tissues, or the intimate phenomena of secretion and assimilation, it will come through the instrumentality of some development of this theory.

I might here appropriately draw your attention to some of the leading advantages which the use of the microscope offers to the medical practitioner. I might state what important aid in the detection of disease and its stages it can supply, and also what indications of treatment it affords; but recollecting the mixed character of the audience I have the honour to address, I shall consult my own convenience and yours by omitting particular mention of it altogether, further than to allude to the striking utility which this instrument has displayed in the detection of poisons and the adulteration of food.

It will be in the recollection of many that a few years ago a very complete investigation was instituted in London, by the Editor of the *Lancet*, in regard to the latter, the result of which has been to draw the attention not merely of the public, but also of the authorities, to this ruinous evil, an evil which presses too most severely upon the most unprotected classes of society. It has been fully ascertained that the effect of inordinate competition in the sale of articles of diet has been to lead to the systematising of many forms of adulteration, the detection of which was hitherto almost impossible, until the aid of chemistry and the microscope was resorted to. And well did they accomplish the object. Nothing was too complex or too minute for their united analysing power. This is more especially the case in reference to vegetable productions, which the most advanced knowledge of chemistry alone was frequently unable to satisfactorily distinguish, when mixed up in various pulverulent combinations. The nature of these compounds, the microscope, in the hands of Quekett, Hassall, and

Letheby, has established in a single trial almost without the slightest risk of failure. The time is, therefore, fully arrived when legislative interference is imperatively called for, to protect the masses of the community from becoming the prey of fraudulent dealers, and when every constituted authority should deem at least as necessary as the protection of property, the maintenance of the lives and health of the community. The subject of poisoning has lately presented itself to us in a fearfully revolting aspect. (Hear.) The rapid succession of these horrible cases recalls to our memories the records of ancient times, when scarcely any public character was safe. Fortunately, however, we, in the present day, are not without redress. I am glad to have it in my power to say, that the detection of almost every animal and vegetable poison is now so sure, that there is little chance of a failure of evidence on this score. Strychnine and hydrocyanic acid, hitherto deemed inaccessible to post-mortem tests, in consequence of the minuteness of the fatal dose, are now readily detected a considerable time after death. I can refer you to some experiments which will be submitted to you in the course of the evening, which will abundantly satisfy the most sceptical as to the practicability of this statement. It is by such triumphs of science that life is really rendered secure. The fear of death under the old system was shorn of half its terrors by the strong impression on the mind of the assassin that the law could not be enforced from want of conclusive evidence; so that in this respect, as well as the other points of view which I have brought under your notice this evening, well may it be said that the progress of science in general is fraught with the blessing of perpetually increasing prosperity to the whole human race, both as individuals and as communities. (Hear, hear.)

As I have set out with asserting the indispensable connexion between general and medical science, so must I conclude with reiterating the spirit of my proposition. There is none amongst us here this evening, who could not, I feel assured, assist in the great work of human amelioration—all, I trust, are more or less acquainted with some branch of scientific research; none of us is so absorbed in the duties of our respective callings, as not to have some moments of leisure daily, to occupy in pursuing some scientific object; and none, I am satisfied, can direct his energies assiduously and continuously on any one worthy object of study, without being, sooner or later, enabled to educe from amidst the multitude of interesting phenomena which his pursuit will elicit, *some practical truth hitherto unobserved*. Well, then, this is the first great step in discovery—the foundation on which, when aggregated, the superstructure of a "Law of Nature" may be ultimately erected. Here, then, we have an ennobling object to stimulate our endeavours after scientific truth. Well has it been said by Galen of old, that "the study of physiology is a hymn in honour of the Deity." But he might, with similar effect, have stated the same of the study of nature in general. There need be no rivalries amongst her votaries: their reward is in the study itself, and the reflection that they are agents in the hands of Providence for disseminating "His praise

through every land."

And now, gentlemen, before I resign my trust into the hands of my respected successor, whom the voice of the Society at large has this day elected to the honourable office of its President, I would ask the members to accept of my very best thanks for the support which they have afforded in strengthening and consolidating the Society during the past session. Never were meetings better attended than our weekly reunions at the General Hospital; never was displayed so much enthusiasm in the transaction of the regular business, which engaged us from week to week; and never, I believe, was there a more auspicious prospect for the session which is now about to open. It is, gentlemen, my most earnest wish that you will, one and all, continue to cherish this common bond of union established for purely scientific purposes, and the common benefit of our profession and the public at large. May the spirit of improvement and of progress never die within us, but, on the contrary, may we continue to emulate each other in striving after the acquisition of that rational scientific knowledge of medicine, which, when chastened by practical experience, is the surest test of the accomplished practitioner, and the best safeguard of the common weal.

The learned Doctor resumed his seat amid general applause.

Dr. MALCOLM then vacated the chair, which was taken by Dr. M'GEE, the President elect.

Mr. BROWNE, Senior Vice-President, moved, and Dr. STEWART V.P. seconded, a vote of thanks to Dr. MALCOLM for the learned address that he had delivered.

Dr. M'GEE put the motion, which passed with acclamation, and in conveying the thanks of the meeting to the Ex-President, said, that the approbation of such a meeting was no mean tribute, and, he should add, that never, in his opinion, were thanks better deserved. (Hear.)

Dr. MALCOLM acknowledged the compliment in appropriate terms. The assembly then rose and again dispersed through the room, inspecting the several collections, and the conversazione ended about eleven o'clock.

OFFICE-BEARERS FOR THE SESSION 1856-7.

President—Dr. M'Gee.

Vice-Presidents—Mr. Browne, R.N.; Dr. Stewart; Professor Stewart; Dr. M'Meehan (Whitehouse); and Dr. MacLaughlin (Lurgan).

Ex-Officio V.P.s.—Dr. Purdon, Professor Ferguson, and Dr. Malcolm.

Council—Drs. Murney, Dill, Moore, Pirrie, Patterson, and Young (Holywood).

Analytical Committee—Drs. Purdon, Malcolm, Murney, and Cuming.

Treasurer—Dr. Halliday.

Rec. Secretaries—Dr. Ross and Mr. H. M. Johnston.

Gen. Corr. Sec.—Dr. Malcolm, 81, York-street, Belfast.

THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY

Numbering upwards of 120 Members, and now the largest Provincial Medical Association in Ireland, is distinguished by the following attractive features:-

1. The very moderate Annual Subscription.
2. The Members' Privilege of receiving Reports of the Microscopical and Chemical Committee, on any morbid specimens sent.
3. The Members' Privilege of receiving (after each meeting) a lithographed abstract of the Weekly Proceedings - and a copy of the annual Transactions (postage being prepaid).
4. The Members' Privilege of access to the Reference to any of the Subjects in the General Note-Book of the Society.
5. The Members' Privilege of admitting Visitors - and inspecting the Contents of the Pathological Museum of the Society.
6. The Members' Privilege of VOTING for the offices of PRESIDENT and VICE-PRESIDENTS (two of whom are non-resident) annually by sealed letter
7. The Members' Privilege of admitting Visitors to the Annual Conversazione held at the close of the Session.

All communications from Gentlemen intending to join this Body to be addressed to

Dr. Malcolm

81, York Street, Belfast,
Gen.Corr. Sec.

N.B. The Session (1856-7) will be opened on the last Saturday in October proximo, at the General Hospital, under the Presidency of Dr. McGee.

Andrew George Malcolm

Obituary and Funeral.¹

DEATH OF A. G. MALCOLM, ESQ., M.D

As though one of our charitable institutions had been suddenly destroyed, the sad news of Doctor Malcolm's death spread over this town on Saturday morning, producing a strong and general feeling of commingled surprise and sorrow. The melancholy event of his demise, so unexpected, at least by the public, took place in Dublin, on Friday morning. He was a benevolent and most useful citizen; one of the men of the age, fond of everything that marks the progress of the times; a warm promoter of all kinds of sanitary reform, of education and self-culture, especially amongst the artisan section of society; an unobtrusive worker, not easily wearied in well-doing; reflective and calculating, he had strong faith in the power of application, and with much less talent than he really possessed, had his days been prolonged; must have attained by his extraordinary industry a high position in the medical profession, to which he was ardently attached. With an intellect of a utilitarian cast, he had an appreciation of artistic feeling and the poetic faculty in others, rarely manifested by the Coke and Cobbett class of thinkers. He had an admirable sanguineness as to the success of any work in which he engaged himself, and, like Jeremy Bentham, possessed "a passion for improvement in those shapes in which the lot of mankind is ameliorated by it." He has left behind him results of his industry, which must "long keep his memory green in the souls" of those for whose advantage he laboured. The loss of such a man—so clever, accomplished, and philanthropic—is, indeed, deplorable—and we fear, to a large section of society, irreparable.

Doctor Andrew George Malcolm was born at Newry, about the year 1816, and was, consequently, in the 38th year of his age at the time of his death. His father, the Rev. Mr. Malcolm, was a Presbyterian minister officiating at Newry, where he died. After his demise, the family removed to this town; and his son, the late Doctor Malcolm (how strange this phrase sounds!) was placed at the Royal Academical Institution, where he received the rudiments of his medical education. In the year 1842, he graduated at the University of Edinburgh, having chosen the subject of fever for his required thesis, his mind having been, it is stated, directed to that form of disease from having suffered by it a short time previously. His success was very decided at the University, whence he carried off one of the three gold medals, besides receiving the thanks of the professors for his "able treatise." Having taken up his residence in this town, he commenced his professional career by qualifying himself to become connected as a physician with the General Hospital. This was done, according to a custom then existing, by attending on the poor for

two years gratuitously—a work which Doctor Malcolm's disposition led him to enter upon and go through. Becoming thus connected with the General Hospital, his feelings of attachment never cooled towards that excellent institution. He regarded it not as a place where practice and profit might be derived, but with the eye of a Howard, as a charitable house of relief to suffering humanity.

Dr. Malcolm had no intention of settling down in a professional position of mediocrity. He contemplated an exalted standing, and the production of works that would endure, and advance the knowledge of the healing art. His contributions to medical works were numerous and valuable. They will be found principally in the Dublin Quarterly Journal of Medical Science, in which he was also the historian of interesting cases that came under his notice or treatment, as well as several reviews of medical books.

It is, however, in connexion with "The Society for the Amelioration of the Condition of the Working Classes" that Dr. Malcolm will be remembered in Belfast. This society was established in Feb., 1845. Its objects were "the advancement of such measures as may conduce to the physical, intellectual, and moral improvement of the working classes." Amongst the measures contemplated for these purposes, two were selected as being most readily susceptible of being carried into effect—the creation of public baths and wash-houses, and the establishment of an Athenæum.

We are inclined to believe Dr. Malcolm was the original projector of this "association." Certain it is, he took a most active part in its formation, and whilst the bath houses were being erected, he had a commencement made of what we hope will eventuate in a complete Athenæum—the newsroom and library, now in a flourishing condition, in connexion with the Belfast Working Classes' Association for the promotion of general improvement. Whilst he was secretary for the more comprehensive organisation above-mentioned, he became president of this society, assisted it with his means, wrote for it, delivered lectures for the benefit of its members, and promoted its welfare with his interest from the evening of the 22nd of June, 1840, when it was founded, till the day of his lamented decease.

He left Belfast for the last time, on the evening of the half-yearly meeting in connexion with the Association, expressing his regret that he was unable to attend it, and promising that, on his return, he would exert himself with a view to carry out the original idea of an Athenæum. But, to use the language of the devout Burke, "A Disposer, whose power we are little able to resist, and whose wisdom it behoves us not at all to dispute, has ordained it in another manner;" and the working men of Belfast have lost an earnest benefactor. The Committee of the Working Classes' Association feel deeply the loss of their steady friend, and will, no doubt, take some steps to put on record their sense of his eminent services whilst, for more than ten years, he discharged zealously the duties of their President, and watched over their interests with parental kindness.

Always anxious to forward the interests of the General Hospital, Dr. Malcolm, in the summer of 1851, turned over in his mind how he could best contribute

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to the success of the fete on Queen's Island, got up for the benefit of the establishment in Frederick Street, and determined to write its history. In order to commend the work to the attention of the general reader, he enlarged his plan, so as to embrace the other medical institutions, and to those he added chronological notes and biographical reminiscences connected with the rise and progress of the town. We have a lively recollection of the history of this work. Dr. Malcolm and his assistant toiled at it literally night and day, so as to have it ready in time for the fete. It is a handsome book, valuable as a work of reference, and will be useful to the future historian of our town and neighbourhood.

The last appearance that we remember of Doctor Malcolm, in public, was at the elegant and intellectual conversazione, which took place a few months ago, in the Corn Exchange-room. It was a meeting of "the Belfast Clinical and Pathological Society," which, we believe, owes its existence to his exertions. The members had invited the principal literary and scientific gentlemen of the town and vicinity. Doctor Malcolm, as president, delivered an address on the occasion. He was much applauded. He was the centre of attraction in that enlightened throng, and earned the golden opinions of those most capable of appreciating his worth and professional attainments. We saw him not many weeks ago at the General Hospital, and were much struck by the sight of his prematurely grey hair. It reminded us of Doctor Moffat, to whom, with the lamented Dr. Sanders, the subject of this article bore no little resemblance in many respects, besides his early and lamented death. Doctor Malcolm, it is believed, had been suffering from a chest disease for some time and proceeded on the 7th of the last month to Rathmines for the benefit of the air and medical treatment, and there terminated his useful existence. What he said of another will apply aptly to himself. The name of Doctor Malcolm will long stand high on that distinguished roll, which Belfast citizens will ever love to honour.

The remains of this lamented gentleman reached town on Saturday night, at half-past nine o'clock, and were conveyed to his residence in York Street. In the course of the day, a special meeting of the medical profession was hold in the library of the Hospital, at which it was resolved, "That, as a mark of respect, the members shall walk in procession at the funeral of the late esteemed and lamented Doctor Malcolm." The profession will accordingly meet at the Hospital to-day, at a quarter before three o'clock, and form four deep in the following order;—First, the attending staff of the General Hospital; then the consulting staff of the Hospital; and, in the third place, the Dispensary attendants, followed by the members of the Medical and Pathological Societies; and, lastly, the members of the profession generally, all wearing crape half-depth on their hats. The body will be removed, at three o'clock, for interment in Dunmurry graveyard.

FUNERAL OF DR. MALCOLM.

Yesterday, at three o'clock, pursuant to arrangement the remains of Doctor Malcolm were removed from his residence, York Street, for interment in the graveyard at Dunmurry. All the medical gentlemen in town assembled at the Hospital a quarter of an hour before the time appointed for the funeral, and settled the form of their procession, according to the resolution previously come to. The Working-Classes Library and Newsroom were closed for some hours, as an indication of respect for the memory of the late President of the Association. There was a very large muster of the most respectable inhabitants in the neighbourhood of York Street, and as the procession moved along, a solemn sadness seemed to be impressed on every countenance, and a deep sensibility as to the loss which had been sustained by the death of Doctor Malcolm seemed generally manifested.

The hearse was drawn by four black horses, and immediately followed by Wm. Malcolm, Esq., and friends and relatives of the deceased gentleman.

Then came the attending staff of the General Hospital, who were succeeded by the consulting staff; then again by the dispensary attendants, who were followed by the members of the medical, and lastly in the arrangement of the faculty, the members of the profession generally. The doctors, who all wore crape, were followed by the members of the Hospital Committee, after whom came the Committee of the Working-Classes Association. Besides the above-named gentlemen, who walked in procession directly after the hearse, there was a very large attendance of the general inhabitants. There were twelve mourning and other coaches, and twelve or fourteen miscellaneous vehicles. The cortège passed up York Street, down Donegall Street, through Bridge Street, along Donegall Place, and by the usual routes to the Dublin Road. On arriving at Dunmurry, the coffin was taken into the church, several members of the Working-Classes Association assisting to carry it. The Rev. William Bruce then read the 4th chapter of Thessalonians, commencing at the 13th verse. He then delivered a suitable address, and offered up an appropriate prayer, after which the coffin was carried out, and committed to the grave, where rest the remains of the late Doctor Malcolm's mother, and, we believe some of his other relatives.

BELFAST
CLINICAL AND PATHOLOGICAL SOCIETY

FOURTH SESSION
1856 – 1857

PRESIDENT—Dr. M'GEE.

VICE-PRESIDENTS—Mr. Browne, Dr. R. Stewart, Dr. H. Stewart (Resident), Dr. MacLaughlan, Lurgan, and Dr. M'Mehan, Whitehouse (Non Resident), Dr. H. Purdon, and Dr. Ferguson (Ex-Presidents).

TREASURER—Dr. Halliday.

SECRETARIES—Mr. Johnson, and Dr. Murney.

COUNCIL-MEMBERS—Dr. Pirrie, Dr. Dill, Dr. Patterson, Dr. Moore, and Dr. Young.

The meetings of the Society were resumed on Saturday, 25th. October, 1856, at the General Hospital, when the PRESIDENT delivered the following Introductory Address, after which the ordinary business was transacted:

GENTLEMEN,—In taking this Chair, hitherto so ably filled, I have to tender you my sincere thanks for the honour you have conferred on me, by my election to the office of President of the Belfast Clinical and Pathological Society.

Some of you have already passed many years in practice, and have deservedly attained to eminence;—others are but commencing that course in which you can reach the goal of success only after many a rude cross and jostle; and, as I myself have had some hard experience, it may not be altogether out of place if I address, especially to our younger brethren, some observations on the medical practitioner and his mission, in relation to his duty to his patient, to his brethren, to society, and to himself.

In other professions, men may draw a boundary or separation line between their professional and personal character; but the duties of the medical man are too closely identified with the man himself to permit, with impunity, excepting in rare instances, any wide departure from the strict, though conventional, rules of society as to manner, deportment, dress, &c., &c.—rules which your own common sense will soon teach you.

Between the patient and his medical attendant there should be the strictest confidence: see that on your part it suffer no breach. You will, at times, be entrusted with secrets by your patient, on which may depend his standing in society, perhaps his worldly prosperity; you should, therefore, preserve all he may tell you as a sacred trust not to be abused.

In giving evidence in courts of law, you may, however, be compelled to disclose secrets entrusted to you in professional confidence: the privilege of professional secrecy is extended only to the case of facts stated to a legal practitioner to enable him to conduct his client's case, and perhaps also to secrets revealed to clergymen in their official capacity. If then the Bench give an express order that you shall answer, you have but to obey, and such a mandate will fully exonerate you from

all blame for your revelations.

Once more, I say, be studiously secret; of old, loquacity has been reckoned as one of a physician's faults that should be punished by law, and in the present day, the tattler is feared and shunned because of his talking.

On visiting your patient, always bear in mind that you have claims upon you, far beyond the consideration of self; that you are called on to give relief to the suffering; that on you depends, perhaps, the safety of the patient; therefore, in the sick room, give your undivided attention to the patient; let it be evident that he is your chief, indeed your sole object of consideration. Be careful that no appearance of haste mark your proceedings, no matter how much you may be pressed for time. Be attentive, be patient, and, above all, be gentle; for though some have made their fortune by rudeness and roughness, those rare exceptions are not models to be copied. I do not say to you be temperate: sobriety is a virtue, the value of which is so well known to you, that I need not urge it on you.

Despise not small details, nothing is trifling or unimportant that can hasten recovery or alleviate suffering; therefore be not laughed out of using every means that can aid you in forming a correct diagnosis. Situated as you will often be, with symptoms entirely, or as far as may be, concealed from you, or incorrectly reported, or exaggerated, you nevertheless must not despair of unravelling the truth. Do not jump hastily to a conclusion, hear with attention the patient's account of his ailments; marking, but not trusting implicitly to his statement of his feelings and impressions; then, taking nothing for granted, till verified, if possible, by your own observation, proceed cautiously and deliberately in forming your diagnosis; a question of vital importance to your patient.

In your inquiry pursue a regular and connected course; letting your questions follow, each its predecessor, in a natural sequence.

Thus your patient and his family will soon perceive that you are familiar with the subject, and will have confidence in your judgment, which is a very important element of success. But, if you wander about in your inquiry, or appear to hesitate, or to be in doubt, or at a loss, distrust of your ability is sure to follow. Ever remember that "people do naturally trust those that trust themselves." Though many sources of difficulty may spring up,—as hereditary constitution, local circumstances, changes in the cycles of disease, the question of fictitious or of factitious disease, and such like, yet attention will often enable you to overcome these difficulties.

Accustom yourself to observe closely and to reason on your observations, so that your clinical pathology may guide you to a correct diagnosis, and thence to a rational treatment.

For your conduct to your brethren, you may safely consult Percival's Ethics, and the code published by the Belfast Medical Society; you cannot wander far astray from the right path, if you adopt the golden rule, "Do unto others, as you would that they should do unto you."

If in any instance you shall differ in opinion from

your co-attendant as to the nature of your patient's disease, or as to the treatment, whether you be the consultant or the ordinary attendant, do not estimate your own abilities as being far superior to those of your adjunct:—admit to yourself that you may perhaps be wrong in your views, and your brother right; and, with that feeling, quietly discuss the subject. If, however, you shall believe a continuance of the treatment to be fraught with danger, it will then be your duty to press for a change, and, if unsuccessful in your endeavour for change, you being the consultant, it may be necessary for you to retire from attendance on the case, unless a third practitioner be called in.

When called on to visit a patient in the absence of the ordinary attendant, or in consultation with him, be not anxious to make a change in the treatment, for the mere sake of appearing to do somewhat, and, perhaps, thereby filch away the credit from your brother; rather continue even the same formulæ, if it may be done consistently with your duty to the patient. Do not unnecessarily multiply your visits, nor by alarming the friends, when you are the consultant, induce them to request your too frequent attendance; but rather arrange with the ordinary attendant, the times at which you should return. On the other hand, if the patient shall have requested, either through you, or with your knowledge, the attendance of another practitioner in consultation with you, be not over anxious that the consultant should discontinue his attendance; but let every suggestion on that subject come either from the consultant himself, or from the patient or his family, unless your opinion be asked for. It may happen that the consultant, however careful he may be, cannot avoid holding conversation with the relatives of the patient, concerning the case, when the ordinary attendant is not present. He may be followed out of the house, or be waylaid in the streets, or called on at his own dwelling, and it may be sought to obtain an opinion from him. If you find yourselves so placed, it will be your duty to say as little as possible; avoiding, however, any innuendo against a brother, whether by significative silence, or shake of the head, or shrug of the shoulders, or an expression of regret that you were not sooner consulted, or that you fear it is now too late. In his absence, do your brother full justice, not grudgingly, nor damning him with faint praise. Avoid yourself questioning the friends of a patient, on whom you are not in attendance, as to his state. To do so, or to declare uninvited, that you take a great interest in his case, or that you have made such cases your especial study, is of very doubtful propriety, and might be deemed a not very indirect mode of seeking to be called in.

In any misunderstanding with a brother-practitioner, be slow to get into print: let newspaper warfare be the last resource; few come unscathed out of such a skirmish. In Belfast, with its Medico-Ethical Society, there can be no excuse for such a proceeding. The kind advice and interference of a senior may do much; but neither to the Ethical Committee, nor to any friend should reference be made, till an explanation shall have been first asked from your supposed offending brother.

Attacks made, in your presence, on the profession in

general, or against a member of it, in his absence, should be promptly repelled. You may, and perhaps should leave the defence of individuals to themselves, if present on the occasion of attack; but if it involve a charge against the profession generally, you, as a party accused or attacked, are called on for your defence.

It has been said, with truth, that the public is a hard taskmaster, and that society makes demands, often most unreasonable demands, on all who will admit such claims. It so happens that this said Public is pleased to consider medical men as bondmen, who are or should be but too happy to do its bidding. Much of this evil, for evil it is, is owing to ourselves, and we have little right to complain, if we suffer for our own weakness. This state of things will and must continue, till the profession shall act unitedly in asserting and defending their rights and privileges; but when will that day arrive? I may hope, but I scarcely expect to see it.

In former days, and of late there is no great change, medical men were considered fair game, whom it was good service to run down; and those novelists, and dramatists, and poets have been most lauded who, in the battue, succeeded in bagging the greatest number—you all are aware of the writers to whom I refer.

Of the high position which our profession has attained in literature and in science, it is not my province here to speak, but if any shall talk slightlying as to the position medical men hold, let us tell such men "it is very true, that distinctive rewards have not been showered with a lavish hand on doctors." True, that, in the distribution of honours for services rendered during the late war, the allocation has at times been in the inverse ratio of merit: true, that an enormous amount of labour fell to the share of the medical officers, and that the labour was most faithfully performed, though death was too often the result of their devotedness: yet they flagged not: —

"Their loyalty was still the same,
Whether it won or lost the game,
True as the dial to the sun,
Although it be not shined upon."

Society has, however, claims upon you that you should not ignore; amongst others, the right to call on you to aid in every good and charitable work, having first set an example; but even though the public may have failed to do its duty, you will not, therefore, be excusable for the non-performance of yours. The question of remuneration I leave in abeyance. Among the onerous and painful duties required, and fairly required of you, there is none demanding more patience, and entailing greater anxiety and sacrifice of time, than the being obliged to give evidence on medico-legal inquiries. You may be called suddenly and unexpectedly to give evidence, where there will be no opportunity for preparation, therefore neglect not the study of forensic medicine. While there is a legal obligation on all to give evidence, if subpoenaed, society holds that there is, in addition, a moral tie or compact by which medical men are bound, and by virtue of which the public claim a vested right to the time, attendance, and skill of the medical practitioner. Percival, to a certain extent, admitted the claim,

though neither you nor I can go the entire length of that eminent ethical authority.

Never volunteer your evidence, nor attend to give evidence, unless legally required. Witnesses, obliged to give evidence, have little or no power of controlling, or even directing it; they are subject to the examining barrister, who will promptly check any wandering that may not serve his client. Smith has compared the witness in our courts to “a harnessed horse in the hands of an able driver, whose duty it is to keep him in the direct road, and who will check and correct him if he wander from the right course.”

The witness can depose only to facts, excepting in what regards matters of science, when he, perhaps, may be permitted, or even called on to tender opinions; but some judges are opposed to such evidence, as being an usurpation of the rights of the jury.

In the witness box, avoid even the appearance of levity, no matter what may be the occasion. In giving your evidence, let not personal considerations have any weight; impartiality should be your guiding star:—Truth, no matter what the consequence may be, the one only thing to be elicited. Justice requires, at your hands, that the innocent shall go forth free and unstained, and that the guilty shall meet due punishment. On your evidence may depend, whether or not the murderer shall be loosed, still longer to infest society;—whether the innocent shall be restored to his family, or doomed to the hulk or the scaffold: when you remember your responsibility, so awful, you will be cautious.

On a late occasion (Palmer’s trial), Lord Campbell said:—“A witness should not be turned into an advocate, nor an advocate into a witness.” Be careful, therefore, that neither by speech nor gesture, you even appear to have a leaning to one side. Never fence nor endeavour to avoid a question; if the question be not clearly understood by you, quietly ask the questioner to repeat it. To questions of fact, answer briefly, if possible, yes or no, explaining afterwards, if needful; but state nothing unnecessarily. Give your evidence in plain terms, so as to be easily understood, avoiding obscure or very learned technical terms. If you be anxious to display your knowledge, you may easily do so; but you may get out of your depth, or you may be laughed at. Have a large stock of patience, you may, perhaps, require it all. Keep your temper, and display proper decorum, for though the examining counsel, by impertinent questions and an overbearing manner, may have forfeited all claim to your respect, yet your duty to the court should restrain ill temper, and cause you to avoid all skirmishing or intellectual warfare with the examining barrister, even though he may have left himself open to severe rejoinder. In reply to queries, state such facts as come within your own knowledge, and do not, unless required by the court, draw any inferences from the evidence given by others; if, however, having been present and heard the evidence given, you shall be asked your opinion as to the conclusions to be drawn therefrom, then give your opinion, which should spring only from well-grounded belief; be ready, if called on to state “the why and because.”

Addressing the medical scholar on the duties which he owes to himself, I speak to old as well as to young,

students and practitioners, for none are too old to learn. Remembering that “knowledge is power,” be earnest in the pursuit of science, which is the knowledge of the truth; and while you make medical science your chief aim, do not neglect general science, unless you are content to be outstripped in the race for distinction.

The spread of knowledge is now so universal that ignorance cannot hope for concealment. Think for a moment of the torture to which an ignorant man, in the witness box, may be subjected under the licensed rack of the cross-examining barrister, and then you will never permit the idea of contented mediocrity to cross your mind.

All your promptings should be onward, and if a stimulus be necessary to spur you forward, think how some have attained to eminence, notwithstanding every possible difficulty; not only do we know of men struggling upward in spite of poverty; but of others, ardent votaries of science, whose progress not even mental and bodily sufferings have arrested. If time permitted, what a crowd of illustrious names might I not parade before you. Need I remind you of Milton, and his blindness; of Prescott, the learned author of so many historical works; he also became blind, but continued his labours unabated; or is there any one here that has not read of the perseverance against difficulties, which led Franklin higher and higher till he reached the pinnacle of his greatness?

Again, some of you may have enjoyed the lectures of the late Sir W. Hamilton, Professor of Logic and Metaphysics in the Edinburgh University: he, though struck by paralysis of one side, affecting, to some extent, his speech also, nevertheless continued his labours, lecturing and writing almost till the close of his brilliant career.

But how far do all those examples fall short of the devoted zeal of the French historian Thierry, the author of the Conquest of England by the Normans, and of the Merovingian era. Afflictions, the result of his too intense study, were heaped upon him; he became blind, then paralysed, so that he could not even hold the pen, and he was quite incapable of motion; yet, as he himself said, never was his march over the difficult ground of history firmer or more assured than when he was guided onward by the brightness of the inward light alone. In the midst of his sufferings he preserved his cheerfulness, and his conversational powers, which were of the first order, continued unfailing to the end. Hear him speak in the preface to one of his works:

“Si j’avais à recommencer ma route, je prendrais celle qui m’a conduit ou je suis. Aveugle et souffrant, sans espoir et presque sans relâche, je puis rendre ce témoignage, qui de ma part, ne sera pas suspecte; il y a au monde quelque chose qui vaut mieux que les joissances matérielles, mieux que la fortune, mieux que la santé elle-même; c’est le dévouement à la science.”

Let the *faineant*, the sluggard, read this and blush.

After such examples, who would not strive? “You cannot all command, but you may deserve success,” therefore would I advise you to compete for every one of the few prizes our profession has to offer, and though unsuccessful, your labour will not be altogether

unprofitable, as you will have acquired knowledge, and have had an opportunity of making your value known.

To the observant physician, there is no such thing as chance; he knows that every effect or symptom has its cause; it is his duty to ascertain that cause, and to trace out the necessary sequence of cause and effect. Unless he do this, his practice will be mere empiricism; but if he observe accurately, inquire minutely, and reason coolly on what he has observed, he will do well. Some physicians, even in our days, owed much of their success to their powers of observation and their shrewdness in balancing probabilities. But on the correctness of his prognosis will the reputation of the practitioner, at least with the public, mainly depend. You should therefore be cautious in forming, still more in pronouncing it. To the family and friends it should be guarded, not gloomy; to the patient your prognosis should be as cheering as a strict adherence to truth will permit.

The young practitioner, just entering on his career, full of hope and trust, believes that medicine is all powerful, and that every disease must and will yield to his remedies; till, after sundry grievous disappointments, to him strange and unaccountable, he perhaps loses confidence in his own judgment, or becomes a sceptic as to the effects of medicine; avoid both these errors and success will crown your honest endeavours.

Be not anxious to cultivate one branch or department of medical or surgical practice, to the neglect of others; but make yourself familiar with all. On the question of specialties, much has been already, and more may yet be said, both for and against, and while some urge that specialties are apt to lead the practitioner to take a narrow or even a microscopic view of the favourite department to the neglect of others, perhaps more important, we can here point to examples of men, eminent in special branches, who are not behind their brethren in the other departments of medical science.

Avoid quackery, and discountenance it under whatsoever form it may appear, all advertising and other puffery included. As regards mesmerism, homoeopathy, hydropathy, kinesipathy, and all the other pathies, which have for some time been distracting or amusing the public, I will not for a moment detain you by arguments, as I feel satisfied that your love for true science will not permit you to be led astray by such ignes fatui.

The physician should not have any pecuniary interest in directing his prescriptions to a favourite establishment; but should ground on merit alone any recommendation he shall give; else his motives for prescribing may be suspected or misinterpreted.

In your converse with your brethren, be modest and unassuming, not prone to take offence, and to construe into intended insult every unguarded word or look. Men will avoid you if you be fretted by every trifle.

In conclusion, above all, do not go motive hunting, nor attribute to the jealousy of your fellows every disappointment you may experience:—Wait patiently—time is a great physician, and works wonderful cures in bringing every one to his proper level. I offer this as a brief and imperfect outline,

leaving for abler hands to fill in much that I have left untouched.

As regards the prosperity of the Clinico-Pathological Society, we have reason to feel confident: already we have above 120 members, and you will find on your notice paper the names of many candidates for admission. Since the close of our last session, however, death has made a sad inroad among us, and we have lost more than mere numbers can replace. It appears but as yesterday since our late President, Dr. Malcolm, commenced his career among us, in the morning of his life, so bright and sunny, full of hope and promise: and we have seen the hope and the promise disappointed, and his sun set; but it set unclouded and in full meridian brightness. The voice that addressed us so eloquently, but a few months since, is now for ever stilled, and the wise counsel, that aided, is lost to us; and yet we have much to cheer us, and to assure us that this society, of which he was one of the founders and chief supports, will go on prospering: for I hope and believe that his spirit still animates you, my friends, and that you will consider it a tribute due to his memory to take care that this institution, to which he was so devoted, and to which he gave so much of his energies, shall still flourish. On the other hand, if, through the apathy or wilful neglect of any of its members, its reputation should sink, or its usefulness be lessened, think how it would grieve him, were he present with us. Let us, then, all join in the determination, communicated to me by some of our members, that the loss of our late much loved President shall stimulate us to increased exertions, so that the Belfast Clinico-Pathological Society shall remain a lasting testimony of his exertions for the improvement of our profession and the spread of medical science. With a mind like his, and with such energy, had he been spared, what bounds could we put to his career? Ever pushing onward, difficulties never discouraged him, never arrested his progress; they served but as incitements to increased exertions, and he preferred to wear out rather than to rust out. Ardent himself in the pursuit of knowledge, he had the rare faculty of infusing the same spirit into those with whom he came in contact.

To you, our younger brethren, I would say, take him as your model. His watchword was *persevere*—“Nil actum reputans, si quid superasset agendum.”

Mr. BROWNE read a very interesting paper from Dr. Neligan, of Dublin, with reference to the last illness of the late Dr. Malcolm. Dr. M. was under treatment for a period of about two months before his death, which was caused by disease of the mitral and aortic valves, followed by enlargement of the liver, congestion of the lungs, effusion into the pericardium, and general dropsy.

SECOND MEETING

November 1st, 1856.

The President, Dr. M'Gee, in the Chair.

Mr. BROWNE exhibited the recent parts in a
*Case of malignant Disease of the Orbit and Base of the
Brain.*

The patient, a female, æt. 26, had been under observation for nearly three years. At first she complained of dimness of vision of the right eye, with a sense of pain in the temples and head on the same side; but the eye presented nothing remarkable, except a peculiar and very slight flickering motion of the globe and lids; the pupil acted under the stimulus of light, and the eyeball was natural in appearance. Sight was, however, very imperfect. After some time she complained of giddiness, when she attempted to walk, and of a throbbing or pulsating sensation over the right ear, which she described as being of a most painful character, and which she referred to a spot within the head, just corresponding to the central point of the squamous portion of the right temporal bone. Mr. B. diagnosed either an aneurism, or a malignant or other tumour, within the cranium. She continued to suffer severely from neuralgic pains in the right side of head and face, and the right eye became gradually very large and prominent, the cornea becoming opaque, the conjunctiva swollen, red, and œdematosus—the whole globe at last forming a large red, fleshy tumour, which occasionally bled, and which totally disfigured the face. Early in the present year, a medical gentleman urged the propriety of being permitted to extirpate the eye, and thus cure the disease, but the operation was declined. In May last she was admitted into the General Hospital, her sufferings were alleviated by anodynes, and she died upon the 26th. of October. Latterly, the left eye had become very sensitive, so that she could not endure the admission of any degree of light; and, indeed, her existence was more animal than intellectual. Upon a post-mortem examination, the tissues of the eyeball were found to be atrophied, but quite free from disease. The orbit was filled with a growth of scirrhouous character, being hard, yellow, and fibrous; the bones of the orbit were soft and degenerated. This growth extended backwards to the base of the brain, forming a tumour beneath its anterior and middle lobes, and engaging the bones of the roof of the orbit, and those of the middle fossa of the base of the skull. The cerebral substance of the lower surface of the middle lobe was somewhat softened, but the optic nerve was not diseased, its fibres being expanded over the new formation.

Dr. Seaton REID brought before the Society the following
Case of Acute Rheumatism with unusual Complications.

A girl, aged thirteen, was sent into the Union Fever Hospital, apparently suffering under the early symptoms of fever; these continued for three days after her admission, when the right ankle joint became red, swollen, and painful, then the metacarpal joint of the left little finger, then the left ankle joint, and lastly the metacarpal joint of the right fore-finger; the febrile

symptoms were rather intense, the pulse varying from 114 to 132.

On the eighth day of her illness, and the fourth of the affection of the joints, some lividity and vesication appeared on the left hand which rapidly passed into a gangrenous state as high as the wrist, where, in a few days, a line of demarcation formed. On the second day of the gangrene no pulse could be felt in the left radial artery, but it was still distinct in the brachial.

The cause of her illness was referred to frequent bathing in the sea when heated by carrying a child to the seaside; she lived in rather a comfortable family, and appeared to have been properly fed. Her death took place on the eleventh day of the joint affection. The most careful and repeated examinations during her illness failed to detect any signs of an affection of the heart, so that the gangrene could not be ascribed to the detachment of any inflammatory deposit on the endocardium, and consequent stoppage of the circulation by it in any of the smaller arteries. Dr. Seaton Reid consequently considered the cause to be an extension of the inflammation from the smaller to the larger vessels of the hand and wrist, and consequent plugging up of the artery. This view he considered all but certain, from his finding, a few weeks afterwards, that the posterior tibial artery was closed for a short distance by an adherent plug in a rheumatic patient whose limb was apparently passing rapidly into a state of gangrene, when he died with head symptoms associated with pericarditis, the post-mortem finding no trace of endocarditis.

The only extent to which the post-mortem examination in this girl could be made, was to ascertain that the ankle joint was filled with bloody pus; pus had previously been found by others and by Dr. Reid in the joints of rheumatic patients, but he could not find any record of mortification as one of the possible results of rheumatism.

Dr. R. BRYCE brought before the Society
A remarkable Example of an Acephalous Fœtus.

The mother, unmarried, quickened about the usual period, and the movements of the foetus were felt until within three or four days of her confinement, which took place about the seventh month. Dr. Murney had kindly undertaken to examine the anatomical peculiarities of the specimen, and the following is the report:—“The head presented a very remarkable appearance, it was perfectly flat from the roofs of the orbits backwards; there was no appearance of any attempt at development of the bones of the sides or roof of the cranium. There was no trace of any of the nervous centres. The bony portion of the spine was very imperfectly formed, showing only the bodies and transverse processes of the vertebrae; the nerves in the upper and lower extremities were largely developed, and upon careful dissection, were found distributed in the normal manner; those of the limbs were traced to their so-called origin, which proved to be the lower part of the cauda equina. The semilunar and lumbar ganglions of the sympathetic were well formed and natural. The heart and other viscera of the thorax were healthy and normal. The contents of the abdomen were also

healthy, the only point worthy of notice being the site of origin of the duodenum. The stomach was of the usual shape, the pyloric extremity was well formed, but had not the duodenum attached to it; this latter sprung from the posterior part of the middle of the great curvature."

Dr. BECK showed some slices from the
*Uterine Surface of a Placenta, covered with a thin Layer
of apparently crystallised calcareous Matter.*

From the effects of tests, he concluded that these concretions consisted of phosphate of lime, and he was of opinion that nearly 7 per cent. of placenta at the full term will be found to contain crystals of such nature.

Dr. BECK also read a paper detailing the history of another

Case of Acephalous Fœtus.

A very large quantity of liquor amnii was evacuated. He had some difficulty at first in making up his mind as to the nature of the presentation, but after careful and repeated examinations, he was enabled to make a correct diagnosis. When expelled, he found that the brain and its bony covering were entirely wanting, and the site occupied by a purple membrane, resembling in appearance the membrane of the placenta. The eyes were wide open, and appeared to project very much, as there were no sockets. The body, limbs, genitals, &c., appeared to be perfect. It was a female, and the patient's third child, the full period of utero-gestation was completed. This was the third acephalous foetus Dr. Beck had met with in about two thousand cases, and all were females.

THIRD MEETING

November 8th, 1856.

The President, Dr. McGee, in the Chair.

The Secretary read a communication from Dr. BABINGTON, containing the account of an interesting

Case of Epithelial Cancer of the Hand, accompanied by the pathological specimen. The following is the abstract of the case:—"Hand of Harper, æt. 55, amputated in County Londonderry Infirmary, on 27th. October. The disease commenced eighteen months since, by a warty excrescence which soon ulcerated, and spread. Previous to his admission into hospital, he was treated, first, with poultices, latterly with what he describes as burning plaster. He has lost much flesh and strength. The pain of the hand is of a burning character, and very severe; it quite prevents his sleep. The smell from the surface of the sore is very peculiar, offensive and nauseating. The glands in the axilla or at the bend of arm, are not engaged or enlarged. He earnestly requested amputation. Since the operation he has gone on satisfactorily. The stump is nearly healed. Dr. B. inclined to look upon the disease as *Epithelial Cancer.*" See Paget's *Surgical Pathology*, vol. ii. pp. 415, 416, 417.

Dr. MURNEY stated that he had examined portions of the diseased structure under the microscope, and from the appearances there seen, in conjunction with the

history of the case, there was no doubt the opinion of Dr. B. was perfectly correct.

Dr. SEATON REID exhibited the kidneys of a man who had been a patient in the Union Hospital, with a very small amount of

Ascites and Anasarca.

His urine was of sp. gr. 1,011, and contained albumen. A few days after admission he began to vomit in the morning, his sight was impaired, and he became daily more drowsy and oppressed, and finally quite comatose, dying about the fifteenth day after vomiting commenced, but without any convulsion. Dr. Reid considered it a good case to test the opinions of those who consider that the symptoms of poisoning in albuminuria are dependent on carbonate of ammonia in the blood, rather than on urea, and who state that carbonate of ammonia can be detected in the expired air, when a rod dipped in muriatic acid is brought near the mouth; but in this case he had failed, as on some previous occasions, to detect any. The noise made during the comatose state in this patient by the air passing in through the lips, had a most marked resemblance to the noisy inspiration in the consecutive fever of Asiatic cholera. The kidneys were found greatly contracted; the tubular structure almost entirely destroyed; the surface of the kidneys quite rough, and the substance under the microscope showing a great amount of fat. Two or three small cysts were found immediately underneath the capsule containing an amber-coloured fluid.

Dr. PIRRIE read the history of a

Case of Retroversion of the Uterus.

Mary McCullagh, æt. 45 years, mother of eleven children; after the birth of the first child she had prolapsus uteri. She ceased to menstruate three or four months ago, and, after some time, from certain sensations in the breasts, morning sickness, &c., she was satisfied that she was pregnant. She is accustomed to hard, out door work. Upon Sunday, October 26th, she found that she was unable to pass water, and upon the following day had above five pints drawn off at the dispensary. As it was discovered that the retention depended upon retroversion of the uterus, and that a similar accident had happened during a former pregnancy, she was sent to the General Hospital, where she was admitted about the 30th. of October, suffering from retention of urine. Upon examination it was found that the vagina was almost obstructed by a large tumour, and that the os uteri could not be felt at all; on a second examination, by placing the patient on her hands and knees, and introducing two fingers into the vagina, the lower tegument of the cervix and os uteri was felt above and behind the symphysis pubis. On Thursday, November 5, some efforts were made to restore the retroverted uterus to its normal position, but owing to the opposition of the woman from nervous terror, they were not persisted in. November 6, McCullagh reported this morning that she passed water naturally, and on examination it was found that the uterus had resumed its natural position. The os uteri could now be easily felt. Nov. 18, the patient has

since aborted.

The PRESIDENT related the history of a
Case of Steatomatous Tumour of the Breast.

On examination he found a flattened oval tumour two and a-quarter by one three-quarters inches. The patient stated that she had, about fifteen years ago, felt a small, hard, painless tumour, in size less than a large pea, which slowly increased to the size of a nutmeg, and this remained stationary for eight or ten years. That about two or three months ago it again began to increase, until it attained the size of a walnut; a few days before his seeing her, the tumour became painful, but the pain was not of a lancinating character. The tumour was freely moveable, and not hard nor nodulated. Tincture of iodine was painted over its surface, and other treatment adopted. In a short time, however, it was evident that suppuration was taking place. Poultices were applied and the matter evacuated, after which, a white membrane-like substance was observed at the bottom of the wound, which latter had an unhealthy appearance. A director was introduced, as a scoop, and he was then enabled to remove piece-meal what proved to be the sac or capsule of a steatomatous tumour, with its dirty yellow granular contents, leaving a deep cavity. In this case suppuration had taken place between the sac and the neighbouring tissues; such a result the President believed to be rare, except in steatomatous tumours of the scalp.

Mr. BROWNE referred to a case of Congenital Cataract, which he will again bring before the notice of the Society.

FOURTH MEETING

November 15th, 1856.

The President, Dr. M'Gee, in the Chair.

Mr. H. M. JOHNSTON introduced a patient affected with *Paralysis of Sensation over the cutaneous Surface of the greater Portion of the Thorax.*

Henry Lackey, æt. sixty years, presented himself at the Dispensary, on Wednesday, November 12th, complaining of severe neuralgic pains, shooting from the right side around the chest, and felt most severely at the angle of the left scapula. In addition, he complains of a numbness, and absence of feeling over the mammary, inframammary, and scapular regions. In the same localities, he has a feeling of itchiness, but this is considered by him to be beneath the skin. He often feels as if hide-bound. On examination I could detect no appearance of any skin disease; but no sensation of pain can be roused by pinching the skin in the regions mentioned above; you may even pass a knife through the skin, or pinch the nipples, without the patient being cognizant or making any complaint; when, however, you pinch him deeper than the skin he is sensible of pain; and as stated above, he believes that the sensation of itchiness exists beneath the surface. He has a pale, anaemic look; but he always enjoyed good health until about three years since, when he found, at

the angle of the right scapula, a patch of skin about the size of a half-crown, numb and devoid of feeling. This gradually extended itself entirely around the chest, until it now engages the regions referred to. About two years since, the itchiness and neuralgic pains attracted his attention, and from these symptoms he now seeks to be relieved. At times the pains are very severe, causing sickness of the stomach, and preventing him from continuing his work. His pulse is about sixty, regular. Digestive functions healthy; in fact, no evidence of organic disease of any of the viscera or cerebro-spinal system exists. A discussion ensued in respect to the pathology of this case; some of the members thought it was a form of neuralgia, others, that the seat of the disease was in the spinal marrow, there being some slight tenderness over the ninth or tenth dorsal vertebra. The patient is daily engaged weaving.

Dr. James MOORE introduced a patient upon whom he had performed

Excision of the Elbow Joint,
some four months ago, on account of gelatinous degeneration of the synovial membrane and its sequences. Prior to the operation the joint was enlarged, stiff, and painful. The arm was nearly straight. At present she possesses a healthy joint, capable of almost perfect flexion, pronation, and supination, and she can use her hand with perfect freedom. Dr. Moore believed that the want of success in such operations depended upon the too free incisions of the skin, and the removal of too small a quantity of bone. Dr. M. exhibited a fatty tumour, about one pound and a-half in weight, nodulated with finger-like projections around its margins; it was taken from the superior surface of the deltoid muscle, on which it was placed, immediately beneath the skin. Before removal, it presented a roundish form. An incision being made, the bands of cellular tissue were divided, and thus he enucleated *seriatim* its several processes, which extended themselves deeply on either side of the shoulder, and close to the joint. The growth was of some eight months' duration. Dr. MOORE referred to the usual location of such tumours in the neighbourhood.

Dr. CORRY exhibited a button with a *lumbricus* entangled in its eye. A patient had accidentally swallowed the button, which had thus acted as a novel anthelmintic.

Dr. BECK exhibited the gizzard of a fowl, with a nail imbedded in its muscular substance. Surrounding the nail there was apparently a gangrenous slough, but there were no evidences of any inflammatory process.

FIFTH MEETING

November 22nd, 1856.

The President in the Chair.

Dr. PIRRIE placed before the Society a very interesting Specimen of *Hypertrophied Heart,*

weighing 21 oz, the normal weight being about 8 oz. The patient, Martha Clarke, aged 57 years, a cook, was first admitted into Frederick-street hospital in December, 1855, suffering from haemoptysis, at that time supposed to be connected with hypertrophy of the heart. She was again admitted in July, 1856, labouring under dyspnoea, with thirst, sickness of stomach, and great debility. The points of middle and little finger were gangrenous, the radial artery was enlarged and tortuous, its pulsations were visible; there was considerable dulness over the cardiac region; the heart's action was increased in force, but not in frequency, no valvular murmur, or other evidence of disease of valves, the sounds were loud and distinct; no dropsey. The gangrene extended until it engaged the hand, the lungs became very much congested, dyspnoea urgent, and patient died rather suddenly, on November 22nd, 1856. No history of any rheumatic attack could be traced. Dr. Murney, who made the post-mortem examination, stated that the heart weighed 21 oz., that the valves were healthy, that no trace of atheromatous deposit could be detected on the coats of the aorta, brachial, or upper parts of radial or ulnar arteries. The right hand was injected from both radial and ulnar vessels. On dissection, the digital trunk for the supply of the ulnar side of the little finger was found much smaller than usual, that which supplied the radial border of the same finger was a good deal larger than natural, so that we might infer an ample supply of blood could be received from the single trunk, even suppose the small vessels were obliterated. He considered there were no evidences of arteritis, and that we must attribute the affection to a debilitated condition of the part, which, when subjected to inflammatory action, was unable to pass through the grades of that process, but immediately perished.

Dr. YOUNG read a

Case of Obstruction of the Bowels.

M. D., a farmer, was a martyr to constipated bowels, for which he was in the habit of dosing himself with blue pill, salts, and senna; he was occasionally subject to slight pain in the descending colon; and a severe attack, which resisted the usual remedies, was the cause of Dr. Young's being sent for. There was neither constitutional irritation, nor pain on pressure, nor any evidence of a tumour. The symptoms were relieved by a dose of castor oil, combined with antispasmodics; the medicine did not affect the bowels, which had not been opened for 24 hours. The following day the pain was as severe as before, the bowels being still confined. Enemata of oil and turpentine were administered, but were returned; and mercurial purges failed to produce any effect upon the bowels. Leeches were applied to the seat of pain; 12 hours elapsed, the pain became much more severe, and the whole of the affected region tender to the touch, pulse frequent, tongue foul, and urine passed every ten minutes; during a paroxysm some relief was afforded by using O'Beirne's tube, but the bowels were not moved, and in a little time his sufferings again were so intense, that his friends anticipated his death. The enema was repeated, leeches applied anteriorly, and a blister posteriorly, blue pill

steadily continued, and anodynes administered. The urine was examined, and found healthy. Upon the fourth day there were some evacuations from the bowels, which were almost white, but no appearance of scybalæ or gall-stones. The paroxysms of pain now recurred at longer intervals, and were still confined to left side; being somewhat periodic in their recurrence, quinine was prescribed, in conjunction with opium. Great relief was obtained by putting the feet into warm water. In ten days the patient was convalescent; the obstruction here only lasted three and a half days; the bile did not appear in the stools for a week. Dr. Young regarded the case as one of spasmodic irritation of the colon, produced by the passage through the bowels of undigested food. The suppression of bile, he believed, was owing to the patient's injudicious system of stimulating the liver by blue pill and aperients, this being followed by a temporary suspension of its functions.

Dr. Seaton REID thought gall-stones were the cause of the attack.

Prof. FERGUSON coincided in this opinion, adding, that not finding gall-stones in the evacuations is no proof of their absence.

Dr. DILL related the history of a

Case of Internal Strangulation.

G. M'C., æt. 17, a stout healthy-looking ship carpenter, was admitted into Frederick-street hospital, on the 17th. September, for obstruction of the bowels. He was quite well until the evening of the 11th, when he was seized with a severe pain in his bowels, shortly after having partaken, rather heartily, of a meal of potatoes. Vomiting commenced during the night, and continued at intervals until morning; he was then visited by Dr. James Smith, who found him with a pulse about 80, no fever, tongue coated with a thick white fur, very slight tenderness upon pressure over the abdomen, and not much distension. He ordered pills of colocynth and calomel, to be followed by a castor oil draught; turpentine stapes to abdomen. Sep. 13th. Dr. S. found that the pills and draught had been rejected, the bowels were still unopened. Patient's state was much the same as yesterday. Pills of calomel and opium were prescribed, sinapisms over the abdomen, and the oil draught repeated. Sep. 14th. For a little the vomiting ceased after he had taken the pills, but it had returned, and the symptoms were rather aggravated. The abdomen was now becoming tympanitic, but not tender; expression anxious; pulse 80. The pills were continued, stapes applied, and enemata administered; these latter were returned, and the symptoms were unrelieved, and there being now little doubt but that some obstruction of the bowels, of an obscure but grave character, existed, he was sent to hospital, where a large blister was applied over the abdomen, and much the same plan of treatment followed as before admission. No relief was afforded, the vomiting continued, the abdomen became more distended, the pulse frequent and weak; and he died exhausted, upon Sep. 19th, the third day after admission into hospital, and the seventh of his illness. A post-mortem examination was made a few hours after death, when the

peritoneum was found very much congested, but no lymph or fluid effused, or other evidence of inflammation. The upper portion of the small intestine was greatly distended, and formed a striking contrast with the lower third, which was small, contracted, and had a dark congested appearance. Upon close examination, this portion was discovered to be tightly encircled by a band which entirely prevented the transit of the contents of the canal. This band was narrow, resembling very much a thin piece of omentum. It was attached above in the right hypochondrium, and after constricting the intestine was found tied down in the left iliac fossa. Such being the cause of the obstruction, it was evident no medicinal agents could have been of any avail.

Dr. James MOORE showed

Six Specimens of Urethral Calculi, which he had removed upon different occasions. He referred to the history of the cases, and to the mode by which he effected their removal.

SIXTH MEETING
November 29th, 1856.
The President in the Chair.

Case of Apoplexy.

Dr. DILL presented a brain removed from the body of a patient, A. B., aged 72 years, who was found lying insensible and collapsed at a late hour, being a night watchman. He was removed to hospital, where he remained in a state of complete unconsciousness for 36 hours. Under the use of stimulants, &c., &c., he gradually recovered his mental and physical powers. He continued to improve for six days, when coma suddenly supervened, and he died in six hours after. On examination, 24 hours after death, a very large quantity of serum escaped from the arachnoid cavity; a large clot of blood was found lying upon the upper and posterior surface of the right hemisphere of the cerebrum. Extending from this point, anteriorly, there was a more superficial extravasation, as seen in the specimen. An animated discussion followed, in regard to the propriety of bleeding in cases of apoplexy, the opinion of the majority of the Society being, that at present such practice should be adopted with great caution, and in very few cases.

The Secretary read a paper communicated by Mr. GRAHAM (Templepatrick), upon a

Case of Anasarca and Puerperal Convulsions,
terminating fatally before delivery.

March 20th, 1855, Dr. Graham visited Mrs. A., æt. 22 years. She was then in the end of the eighth month of uterogestation, being her first pregnancy. She had enjoyed very good health until about two months before being seen by Dr. G.; at that time her feet and limbs began to swell, and now there was anasarca of the entire body. The eyelids were so distended, that she was unable to open them. For two weeks past she had been much annoyed with headache, and the bowels were constipated. The urine was secreted in

very small quantity, and upon being tested afforded no evidence of albumen. She was treated with diuretics and purgatives, and there was a decided improvement in her symptoms until the morning of the 27th, when Dr. G. was called to see her, as she had been seized with a "fit." He found her seated at the fire, complaining of severe headache, and rather incoherent. He bled her freely, after which she expressed herself relieved. The hair was cut, cold water constantly applied to the head, and a draught of castor-oil and turpentine administered. At this period the movements of the child were strong, and the foetal pulsations distinct, but on examination there was no evidence of labour having commenced. Dr. G. saw her again at three o'clock, p.m.; she had five attacks during his absence, and was now unconscious. He bled her again, but not so freely, after which she answered questions that were put to her. An enema was administered, which acted satisfactorily. There was great restlessness and tossing, and the tongue had been very much lacerated. In a little time another strong convulsive attack occurred, in which she died. The child was alive for some minutes after the respiration and circulation of the mother had ceased, but no interference would be permitted. Dr. FERGUSON did not think that this case could come properly under the category of puerperal convulsions. He considered it one of albuminuria; and he wished to draw attention to the fact, that towards the close of such cases it often happened that the albumen disappeared, neither heat nor nitric acid affording any evidence of its presence. The sp. gr., however, continued low, and he attached much weight to this.

Dr. BECK read a paper on a

Case of Puerperal Convulsions.

March 7th, 1856, he was called to visit M. M. C., æt. 20 years. He was informed that she had dropsy, and had been working in convulsions for 16 hours. He found his patient to be a muscular, stout woman. She was strongly convulsed; her face was gorged with blood, and her features distorted. Her lower extremities were enormously swollen; the abdomen was larger than usual at the full time of gestation. She was unmarried, and having concealed the fact of her pregnancy, had been under treatment for "dropsy" for two months past; and even since the convulsive seizure, a blister had been applied to the nape of neck. Dr. B. suspecting that there was an eccentric cause, at once proceeded to make a vaginal examination, and was not surprised to discover a soft os-uteri, pretty well dilated, with the membranes tense and projecting. He bled her to about 30oz., and ruptured the membranes: in a few minutes she was delivered of a male child of about eight months. On again examining, he found a second bag of waters, which being ruptured, the feet of a second foetus came into his hand. This passed easily; both were dead. The convulsions had now ceased, but she was comatose. A large dose of calomel was given, and the blister dressed with mercurial ointment. The convulsions did not return; the oedema disappeared; and in a few days she became quite sensible, but had no recollection of what had taken place.

SEVENTH MEETING
December 6th, 1856.
The President in the Chair.

Case of Disease of Right Side of the Heart.

Dr. PIRRIE exhibited a heart removed from the body of Margaret Murphy, æt. 24 years, a sempstress, who was admitted into the General Hospital on the 28th. of October. She had been ailing for about 10 days before admission, and was evidently labouring under an attack of acute rheumatism. She complained of pain in the cardiac region, and had some dyspnoea. At this time the affection of the joints was not very acute. A loud bruit was heard, most audible at the base of the heart. From the history of the case, and other symptoms, Dr. P. inferred that there had been pre-existing heart disease; however, shortly after her admission, an acute attack of endocarditis supervened, as evidenced by rational symptoms, and by a modification in the tone and intensity of the pre-existing abnormal sounds. Under treatment she gradually improved, and was considered convalescent, when a sudden attack of difficulty of breathing seized her, attended by great prostration, and followed by death, after six hours' agony, on 28th. November, one month after admission. On making a post-mortem examination, the right side of heart was found much distended with venous blood; there was considerable hypertrophy, with dilatation, especially of the right ventricle and pulmonary artery. The tricuspid and pulmonary semilunar valves were thickened, and covered with fibrous vegetations. The margins of the aortic semilunar valves were also roughened by fibrous deposit, but not to the same extent as the pulmonary and tricuspid. The mitral valves were smooth and perfect. Dr. P. considered that the interest of this case lay in the fact, that the right side of the heart was found to be the chief seat of disease, which we know is contrary to the general law.

Dr. Seaton REID referred to a case with which he had met some years since, and in which he believed the pulmonary semilunar valves to have been those solely affected. Under mercurialization the symptoms were removed, and the patient recovered.

Mr. HARKIN read the following interesting history of a
Case of Cerebral Disease.

D. C., æt. 47 years, by profession an architect, had been suffering from general paralysis for several months before I saw him. The disease manifested itself at first by a severe pain in the tongue, for which, having been unsuccessful in obtaining relief in this town, he consulted Mr. COLLES. That gentleman immediately pronounced the ailment as a symptom of incipient cerebral disease, and described to his ordinary medical attendant the future symptoms most accurately, just as they afterwards occurred, terminating at length in mental aberration, paralysis, and death. The first symptom of derangement which he exhibited happened while superintending the erection of the savings bank in Waterford, several of his Belfast friends having been favoured every week, for some time, by a present through the post of "hat almanacs;" and this circumstance led his friends to pay more attention to

his state, and finally to put him under strict surveillance. His symptoms gradually increased: constant headache, occasional epileptic attacks, paralysis of upper and lower extremities, loss of hearing, of voice, &c.; ending in complete mental imbecility. When I first saw him, he had been ill for 18 months; all his senses absent but those of touch and vision. He uttered piteous moans when anyone approached him, was suffering from bed-sores which he could not bear to have examined, voided all his evacuations involuntarily, and died at last in a complete state of marasmus. On removing the cranium, a few hours after death, the dura mater was found attached to it in several places by bony deposits, particularly in the vicinity of the frontal eminences; their shape was circular, and their diameter about an inch in extent. The arachnoid appeared much thickened, and was separated from the pia mater, throughout its whole extent, by serum and coagulated lymph. The substance of the brain was flabby, and much softer than natural, and the distinctions between the cortical and medullary substances almost entirely obliterated. The spinal marrow was very much reduced in size, but firm. The serous fluid measured fully 12 ozs., and had penetrated between every convolution of the cerebrum and cerebellum, extending even to the spinal canal. The ventricles were quite distended with serum, communicating with the general mass of effused fluid through the infundibulum. The inner surface of the ventricles was highly vascular, and the corpora fimbriata were studded over with small hydatid-looking vesicles. The nerves and their origins appeared in a perfectly normal condition, with the exception of the fifth of the right side, which was considerably wasted and softened. The basilar and other arteries were unusually developed, and contained numerous coagula, but whether cadaveric or not was not apparent. There was great engorgement and congestion of all the vessels, more strongly marked in the vicinity of the pineal gland and corpora quadrigemina. There was not any opportunity afforded of weighing the brain.

EIGHTH MEETING
December 13th, 1856.
The President in the Chair.

Case of Suspected Abdominal Aneurism.

Surgeon HARKIN introduced a patient, R. K., æt. 27 years. The nature of his disease he considered obscure, and he wished to have the opinion of the members as to whether an abdominal aneurism existed or not. Since July 17th. he had attended him repeatedly, owing to his being seized with sudden fits of fainting and debility. On examination Mr. Harkin discovered a strongly marked abdominal pulsation, and a loud bruit de soufflet, which was heard most distinctly to the extent of three inches from the umbilicus, in a direction towards the right costal cartilages. Though there were no indications of anaemia, he was decidedly of an hysterical temperament. The opinion of the Society generally was, that no organic disease existed, but that the case was one of a functional derangement,

probably depending on gastro-intestinal irritation.

The Secretary presented, from Dr. HANNAY, of Lurgan, a series of engravings of pathological specimens in the Military Hospital. The Secretary was directed to convey to Dr. Hannay the thanks of the Society for his contribution to the Museum.

Mr. BROWNE exhibited a

Fatty Tumor removed from the region of the Axilla.

It weighed four pounds, and was of four years' growth. He was of opinion that the disease originated in a fatty degeneration of the glandular structure, the outline of a number of these being still distinct in the morbid mass.

Dr. Seaton REID exhibited

Diseased Ovaries, Kidneys, and Bladder, recently removed from a patient who died in the Union Hospital. The patient had been sent in suffering under dysenteric symptoms of eight days' duration, associated with vomiting, and frequent calls to pass urine, with much pain in the region of the bladder. At the first visit the dysuria was looked upon as sympathetic with the irritation in the rectum, but on being much complained of on the next day, it led to a more minute examination of the region of the bladder, where an elastic tumor, evidently containing fluid, and partially moveable, was discovered. As it was possible to be a distended bladder, the catheter was passed, but failed to obtain any urine, and it was then considered to be ovarian. The patient's age was near 40, and she stated that she had been pregnant five or six times, that she had ceased to menstruate at the age of 31, and that for the last year she had suffered much from frequent calls to pass urine, and pain in the hypogastric region. The catheter was passed a second time, but failed to obtain any urine for the purpose of examination. The vomiting continued, the evacuations, which at first were yellow and fluid, became now bloody and rather viscid, and she died at the end of 48 hours more, without convulsion, and remaining sensible till near the close. On post-mortem examination both ovaries were found diseased, the right was considerably the larger, and on its being laid open, a band with a rugged edge was found encircling the interior, most probably the remains of a cyst that had burst at some former period, and there was also found a small sessile cyst, containing a reddish fluid; the left ovary was changed into one cyst, containing a clear fluid. The uterus had become reduced in size to that of a very small virgin uterus. The bladder was found contracted, greatly thickened, and rough internally, and containing a small quantity of bloody purulent fluid; the ureters were widened and thickened, the pelvis of both kidneys enlarged, and containing a fluid similar to that in the bladder, the lining membrane of the right was found granular, and had numerous bloody points on an ash-coloured surface; the membrane of the other pelvis, although thickened, still remained smooth. Dr. Reid considered that we were justified in supposing that the cessation of the catamenia at the age of 31 was indicative of the commencement of the ovarian

disease, as she was then too young to suppose it had ceased in the ordinary course of events. The well known sympathy of the bladder, with an irritated rectum, caused him to overlook at first the serious vesical disease, which had been in existence for the previous year, and the exhaustion and irritation of which were no doubt the cause of her death. He also suggested whether the vomiting and dysenteric symptoms were not indicative of an attempt to establish a vicarious discharge from the stomach and bowels, for the purpose of eliminating the urea, which the diseased state of the kidneys prevented from passing off in the usual way. This view he considered supported by a case recently published by Dr. M'Dowell, of Dublin, in which urea was detected in the vomited matters; and also by the fact that dysenteric symptoms are not uncommon in the advanced stage of Bright's disease, and that in this patient no ulceration was found on either the small or large intestine, the lining membrane being only intensely engorged, or perhaps inflamed. Dr. Reid also considered some interest was connected with the withering effect the ovarian disease had exercised upon the uterus, reducing it to so small a size, after giving birth to five or six children, and when the female had only reached the age of 40.

Dr. T. C. CORRY, presented the

Dismembered Remains of a full-grown Fœtus, the history of the case conveying a sad lesson of obstetric practice in the hands of uneducated midwives. December 10th, he was requested to visit a poor unmarried and unfortunate woman, æt. 35 years, who had been 48 hours in labour. This was her first confinement; and on enquiry, Dr. Corry found that there had been an arm presentation, but the midwife, in her anxiety to effect delivery, had torn it from the body; he subsequently discovered that one of the thighs was fractured, the body having been forcibly brought down, and from the extractive force which had been applied, that the body was now barely attached to the neck by but a slender fold of integument, which giving way, the uterus contracted upon the head and neck. Dr. Corry now obtained the valuable assistance of Dr. Dill, and with difficulty they succeeded in emptying the uterus of its contents. Craniotomy having been first performed, the common blunt hook was found too short to be of any service. Dr. Dill suggested the use of an extractor made for the occasion, resembling somewhat the crochet, only longer. The operation was performed when the patient was under the influence of chloroform. She never rallied, but died from exhaustion in about 48 hours after.

NINETH MEETING

December 20th, 1856.

The President in the Chair.

Dr. HALLIDAY brought before the Society a young female aged 13 years, having a

Tumor in the Hypogastric Region, the nature of which was very obscure. Her mother stated that she had observed it for the first time, about

two months ago, since which period it had continued to increase, until it had now attained the size of a melon. There were no evidences of puberty, the menses had never appeared, and her health seemed good, urine was passed freely, and the bowels were acting. The tumor, however, was somewhat painful, without any discoloration. The Members were divided in opinion as to whether it might arise from obstructed menses, impacted faeces, or be of a malignant nature.

Dr. MURNEY exhibited a

Specimen of a Deformed Skeleton,

and gave some account of its peculiarities. About three years ago, the subject of this notice, a man about 40 or 45 years of age, was admitted into the hospital, labouring under bronchitis. From his inability to speak any but the Irish language, his place of birth, precise age, &c., could not be ascertained. After remaining some time in hospital he succumbed to the bronchitis. Among the peculiarities described were the following: About the base of the skull, the different muscular impressions were remarkably prominent; the spine presented the unusual arrangement of a sixth lumbar vertebra, the adjacent dorsal and sacral regions being composed of the usual number of parts. The axis, or second cervical bone, was well shaped in every respect, save that there was no development of the odontoid process. It could not be ascertained if the ligaments which connected the head to the spine presented any peculiarity, as the absence of this process was unknown until the complete maceration of the specimen had been effected. All the bones of the extremities were, as nearly as possible, about half the average length, considerably curved, and presenting the muscular impressions in a most exaggerated form. The head of the femur and humerus were almost completely flattened out, and the trochanters and insertion of the deltoid were enormously developed. Some of the long bones of a tiger were shown, and the many points of resemblance between those and the skeleton were dwelt upon; Dr. Murney remarking, that this but corroborated the frequently repeated observation, that in cases of variation from the normal standard in the human subject, we have the natural condition of some other portion of the animal kingdom assumed; he also directed attention to the remarkably curved condition of the bones in both forearms, more particularly the radii, the appearance naturally suggesting the idea of ostio-malakia, or mollities ossium; this he considered of some little interest, as all the cases which have been described of that disease have occurred in the female.

The Secretary read a communication from Surgeon M'GOWAN (Tanderagee), detailing the history of a
Case of injury of the Scrotum,

caused by the horn of a cow. The testicle protruded, the tunica vaginalis being quite exposed. Under judicious treatment, the wound healed in a few days, without a bad feature, no symptoms of inflammation of the testicle having been manifested. Dr. MURNEY narrated the history of a similar case.

The Secretary read a paper contributed by Dr. H. THOMPSON (Omagh), on a case of

Paracentesis Vesicæ.

William Elkin, æt. 80, affected with symptoms of prostatic disease for some years, was seized with complete retention on the 31st. January, 1856. I saw him on the 4th. of February. Many vain attempts had been made to pass an instrument, and the urethra was riddled with false passages; in order to give these a chance of closing, I deferred any attempt at relieving him until the following day, having prescribed a hot bath and a purgative, which he required. On the 5th. I tried to get in an instrument, but could not succeed; so I had no alternative but to tap the bladder, which was accordingly done by means of a long curved trocar and canula, above the pubis. A gallon of high-coloured urine flowed away, with complete relief. I left in the canula for two days, and then replaced it by a gum-elastic catheter, to the free end of which I attached a large-sized Indian rubber ball, fitted with a quill and a peg, by way of a stopcock, which acted as an artificial bladder, and succeeded perfectly in keeping him dry and comfortable; he went on in this way very well until the 25th. February, when I made another attempt to pass a catheter per urethram, and with great difficulty got through No. 6; the prostate was much enlarged laterally, and the passage through it seemed to be very narrow and tortuous. The instrument was left in for a few hours, but finding that he could not bear it, that its presence, whenever attempted, produced a tendency to urinary fever, and considering the extreme difficulty of passing the instrument, and the determination of the old man not to leave his home, which was at too great a distance to admit of his being regularly attended, even supposing the use of the instrument had been unattended by any bad consequences, I had no other course open to me but to leave him as he was. He has been ever since in the state described above, with the catheter constantly in the bladder, through the opening above the pubis, and the ball receiving the urine as it flows away. He suspends it to one of his buttons, and walks about his farm, much more at ease than he had been for some months before the operation. I certainly never saw, and I do not remember to have read of, a case in which an instrument was retained in the bladder for so long a time. It tends to prove that the bad effects which so frequently follow the continued use of an instrument in these cases depend more upon irritation of the prostate than on the coats of the bladder, and that in cases similar to this, there is a better chance of prolonging life by the proceedings here adopted than by persevering in the use of the catheter in the usual way. The catheters are of course changed as they wear out.

TENTH MEETING
Saturday, January 3rd, 1857.
The President in the Chair.

Dr. HEANY read the history of the following
Case of Puerperal Convulsions, followed by Mania.
About nine o'clock, on the morning of the 3rd.

September last, I was called to visit Mrs. I., a young woman of 19 years of age, and in the ninth month of her pregnancy. I found her just recovering from a fit of convulsions. Upon inquiry, I learned that she had been suffering from them during the whole of the previous night, with intervals of about half an hour between each attack; I learned also that for the preceding three days, she had suffered greatly from a very severe pain in the head and occasional vomitings, and I found that her tongue had been rather extensively injured during the fit; pulse 126. Before I had finished my inquiries, she was again seized with an epileptic fit of great severity, during her struggle, in which bloody froth issued from her mouth, and her lips and face assumed a congested and purplish appearance, she did not shriek, but there was evident spasm of the muscles of the larynx. I immediately proceeded to draw blood from her arm, not only with a curative, but also a prophylactic view; I took away about 24 oz. of blood; this appeared to produce but little effect, as she had another fit of equal severity in the course of half an hour. On examination per vaginam, I found the head of the child pretty low down, but the os uteri undilated. In a little time further she had another fit equally severe, after which I untied the arm, and drew off about 16 oz. more of blood, after which I administered a turpentine enema. Notwithstanding the prompt administration of these remedies, the fits continued to recur at irregular intervals. It was impossible to administer any medicines by the mouth, owing to her total state of unconsciousness. I apprised her friends of the dangerous condition in which she was placed, and it was determined that additional advice should be obtained. An expert accoucheur was called in; and as the os uteri had now dilated to about the size of a shilling, and its margins were thin and soft, we determined to await its more perfect dilatation, and, if possible, apply the forceps. Cold applications were applied to the head, and turpentine fomentations between the shoulders; the latter with a view to arouse her to a state of feeling, and act as a derivative from the brain and spinal cord. The convulsive motions were now accompanied with strong uterine action; and in about one hour from the arrival of my colleague, I was enabled with ease to effect delivery with the forceps. The child was still-born, and the placenta shortly followed. The convulsions, however, continued for 32 hours after, the intervals gradually getting longer, about eight hours, before they finally ceased. I was again induced to bleed her to 10 oz., there being symptoms of an increased determination of blood towards the head. When the power of swallowing was restored, 10 grains of calomel were administered, followed by a draught of castor oil and boluses of camphor, tartar-emetic, and hyoscyamus. The urine was examined, but no albumen was found present. On visiting my patient on the second day after delivery, I found that her intellect was completely deranged, the derangement resembling the symptoms of "mania a potu," except that there were no tremblings; she fancied that she had been speaking with the dead, and she was constantly looking to various parts of the room, where persons were supposed to be assembled,

plotting mischief against her. It was with the greatest difficulty she could be persuaded to take either food or medicine. I directed the continuance of the cold applications to the head, and epithems of turpentine on flannel, wrung out of hot water, to the abdomen, as the lochia had ceased to flow. I ordered a mixture of the spiritus mindereri and spirits of nitre. These means, with the occasional use of calomel, castor oil, and turpentine enemata, were the principal means that were adopted for the course of four days, when she was again restored to her proper senses, and afterwards made a very good recovery, and at the present time is perfectly well in every respect. The chief peculiarity in this case, was the supervention of the mania on the termination of the convulsions; and the question that may arise, whether the bleeding, in all, to the extent of 50 oz., may have had any influence in producing the mania; in my opinion, it had not; and (even if it had) I think the bleeding was more than justifiable, taking into consideration the concurrent testimony of almost all the best obstetrical authors and practitioners, as to the propriety and necessity of a free and copious bloodletting in puerperal convulsions, and that there is less risk of life from this form of mania (even were it possible to foresee it,) than there would be from extreme congestion of the nervous centres, or from apoplexy, a result not uncommon in this disease.

The PRESIDENT reported, as occurring in his practice, the following

Case of Vaccinia and Rubeola running their course together, and followed by Lichen Lividus.

In a patient, five months old, the arm, on the fifth day after vaccination, showed a very minute but distinct vesicle; the child was somewhat feverish, and had been restless and fretful during the preceding night, which the nurse referred to dentition. On the seventh day the vaccine vesicle was progressing, though slowly; the fever continued, and catarrhal symptoms had set in, with a rash over the back and chest, not well defined. The children in the adjoining premises were, at the time, passing through an attack of measles. On the following day, the eighth, the measles were well out; the vaccine vesicle arrived at maturity on the tenth, and on the twelfth was surrounded by the usual erythema, or roseala vaccina of Willan. Under mild cooling treatment, the measles rash began to fade away on the third day from its appearance, and was soon entirely gone, viz., on the twelfth from vaccination. Five days after, viz., on the seventeenth, a distinct eruption of lichen lividus appeared over the face and chest, and continued to come out in successive crops for the space of eight days, attended by itching, and leaving behind minute flea-bite-like spots, which after a week disappeared. The other children in the house, three in number, were, at the same time, attacked by measles, and in every one of them, also, the measles were followed by the lichen rash; in one of these there was much swelling of the face. The President remarked on these cases as bearing on the opinion of Devergie, who is inclined to consider lichen lividus contagious. Some discussion arose as to the opinion of Hunter, Cazenave, and others, who believe that one eruption always

suspends the march of any other with which it may be complicated. In the foregoing case, the vaccinia was merely rendered more slow in its progress, not suspended. Some of the members were of opinion, that, as a general rule, the rapidity of development and maturity of the vaccine vesicle was in the inverse ratio of the age of the patient, being more rapid in the very young.

Dr. MOORE exhibited

A Hand shattered by a discharge of a pistol, the palm being completely lacerated. Amputation was performed above the wrist, about one hour and a half after the accident. The wound healed by the first intention. Dr. M. recommended an early operation, to avoid the risk of tetanus, which is more likely to follow the laceration of such tendinous structures.

He also exhibited a

Phalanx of the Great Toe, removed in consequence of the non-union of a compound fracture.

In this case, shortly after the occurrence of the accident, there were muscular twitchings along the limb, as far up as the hip, which ceased when suppuration set in.

The SECRETARY presented from Dr. HALPIN, of Cavan, a cast of the abdomen of a patient in Cavan Union Hospital, in whom there was an

Abnormal Enlargement of the Superficial Abdominal Veins.

The patient had a severe attack of dysentery in 1852, from which he recovered. As yet the cause of the enlarged and varicose veins is a matter of surmise.

Dr. HALPIN also sent for exhibition the cast of the foot of a man who had the

Astragalus removed, in consequence of Compound Dislocation.

Dr. H., in his communication says:—"I also send a cast I made, of an extremely interesting case, that occurred in the Co. Cavan Infirmary, about 24 years back, compound dislocation of the astragalus. Reduction was found impracticable, and the dislocated astragalus was extirpated. It is upwards of 20 years since I made the cast. The man is alive still. The motions of the foot are imperfect. There is no spring in the arch of the foot. It will be observed that the foot is fore-lengthened; the opposite doctrine is maintained by some practitioners, that the foot is foreshortened after this accident."

ELEVENTH MEETING
Saturday, January 10th, 1857.
The President, Dr. M'GEE, in the Chair.

Mr. BROWNE introduced a patient presenting an example of

Congenital Malformation of both Irides, a deficiency existing in the lower margin of each. He referred the Society to Mr. Wilde's interesting paper on such malformations.

Mr. B. also exhibited a

Tumor of a Scirrhouss character, removed from the breast of a female aged 62 years.

Mr. H. M. JOHNSTON presented a

Specimen of Perforating Ulcer of the Ilium.

The patient, a sailor, had been for weeks suffering from diarrhoea. On arriving in port he was admitted into hospital for a frostbitten condition of the feet. On the evening of his admission he was suddenly seized with symptoms of perforation of the intestines, and died in about 15 hours after. When the abdomen was opened gas escaped; there was a large amount of seropurulent effusion, and other evidences of intense peritonitis. The perforation was discovered in the upper third of the ilium. The ulcer occupied the site of one of the glandulæ solitariae, and had a well defined margin. There were several other ulcers, similarly placed, in the tract of the ilium. The mucous membrane in the intervening space appeared healthy. Mr. Johnston was of opinion, that during his passage he had been labouring under typhoid fever; and he regarded the ulcerated state of the glands as the pathological result of that disease.

Dr. Seaton REID exhibited the

Kidneys of a patient who had recently died of Phthisis, in the Union Hospital, and who had been diabetic for six or seven years. She had visited the hospital on several occasions; the urine, during her stay, varied from four to five quarts daily, and had a specific gravity of from 1,034 to 1,040; and always gave indications of sugar, on the application of Heller's test. Two days before death the urine was reduced to three pints daily, but still was distinctly saccharine. Rennet, opium, iron, cod-liver oil gave but temporary relief; her death being caused at last by a profuse diarrhoea, which was probably the cause of the diminished amount of the urine. The kidneys, on removal from the body, were found intensely congested, rather smaller than usual, but the tubular structure apparently healthy. Dr. Reid having remarked that he did not present them as showing the pathological seat of diabetes, noticed briefly the entire change in our views of this disease that had been caused by the experiments of Dr. Claude Bernard, of Paris, who had proved that one of the natural functions of the liver was to secrete sugar; that this was always capable of detection in the blood, after it had passed through the liver, and till it reached the lungs; that it was formed irrespective of the digestion of vegetable substances, being found even in the chick, before it had escaped from its shell. Dr. Reid then referred to the very interesting and almost fabulous results that followed the irritation of different parts of the fourth ventricle, in the experiments of Dr. Bernard. One point, on being irritated, caused the animal to suffer under saccharine diabetes; another point producing simple diuresis; and a third, the secretion of sugar, without any increase in the amount of urine. These results caused him to look with much interest to the examination of the brain in this patient, with a view of ascertaining whether, in the human diabetic patient, any morbid state existed in the fourth ventricle, that

could be looked upon as producing this fearful disease. Anxious, therefore, for a careful examination of the brain, Dr. Murney, Demonstrator in the Queen's College, kindly consented to dissect it for him, after its removal from the body; but after a most careful and cautious examination of the region of the fourth ventricle, he found nothing to indicate that in this patient there had existed any kind or amount of disease in that part of the brain to which her attack of diabetes could be referred.

Dr. MOORE exhibited an example of
Pulpy Degeneration of the Synovial Membrane of the Knee-joint, and Ulceration of the Cartilages.

Also a *Tumor of a scirrhous character, removed from the breast.*

Dr. MOORE introduced a patient on whom he had operated for *Talipes Equinus* six weeks previously. The patient had walked on his toes, his heel elevated from the ground above four inches. Dr. M. cut the tendo Achillis, and applied a bandage; some days afterwards he divided the plantar fascia and the opposing tendons; a bandage was again applied. The patient now was able to walk well on the sole of his foot, and the muscles of the calf were becoming developed. Dr. M. used no splints, and recommended that the knife should be inserted beneath the skin, and its edge merely pressed against the stretched tendinous structures, which are readily severed; thus nerves and arteries escape being injured. Dr. M. never met with haemorrhage, tetanus, or any unfavourable result, by such mode of operating. Dr. M. had formerly operated on a girl (the patient's cousin) for a similar defect, with equal success.

Dr. MOORE exhibited
A Cyst containing an oleaginous fluid, about the size of a goose's egg, which he had removed from the lumbar region.

Dr. MOORE also related the history of
A case of Abscess of the Pharynx, which, pressing forward the uvula and tonsils, and resting on the epiglottis, caused suffocative and other urgent symptoms. With the long bent trocar and canula, he evacuated about three ounces of fetid pus, affording immediate relief.

Dr. PIRRIE presented the Lung, &c. &c., of a patient who had died with

Pneumothorax, and related the following history of the case and post-mortem examination. Thomas Campbell, æt. 18 years, was admitted into Frederick-street Hospital, on the 18th. of August. He stated that he had been ailing for a period of 18 months, but much more so for the last six. On examination, the heart was found beating to the right of the sternum, and there were the other decided evidences of pneumothorax of the left side. The patient lingered on until the 29th. of December. Post-mortem.—The body was much emaciated; on opening the left side of the thorax, air gushed out. The

heart was found lying to the right of the sternum, the left margin of the left ventricle being fully half an inch to the right of the right margin of the sternum. The left side of the thorax had the appearance of an enormous cavity, containing about half-a-pint of fetid purulent matter, and was lined throughout by a soft, pulpy false membrane, about quarter of an inch thick. The lung, which was firmly compressed, and bound down to the spinal column, contained indurated tubercles. The right lung was universally adherent to the thoracic walls, and filled throughout with tubercular matter in all its various stages.

TWELFTH MEETING

January 17th, 1857.

Professor FERGUSON, V.P., in the Chair.

Dr. John MOORE read the history of a
Case of Scarlatina occurring during the puerperal state.

On Sunday, November 16th, 1856, I attended Mrs. M'L., æt. 28 years. It was her first confinement, and she gave birth to a female child, after about 10 hours' illness. There was nothing unusual in the labour, except that the cord was only a span long. On Monday her pulse was 110. Tuesday, I found that she had spent a restless night; pulse 120. There was a considerable degree of feverishness present; there was, however, no abdominal tenderness; the lochia continued to flow; she had passed urine freely, and the bowels had acted. I ordered her powders containing *hydrarg: c. creta*, and *Dover's powder* night and morning, with nitre during the day. Thursday I found her covered with the eruption of scarlatina. The attack seemed a very mild one, as there was a total absence of any tendency to sore throat. The uterus manifested no signs of being implicated, and at this period my prognosis was favourable. She was nursing the infant, which manifested no symptom of the disease. Friday morning I found that the baby (which I had left in good health on the evening previous) was dead. At twelve o'clock it had been placed in bed with the mother; in about two hours the nurse was awake by her in a state of delirium, and found the child dead where the mother had overlain it. Dr. Halliday visited my patient in consultation, and from the absence of any throat or uterine complication, was also inclined to take a favourable view of the case. Saturday there was little change in the symptoms, but on Sunday she sank into a comatose state, and died the eighth day after her confinement, and the fourth after the appearance of the eruption. On the Thursday preceding her confinement she had gone to visit a family where she had lived as a servant, and where one of the children had been ill. She remained all night, and slept with the child, which afterwards turned out to be suffering from scarlatina, though at this time the eruption had not appeared, and she did not see it afterwards. As scarlatina is a disease of so frequent occurrence in children, and as parturient females are most frequently to be found where children are, it is a complication which we ought to be prepared to meet with. There are several points in the case which appear to me interesting. 1st.—The period at which the disease

was communicated, viz., before the eruption had appeared. Patients are said to be much more likely to communicate scarlatina in the latter than in the early stages. 2nd.—The period of incubation—from Thursday until the appearance of the eruption on the following Wednesday. 3rd.—The absence of what we might *a priori* expect, any uterine affection. The fatal termination, notwithstanding the absence of what, in this disease, is the most fatal of its symptoms, viz., the throat affection. And last, but not least, the freedom of the child from the disease; for on the evening of its death there was not a trace of it, although it was nursed by the mother, who was at the time covered with the eruption; showing that those poisons which, when introduced into the system either by inhalation or inoculation, act injuriously, will, when taken into the stomach, prove harmless. But I cannot tell how the infant escaped, with the mother's blood circulating through its veins, charged with the combustibles that were so soon to explode and destroy her.

Mr. BROWNE introduced a patient on whom he had operated for

Congenital Cataract.

He was 21 years of age at the time he presented himself to Mr. B.; since then he had undergone two operations—one with the needle, and the second with the canula forceps—to remove a piece of the capsule. The result has been very satisfactory, as he can see near objects very well by the aid of 2½-inch glasses, and distant objects by means of a 4-inch focal power. The patient already begins to know surrounding objects, of which he had hitherto been quite ignorant. He intends to learn to read and write. Mr. Browne also presented a patient, aged 66 years, from whom he had extracted a cataract. The patient had been operated on a fortnight previous to his appearing before the Society. The section of the cornea had healed so completely, that the cicatrix was scarcely discernible. The cornea, Mr. Browne remarked, was quite healed on the fifth day. Vision, in this case, was good, and improving rapidly.

Dr. MOORE introduced a patient suffering under *Cancer, engaging the Breast, Axilla, and Scapular Region.*

The arm and hand were swollen to a great degree. The patient concealed the existence of the disease in the breast for more than nine months, and when she first sought advice, there was a tumor the size of a turkey egg. At that time (above one year since) she was urged to allow an operation, but refused; and since then the disease increased to its present extent.

Dr. PATTERSON referred to the treatment of cancerous ulceration by the application of finely powdered sulphate of zinc, as recently suggested by Professor Simpson. The following is the formula:

: Zinci Sulph: Exsicc: ʒj.

Axungiae 3 ii.

Misce et fiat ungt. —

Or, Zinci Sulph: Exsicc: ʒj.

Glycerinæ 3 i.

Misce et fiat ungt. —

Either of these being applied and renewed, until a healthy surface is obtained.

Dr. MOORE also exhibited a

Diseased Ankle Joint,

affording an example of gelatinous degeneration, with ulceration of cartilages, which he had removed from a girl 23 years of age. Patient has gone on satisfactorily, the wound having healed by the first intention. He presented a morbid mass, about 1 lb. weight, removed from the labium of a prostitute. The disease had its origin, some 12 years since, in a hardened extensive syphilitic ulcer, and had increased until it attained its present dimensions.

The SECRETARY read the following communication from Dr. HALPIN, of Cavan, on

Retroversion of the Uterus.

"In the Abstract for 1st. November there is a report of a case of retroversion of the uterus, read by Dr. Pirrie. As this is a subject to which I have devoted a good deal of attention, I felt very much interested in that case. If I might offer an opinion, from impressions derived from similar instances in which I have been engaged, I would say that the woman might have been relieved at the earliest stage at which we have her history, and probably the process of gestation would have gone on to the full period. I do not know whether you ever met with a paper that I read on this subject before the Dublin Obstetrical Society, January 2nd, 1840. It is reported in the *Dublin Journal of Medical Science*, vol. xvii. page 67 (old series). The method I had recourse to was extremely simple—inflate the pelvis. It restored the uterus immediately to its normal position. I have had very many communications from medical practitioners who have tried the means I recommend with the happiest results. Should any member of your Society meet with cases of retroverted uterus, he will find no difficulty in relieving them by this method. I had a case of anteverted unimpregnated uterus, in which I was enabled to restore the organ to its natural position without difficulty, by inflating the vagina." Dr. Charles Purdon described the mode of inflating—viz., by placing an Indian-rubber bag, with a tube attached, in the vagina, and then distending it with air.

Dr. BRYCE related the history of a case of retroversion. The uterus was not restored to its normal position. The period of uterogestation was prolonged for nearly 12 months, when the patient died, delivery not having been effected.

THIRTEENTH MEETING

Saturday, January 24th, 1857.

The President, Dr. M'GEE, in the Chair.

After the minutes were read, Dr. HALLIDAY introduced a patient, the subject of

Hepatic Abscess,

and related the following history of her case. Rebecca

Carvel, aged 26 years, about two years since applied at Dispensary, stating that up to three months previously she had enjoyed good health, when the catamenia ceased to appear—from what cause she could not state. She now complains of œdema of the lower extremities. This, notwithstanding that she remained under treatment for some months, went on to general dropsy. She sought admission into Union Hospital, where she remained but a fortnight, the urgent symptoms passing off. She returned to her work at the mill, at which she continued only three days, the swelling having reappeared. Again she came to Dispensary; and finding she improved under the treatment adopted, resumed her work, at which she continued for five months, taking no medicine whatever. At this time she became much worse, and in addition to her former symptoms, complained of frequent chills, with cough, and pain in the right side, shooting up to the shoulders. She now passed into Frederick-street Hospital, where she was cupped and blistered over the affected side. Here she remained nearly three weeks, and finding no improvement, left. About five weeks ago Dr. H. was again called on to visit her, and found the liver very much enlarged, extending up into the thorax, protruding across the epigastrium, and downwards near to the umbilicus. She had also general dropsy. Posteriorly the right side of the chest, for two-thirds up, was dull on percussion, with almost total absence of respiratory murmur. She had never expectorated blood, nor was the sputa at all pneumonic. At this time the pain, a little to the right of the epigastrium, was intense; and here the enlarged liver assumed somewhat a dome shape. The bowels were regular. She had no rigors, nor could fluctuation be detected. About one week after, on the 24th. December, when dozing in her mother's arms, in the evening, she awoke, saying she had neither pain or ache; and on next morning she passed, by stool, a quantity of slimy matter, mixed with dark blood and pus. Up to the present the stools are of the same character, but not to the same extent. Her general health is improving rapidly. The enlargement in the right hypochondrium has almost disappeared; her dress now meets upon her, which before it would not do; but the dulness of the chest posteriorly remains in pretty much the same state. There is still, also, some cough, with slight œdema of the legs. The menses have not returned.

Professor FERGUSON drew attention to the contracted state of the lower part of the right side of the chest. He accounted for the dulness still existing posteriorly, by the presence of some amount of pleuritic effusion.

Mr. BROWNE presented a patient who had been introduced to the society about two years since, as affording a well marked example of an

Extensive Serpiginous Syphilitic Ulcer.

Great difficulty had been found in healing it. Fumigations of cinnabar directed to the ulcerated surface by means of vapour baths, and ten grain doses of iodide of potassium, had at last proved effectual.

Mr. B. also exhibited a portion of the lower extremity of

the Humerus, removed in performing the operation of excision of the elbow joint. The origin of the disease was attributed to injury, and a small cavity was detected in the diseased portion of bone, the probable seat of an abscess.

Dr. MOORE presented

A Cyst removed from the side of the Frænum.

It was about the size of a nutmeg, and was removed with a portion of loose skin. He remarked that he had never before seen a tumor of such a nature removed from the penis. It contained a clear glairy fluid, and was of six years' growth. Dr. M. also exhibited a small body about the size of a pea, removed from the anus. It had caused a gnawing uneasiness both before and after stool, which was quite relieved by the operation.

FOURTEENTH MEETING

Saturday, January 31st, 1857.

The President, Dr. MGEE, in the Chair.

Surgeon HARKIN gave the following history of a

Case of Punctured Wound of the Thorax,
presenting features of great interest in a medicolegal point of view.

J. S., æt. 20, was knocked down in a quarrel; when he rose he found that he had been stabbed in the chest. His wounds were dressed, and he was then removed to the General Hospital. His adversary was arrested, and committed to jail; and my connexion with the case arose by the solicitor for the defence requesting me to watch the progress of the case in the interest of the prisoner. On more careful examination, it was found, that out of four punctured wounds of the left side of the chest, at least three were penetrating. In hospital the patient passed through the inflammatory stage very safely; and although there was evidence of effusion, it was rapidly disappearing. The external wounds had closed; the patient was removed into the convalescent ward, and allowed to sit up at the fire and walk about the ward. The beginning of another month brought with it a change in the medical attendant. The new medical officer finding some pleuritic pain persistent, applied a blister over the seat of pain. This application relieved the pain, but opened the wounds anew. Dysentery was then epidemic, and the patient partook of a bowl of soup along with some dysenteric patients in their convalescent ward. The immediate result was an attack of acute dysentery, under which the patient died in about 12 days. The question then arose—what was the cause of death? Was it the result of the injury to the chest and thoracic viscera, or of the dysentery?—and if of the dysentery, was that disease the natural consequence of the wounds—a symptom of hectic fever, in fact—or was the dysentery caught in the convalescent ward? If the former, then the man was murdered; if the latter, he died of disease caught in the hospital—a conclusion widely different, and of vital importance to the man who inflicted the wounds. To remove these doubts a *post-mortem* examination was held in presence of the medical men connected with the hospital, and others concerned for the next of kin.

The following is from my notes taken on the occasion:—The body was very much emaciated. There were found on the left side of the chest the marks of four punctured wounds—one completely cicatrized, two partially healed, one quite patent. On removing the sternum and portions of the ribs, we found a perforation between the third and fourth ribs corresponding with the cicatrized wound; further down, a second opening, between the seventh and eighth ribs, corresponding with the open wound; and again, opposite one of the partially healed wounds, a third perforation, complicated with caries of the ribs. The knife, in this instance, had pierced a fold of the diaphragm, without entering the cavity of the abdomen. The left side of the chest contained about eight ounces of purulent matter; the pleura of that side was thickened, and covered with coagulable lymph, partially organized, and red. That portion of the pleura lining the left side of the sternum had been removed by ulceration, and a layer of thick pus deposited in its place. The left lung was, almost to its whole extent, solidified; near its apex we found a scar, as if where the knife had entered, but it was healed up. The inferior part of one of the lobes presented an open wound, looking towards the ribs, and evidently much contracted in size, the result of the wound in that part of the chest. There was not any evidence of pneumonia, the solidification having been the evident effect of the effusion. The right lung was quite sound; the right pleura contained scarcely any fluid. The pericardium contained about two ounces of fluid; no adhesion, or other indication of disease. The heart itself perfectly healthy. The bronchial tubes were rather congested, but the redness, &c., was cadaveric. On opening the abdominal cavity, the omentum wanted its usual supply of fat; the liver and spleen were healthy, the latter slightly adherent to the diaphragm. No renal disease; the stomach and abdomen very healthy; they contained a little yellowish fluid. The small intestine, for about 18 inches above the cœcum, presented every symptom of acute inflammation of the mucous membrane. The large intestine was distended through its whole extent, and on being slit up, exhibited the appearance of extensive ulceration of the mucous membrane, most highly intensified in the cœcum, and gradually declining, yet still well marked to within two inches of the anus. The lining membrane was completely honeycombed, and the whole looked much more like tripe than human intestine. The mucous membrane between the ulcers was covered with layers of lymph, and the glands much enlarged; but no complete perforation existed. No effusion into the peritoneum, nor any adhesion of the intestines. As there had not been any sign of head symptoms, the brain was not examined. The conclusion I came to was, that the symptoms during life, as well as the pathological appearances, fully justified a favourable prognosis up to a certain point; that the reparatory process was steadily progressing, up to the period of the patient's visit to the dysentery ward; and that he then contracted the disease of which he subsequently died. At the Coroner's inquest I gave evidence to this effect. The medical men connected with the hospital concurred with me in every particular; one medical

man, however, who did not believe in the infectious nature of epidemic dysentery, delivered a contrary opinion; but the weight of medical testimony having been on one side, the jury returned a verdict of "death from natural causes."

Dr. C. PURDON read the following

Case of Poisoned Wound, complicated with Delirium Tremens.

A. B., æt. 33 years, stout and able-bodied, of a healthy constitution, was attacked with delirium tremens, after above three weeks' drinking. He became slightly jaundiced, and had vomiting and hiccup. These latter complications were removed by appropriate treatment; and as he was progressing towards recovery, he suddenly jumped out of bed, and before he could be prevented, plunged a dagger-shaped knife, about six inches long, into his abdomen, about one inch below the ensiform cartilage: this he did three times, driving it up to the hilt. Very little blood issued from the wounds. The knife had been used for cutting tobacco. When visited immediately after, he was lying on his back, breathing calmly; pulse, 84, and good. The wounds were dressed, and he was kept under the influence of opium, which soon produced sleep; and he awoke quite recovered from the delirium tremens. The opium was continued; and for the next six days there was no tenderness, on pressure, over the wounds, nor any hardness in the hepatic region. His pulse varied from 76 to 80, and was steady. He slept well each night. The wounds cicatrised; and he was so far recovered as to be able to remain down stairs for some hours. In two days after he became worse; he ceased to sleep, and the opium was resumed, and continued in large doses, without any effect for 36 hours; at the expiration of this time he slept for a little. Pulse 84; no nausea or vomiting; tongue creamy and moist; no tenderness; no hardness over the liver. He now became suddenly collapsed; pulse barely perceptible and fluttering, about 130. After much trouble he was restored from this state, and the pulse fell to 108. Violent hiccup supervened, which was removed, at first, by warm applications; but returned again and again, for 36 hours, and was only checked by a horse-shoe-shaped blister, applied over the insertion of the diaphragm. The heart at this time was beating very irregularly, and would sometimes stop. The treatment consisted in the exhibition of opium and mercury; the latter by inunction, as well as internally. The system resisted its influence very much. After a short time, the patient's state seemed to improve; the tongue became clean; and the opium alone was now continued. The heart's action still continued irregular; and he had at this time two severe attacks of colic, with slight tympanitis; these were easily relieved at first; but after one of these seizures, for which his brother had given him some ether and laudanum, the vomiting recurred, he again became jaundiced, his feet oedematous, and the hiccup also returned at intervals, though he had been free from it for seven days. It now continued for 24 hours, when he suddenly felt something give way in his back, at the right side; He obtained immediate relief from the hiccup, and the heart's action became regular. The next

day he passed a considerable quantity of matter from the bowels. The œdema became less, and the jaundice almost disappeared. Some hardness could now, however, be felt over the liver, and it began to enlarge, and continued to increase, at its left side particularly. Leeches were applied, followed by a blister. Shortly after this he had a rigor; the œdema again increased, and he suffered under frequent attacks of hectic fever. He became sleepless, and frequently delirious; there was a good deal of nervous agitation, with picking of the bedclothes. The muscles at the back of the neck became rigid and contracted. There were frequent attacks of rigor; and a crepitus was heard over the right lung, with dulness on percussion. The supervention of these symptoms was attributed to a poisoning of the system—pyæmia. On the 12th of November, after an attack of delirium, he became agitated in a peculiar manner, like one stuttering, and afterwards was not able to pronounce the letter "I," and instead of saying "I want," would say "me want." For a day or two he was free from any fresh attack; the hectic however continued, his voice became changed, and he again had several attacks of a similar nature to that described above; before each, the pulse rose, and he complained of pain at the epigastrium. The left lung now became similarly affected to the right one; as regarded the hepatic symptoms, he seemed to improve. Nov. 16th.—Had a severe attack, during which the arm became quite rigid, the jaws locked, and the speech affected. 17th.—Twitching of the muscles of the face; opisthotonus delirium. 18th.—Eyes suffused; opisthotonus, subsultus, and picking at the bedclothes. 19th.—Comatose; and died quite typhoid.

Dr. MURNEY introduced a boy under 10 years, with a
Chancre on the Glans Penis.

The case was brought forward from the rarity of primary syphilis in such a young subject.

Mr. H. M. JOHNSTONE presented a specimen of
Rupture of the left Ventricle of the Heart, near its apex.

The patient was in hospital to have his finger removed, but died suddenly, a few hours before the time appointed for operation. He had made no complaint of any cardiac uneasiness, and yet there was evidence of intense pericarditis. On removing a layer of lymph near the apex of left ventricle, the rupture was discovered—the lymph lying in direct contact with a coloured clot, which lay in the ventricle, and had apparently prevented the effusion of blood into the pericardium.

Dr. MOORE exhibited the recent parts in a
Case of Femoral Hernia,

on which he had operated some months previously. The patient was admitted under the care of Dr. Malcolm, for constipation, when a hernial tumor was discovered. The sac was opened; it contained no fluid, but a portion of gut, very much discoloured, being of a dark brown chocolate colour. The canal in which it was contained was much larger than usual. The intestine was returned; the bowels were acted upon; but at the end of the fifth day she sank from peritonitis. The

recent parts displayed a canal, one inch-and-quarter long and very much indurated. Dr. Moore referred to a second case, on which he had operated in the same week, in hospital, and in which there was great difficulty of diagnosis; when the sac was opened, and nearly one ounce of clear fluid discharged, he naturally sought for the intestine, but was unable to detect it, having in fact opened, what is rarely met with—a false sac. There was still the tumor, but no appearance of an opening into the abdomen. After slight manipulation, and when about to open the true sac, the gut was returned, and the sac collapsed. The bowels then acted naturally, and the patient made a good recovery.

Dr. MOORE also presented the matrix of a nail, removed in a

Case of Onychia Maligna.

In operating, he recommended the matrix to be entirely cut out, as the most successful means in these troublesome cases.

Dr. BRYCE objected to any operation for the cure of onychia maligna, having invariably found that he could cure such cases by removing the dead portion of nail, and strapping the toe.

Dr. MOORE also presented tonsils, removed in consequence of their enlargement causing impairment of the functions of deglutition, articulation, and respiration. In operating, he recommended that the tonsil, being seized with a double hook, the incision should be made from below, upwards, inasmuch as we may thereby complete the operation should any interruption occur, as the tonsil would remain "*in situ*," by its upper attachment.

The PRESIDENT did not consider that there was a pressing necessity for the removal of the tonsil. He preferred attending to the general state of the constitution; and he had found that the enlargement disappears as the system becomes developed.

SIXTEENTH MEETING

14th February, 1857

The President, Dr. McGEE, in the Chair.

Dr. MURNEY presented a well-marked specimen of
Cirrhosis of the Liver.

The organ was in the contracted stage of the disease; its surface was nodulated, and its substance firm. On examination of sections under the microscope, the fibrous element was found in very large proportion. There was no dropsical effusion; the early history was unknown.

Edema of the Glottis in Typhus Fever.

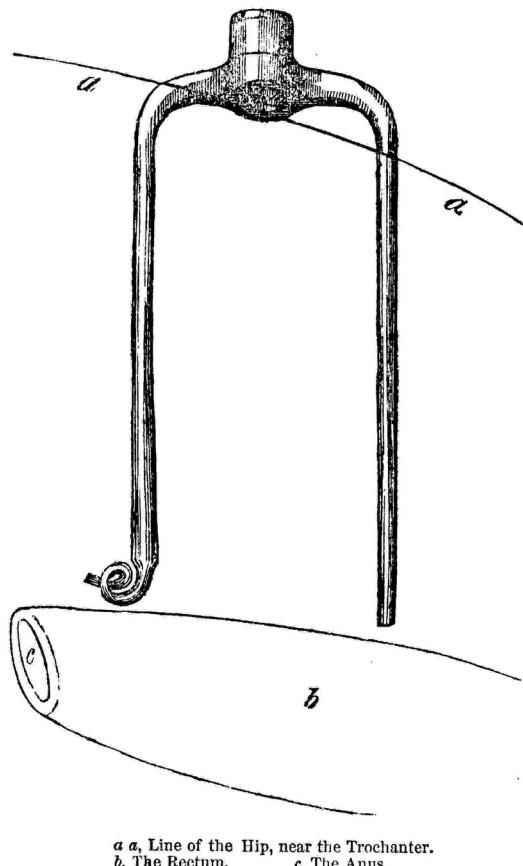
Professor FERGUSON referred to a case of typhus fever under his care in hospital, in which, in the advanced stage of the disease, an asthenic form of œdema of the glottis had supervened, causing symptoms of a most urgent nature. The patient's strength was supported, stimulants exhibited, and a large blister applied, under which treatment recovery had taken place. Dr. F. remarked, that by some the symptoms would have

been considered sufficiently urgent to demand an operation.

Dr. FERGUSON also introduced three male patients with *Paralysis of the superficial and deep Extensors of the Forearm and Hand.*

In all the loss of power was attributed to accidental pressure, causing mechanical injury of the musculo-spinal nerve. The paralysis was strictly local, and the power of extension could, for the time, be restored to the muscles by electricity. There was very slight impairment of sensation; and Dr. F. looked upon these cases as consisting in a debilitated condition of the muscles, caused by the injury of the nerve-tube, and consequent interruption of the supply of nervous energy. The atrophied state of the muscles supported this view of the pathology of such cases. He regarded the prognosis as favourable; and as for treatment placed most reliance in the continued application of the electric current.

Dr. MOORE presented an enlarged labium, which he had removed, and which was of a similar character to that previously shown; it also originated in syphilitic ulceration. There was considerable venous haemorrhage and a watery discharge during the operation. The wound healed by the first intention.



Dr. MOORE exhibited a spindle, which he had removed from the buttock of a boy aged 12 years, who had by accident fallen upon it from a height. It penetrated immediately behind the trochanter major, and could be felt pressing against the rectum, on the finger having been introduced. Repeated attempts were made to pull it out; and these having failed, he was brought to hospital, where, under the influence of chloroform, a bandage being inserted beneath the area of the spindle, and traction made, it was withdrawn. The difficulty of its removal arose from its end having a brass screw attached, and turned outwards. Dr. M. preferred, if possible, to avoid interference with the knife, as he had seen a diffused aneurism originating from a deep wound in the gluteal region.

SEVENTEENTH MEETING

February 21st, 1857.

The President, Dr. M'GEE, in the Chair.

Muscular Paralysis of Arms, &c.

Dr. Seaton REID introduced a man to the Society who was just leaving the Union Hospital, where he had been a patient for some time, in consequence of having lost almost entirely the power of motion in his arms, forearms, and hands; sensation remaining perfect. The disease in this patient had existed for several years, and appeared to belong to the interesting class of cases that had been described by Drs. Darwall, Cruveilhier, and others, under the names Muscular Atrophy, *Paralysie Musculaire Progressive*. Dr. Reid refrained from any remarks relating to this rather rare form of disease, as he intended, on some future occasion, going fully into the history of this and three other similar cases, and communicating the results of some post-mortem examinations which had a bearing upon its pathology.

The PRESIDENT read the history of a case of *Cardiac and Hepatic Disease*, with an account of the result of the post-mortem examination.

On the 10th. of June I was called to visit Mr. ___, aged 22, said to be ill with cholera.

His parents report, that of late he has had morning nausea and loss of appetite, that he could not walk quickly nor use much exertion, especially after meals, without inconvenience, and that standing or stooping gave him pain or weakness in his back. For the last three or four years he has indulged in the free use of ardent spirits.

On the 7th. June he was observed to be looking ill, but he would not admit that he had any ailment.

His family have no knowledge as to where or how he passed the night of the 7th. He returned home at noon on the 8th, and went to bed, being too unwell to attend to business.

He complained that his bowels were much relaxed, to which, he stated, he had been subject at intervals, during the preceding seven or eight weeks, and he took a few drops of tinct. morphiæ, from which he had before found relief.

It was observed that his countenance and lips were pallid, and that he had much thirst, with total loss of appetite.

On the afternoon of June 9, the medical attendant of the family visited and prescribed for the patient, and remained with him all night. His report is as follows: –

"About 7 p.m. of the 9th. instant, I was called, for the first time, to visit Mr. ___, who I understood was a free liver. He had been for the twelve hours previous affected with severe and frequent vomiting and purging, attended with slight cramps of limbs; pulse 120, weak; tongue slightly furred. On palpation of abdomen there was no perceptible enlargement of any viscous; but slight tenderness on pressure over the epigastrium; the temperature of the skin of the body was natural; the feet rather cold. I ordered a sinapism over the epigastrium, and acetate of lead and opium every hour for the first three doses, and afterwards every two hours, till the evacuations would be checked. This had the effect of checking the frequency of the evacuations, but they never entirely ceased."

On my first visit, in consultation with Dr. S., at 1 p.m. of the 10th, I found the patient perfectly sensible, his countenance anxious, pallid, but not yellow; his eyes sunken; conjunctivæ, not injected, and free from bilious tinge; lips pale; his tongue slightly furred, creamy, without red tip or edges, its heat natural; voice strong and unchanged in its character; respiration variable, hurried by exertion of moving or speaking, but not laborious; skin warmer than natural, and moist; extremities warm; pulse from 110–130, very irregular and unequal, at times firm and full, again small and compressible, occasionally intermitting; no hardness nor very prominent swelling in the hypochondria; dulness on percussion over the upper part of the abdomen and lower region of the thorax, with almost tympanitic resonance over the apex of the lung on both sides. The stethoscope gave bronchial respiration at both infraclavicular regions; heart displaced, being abnormally high and to the left; there was a distinct double impulse, or rather a reduplication of the second sound, with regurgitant murmur after both systole and diastole; no friction sound; no cedema of face, nor anasarca of feet or ankles. His friends, however, say, that of late there has been considerable puffiness of the face, but that during the last few days it had disappeared.

The patient complains of some pain or discomfort in the left side of the chest, which had been more severe two days ago; moderate pressure over the epigastric and right hypochondriac regions gives pain; much thirst; stomach irritable; bowels relaxed. Yesterday and last night, "slight pain, but not exactly cramp," in his lower limbs; says he has for some time had morning cough with expectoration.

It was agreed that he should take, every third hour, calomel and opium, that a blister should be applied over the epigastrium immediately, and an opiate given whenever the state of the bowels required it.

Soon after our visit he vomited about six ounces of serous-like fluid, containing flocculi, and tinged with bile, and he passed four or five ounces of very natural looking urine. Bowels were moved, the evacuation

trifling in quantity, consisted of yellowish green serum.

His pulse, when I left the room, was moderately firm, and his voice strong. In one or two minutes after, his servant recalled me hastily, and on reaching the patient's room I found the heart had ceased to beat, and after a few gasping inspirations he died without a struggle.

Post-mortem examination.—On opening the chest, 20 hours after death, there was no effusion, the lungs were free from adhesion, crepitating freely, and healthy looking, with the exceptions that at their dorsal aspect they were congested, perhaps owing to gravitation from position, and that both lungs were much compressed and pushed upward by a greatly enlarged liver.

The heart was placed unusually high and to the left, its apex not below the middle or inferior margin of the fifth rib. On opening the pericardial sac, it was free from adhesions, and contained not more than two oz. of reddish serum, without flocculi.

At the centre of the anterior septum of the heart, (underneath the pericardium,) was a very distinct milk spot, $1\frac{1}{4}$ inch by 1 inch, depressed rather than elevated, and very slightly corrugated; no other evidence of pericardial disease; coronary veins turgid.

Heart abnormally large; left ventricle empty, and feeling firm and solid; right ventricle loose and flaccid.

On cutting through the aorta a fibrinous polypus, or rather polypoid concretion, was observed within it, issuing from the ventricle and passing into the innomina and subclavian and carotid arteries. A similar but larger fibrinous concretion was observed in the pulmonary arteries, issuing from the right auricle, and passing through the ventricle.

On cutting through the walls of the ventricles the muscular fibre of the left was unusually firm, and both were of a darkish red hue.

The endocardium was deep red, in patches, especially about the region of the semilunar valves.

On the ventricular surface of the semilunar valves, aortic and pulmonary, was found a deposit of coagulable lymph of recent formation, and easily removed by the finger. The left auricle and ventricle were empty; the right auricle and ventricle flaccid, and nearly filled with black semicoagulated blood; all the cavities were enlarged, the right ventricle especially so; its walls at centre $7\frac{1}{2}$ to 8 lines thick; left ventricle 10 lines.

Of the fibrinous substances above mentioned, that from the aorta, having been incautiously removed before testing the efficiency of the aortic valves, those valves were found to act perfectly. The place of attachment of the polypus to the mitral valves within the auricle, was shewn by a bloody mark or root. On the right side, the polypus being in situ, the pulmonary semilunar valves were found to be totally inefficient, until the polypus was withdrawn, and then those valves were as efficient as the aortic valves.

The fibrinous concretions or polypi when removed, were whitish-grey, elastic, with a very few small spots or streaks of blood, and had no appearance of layers or filaments; but they became so after a few days, and shrunk much. That from the right side was much the

longer, with a broad attachment and interlaced root appearing at its origin from the tricuspid valves, almost sanguineous. The valves were nowhere adherent to each other, nor was there any rupture of the cordæ tendineæ, columnæ carneæ, or musculi papillares.

The stomach was pressed back and covered by the left lobe of the liver, was little larger than natural, and shewed no saccular dilatation, excepting at its cardiac extremity, where it was slightly pouched. Its peritoneal covering and muscular tissue were normal;—veins at the great curvature much congested.

On slitting it up, it was found to contain a small quantity of a thick, ash-grey fluid, with flocculi; two or three large ecchymosed patches near its cardiac end; and numerous red stellated spots, not tumid nor elevated, on other parts. In some places near the pylorus, the mucous membrane was thickened; in other places, and especially along certain elevated rugæ on its anterior aspect, between the greater and lesser curvatures, the mucous membrane was softened, in spots disorganized, or entirely removed; the ulcer-like spots being covered by a greyish-white exudation or deposit, easily removable. The submucous cellular tissue very little changed.

The liver was very much hypertrophied, more especially in its vertical and transverse diameters; and by its size and position must have materially interfered with the due performance of the functions of the lungs and heart. We had no opportunity of weighing it; but, as by measurement, it displaced 10 imperial pints of water, its weight was estimated at not less than 14lbs.

The right lobe was tumid, semiglobular, and reached in front as high as the inferior margin of the third rib, pushing the heart to the left of the mesial line. The left lobe over-lapped the stomach, and extended even beyond its cardiac extremity, pressing the spleen far back, and trenching somewhat on the left cavity of the thorax.

The surface of the liver was tense, smooth, and shining; when cut into, its colour and firmness were natural, and it did not appear to have undergone acute disease. There was venous congestion, not hepatitis. The tubuli were gorged with bile, and the handling the liver left on the fingers and palms of the hands, an orange-yellow stain, not removable for many hours. A portion of the liver under the microscope showed fatty degeneration. The gall-bladder, not larger than such a liver demanded, contained 1½ oz. of bile.

On reviewing this case, one is struck by the remarkable absence of complaint on the part of the patient, in the early stage; and by the extreme rapidity with which it hurried on to its fatal termination. No opportunity was afforded of making a second examination before death; but serious heart disease especially involving the valves, was clearly diagnosed.

If we may inquire into the rationale of symptoms, as well absent as present, it seems strange that the tongue gave no evidence of the gastritis which had existed; why the hypertrophy and congestion of the liver were not accompanied by œdema or anasarca, or by a jaundice tint of the conjunctivæ; or why the vomiting and purging did not call forth more of the symptoms of gastrenterite during life.

The only detail of symptoms evidencing inconvenience from the bulk of the liver, was the statement of a friend, who, about a week before, had observed the patient, when stepping off the curbstone on the street, throw his right arm across the stomach, as if to give support. Perhaps, also, the difficulty of walking rapidly, after a full meal, is in some degree referable to the state of the liver.

Though I believe the immediate cause of death to have been the interference with the heart's action caused by the fibrinous concretions; and Hasse says such are often the immediate cause of death; yet from the previous history of the patient, I suppose the liver to have been the seat of the first serious disease. It may be urged that the fibrinous concretions were produced by or during the agony, or immediately after death, as is often the case in stout muscular patients; or again, that they may have been the result of some cause tending to produce coagulation of the blood, as absorbed pus, phlebitis, or softened tubercle; but no such causes existed here, nor was there any agony, and the concretions differed much from the soft amber-coloured coagula which are found occasionally filling the ventricles. I believe the concretions to have been the result of endocardial inflammation, and to have permitted the regurgitation indicated by the stethoscope; for though it has been asserted that there is always some reflux permitted from the pulmonary arteries, yet after the removal of the polypi, the semilunar valves were found to be efficient.

The amount of serum found in the pericardial sac cannot have had much effect in producing the rapidly fatal result; for though Rokitansky considers half-an-ounce of serum a normal quantity, other pathologists believe that a much larger quantity may be present without it being deemed unusual.

As regards the reddening seen on the endocardium, it is often observed, produced by imbibition &c, independent of endocarditis; but in this case it could not be referred to imbibition, as it was observed in the left ventricle, which was found empty; neither could it have had as its cause low or typhoid pneumonia; but it has also been observed in those dying from the abuse of ardent spirits. If, then, we consider the carbonized state of the blood from the pressure of the liver on the lungs, and the consequent congestion, we had both causes here present, operating powerfully; yet from a review of all the evidence on the case, I am led to refer the reddening to endocarditis.

Were the appearances observed in the stomach the evidence or the results of an acute attack or exacerbation of mucous gastritis or gastric catarrh, induced by hyperæmia, whether active from continued stimulation, or mechanical from hypertrophied liver; or did both these causes, as I believe, operate?

Drunkards, we know, are prone to gastric catarrh; and while the vomiting is spasmodic, as in cholera, and in some forms of yellow fever, the affection often extends to the entire intestinal canal. The cause of the hypertrophy of the liver is too evident to require comment.

In the *Medical Times and Gazette* of May 8, 1852, Mr. Richardson gives a report of the case of a girl of 14, on

whom he had been in attendance for sixteen days, for cardiac disease. On the morning of the sixteenth day, she had a sudden sensation of faintness. She rallied; but same evening, raising herself for drink, she complained of great weakness, and instantly expired.

"The post-mortem examination shewed, among other evidence of disease, dilatation of all the cardiac cavities and vessels; and also three fibrinous deposits, weighing collectively above 200 grains; one filling the right auricle in the pulmonary artery, at its root, in the left ventricle, so entwined with the mitral valves, that the faces of the valves were brought close and bound together by it. These concretions were true and direct depositions from the blood, and not from exudation. There was no trace of endocardial lesion. It was clear they were formed during life, and while the blood was circulating. The heart might be said to have churned the blood, which in passing left portions of its surplus fibrine on the elevated structures. The heart was choked on one side, its valvular apparatus prevented free play on the other, and death was the necessary result."

EIGHTEENTH MEETING,
Saturday, Feb. 28th, 1857.

The President, Dr. M'GEE, in the Chair.

Mr. BROWNE presented a small Neuromatous Tumour removed from the leg of a man aged 58 years; it had been located near the head of the fibula, and was of twelve years growth, during which time he had suffered great agony in the part, the attacks being periodic for three hours each day about noon, and for the same period about midnight. The growth was evidently in connexion with a branch of the anterior crural nerve. The removal of the tumour completely relieved the patient from his long state of suffering.

Dr. HALLIDAY read the following history of a case of Spinal Arachnitis.

Wednesday, June 3rd, I was called to visit a young lady æt. 20 years, and found her complaining of intense pain in the back, corresponding to the tenth and eleventh dorsal vertebræ—pulse 110, skin hot, thirst, tongue slightly furred. On the previous Friday, whilst feeding fowl in the yard, during a shower of rain, her dress being somewhat open behind, she felt a chill down the spine which she thought of no consequence, until the following day, when she was seized with a rigor. The next day, Sunday, she was able to attend her place of worship, but felt very unwell that night, complaining of intense pain in the back, accompanied with a great sense of lassitude, and inability to move about. The catamenia had appeared on Saturday, and continued to flow, but not freely, until the time of my first visit. The bowels were constipated, the stomach rejected even drink—firm pressure over the spine afforded relief—over no part of the surface was there any increased sensibility, and in very many points the case resembled one of acute lumbago; a brisk calomel purgative was prescribed, and turpentine fomentations, to be followed by a large bran poultice to the affected

part. Thursday, June 4th, I found that the powder had been rejected, and a stimulating enema was administered, by which the bowels were moved. She now began to find much difficulty in drawing up her lower extremities, this, in conjunction with the want of any improvement in the symptoms above mentioned, led me to cup her on both sides of the spine, and steadily administer mercury; in addition the compound decoction of aloes was given, with a view to cause the menstrual flow. Saturday, June 6th, there was complete paralysis of motion and sensation in the lower extremities, together with retention of urine. The paralysis of sensation extended as far up, as a line drawn around the crest of the ilium. The pain in the spine now occurred in paroxysms, which were very greatly increased when she was moved—there was retraction of the head, accompanied with a mixed tetanic and hysterical expression of countenance—the pulse was only 100, and not full, and there was not the slightest pain on pressure over the spine; the calomel was continued, but its constitutional influence could not be attained, nor did it seem to have any effect over the progress of the disease. Blisters were applied, but the symptoms continued unrelieved; there were no convulsive seizures; her intellect remained perfectly clear to the last, and she seemed to sink from exhaustion on Tuesday, June 9th, being the twelfth day of her illness.

Dr. YOUNG read the following paper

On the Tests for Diabetic Urine.

Our knowledge regarding diabetes is not altogether so imperfect as formerly. Bernard's experiments have cleared away much of the obscurity that previously hung about the question. As a general rule, sugar is always to be found in the hepatic veins, but never in the portal—so that it is now established, that one of the functions of the liver is to prepare sugar from the portal blood. What precise object the sugar fulfils is not yet accurately determined. It ought not, however, to get into the arterial circulation. When it does, part of it passes off by the kidneys, and causes diabetes. The tests are innumerable, and the practitioner is often sorely perplexed with the wearisome directions and the costly apparatus necessary to attain a positive diagnosis.

For the practical, though not the purely scientific man, the sulphate of copper, and nitrate of silver tests are quite sufficient, and will decide the point in a few moments, very unlike the yeast, the bile trisacetate of lead, the chromate of potass, the microscopic, and the bi-chloride of tin tests. These are expensive, troublesome, and tedious methods. But blue stone, and liquor potassæ, nitrate of silver, and strong ammonia, are not only cheap and simple, but may be found in every dispensary in the kingdom. Bence Jones says:—"To a drachm of suspected urine add two or three drops of a saturated solution of sulphate of copper, then two drachms of caustic potass, at first a beautiful blue is produced, apply heat, and if grape sugar be present, the oxide of copper is rapidly reduced, and reddish yellow suboxide of copper is precipitated." If the result be negative, we may be certain there is no sugar in it; but if positive, we ought to try the second one also.

Place a few drops of a saturated solution of nitrate of silver in a test tube, and add one drop of caustic ammonia, then add one drop of the suspected urine, heat the tube and shake the contents, and in a few seconds the metallic lustre will appear on the side of the tube.

Reynoso says:—“Sugar is always present in the urine of the aged. I had an opportunity lately of examining this point. An old gentleman took ill and requested my advice. His ordinary medical attendant told me that the case was one of glucosuria. The sp. gr. was not very high, 1,030; in using the copper test the reaction seemed to indicate sugar, but with the nitrate of silver there was nothing of the kind—the fluid did, however, contain an excess of urates as well as urea, which will behave with the copper test very like grape sugar, with this decided difference, the changes with the latter take place almost immediately; with the former very slowly. I had therefore the satisfaction of knowing that I had not an incurable disease to deal with. But I need not observe how important it is to form a correct diagnosis, even when the prognosis must be the worst. A gentleman, well known to all here, was dying rapidly, (he was going about his usual business on Saturday, and was dead on the following Wednesday,) and it seemed impossible to say what he was dying of, but the urinometer and the two tests already given, settled our doubts, and enabled us to foretell with a melancholy certainty the hopeless issue of this formidable and intractable complaint.”

NINETEENTH MEETING,
Saturday, March 7th, 1857.

The President, Dr. MGEE, in the Chair.

Dr. R. TEMPLETON, First-class Staff Surgeon, called the attention of the Society to the fact, that in the East an infusion of Raspberry Leaves is administered, *for the purpose of originating uterine contraction*, and seems to produce much the same effects as the ergot of rye.

Dr. John MOORE read a paper on the following cases of Fever with unusual complications:—June 30th, 1856. James O'Neil, aet. 21 years, was admitted into the Royal Tyrone Detachment Hospital, stationed at that time at Lifford. He complained of languor, lassitude, and debility; his pulse was quick, skin hot, tongue coated; there was also thirst and loss of appetite. He was put on spoon diet, and got a diaphoretic mixture, with some antimonial and grey powders night and morning. The fever was of the mildest description, and he would not have been confined to bed, had his own wishes on the matter been consulted. He progressed favourably, without much change in the symptoms, or any local complication arising, until the 5th. July, when he accompanied the detachment to Omagh. On the day following he seemed better, the fresh air (as he himself said) had done him good. He continued to go on favourably until the 9th, when he was attacked by a violent fit of convulsions, which continued for nearly an hour, and momentarily threatened dissolution. There had been no premonitory symptoms that I could

detect to tell of the danger that was coming; there had been no sleeplessness, headache was not complained of, and there was not the slightest tendency to delirium or wandering. On making a careful examination of the chest, however, we found considerable pleuritic effusion, with consolidation of the lower lobe of the left lung; there was no discharge, and nothing but the physical signs to indicate the presence of so much organic mischief. Dr. Thompson looked upon the attack of convulsions as arising from sympathy with the chest affection. I was inclined on the other hand to look upon them as an attack of epilepsy, occurring during the course of the fever. I was not able to learn, however, that he had previously been subject to such fits. He recovered from the convulsions, and the day following there was apparently not a trace of mischief left behind, still, no headache, nor intolerance of light, no sleeplessness nor delirium; in fact, he said that he felt nearly well; indeed, this was the only suspicious symptom of the mischief going on within the encephalum, that there seemed to be an unconsciousness of the amount of organic mischief which had taken place within the chest. A large blister was applied to the side, and three grains of calomel given thrice daily.

At my morning visit, on the 12th July, three days after the first attack of convulsions, he requested me to permit him to get out of bed, as arrangements were being made at that time for the disembodiment of the regiment, and he had his accounts to settle. I replied that I could not comply with his request, and told him that he was far from being as well as he thought he was. Two hours afterwards the convulsions returned, and quite suddenly and unexpectedly he expired.

The post-mortem examination was made 20 hours after death. On opening the chest, more than a pint of fluid was found in the left pleural cavity, and the lower lobe of the left lung was greatly gorged with blood. On opening the head the veins of the brain were greatly congested, but the substance of the brain was healthy, the left ventricle was filled with fluid, and on removing the brain, more than 4 ozs. were found lying at its base. This to my mind appeared to be the immediate cause of death.

In connexion with this case, I may mention that of Mrs. J., whom I saw on the 10th. day of her fever. Up to that period she had been progressing favourably through a mild attack of simple continued fever. At the time I saw her there was no local complication, and the only thing complained of was want of sleep, she had then been two nights and two days without rest. An opiate was administered at bedtime, which procured a little, though not refreshing sleep. On the following day there was double vision, her attendants had two heads upon each of them, at least in her eyes; when a drink was given her, the vessel which contained it appeared like two vessels. Half a dozen leeches were now applied to the temples, a blister to the nape of the neck, cold applications to the head, and sinapisms to the calves of the legs. Mercury at the same time was given in moderate doses. After the leeching the vision was quadrupled, every thing appeared multiplied by four. There was still very slight headache, the mind was

perfectly calm and collected, there was no subsultus; and the double vision was the only indication of danger present. The next morning there was slight squinting of the left eye; an hour afterwards violent convulsions set in, which speedily terminated in death. No post-mortem examination.

I am sure that to many of you there is nothing novel in either of these cases, and the only deduction which I would draw from them is, that those changes which take place in the brain during fever, are of a passive and not an active character. Now there is a wide spread opinion abroad, that wherever the head is involved in a fever, and where, as they term it, there is congestion or inflammation of the brain present, that wine and stimulants should be most rigidly withheld. I think, however, that this is a great mistake.

TWENTIETH MEETING

March 14th, 1857.

The President, Dr. M'GEE, in the Chair.

Mr. BROWNE detailed the history of a case of *Tubercular Meningitis*,

and presented the results of the post-mortem examination. The subject, a child of three and a-half years old, had been labouring under some slight malaise for some days, complaining only of loss of appetite and listlessness; the bowels were obstinately constipated, and they being relieved by active purgatives, the little patient seemed to improve, but in a very short period convulsions came on, which, without ceasing, proved fatal in seven hours. On making a post-mortem examination, Mr. B. found extreme congestion of the meninges, especially of the pia mater. At some points this amounted to sanguineous effusion. There was not any great quantity of serous effusion either in the sub-arachnoid spaces, ventricles, or base of brain, but at several points there were deposited in the sub-serous tissue numerous small tubercular masses, about the size of millet seeds. These were especially evident between the central hemispheres, along their inferior margins in the median fissure, above the raphe of the corpus callosum.

Dr. MOORE presented a fatty tumor nearly two pounds weight, which he had dissected from the lumbar region. The patient attributed its origin to an injury which he had received six years ago. During the operation there was not over half an ounce of blood lost; sutures were applied, and the wound healed by the first intention. The patient was moving about in six days.

Dr. MOORE exhibited a globular pessary $2\frac{1}{2}$ inches in diameter, which had been introduced into the vagina six years ago; it had never been removed since, and latterly caused such an amount of irritation as to demand its extrication, which was effected with some difficulty by the lithotomy forceps.

The SECRETARY presented a
"Mole,"

sent for exhibition by Dr. H. PURDON. It was about $4\frac{1}{2}$ inches in its perpendicular diameter, and $2\frac{1}{2}$ in its transverse. In form it represented a model of the uterine cavity. The structure was loose, reticulated, and of a fibrinous character. On making a section, a cavity was laid open, containing a small amount of serous fluid, and lined by a thin serous-like membrane, but no appearance of any blighted foetus could be discovered; seven months had elapsed from the cessation of menstruation until its expulsion. The uterus continued enlarging for four months and a-half, it then began to decrease in size. The os was dilated, and the cervix continued enlarged. During the time it was carried, no sickness was experienced, and the patient became very fat. Once or twice there was a slight discharge of blood from the uterus, and at the termination it was shed with a good deal of pain and haemorrhage. There was a well-marked areola. Dr. Purdon had known, during the time a mole was being carried, the patient to suffer from constant tinnitus aurium and vertigo.

Prof. FERGUSON inquired as to the opinion of the members in regard to the pathology of such masses. He considered that when an ovum was conveyed into the uterine cavity and died, that it acted as a foreign body, causing irritation and inflammation. He therefore regarded the present morbid specimen as a product of inflammation.

Dr. ROSS referred to Dr. Montgomery's classification, into true and false moles, and stated that he considered impregnation as necessary to the production of such masses.

Dr. BRYCE referred to a mole which he had examined some years ago, and in the cavity of which he discovered a blighted foetus, weighing only six grains. Under the microscope, however, he was able to distinguish different members of the body.

TWENTY-FIRST MEETING

March 21st, 1857.

The President, Dr. M'GEE, in the Chair.

Dr. ROSS detailed

Two cases of Pyæmia.

The first was that of a boy, aged 3 years, "who", said Dr. Ross, "had been in good health until a few days before I saw him. His friends attributed his illness to a beating by an elder boy. He had slept in a room, the air of which was polluted by a number of pet birds, amongst which, even by day, he spent much of his time. I visited him on the second or third day after a rigor, and the sixth after the beating. I found great sinking of the vital powers; his pulse very quick, sordes on his teeth, and a dry, brown tongue; and great pain and tenderness behind the left trochanter, where a large abscess formed in a few days. Its situation was so deep, that I introduced a bistoury nearly its entire length before I reached the matter. Considerable relief followed its evacuation; but in a day or two the left testicle swelled to about four times its natural size, became very tender, and the scrotum red and inflamed,

and *pari passu*, a large, inflamed, and tender tumor appeared over the acromial end of the right clavicle. In a few days a similar kind of tumor was observed over the left ilium. These three, viz., the one of the testicle, that on the clavicle, and that on the ilium, disappeared without ending in abscess, though the formation of matter appeared imminent. I treated the patient with quinine, stimulants, and good diet. Diarrhoea was frequent during the most severe period of the attack; the evacuations were very offensive. The emaciation and debility were for some time extreme.

The second case was that of a boy aged eight years, in whom pyæmia supervened on ulcers of the mouth, produced by mercury given for pneumonia; six or eight large abscesses formed in quick succession on the front of the neck, chest, and scapulæ. It was quite surprising the amount of purulent matter evacuated from them. The pulse was for several days scarcely perceptible, and the depression very great; but yet, after a tedious illness, the boy recovered. These were apparently the most hopeless cases I ever had under my care; and yet, by supporting the system well, by evacuating matter when formed, and by general attention to health, they did well. The most practical view to take of pyæmia is to consider it a disease of the blood, induced by the addition of pus, or some other septic matter, which deteriorates that vital fluid. In this way we can rationally account for the sudden prostration that attends the absorption of animal poisons. Without entering into the controversy as to whether the abscesses, which are secondary to the contaminations of the blood, are more of than in the part, I may express my opinion that they are more or less both; one or other character predominating in different cases. From the careful examination of the above cases, it appeared to me that the symptomatic deposits are in some cases not pus, but unhealthy fibrine; and that while the effusion is of this character we may hope, by careful constitutional treatment, to cause its absorption. When pus has formed, the sooner, as a general rule, we evacuate it the better. The treatment should be mainly constitutional. The remedies which I consider best are, quinine, stimulants, and nutritious diet; and if there be much sleeplessness or irritability, morphia at bed-time."

The PRESIDENT referred to the case of a young gentleman who received a poisoned wound from handling the feathers of a foreign bird, and shortly afterwards died from pyæmia. He also made several remarks in regard to the relation existing between phlegmonous erysipelas and pyæmia, illustrating his observations by reference to a case of phlegmonoid erysipelas of the leg. One of the medical gentlemen in attendance had very soon after a very severe attack of erysipelas of the head, and a second suffered from a pustular eruption of the hands, and the patient's sister was also similarly affected.

Dr. MOORE exhibited a fibrous tumor, the size of a wallnut, which he had removed from the breast of a female, æt. 25 years. It was of four years' growth, and attached to the upper and outer part of the left mamma; of late it had become tender on pressure, and

accompanied by severe neuralgic pains, extending along the inner side of the arm to the point of the shoulder and scapula. He also presented a tumor of a cancerous nature, removed from the right breast of a female, æt. 44 years, about the size of a nutmeg. There was no swelling of the glands in the axilla, or above the clavicle.

TWENTY-SECOND MEETING
March 28th, 1857.

The President, Dr. M'GEE, in the Chair.

Meningitis.

Dr. DILL exhibited the brain and stomach removed from the body of an infant eight months old, who had suffered for a considerable time from vomiting, ultimately dying with symptoms of cerebral disease. The lining membrane of the stomach was considerably congested, and its coats thickened, particularly at the pyloric orifice. The pia mater was found intensely inflamed, with distinct purulent deposit at the base of the brain. The lining membrane of the ventricles was found greatly thickened, opaque, and covered with a gelatinous exudation. The substance of the brain was considerably softer than usual. Dr. Dill not having been the patient's medical attendant, was unable to give a detailed history of the case.

The SECRETARY read the following history of a case of *Psoriasis occurring during the early stage of Pregnancy*, communicated by Surgeon Hawthorne, Dromore:—Mrs. C., æt. 34, states that she emigrated to a southern state of America, when she was pregnant of her first child, and enjoyed good health until it was weaned. After becoming pregnant of her second, she observed a scaly eruption over the abdomen and flexor surface of her extremities, which lasted about four months, and gradually disappeared. After her second confinement, her husband was obliged to come to Ireland, and she was separated from him for two years, during which time her skin remained perfectly clean. She then joined her husband in Ireland, and again became pregnant, when immediately the eruption appeared, and gradually disappeared about the time of quickening. I saw her for the first time in November last. The anterior surface of the body, except the legs, was covered with patches of psoriasis, from the size of a pea to that of a four-penny piece. I gave her arsenic in ordinary doses, but without any benefit. It disappeared at the usual time, as in the previous attacks. This is now her ninth pregnancy, and since the eruption appeared first, it has invariably recurred after fecundation, and persists till about the period of quickening, when the skin gradually assumes its normal appearance. The patient is in other respects perfectly healthy.

Dr. John MOORE detailed the following
Case of Cerebral Disease, occurring in a child.

On Friday, 20th. inst., I was requested to visit A.M., æt. eight years, of whom I received the following history. She had been a remarkably sprightly child until a few months ago, when her manners became changed,

and she became quiet and taciturn. About a fortnight ago she began to complain of headache, which at the time caused no uneasiness to the family. It increased, however, and she was placed under the care of a homœopathist. Ten days before I saw her, she went up to her mother's bedroom, who was in bed at the time, and said, "Why, mother, I see four people in the bed." From that time the headache continued to increase in severity, and she was confined to bed. She had also been suffering from cough for some time past. When I saw her, she was lying in a semi-conscious state; would remain in a restless sleep for about five minutes, and wake with a moaning cry and contorted features, and cry, "My head, my head." There was urgent thirst present, and the pulse was only 80. A brother had died of hydrocephalus. I ordered counter irritation to the nape of the neck; gave her calomel and rhubarb, followed by castor oil; and, as this failed to move the bowels, a turpentine enema was thrown up, which produced a copious foetid discharge. The pupils were dilated, but contracted on the application of light. I then ordered Hydr. c. cretâ every two hours, which in twenty-four hours produced violent salivation, with swelling of the tongue, but without any improvement in the symptoms. She was now restless, and mostly in a state of insensibility, and when awake, she was delirious. She soon began to sink, and stimulants were administered, which quieted her a good deal. She finally sank, however, on Tuesday night. There were no convulsions nor strabismus at any time during the progress of the disease.

The post-mortem examination was made thirty hours after death. On removing the calvarium, the veins of the brain were found to be congested. The membranes were healthy, and no trace of tubercle could be detected either in them or throughout the substance of the brain. About two drachms of fluid were found in each of the ventricles; and on removing the brain, between five and six ounces of fluid were found at its base. The substance of the brain was not diseased. On opening the chest we found tubercles scattered through the left lung. The pericardium was found universally adherent. The liver was also very large.

TWENTY-THIRD MEETING

Saturday, April 4th, 1857.

The President, Dr. M'GEE, in the Chair.

Dr. Seaton REID exhibited the heart and large blood-vessels of a man, aged 47, who had recently died in the Union Hospital, into which he had been admitted in August, 1855, when he stated that about one year and a half previously he had suffered from pain and swelling, without redness, in the right ankle; that a few months since he had been under treatment in the General Hospital, for disease of the heart; and that he had lost the power of his right side eleven weeks ago, but had now partially recovered it, and suffered chiefly from pain between the shoulders, and palpitation. In the region of the aortic valves a distinct murmur was heard with both the systole and dyastole of the heart, associated with a jerking pulse and lateral motion of

the arteries. The diagnosis made on his admission was, that there existed dilated hypertrophy of the heart, with patency of the aortic valves, supposed to be the result of the rheumatic attack presumed to have existed a year and a half ago; and it was thought that the paralysis of the right side was caused by the detachment of some deposit from the valves obstructing some of the cerebral arteries. He remained in hospital for several months, suffering with varying intensity from cough, dyspnoea, pain in his right shoulder and arm, and between the shoulders; but in none of the repeated physical examinations that I made, especially with regard to the last symptom, did I hear anything to lead me to change or add to the diagnosis I had made. He left the hospital in May. He was readmitted in August, 1856, in consequence of a great increase in his sufferings from dyspnoea, oppression in his chest, and palpitation; and he stated that for the first time he had been anasarcaous when at home. This had greatly subsided before he returned, and there was now heard a single systolic murmur, in place of the double murmur, in the region of the aortic valves, and also a systolic murmur at the mitral orifice, which if observed before, was not recorded. In December he complained much of pain along the spine, but repeated examinations detected no murmur along the vertebræ. In the month of January, 1857, a very indistinct diastolic murmur was again heard in the region of the aortic valves, and on two occasions blood was now observed in the sputa; but his chief complaint was still of the oppression in his chest, of the dyspnoea coming on most frequently about two, a.m., of pain between his shoulders, and of startings in his sleep; and the lower limbs now became very dropsical. During the last two months repeated examinations were made, without detecting anything to change the original diagnosis. Forty-eight hours before death, all his symptoms became much aggravated, and he was seized with a severe pain in his right side, which was only partially relieved by a blister; but as his life was now evidently drawing to a close, I did not feel justified in disturbing him by any further stethoscopic examinations. He never complained of any difficulty in swallowing, of any stridor in breathing, nor had his cough any peculiar sound. There was no tumor observed at any part of his chest, nor any local impulse that would suggest the idea of an aneurism. I obtained leave to make a post-mortem examination, when it was found that there was recent pleuro-pneumonia of the lower lobe of the right lung; the left lung healthy, and no tubercle at any part. About the base of the heart there was some easily-removed lymph, indicating recent pericarditis. The heart was enormously hypertrophied and dilated, and the aorta, from its origin, and for several inches in extent, was also greatly dilated, and had a small pouch at the upper portion of the ascending part. The hydrostatic test showed the existence of free regurgitation into the ventricle. On slitting open the aorta, its interior was found quite wrinkled and rough, from a large quantity of calcareous deposit in its coats. The entrance to the pouch was found narrower than the interior, and had projecting across it, for near half an inch in depth, and more than

half its circumference, a sharp ridge of calcareous deposit. There were no laminated coagula in its interior. The ventricular surface of the aortic valves was found roughened, but without any vegetations. The substance of both ventricles was enormously thickened, and the cavities dilated, the carneæ columnæ enlarged, and the mitral orifice dilated. There was no erosion of either the sternum, the ribs, or the vertebræ. While the post-mortem examination showed the correctness of the diagnosis respecting the state of the heart's substance and its orifices, it revealed the existence of aneurismal disease, that, although looked for, I had failed to detect. Finding that my diagnosis was thus incomplete, I naturally turned to the work of our illustrious countryman, Dr. Stokes, and found there an acknowledgment of the extreme difficulty of diagnosis in cases of mixed sacculated aneurism, such as this was; and while he points out the value, in such cases, of the jerking pulse and lateral motion of the arteries, he admits that their value is dependent on our being certain that no such heart disease existed as was present in this case, and relates an instance where an aneurism of this kind had escaped detection, although two of the most eminent practitioners in Dublin had made repeated physical examinations. Dr. Reid remarked, that while there did exist in this case some roughening of the ventricular surface of the aortic valves, yet he considered that the murmurs may have been chiefly owing to the blood passing so suddenly into the dilated aorta; it having been shown that the passage of blood from a narrow to a much wider tube is capable of producing such murmur; and that, disease being so far advanced in both heart and aorta, there were no data to prove in which it had commenced, or the relation in which they stood to each other. It was known to all how frequently pain in the shoulder and arm preceded or followed paralysis; and lately in a case in which severe pain between the shoulders had caused him to make fruitless searches for an aneurism, the post-mortem examination only exhibited concentric hypertrophy of the heart.

TWENTY-FOURTH MEETING

Saturday, April 11th, 1857.

The President, Dr. M'GEE, in the Chair.

The PRESIDENT read a case of
A Case of *Ramollissement of the Brain*, of Seven Years'
Duration.

Preliminary history, given by a relative, a non-medical man:—"In accordance with your wish, I send the early history of Mr._____, illness. In May, 1844, then aged about 24 years, he experienced considerable difficulty in speaking, and had so much numbness in his right arm and hand, that he was unable to use them.

"In the first week in June he consulted my medical adviser, who said he was threatened with apoplexy. By his order the patient was bled severely, and strong purgatives were administered; but a few days after, on the receipt of some exciting intelligence, a very severe attack took place. For some weeks previous to this attack he had, at intervals, severe pain in his head,

referred chiefly to the left side, with drowsiness; his face at times flushed; appetite not good; no sickness of stomach.

"On the occasion of this, his first attack, the doctor of our village saw him, again bled him, shaved the head, and applied blisters. Mr.—remained unconscious for two or three weeks, and then gradually recovered, but with loss of power of his right arm and side, and inability to speak. Blistering, especially over the crown of the head, bloodletting, and purgatives, were adopted; and after some time magnetic-galvanism was used, and the power of the leg was so far restored, that he was able to walk with a halt; but the arm remained almost useless. After some time the power of speech returned, so that he could utter single words, but could not express three or four words consecutively, even though dictated; and he often used one word in mistake for another. He could not himself read a paragraph or sentence, so as to understand it; but if he knew the subject, he would ask others to read it to him; and if read slowly, he understood it. He could neither write nor dictate a letter. In June, 1845, he experienced his first convulsive attack, and one month after had three similar attacks in one day. These were afterwards repeated, at intervals varying from one to twelve months. His state appeared little affected by those attacks; but he was on some occasions aware that they had occurred, and he was, in consequence, more than usually despondent.

"As you subsequently became his medical attendant, I need not give you further details than to state, that he was said to have been, in infancy, unusually slow in learning to speak; and in childhood and youth was more taciturn, and yet more irritable, than the generality of children. Prior to his illness he had been very closely and anxiously occupied with business matters. He was an excessive smoker.—Yours truly, A. B."

I visited him first in 1847, and I became his medical attendant early in 1848; I then found him in fair bodily health, but restless and unhappy in his mind, with the power of speech as described by his friend in the preceding history. He was able to walk with a slight limp, or rather a dragging of the right leg; the right arm of little use, being contracted, owing to the overpowering action of the flexor muscles; sense of feeling perfect; tongue slightly drawn to the right side; very little twisting of the mouth; no paralysis of either side of the face; countenance not expressive of imbecility. His memory of words was so far lost, that though he was sensible of the precise meaning of what was said to him, and aware of what he himself intended to say, he had difficulty in making himself understood, excepting by his relatives. He had no childishness nor confusion of thought, and he was clear and shrewd in matters of business. He evinced considerable fretfulness, and was wilful or wayward in his conduct. Though I was often called to visit him, in consequence of the attacks of convulsions, they had always passed away before I reached him.

The treatment adopted was chiefly expectant. Laxatives were given, and he used *cotyledon umbilicus* freely; but he did not improve, nor were the convulsive

attacks rendered thereby less frequent or less severe.

Urtication and other rubefacients and stimulants were applied along the spine and nerves of the paralyzed arm, but without advantage. He derived some benefit, while under my care, from a continued use of sulphate of zinc, in five-grain doses, thrice daily; and subsequently from the use of bichloride of mercury, in doses of one-sixteenth of a grain three times a-day; both of which remedies were suggested by Sir B. Brodie, who agreed in viewing the case as one of brain-softening, and prognosed a gradual increase of the disease.

Late on the evening of 1st. August, 1851, Mr.—was killed by the falling of the floor and roof of a building. He was precipitated a depth of 20 feet, and received such wounds from the stone and woodwork, that his death must have been instantaneous. When removed from the ruins, a few minutes after the casualty, he was quite dead. He had lost much blood from a wound in the neck. There were very severe injuries, with fractures of both superior extremities; and he had two scalp-wounds over the right side of the head.

On making a post-mortem examination, 36 hours after death, it was found that of the two wounds of the scalp, the upper one had denuded the right parietal bone at its upper part; the lower wound was near the anterior and inferior angle of the right parietal bone, and accompanied by a fracture of three inches in length, which crossed the parietal bone diagonally, terminating superiorly in the coronal suture, and inferiorly in the right temporal bone, into which it extended about three quarters of an inch. There was very little depression of the bone. The course of the coronal suture, from the inferior angle of the right parietal bone, was marked by a narrow line of blood effused under the periosteum, one-eighth of an inch broad on the right side, gradually narrowing, till it disappeared before reaching the left temple. The bones of the cranium were pale and bloodless. When the dura mater was removed, above six ounces of serous cerebro-spinal fluid escaped, and the brain appeared much collapsed. Over both hemispheres there was slight effusion of blood under the arachnoid, following and marking the sulci of the brain's convolutions. The arachnoid was unusually firm, thickened, and somewhat opaque.

A considerable depression was observed on the left hemisphere of the brain, occupying the posterior portion of the anterior lobe, and the anterior and inferior portion of the middle lobe; taking a course from above, downward and backward. This space was filled with a soft, tremulous, and almost diffusible substance, approaching in colour to black currant-jelly, mixed with whitish coagula, without foetor, or any appearance of pus. The sac occupied a space nearly the depth of the hemisphere, the membranes forming its outer wall; the inner wall, which separated it from the ventricle, was an indurated buff-coloured substance, a quarter of an inch thick, into which the brain seemed to have been converted. This change of structure involved a small portion of the left corpus striatum. The cavity or sac contained no apoplectic clot, nor was it traversed by any membranous bands. In both hemis-

pheres the grey substance of the brain was abnormally pale; the white substance was of the natural firmness, and very free from red points. There was no fluid in the ventricles. The plexus choroides was tinged with reddish serum, and contained near its centre a small hydatid. With the above exceptions, the cerebrum and cerebellum were, in appearance, free from disease. There was no disease observable in the arterial system. The brain, when replaced, did not nearly fill the cranium. No other part of the body was examined.

The softening found after death in this case was not *ramollissement* surrounding a coagulum or the cyst of a coagulum, nor did the cyst, if it might be so termed, contain membranous bands or septa. Was the disease, then, *ab initio*, a case of brain-softening, or was the paralysis the result of extravasated blood; and the clot having been absorbed, was the cavity filled with the jelly-like substance? This is quite contrary to what is usually found, for "in ordinary cases of extravasation, which do not at once terminate fatally, the effused blood is soon changed in character: in a few days or weeks the thinner parts, absorbed, leave a firm dark-brown coagulum, which, after a time, assumes a firm fibrous texture, gradually changing from its dark colour to a slightly reddish tint. This mass of fibrine lessens by degrees, and at length disappears. While these changes are going on, the cavity containing the coagulum becomes lined with a distinct firm membrane, of a yellowish colour, and has frequently bands or septa of the same yellow substance. The cyst or cavity is found to be distinctly organised, often with numerous blood-vessels ramifying on it." *Ramollissement* has been divided into red, and white or gray—into that of the young and of the aged—of increased and of diminished arterial action. Though occurring in so young a man, I am disposed to consider the case as one of gray or white softening, or the *ramollissement* of diminished arterial action. Its cause may be found in the excessive mental fatigue which the patient experienced, even without reference to hereditary and other causes. The preliminary history given by the relative of the patient is graphically and lucidly detailed.

As is not unusual, the patient had occasional attacks of convulsions, which appeared to increase in frequency and in severity. I did not see him in any of these attacks, but I have been informed, that while the paralysis was confined to the right side, the muscles of the left side were convulsed during the attacks of eclampsia.

Dr. MOORE exhibited a fibrous tumor, which he had removed from the breast of a female, *aet.* 25 years. It was of four years' growth, about the size of a large walnut, and of late was very sensitive, and attended with pain in the shoulder and inner side of the arm. The patient recovered perfectly. Dr. M. presented another tumor, of a cancerous character, removed from the breast of a female, *aet.* 46 years; also a morbid growth, about 1 lb. weight, removed from the labium of a prostitute; it contained a watery fluid, and originated in syphilitic ulceration.

The SECRETARY presented a section of a fatty tumor,

sent by Dr. BABINGTON, Londonderry, and read the following history of the case:—"You have herewith part of a tumor, removed on Saturday, the 4th. instant, from a patient in the County Londonderry Infirmary. It was situated on the outer side of left thigh; was of a flattened oblong shape; its lower end was close to the outer side of the patella, and extended upwards about five inches. It was seven years attaining its present size; and when first noticed, was about the size of a garden pea. Within the last six months it had increased rapidly in size. It had an elastic feel, as if fluid was contained in it. The removal was easily effected by a simple linear incision through the skin, and dividing some bands of condensed cellular membrane, strong enough to have a fibrous appearance. It was contained in a strong capsule of thickened cellular membrane. There was not a single bloodvessel running into the tumor, nor was there an artery divided in the operation. The loss of blood did not amount to two ounces."

Dr. Seaton REID exhibited the following specimens, recently removed from patients who had died in the Union Hospital.—

The first was a case of

Cancerous Disease, seated at the Pyloric Orifice of the Stomach,

in a female aged 45, who had been admitted into the Union Hospital in January last, stating that she had, for some months past, suffered from pain in her right side, and that latterly she had been losing her strength, and was steadily emaciating. She had never vomited, but had been much troubled latterly with acidity of her stomach. On examination a distinct tumor was found in the right hypochondrium, which was quite immovable. Between its upper margin and the ribs a distinct sulcus was felt, the base of which was dull on percussion, and resisted pressure. She had never been jaundiced and the bowels were regular. The immobility of the tumor, the absence of vomiting, and the regularity of the bowels, caused, at first, some difficulty in deciding whether the liver or the pyloric orifice of the stomach was the primary seat of the affection; but as the disease advanced, this doubt passed away, in consequence of the steady and rather rapid enlargement of the tumor, the sulcus alluded to remaining the same; so that for some time before death it was considered that the disease was seated in the pyloric end of the stomach. She became gradually weaker, and for the first time, about 24 hours before death, was seized with vomiting. The matters ejected by the stomach and bowels were dark and like tar. She was very desponding and querulous from the time of her admission into the hospital. The post-mortem examination found a large amount of cancerous deposit in the region of the pyloric end of the stomach, but so situated that the pyloric orifice was retained permanently open, and free from contraction. Fibrous adhesions existed between this deposit and the margin of the liver and the tissues behind it. Cancerous deposits were also found in the liver, in the mesentery, in the uterus, and a cancerous ulcer in the rectum. No ulceration had taken place in the stomach, and the duodenum was free from disease. The heart was

greatly atrophied, as was also the spleen.

In the second case the disease was seated at the entrance, or cardiac end of the stomach. The patient was a male, and said his age was 50; but he looked more like a man of 70. He had been intemperate. He was fearfully emaciated, and his voice little louder than a whisper; his abdominal parietes were retracted in upon his spine. He stated on admission that he had lost his appetite about December last; that he had frequent eructations of acid fluid; had vomited everything for the previous three weeks, and the bowels had not acted for 15 days. He was very pale, and remarked that the vomiting generally took place immediately after the food reaching his stomach; but that at times the food appeared to stop at a spot pointed out by him as immediately underneath the ensiform cartilage, and did not get into his stomach, but after struggling for a time with what he called "his pipes," it returned again into his mouth.

There was neither tumor nor dulness on percussion in the region of the pyloric end of the stomach or liver, nor could any hardness be felt in the epigastrium, even when he was asked to cough, so as to tilt forward the cardiac end of the stomach; but the frequent stoppage of food at the point he mentioned, and its immediate rejection from the stomach, even when it had apparently succeeded in passing on, indicated at once that he suffered under obstruction at the lower end of the oesophagus, and disease of the cardiac end of the stomach.

His food, up to his admission, had been partly solid and partly fluid, but he thought he got on better with fluids than solids. He was ordered a pint of sweet milk, and 4 oz. of spirit in it, to be given in tablespoonful doses at regular intervals—a mode of giving nourishment in such cases that has often been very successful. He was also to take a teaspoonful of castor oil every four hours till the bowels acted, which they did after the third dose. He retained a considerable portion of milk during the next 24 hours, and was most cheerful and hopeful as to the result, and approved highly of the whiskey and sweet milk. The evacuations from the bowels were greenish, and continued so for several days. During the three weeks he survived in hospital he was, as is usual in such cases, sometimes better, sometimes worse; but there was, all through, an entire absence of the despondency so characteristic of cancerous disease. For the last ten days of his life the evacuations from the bowels resembled a mixture of black earth and water, but no discoloured fluid was at any time vomited. He complained so much of severe pain in his back, that he was examined repeatedly with the stethoscope for other indications of aneurism.

On slitting open the oesophagus, there was found some morbid alteration of the mucous membrane, at various points within two or three inches of the stomach; and there was found also an elongated tubercle, having a strong resemblance to a tongue, even to its possessing a frenum, extending from the cardiac orifice up into the oesophagus, which at once accounted for the feeling he experienced of the food being stopped at that part, and having to struggle back into his mouth; for it was evident that a perfect valve

against the passage on of food would be formed by this substance, if by chance the first morsel that went down got impacted between it and the walls of the œsophagus, in this way forcing it down over the entrance to the stomach.

The cardiac orifice was also found thickened, hardened and contracted, from the cancerous deposit; and immediately after entering the stomach, towards its lesser curvature, there was found an excavated sloughy-looking ulcer, with inverted edges, which at once satisfactorily accounted for the immediate rejection of food, even when it had been successful in passing the obstructing valve which has been just described.

The remainder of the stomach was rather thickened, the pyloric orifice narrow, but entirely free from disease. The liver healthy. The spleen not less than natural, and the heart considerably atrophied.

The œsophagus was not dilated above the obstruction, as often takes place in such cases; which probably depended on the fact, that the obstruction here was rather owing to this valve-like substance only obstructing occasionally, than to any very great or constant contraction of the cardiac orifice. The post-mortem examination of these cases is very instructive.

In the first patient there were absent two of the most diagnostic symptoms of disease at the outlet of the stomach, namely, vomiting, and the power of moving the tumor across the mesial line; the former, the inspection after death showed to have been owing to the cancerous deposit being in such a position that it retained (contrary to the usual course), the orifice perfectly open, so that there was no obstruction to the passage on of the food; the latter was dependent on the firm adhesions between the liver and stomach, and tissues behind it rendering the tumor incapable of being moved out of its position.

In the second case the post-mortem was equally instructive, from its confirming how accurately the patient had described the locality at which the food was occasionally stopped when it was passing into the stomach, and gave rise to "the struggle in his pipes," which followed before it returned into his mouth; and because it also showed the dependance that could be placed in such cases, on the immediate rejection of food, as diagnostic of disease at the cardiac end of the stomach.

The examination of these cases proved also the correctness of the opinion, that when cancer is seated at the pylorus, the duodenum is never involved, but when seated at the cardiac orifice, the œsophagus is always more or less diseased.

ADDRESS DELIVERED BY Dr. M'GEE, PRESIDENT,

At the close of the Session, 1st. May, 1857.

GENTLEMEN,—In my inaugural address I brought under your notice some of the more important duties of the physician, and I have selected, as the subject of my present discourse, the progress of science during the

present century, more especially of medical science, and its collateral or allied branches. Progress, which, like the river flood, ever rolling onward, ceases not to swell till it overflow and fertilize the thirsty, barren land it passes over—progress, than which, of all the laws stamped on the universe, we shall find none more deeply impressed.

Those who love to trace back the spring of all knowledge to ancient days, believe that it had its source in the East, and flowed thence, with a fertilizing current, westward: and true to the spirit of the *Laudator temporis acti*—they dwell on the glories of bygone days—lament how degenerate we have become: and pointing to the poets, painters, sculptors, orators, dramatists, historians, philosophers and physicians, of Egypt, Greece, and Rome, they ask, where in these days we can find an equal to the men of note who then flourished? It is true they were giants in their time, yet we also can boast of the celebrities of our days.

If, in this onward march everywhere observable, mental science has, as some assert, made less progress than physical science, it is chiefly owing to the more attractive character of the latter branch; still we cannot fail to observe the mutual dependence of all departments; for we shall find none that does not give to, and receive from, every other department, material aid, thus forming, when united, one firm chain, every link of which is of importance to their common bond of union.

It would be to take a very narrow view, if we classed, for instance, natural philosophy and chemistry, as subjects merely of amusement, or relaxation from other studies. There are few of the later discoveries, in these departments, that cannot be shewn to be of primary importance in promoting the health or the worldly comfort of man.

How ennobling to the name of Davy has been his safety lamp? Of less brilliant pretensions, yet of much value to the artizan, is the simple but effectual means of preventing that fatal disease, "the dry grinders' rot," viz., the use of the magnet, which arrests the fine steel dust, formerly inhaled; in short, I may ask, what art or trade has not been benefitted by chemistry or natural philosophy?

In our own department, the anatomist is indebted to the microscope for his knowledge of the minute structure of tissues, healthy as well as diseased. Again, when some careless observer shall inquire how the discovery of the polarization of light, which he views as a mere amusing trifle, can possibly benefit man, to those who are in the habit of using the microscope, the value, indeed the necessity, in certain cases, is well known; but on a more important point, let us hear what Arago says. He has shewn that polarized light, which is contained in the moon's rays, in the light from the clouds, and in all reflected light, carbonizes, while direct light oxygenates; hence the unhealthy effects of the light in the dwellings of the poor, situated in narrow alleys, reflected from opposite walls, as compared with direct light. But not alone does the kind and amount of light enter materially into the sanitary condition of dwellings, but colour also must now be considered an important agent. (Dr. M'Gee here referred to an article in the *Dublin Medical Press*, shewing that rooms

coloured yellow were productive of disease among the inmates, which disappeared on the white-washing of the walls; and he observed in confirmation of the theory, and as a proof that it was not a mere coincidence, the effect of yellow light in preparing for photography).

Again, where it is proved to us that the electric, galvanic, and magnetic fluids, and even highly concentrated steam, are identical, we must not consider such knowledge as unimportant. Scoresby, that ardent votary of science, made a voyage of 30,000 miles, out and home, for the sole purpose of testing his theory of magnetic deviation on shipboard, thus benefitting man as regards navigation; then in furtherance of physiology, we find Dr. Radcliffe asserting, as the result of actual experiment, that an electric current exists in a muscle of the body during rest, and ceases during contraction; that then, as also during cadaveric rigidity, the needle of the galvanometer stands at zero, and that it is by neutralizing the already existing natural electric current, that artificial electric currents produce contractions in a limb.

It would be to prolong this single question of magnetism or electricity to an infinite extent, if I entered on the various modes of generating those powers, or the laws that govern them; hereafter I perhaps will refer to some of their uses.

In natural history we find some lessons of importance; among the many that press on us, and injuriously effect our interests, I may remind you of the *Tænia*, and *Cysticercus Cellulosus*, and their transformations; and the student of skin diseases will have brought vividly before him the vegetable and animal parasites.

Yet, notwithstanding all the benefits she has conferred, science has been accused of fostering crime, by the facilities afforded for its perpetration; in her defence we can plead that science has deprived the criminal of all reasonable chance of escaping with impunity.

The electric telegraph enabled the officer of justice to arrest in his flight, and bring to punishment, the murderer Tawell. The microscope, by its revelations, gave the clue to the detection of the gold dust robbery, and enabled the observer to prove the forgeries of the *Uranius Manuscripts*; and if last, certainly not least among its triumphs, the microscope has shewn forth, in all their enormity, the food and drug adulterations. Photography has, with other discoveries, in some degree aided the forger in victimizing the unwary; but in return, as has been well observed, "it takes and multiplies the felon's portrait, and so insures his capture." Chemistry may aid, and may have aided the secret poisoner, in effecting, with some degree of certainty, his wicked designs: but it has done much to lessen his hope of escape; and the question of Hamlet, "How long will a man lie i' th' earth ere he rot?" would now receive a different reply from the philosophizing grave-digger, and it would not be merely, "I faith, if he be not rotten ere he die, he will last you some eight or nine year. A tanner will last you nine years; for his hide is so tanned with his trade, that he will keep out water a great while;" for we know now that some poisons

serve, as it were, to embalm their victims, and so secure evidence for the conviction of the murderer.

If Marshall Hall had in no other way benefitted science, his application of the frog as a strychnometer, as well as a galvanometer, would immortalize him. He thus detected $\frac{1}{2500}$ part of a grain of acetate of strychnia.

In considering what are the qualifications requisite for an accomplished physician, it is manifest he should be sufficiently well acquainted, not with languages alone, but with general science; a man not merely of one idea, or devoted entirely to medical pursuits, in the ordinary sense of the word; but a man of varied accomplishments and enlarged ideas. Currie of Liverpool was not less estimable as a physician, or Charles Bell as an anatomist and surgeon, because they travelled into the field of literature and general science; and our profession can boast of many such ornaments.

Medical science, like a goodly tree, spreading far and wide, and drawing life and strength from every quarter, despises not the aid and support afforded by the humblest plant, repaying by its shelter, when at maturity, the aid formerly lent to it. Closely connected, as it is, with its allied branches, it would be difficult to draw the line of demarcation, and say that here or there the province of the physician ends, and that of the anatomist, or surgeon, or chemist begins.

Medicine, as a science, has had many difficulties to contend with, which have retarded its progress. Of these difficulties, the most obstructive, perhaps, has been the system of theorizing. It has been urged that there have been more false facts than false theories; perhaps people should rather say, "ingenious theories, that make the meat they feed on." Be that as it may, we cannot but feel that the theories of spasm, the Brunnonian theory, the theory of inflammation, and many others, have been the drag on the wheel of science. These, and various other theories, which sank as rapidly as they rose, failed because they were applied each as a master-key to unlock every door. We have seen some sink, to rise again with greater brightness; and in reviewing the history of medicine, nothing can be more strange than that of the Humoral pathology; this for a time exploded and forgotten doctrine, has again appeared, and we have clearly displayed by the aid of chemistry and natural philosophy, through the microscope and chemical analysis, facts of which the Humoral pathologists, in days of yore, got but an indistinct glimpse. Many late discoveries confirm the truthfulness of the Humoral or Blood Pathology. I may here instance, as the result of medical research, amyloid, or starch degeneration, fatty degeneration, pyæmia, uræmia, Bright's and Addison's diseases, the intimate and almost necessary connection between certain diseases, or diseases of certain organs, as for instance, heart, brain, and kidneys; and the diagnosis between the idiopathic and symptomatic forms of some ailments, may be classed among the valuable labours of our physicians. I will merely name the now almost settled question of the non-identity of typhoid and typhus fever—a question all important, and leading to some important pathological results; simply observing that Professor Huss, of

Stockholm, dissents from the opinions of Louis and Jenner.

In mental disease, though the moral and non-restraint system have done much, yet the labours of William Tuke, the quaker, and his cotemporary Pinel, leave much still to be effected.

Industrial pathology, in addition to the instances already quoted, has to acknowledge many other boons that she has received from the chemist; in illustration I have to refer to the proposition of Liebig, who would prevent lead colic by keeping the men engaged in lead manufactories charged, so to speak, with sulphurous acid.

Vital statistics and medicine mutually act and re-act on each other; and people are now, from witnessing the results of statistical returns, forced to admit that the influence of offensive and objectionable trades operates powerfully on health, and on the duration of life; and that they are indebted to the physician for the evidence that famine and pestilence stand in the relation of cause and effect.

The statement put forth that many of our sufferings are self-inflicted—that much of the disease men labour under, especially of the class termed zymotic, a name of itself conveying much to our minds—that a large portion of the ailments that are daily and hourly shortening the brief span of our existence, is preventable, startles us; but does it lead us to adopt preventive measures?

Have the statements again and again trumpeted in our ears, that when disease visits the cottage of the poor, it seldom passes by without leaving a summons at the palace of the rich, made any change in our plodding policy? But if men are to be guided only by mere money considerations—by the *argumentum ad crumenam*—then, in following up the financial view of the subject, we may remind all such that preventable disease does much to fill our workhouses; and it might be worthy inquiry what cost the death of one head of a family entails on the poor-rate.

I will not detain you with the history of the sanitary reform movement, lately roused to a state of active progress by the efforts of some benevolent but bold men—men earnest in carrying out their honest views, bold in setting at nought public ridicule, and persevering in their efforts to induce others to join their ranks; but I must claim for my medical brethren of the army and navy, the merit of being the pioneers in leading what might then be considered a forlorn hope against existing evils. I give due credit to Howard, who carried into active operation, in civil life, the suggestions given by the example of our military and naval surgeons.

The labours, in late days, of Southwood Smith, Chadwick, Arnott, Kay, and Gavin, are now matters of medical history; and the “Enquiry into the condition of the Dwellings of the Poor,” and “Snow’s Researches,” are no mean additions to our medical literature.

I cannot, however, pass by in silence the important data as to the statistics and geography of disease, supplied by the reports and returns of our naval and military surgeons. By them we are instructed as to the influence of season, locality, temperature, latitude, age,

and even diet, in the production of disease; thus following up the observations of Humboldt as to the effects of mere altitude in checking yellow fever. By these returns we find that while some diseases prevail only in certain zones and isothermal lines, others are ubiquitous. We moreover now know that human epidemics are coincident with, or follow close upon, if they are not governed by epidemics among the lower animals. Again we are reminded, in our sanitary measures, when warned by offensive smells, not to be satisfied with the removal of the odour, but to remove the cause also; and not to consider deodorizers and disinfectants identical. The using a mere deodorizer has been quaintly compared to the “putting a clean shirt over a dirty skin.”

The physiologist, far from idle, has taken a first-class place in the race. We have had produced to us the nerve theories—not mere theories—of Charles Bell, and Marshall Hall, and Browne-Sequard, ardent and devoted labourers in the field of nature. Our present knowledge of the structure, and functions of the pancreas, spleen, liver, and perhaps of the supra-renal capsules also, is tolerably correct; and among the latest additions to our stock of knowledge is Richardson’s discovery of the cause, or supposed cause, of the coagulation of the blood.

Medicine has had vast and important additions made to its list of therapeutic agents; and I shall only contrast the mode of curing intermittent fever proposed by Mathew Henshaw in 1677—viz, the condensing or attenuating, as required, the air in a chamber, at the same time ventilating by the action of common organ bellows, with the use of quina. The merest tyro would deem me trifling if I mentioned cod-liver oil; but the most remarkable propositions we have had placed before us are, “the Ready Method” of Marshall Hall, for restoring suspended animation, and his tracheotomy in some forms of epilepsy.

Looking back to the state of chemistry at the beginning of the present century, and then considering what we have since had revealed to us, we find a state of things setting at defiance nearly all our preconceived opinions. We find the earths and alkalies of those days now proved to be metals. We see metals no longer distinguishable by ponderosity, or almost any of their former characteristics. We know that many of the bodies, then considered elementary, are not only compound, but have actually been resolved into what we, for the present, believe to be their primary elements. Can we be certain that the voltaic pile has revealed to us all the wonders of creation? Who will now venture to assert that other and more powerful agents will not be discovered, enabling future chemists to outrival Davy and his compeers? Can we be assured that even one of our gases, hydrogen, is not really a metal? There are some analogies that make the idea more than possible. We have seen, in our times, strange metamorphoses: We have seen common clay, or rather its alumina, converted into a metal, brilliant, sonorous to a high degree, ductile, malleable, not easily oxydizable by the atmosphere, and non-magnetic. It was originally obtained from cryolite, a Greenland mineral, but its present price is not much above the

price of silver, while its specific gravity is much less. Sanguine chemists express a belief that aluminium will be produced from clay, at a price as low as that of iron. Should this belief prove well-founded, what a revolution may be thereby produced, especially in ship building, aluminium being non-magnetic. Chemistry has taught us, not only how to separate or divide compound bodies into their primary elements, but also to combine and form, or reform, some substances from their elements; and here it is that the atomic theory of Dalton has done good service. Oil of mustard and taurine have been thus produced; and Daubeny, last year, announced the formation of several species of alcohol from coal gas, and the manufacture from guano of a beautiful crimson, rivalling cochineal; but you are aware that alloxan, with its rose-colour, ranging up even to deep crimson, and murexid, both obtained from guano, are products derived from uric acid, one of its constituents.

In science, names have not always been correct definitions of things. We now find chemistry rendering one name appropriate, inasmuch as photographs are now, or *may* now be light writings, instead of necessarily being sun pictures; they may now be produced by powerful artificial light, as that from sulphur burned in oxygen, or from phosphorus.

Chemistry has given material aid to the physician in his inquiries; has enabled him to verify Bright's discoveries, and to demonstrate, not only the existence of glucosuria in gravid, and in 50 per cent. of all nursing women, but to prove moreover, that glucosuria, being in the direct ratio of milk secretion, in the lower animals as well as in the human species, would serve as a good test of the value of a nurse.

In the industrial arts, chemistry has led to the adoption of many new and economical processes; while in the cure of disease our treatment has become more and more precise and effective, since the separation and purifying of the vegetable alkaloids.

Improved articles of food for our hard-worked soldier and sailor—such as preserved fresh meats and fish, and compressed vegetables, condensed eggs, &c., &c.—are amongst the boons given us by chemistry.

If, during the present century, the advancement of medical science has increased the average duration of human life—and the truth of the statement cannot be denied—we may equally claim for surgery the merit of having borne a fair share in the good work. In endeavouring to select subjects in illustration, one feels embarrassed by the superabundance, rather than by the lack of material.

Hæmorrhage, once the surgeon's dread, has now lost its terrors; and when we but think of the painful means formerly in use, we are surprised that the modern improved treatment was not sooner adopted. The ligature of arteries, in amputations and other surgical wounds, naturally led to its use in aneurisms—in popliteal, and afterwards, as we became more assured, in other aneurisms. The first attempts to tie the common carotid, the subclavian, the external and internal iliacs, may be remembered by some present, and the endeavour to prolong life by tying the abdominal aorta, in Dr. Monteiro's case, the patient dying on the tenth

day of secondary hæmorrhage, should be in the recollection of the youngest of you. The first attempt to ligature the internal iliac was made in Jamaica, that of the abdominal aorta in Rio Janeiro—both within the tropics!!

Not satisfied with the triumphs he has obtained, the surgeon seeks further victories over disease and death, by the application of the ligature to the distal side of the tumor, when there may not be space on the proximal or heart side. Beyond this a further advance has been made, in the treatment of aneurism by pressure—an improvement originating in our own island. Conservative surgery, however, has more brilliant trophies to boast of: witness the resection of joints—of the elbow, shoulder, knee, and hip joints. Under conservative surgery may be classed plastic surgery, now so general. Adopted in Egypt and India in the fifteenth, and by Taliaconius in the sixteenth century, it was brought into notice in England by Lucas in 1803, and in 1814 by Carpe, whose success gave it a firm basis. Urethroplastie, first practised by Earle and Sir A. Cooper; and staphyloraphe, by Roux, in the case of my college friend, Professor Stevenson, of Montreal, were added to the triumphs of surgery. A good surgeon is no longer a man who is merely *a good cutter*; the desideratum being how much may be saved, not how much may be removed. I by no means object to legitimate operative surgery, and do not recommend for your adoption the course which Haller pursued, as he himself tells us in his biographical account, in his *Bibliotheca Chirurgica*. Eminent as he was as a dissector and consulting surgeon, and for seventeen years professor of surgery, he never ventured to operate on the living body—"nervis ne nocerem veritus."

When I merely name lithotomy, tenotomy in cases of contracted joints, as well as in talipes, Symes, perineal section, and the reduction of dislocations by manipulatory movements, so long urged on the student by John Barclay of Edinburgh, what a field is opened to our view. War, in itself a monstrous, though at times perhaps a necessary evil, has enabled the navy and army surgeon to contribute much to our stock of surgical knowledge, and the opportunity so afforded has been turned to good account by the establishment of chairs of military surgery in London and Dublin—a boon conferred on the metropolis of Scotland soon after the battle of Camperdown, at the instance of John Bell. In its advance, surgery has been greatly assisted by the chemical and physiological reasoning of Simpson and others; for it may fairly be questioned if, without the aid of ether, or chloroform, or amylene, operative surgery would have made such progress. These and other anæsthetics, as cold, aconite, and belladonna, by lessening the nervous shock, have greatly diminished the mortality after capital operations.

You all know that the road to the Temple of Knowledge is rugged and beset with difficulties—that the path is steep and toilsome; but though it be so, each step upward fully repays the fatigue; and the higher you ascend, you are the more raised above the clouds of prejudice, and obtain such views of the promised land of science as are forbidden to the low

grovellers on the earth. Knowing, then, that such is the route to the promised land, how grateful should the student of these times be for the facilities afforded him by the labours of those who have preceded him. He has now to guide him onward the experience of many who were obliged, as it were without a pilot, to grope their way in doubt and uncertainty. We have, in the works of our predecessors, an amount of medical and surgical knowledge which the most lengthened life and extended practice could not of itself supply. On every subject in medicine, surgery, and their allied branches, we have special treatises or monograms, giving us the accumulated experience of all former authors; thus affording abundant sources from whence the student may drink deeply.

Rapid as has been the march of improvement in every walk of medical science, there yet remains much to be done, leaving ample ground for profitable labour. If we may judge of the future by the past, a large field is open to the student anxious for a knowledge of the truth. Will the physiologist tell us why the mere malposition of certain secreting glands should prevent the efficient performance of their normal duties? Why cryptorchidii, men as well as the lower animals, should be incapable of fecundating?—why no spermatozoa are discoverable by the microscope in their seminal fluid? Will the chemist pronounce for us whether the presence or absence of ozone in the atmosphere be the cause or the effect of certain epidemic diseases?—or can he declare whether this ozone be a distinct appreciable substance, or merely an allotropic condition of oxygen? Or will the chemist aid us in preventing the disease of the jaw-bones caused by the phosphoric acid in the manufacture of lucifer matches?

Never consider any discovery unimportant, however trifling it may seem to be. Let each new fact serve as the means of further advance. It may be, that though in appearance trifling, it will prove to be the one link wanting to complete the chain of evidence by which some important theorem shall be superseded. For instance, after Serostus had, in 1553, announced the pulmonary circulation, Cæsalpinus the swelling of the veins below the bandages in bleeding, and Fabricius, in 1574, the the valves of the veins, our immortal Harvey, connecting these links with his own discoveries, at length, in 1628, gave to the world his account of the circulation of the blood. Harvey proceeded on the principle that every effect must have a cause, cause and effect being in indispensable union; that there could be no such thing as chance or accident; and that it was the duty of every philosopher or lover of wisdom to search out carefully the rationale of every result. Thus acting, Leverrier and Adams foretold, not only that a disturbing cause acted on certain planets, but they pointed to the very spot in the boundless firmament where that element of disturbance should be found; and accordingly the telescope verified their inductions by the discovery of the planet Neptune. They were led to their convictions by reasoning on irregularities they had observed in the motions of Saturn and the Georgium Sidus.

In your pursuit of knowledge let not any unworthy motive sway you, but love knowledge for her own sake.

That strange old author, Bernard, says—“Qui scire volunt, eo fine tantum ut sciant, turpis curiositas est: qui scire volunt, ut scientur, turpis vanitas est; qui scire volunt, ut scientiam suam vendant, pro honore præmio, &c., turpio quæstus est; qui scire volunt, ut ædificant, charitas est; qui scire volunt, ut ædificantur, prudentia est.”

In conclusion, permit me, gentlemen, to thank you for the kind and able support you have on all occasions afforded me. To you I am indebted for my duties having been so easily performed. I have further to congratulate you on the increasing prosperity of the Belfast Clinico-Pathological Society; on the position it has obtained, and the high character it deservedly enjoys.

To say that the session now brought to a close has been prosperous to the Society and profitable to its members would but faintly express what I believe you all feel. The discussions have been truly practical, and that man must have been dull indeed who did not derive benefit from them. For myself I have to admit that week after week I found instruction in all that I saw and heard—a further proof of the adage, that it is never too late to learn. With an increasing list of members—those members fully impressed with the advantages of our weekly conferences—your prospects are most promising; and I have no doubt that your progress will be continuous. *Esto perpetua!*

BELFAST
CLINICAL AND PATHOLOGICAL SOCIETY
FIFTH SESSION
1857 – 1858.

The opening meeting of the fifth session was held on Saturday, 31st October, 1857, in the Museum at the Belfast General Hospital.

The following members were present:—Dr. Thomas Reade, Dr. Ferguson, Professor of the Practice of Medicine, Queen's College; Dr. R. Stewart, Resident Physician, Belfast Hospital for the Insane; Dr. Drennan, Dr. M'Mechan, Whitehouse; Dr. J. Moore, Tyrone Militia; Dr. Dickie, Professor of Natural History, Queen's College; Dr. Seaton Reid, Professor of Materia Medica, Queen's College; Dr. Patterson, Surgeon Browne, R. N.; Dr. Corry, Dr. Mulholland, Dr. Johnston, Dr. Cuming, Dr. Murney, Dr. Bryce, Dr. Smyth; Dr. Heaney, Dr. Thompson, Dr. Wales, Surgeon Lamont, Dr. Dill, Dr. M'Cleery, Dr. Halliday, Surgeon M'Clements, &c., &c., in addition to a number of the medical students.

Surgeon JAMES MOORE, M. D. President of the Society, delivered the annual address, as follows:—

GENTLEMEN,—On this day, opening the fifth session of our society, I have the pleasing duty of returning the members my thanks for the honour they have conferred upon me in electing me as their president for the ensuing session.

Since we last met, death has been busy among our ranks. Three of our members have been removed from us—Doctor Horatia Stewart, Doctor Robert Gordon, of Castledawson, and Doctor Magowan, of Carrickfergus. Doctor Horatio Stewart, the worthy son of a worthy father, was known to you all, as Professor of Materia Medica in the Queen's College, and as a Surgeon connected with our Hospital; and may be best recommended to you by your recollection of the cases dilated on by him before your society. In personal character he was mild, open-hearted, generous, and honest—what occasion to say more; yet of his professional skill and abilities, had his life been prolonged, much more must needs have been said. Also of us was Doctor Robert H. Gordon. His nature was to inspire affection, his disposition to retain it; human kindness, a simplicity of heart, were the salient points of his character; you were attracted to him by the heart; the intellect, in all its varied and delightful power, was in him subordinated, uniformly, to the law of kindness. We have also to regret Doctor John Magowan, who was held in high esteem by all the members of our profession who knew him. He, also, was kind, affectionate, open-hearted, generous; and benevolent humanity marked every action of his well-spent life.

To proceed with the more immediate business of the day, I need hardly recapitulate the advantages of a society like the present, especially in the all important matter of verifying the results of diagnosis in the often

obscure and apparently contradictory indications of disease. Nor is it less important, by manifestations of diseased structure, to satisfy the mind of the practitioner in cases wherein the diagnosis and prognosis agree with the conjectural result. The mutual benefit to be derived from the free and candid interchange of professional opinion, and the new and unexpected lights thereby thrown upon the several cases brought under your notice, deserve also to be mentioned as illustrations of the value and importance of societies such as that which I now have the honour to address. Nor must it be altogether forgotten that, in addition to the special objects of our assembling, there is afforded by our regular meetings an opportunity of social communion and personal intercourse, naturally gratifying to the members of a learned and liberal profession.

That the benefits which might have been expected from such a society have been appreciated may be understood by referring to our list in the fifth year of its existence, embracing, as it does, the greater portion of the leading members of our profession throughout Ulster. Nor is it easy to estimate the effect on the progress of the healing art that may reasonably be expected to accrue, for the benefit of the world, during a long series of years devoted in the future to the objects of this society, with the earnestness and intelligence that have hitherto distinguished its members.

The great value of our society consists in its exhibitions, in connexion with specific cases, of the whole, or portions of the parts affected, so that any one present is in a position to see, as well as to judge for himself. Our meetings, therefore, are greatly in the nature of demonstrations; our preconceived speculations are compared or contrasted with morbid tissues; we are invited, by the constitution of our society, to enforce what we are able to say, by what we are able to show. Our theories of disease are put in comparison with the workings of disease itself; and from the frequent contemplation of cause and result, we are led, by analogy, to the confident expectation of future remedies in more favourable cases.

In many cases, however, we are unable to preserve for exhibition the morbid tissues; putrefaction, decolorization, render them no longer fit to lay before you; in such instances we have recourse to the assistance of Art.

Art, considered with regard to anatomical and pathological illustration, is either plastic or graphic. Of the former, casts in plaster of Paris, and models in wax, are the principal. The former is sufficient for the purpose of exhibiting mere outlines of form or dimension, as in tumours; many forms of extraordinary excrescences, as I may call them, are thus perpetrated for our information by casts in plaster. But the model in wax, from the pliability of the material, and its capacity for readily taking colour, is of infinitely more value in the demonstration of morbid structure, as it is also in strictly anatomical delineation. The parts exhibited in relief thus appear as in nature, of the dimensions, and with the colouring of nature, or, of diseased alteration, conveying an idea more vivid than can be reasonably expected from any merely graphic portraiture of the

parts affected.

To illustrate this, I need only refer you, for example, to a model in wax of the parts involved in the operation for lithotomy, as compared with an engraving on copper, or lithographs of the same. It is, indeed, evident, that no skill on the part of the artist, in the management of light and shade, could produce so clear and satisfactory a delineation, in the drawing as in the model. Other examples, where great inequalities of surface occur in the human subject, both in health and disease, will readily suggest themselves to you, so that it is unnecessary to dwell more particularly upon them.

The graphic art of engraving, applied to anatomical purposes, dates from a very early period, and its progress has kept pace with the progressive advance of the science, whose illustrator and interpreter it is. In its earlier stage, rude and clumsily-executed wood-cuts can scarcely be said to have illustrated the letterpress descriptions of our older anatomical writers. As an example of illustrations of this rude and imperfect class, I may refer you to the works of the celebrated Surgeon Ambrose Paré, printed a little more than two centuries since. The wood-cuts illustrating this writer are small, rude, and ineffective. A curiously illustrated work, the "Armamentarium Chirurgicum," of Scultetus, 1633, is enriched with wood-cuts of all the instruments and appliances then known to surgery. These, although they will bear no comparison with the best style of illustrative wood-cutting of our day, are curious and useful, especially as exhibiting to our view instruments supposed to have been the invention of celebrated surgeons of a very late date. I only mention this as one of many cases in which in all departments of science and of mechanical skill, wherein we find that many of our inventions and discoveries merely reproduce the ideas of our ancestors.

We shall here observe that while the art of wood-cutting as applied in illustration of surgical and pathological science has kept pace with the advance of their subjects, we find the higher branch of art, that of line engraving, or engraving upon copper with the tool, has not advanced by any means in a like proportion. In proof of this somewhat bold assertion I shall merely take the liberty of referring you to the plates illustrative of the collected edition of the works of Haller, published exactly one century since. These splendid line engravings require nothing but greater size to render them among the first of their class; clearness of outline, with careful discrimination of structure, a fulness and conscientiousness of delineation of nerve, muscle, bone, artery, and ligament painfully indicated, line by line, yet without harshness, coldness, or mere etching; in short, all the merits that an anatomical illustration should have, with just so much artistic character in the plate as can be given, without confusing the subject, from the high, but, by no means, undeserved honour which I think it proper to pay to this honest and careful work of one of our earliest and greatest anatomists.

These remarks, which are not made with a view of deprecating other and later illustrated anatomical works, may be excused for this reason—that, while they give honour where honour is due, they may faintly

indicate to the members of the society, the ideas that arise in my own mind, as to the nature of the merits of works so important to the student of anatomy and pathology. Of the requirements of such illustration, fidelity to nature is, of necessity, the very first; and, doubtless, all that the engraver's art can do, may be best accomplished in line by a superior artist; the mechanical operation of the engraving tool is a following out, fibre by fibre, as it were, of the structure intended to be pourtrayed.

Next to the plates of Haller, in order of time, and by no means inferior to them in merit, are those of the celebrated Scarpa (1794) distinguished also by faithful delineation and force in the engravings.

I might enumerate a vast number of anatomical works, in which the contrast to the plates of Haller and Scarpa is painfully evident, arising from carelessness in the drawing, or confusion, feebleness, or haste in the engraving; but this unpleasing task can best be performed by those whose inclinations and opportunities lead them to large libraries. I may observe that, by far the greater number of failures in illustrating anatomical descriptions, with effect, arises from the sketchy and feeble character of the plates, and the same objection applies to surgical illustrations in some cases, wherein, from a certain indistinctness and confusion, added to the very small size of the illustrations, a puzzling effect is produced; and the letterpress description, instead of being illustrated thereby, is apt to be rendered even less intelligible.

On the other hand, we must not forget the great expense incurred in illustrated works, especially those illustrated by line engravings, which must ever tend to limit the employment of this high branch of art, in delineations of anatomical and pathological subjects.

Before we quit the consideration of engraving in line, I think it necessary to direct your attention to the great work of Dr. William Hunter on the gravid uterus. Two of the plates—namely, plates 4 and 6, were engraved for this noble work by Sir Robert Strange, the pride of the English school of line engravers, and the unsurpassed ornament of his art. The connoisseur in art will be struck with admiration in contemplating these magnificent plates, while the anatomist and obstetrician will be delighted and instructed. It is not surprising, indeed, that the author of this work should have declared in the preface that his artist co-labourer had, by these plates, "conferred immortality upon the subject." How great must be the skill displayed by the engraver, you can imagine, if, upon inspection and careful consideration, you should come to the conclusion, as I did, that no colouring, however artistic, could give more reality, force, and natural character to the subject than the simple lines of the graver. I refer more especially to plate 6, which yields to none of the much coveted and universally admired works of this great master; and with this, the finest anatomical delineation in line engraving known to this, or, perhaps any other country, I quit the highest branch of the engraver's art.

Before doing so, however, I may be allowed briefly to refer to the works of an eminent surgeon, whose assistant at Edinburgh I was—Sir Charles Bell. His anatomy of expression, in connexion with the fine

arts—illustrated by his own hand, exhibits a high degree of skill, considered in a merely artistic point of view; while his operative surgery and work on the nerves, show the same artistic skill, dexterously applied to the more immediate service of his profession. Many of my hearers must recollect the large and admirable drawings—remarkable for the delicacy of colour and force of effect—with which he was accustomed to illustrate his surgical lectures.

The lithographic art, from its softness, easiness of execution, susceptibility of exact colouring after nature, and last, though not least, its comparative economy of cost, is largely employed, of late years, in the illustration of anatomical and pathological subjects. To it pathology especially is much indebted. By it one morbid preparation is multiplied and diffused, as it were, among many, so that the fleeting and changeable colours and external structure of rare disease can be preserved for recognition at distant periods, and the experience of one pathologist diffused among many more.

The plates of Cruvellier may be referred to as good examples of this important department of art; and we may here observe, that, in lithography, the French may claim the merit of combining, in an eminent degree, nicety and clearness of delineation, with natural effects of colour. The defect of lithography, when not carefully guarded against, is a softness, having a tendency to degenerate into obscurity. This is more observable in details and small objects, which may be better expressed, in many cases, by a clear and precisely executed wood-cut.

In justice to our own country, however, while we admit the merit of the French, we must not fail to recognise the excellence of a work designed, drawn, engraved, and edited by Dr. Quain and Dr. Joseph Macclise. The drawings, equally correct and spirited, by the latter (whose name is associated with the highest branch of art), show the great advantage of delineations from the hand of a surgeon and anatomist, who is also an artist. There is a spirit and character imparted to drawings by a hand equally skilled in the use of the scalpel and in pencil which it is impossible for the best artist, who merely mechanically follows out the details of the subject before him, to attain. We may, therefore, point, without vanity, to the anatomy of Drs. Quain and Macclise as a work of which any nation may be justly proud; and we, especially, of this part of the empire, who have the pleasure to know that both these gentlemen are our distinguished countrymen.

The observation, that what is subjected to our eyes conveys ideas to the mind quicker and clearer than descriptions, which are addressed to the ear, is as old as Horace, or, probably, as old as literature itself:—

*"Segnus irritant animos demissa per aurem,
Quamquæ sunt oculis subjecta fidelibus."*

We need not be surprised, therefore, to find that pathology, anatomy, and surgery, are largely indebted for their better illustration to the wood-cutter's important art. The advantage is, being able to print the illustrations with the letterpress, and thus have the woodcut and description side by side, may be appreciated best by the laborious student, for whose use in

various excellent hand-books and elementary works, these illustrations are abundantly, yet not quite enough, provided. These works it would be too tedious to enumerate, and invidious, partially to select from; the merit of the wood-outs is, of course, extremely various. Indeed, it may be observed of this useful and popular style of engraving, that it is capable, in skilful hands, of exceeding power, clearness, and force, and is equally liable, by carelessness, inaccuracy, or unskillful cutting, to render the text which it ought to illustrate less intelligible than it would have been without it.

Of the photographic art, from which the most important element of fidelity may most reasonably be expected, we have to lament, as yet, that the delineations produced by its aid are defective in permanence and durability—not much less to be desired than fidelity to nature itself.

It must be obvious to this society, that in applying art to pathological purposes, the readiest vehicle is the best. The readiest vehicle is, without any question, water colour. Without the depth, richness, and fulness of oil, which is requisite in the embodiment of conceptions of high art, the water colour has in skilful hands, a transparency and clearness which render it highly useful as an educational agent of pathological instruction. Any gentleman present who has had the advantage of looking over a portfolio of the water-colour drawings of diseases of the skin, for example, by Connolly, of Dublin, will at once recognise the fidelity to nature, and the value to the profession of such drawings.

It is much to be desired that our students—such of them, at least, as possess a taste for colour—could be induced to turn their attention to pathological water-colour drawing. To copy accurately the outward aspect of the morbid appearance set before them, without exaggerating the colour, on the one hand, or losing the true effect by feeble touchings, false tints, a striving after effects neither required nor permitted by the subject, on the other—this is the only requisite in drawings of this nature. Nor is it always or altogether easy, and is to be attained alone by a conscientious determination to produce no drawing that does not faithfully represent, and can be distinctly recognised, as representing what it professes to imitate from nature. Another accomplishment will, by the practice of this art, be added by the student to the many that are required by the truly learned physician, and his labour in art may be rendered creditable to himself, and interesting to his professional brethren, and, above all, useful to society.

I should, perhaps, apologise for having detained the society so long by this detail of the rise and progress of the graphic arts, in connexion with pathology, anatomy, and surgery; and I must admit that my review is not only imperfect, but, I fear, may be considered tedious. Yet I can conscientiously state to the society that, if I had entered into all the details which the importance of the subject deserves, I should have been compelled to make further demands upon the patience which they have so generously extended to me on this occasion.

I must find an apology for the manner in which I have treated this subject: in the importance of the

subject itself; it would be impertinent to dwell further upon the importance of art, in connection with the medical sciences. We may also plainly see that medical art, as I may call it, is greatly extending itself, and becoming popular, which it would not do, if its value and importance had not begun to be generally appreciated by the profession. I may also plead that I was induced to direct your attention to the subject of art in connection with the profession, partly because my own tastes, habits, and opportunities have led me a good deal into the practice and observation of it—and, partly, because I do not remember to have seen this subject treated of before in an inaugural address. I must do myself the justice to say, however, that I should not have taken up the subject because it is new, if I had not been convinced at the same time, that it is eminently useful.

Art speaks a universal language. It reproduces the forms of disease, whose colours, texture, and, if we may say so, characters have faded away; it multiplies transcripts of morbid appearances, each of which is a copy of the other, and of the original; it thus extends beyond a narrow circle or a short period of time the results of our separate experiences, and combines them for the benefit of the whole profession. And here, I may be permitted to observe that the benefit of art, as applied to the medical sciences, will be still further extended when we boast of greater numbers of the profession, who, with natural taste for the arts, improved by practice, shall devote their talents to the pictorial illustration of disease. There is a constant and unavoidable loss of effect in every transfer from the drawing to the engraving, which would be avoided if such of our students as may manifest a talent for drawing, would extend their labours, like Sir Charles Bell and Dr. Joseph Macrise, to the acquisition of the engraver's art, in connexion with professional subjects.

While I am fully aware of the necessity of art in connexion with our profession, I must not be understood to exaggerate its importance. Till we make every proper and legitimate use of these our pathological, anatomical, or surgical studies from nature, we must never cease to refer, upon every practical occasion, to the indications exhibited to us by nature herself.

We must continue industriously, perseveringly, to exhibit our morbid appearances, to produce the curative results of our treatment, whenever practicable, in the persons of the living subjects, as it is our custom to do; to confirm principles by experiment; to decide theories by facts; and to escape from the doubtful and contradictory sea of opinion into the safe calm haven of actual demonstration.

* * *

The following interesting communications (among others) have been made to this Society during the present Session.

SECOND MEETING
November 14th, 1857.

Dr. H. THOMPSON, of Lisburn, reported two cases as illustrative of the efficacy of Arteriotomy in Inflammation of the Eye. The first case was of a man, æt. 60, blind for the last year from hard cataracts. The operation of extraction was performed on the right eye, and all went on well until the tenth day, when, in consequence of an accidental blow, acute inflammation set in. Six hours after the injury six ounces of blood were abstracted from the temporal artery, with complete relief to the pain, which had previously been constant and intense. Calomel was given to salivation, cold water kept to the eye, and a couple of leeches applied, from time to time, to conjunctival margin of lower lid. These measures subdued the inflammation, and he soon left the hospital, able to read large letters.

Second case.—A man, aged 20, had received a blow from a thorn branch in the left eye, three weeks before his admission into hospital. An opaque lens, projected through the pupil dilated to its utmost extent, was then in contact with the back of the cornea. There was vascularity of the conjunctiva, with chemosis and swelling of the lids; excessive pain of head and eye, and vision totally extinct. Arteriotomy to eight ounces at once relieved the pain of the head. The next morning an iris knife was passed into the opaque lens, which flowed out as a milky fluid. The pain of the eye ceased in half an hour. On the third day the iris had resumed its natural position, the pupil was half dilated, and a clot of blood could be seen in posterior chamber. A couple of leeches were applied every two or three days, and wet lint to the lids. Salivation had been induced before admission. Absorption of the clot gradually took place, and vision improved slowly but perceptibly.

In the discussion that followed, Mr. BROWNE declared himself decidedly opposed to general depletion in ophthalmic inflammation, considering the very opposite line of treatment much more generally advisable. Where blood is to be abstracted, he preferred leeching to arteriotomy.

Dr. BRYCE spoke strongly in favour of early and copious bloodletting in inflammation of the eye; and Mr. LAMONT thought, that in iritis at least, free bleeding was of decided benefit.

Professor FERGUSON deprecated the abstraction of blood in general as a means of subduing inflammation.

FOURTH MEETING
November 28th, 1857.

Dr. BABINGTON, V.P., reported a case of
Prolapsus Recti

in a young woman, supervening on diarrhoea, which set in after an easy childbirth. The protrusion had been mistaken for piles by another practitioner, who

included it in a ligature. This caused intense pain, and on the second day he removed it, and did not see his patient again. On her admission to the Co. Londonderry Infirmary, the prolapsus was of ten weeks standing, and eight inches in length. Its surface was glazed and dry, and at about three inches from the end marked by the ligature. There was emaciation, with irritative fever, stomach rejecting all food, and no alvine evacuation for three weeks. There was distension of bladder, with escape of urine on vomiting; three pints of water were drawn off, and the intestine was reduced with very slight pressure. Its return was immediately followed by a considerable muco-purulent discharge, and great relief to the patient. Two grains of opium were given, to be repeated at bedtime. On the next day (September 7th) the abdomen was distended, but not tender. The sickness continued; pulse 120, small. Ordered castor oil and turpentine; enema in the evening. The abdomen to be well fomented.—8th. Draughts had been rejected, nor could an enema be given, as neither a stomach pump tube nor a No. 13 catheter could be introduced further than three inches. The abdominal distension was very great; vomiting incessant; retention of urine continued. Calomel and opium, and draughts of hydrocyanic acid, were ordered.—9th. Had passed water, but bowels had not been moved. Abdominal distension so great as to impede respiration; pulse 130. Dr. B. proposed Amussat's operation, but the patient refused to submit, nor would she allow any further instrumental examination of the anus, from which there continued to flow a considerable muco-purulent discharge.—10th. At 2 a.m., she passed a foecal evacuation, mixed with blood and mucous shreds. These evacuations continued with irregular frequency for several days; the vomiting ceased; the abdominal distension gradually diminished, and in three weeks she walked out of hospital. The remarkable features of the foregoing case, viz., the size of the prolapse, the prolonged period of constipation, the cause and source of the purulent discharge, with the propriety of resorting, in such cases, to Amussat's operation, were briefly commented on by some members, but in the absence of the writer, it was not thought desirable to protract the discussion.

FIFTH MEETING
December 5th, 1857.

Mr. BROWNE, V.P., introduced a patient suffering from a peculiar displacement of the

Crystalline Lens of the Left Eye.

The man was a nailer, aged 55 years, who, when a child, lost the sight of the right eye by the stab of a penknife. He had enjoyed good vision in the left eye till within eighteen months, at which time sight began to decline gradually, till it became extinguished completely, save the appreciation of the difference between light and darkness. When Mr. Browne first saw the case, the left eye presented the usual features of cataract, the pupil being undilated; dilatation, however, exhibited the opaque lens, drawn, as it were, to the

inner side of the pupil, leaving a small space to the outer side, through which tolerable vision was obtained. The lens was evidently displaced from its bed in the vitreous humor, probably from disorganisation of that body, and partial destruction of the ciliary processes. It was tremulous, and held in situ by the attachment of some few of the inner ciliary processes, while its outer edge projected into the pupil. Mr. B. considered the lesion to depend on disease of the hyaloid membrane, and that the disorganisation of the vitreous body was not the result of sympathetic ophthalmia; he proposed to puncture the lens with a fine needle, and when partial absorption had taken place, to extract the nucleus.

SIXTH MEETING
December 12th, 1857.
The President in the Chair.

Last session (November 15, 1856), Mr. JOHNSTON presented a man, aged 60, affected with

Anæsthesia of the Cutaneous Surface of the greater portion of the Thorax.

Some members at that time thought it was a form of neuralgia; others that the seat of the disease was in the spinal marrow. Mr. Johnston again brought the patient under the notice of the society. The disease has existed above four years. The symptoms have made very considerable advance during the past twelve months. Neuralgic pains, shooting from the dorsal region around the thorax to the epigastrium, are very severe. The cutaneous anaesthesia still exists, but does not seem to have extended; for a time the patient thought his sense of feeling improved. He has often in the affected part sensation of warmth and cold. In addition, however, to the previous symptoms, he now presents manifest unsteadiness of gait. When he sits he wishes to relieve the spine of the weight of the body by supporting himself with his hands, and leaning back. The functions of the bladder are unaffected—there is some difficulty in defecation. There is no paralysis of motion or of sensation in the upper extremities. No decided evidence of any cerebral lesion. The senses are perfect. No evidence of cardiac or pulmonary disease. Mr. Johnston considered the case as one of organic disease of the spinal marrow—probably ramollissement—seated in the upper portion of the dorsal region. He regarded as a feature of special interest, the first manifestation of the disease (four years since) in the “numbness” of a patch of skin about the size of a half-crown at the angle of the right scapula. The man himself attributed the disorder to cold.

Mr. BROWNE, V.P., shewed a case of Conical Cornea in a woman, aged 39. She had suffered from ophthalmia from infancy, and the affection of the cornea had existed from eight to ten years in one eye, and six in the other. There was still tolerable vision in the right eye. Mr. Browne considered this affection to depend on a chronic form of inflammation; that it was incurable by operation or otherwise; but that its progress might sometimes be arrested by a tonic plan of treatment.

Nature seemed sometimes to resist the thinning process by the effusion of lymph. A concave glass, with diaphragm to exclude the outer rays, was occasionally of use.

The PRESIDENT presented a female with what he believed to be Osteosarcoma of the hard palate. It was of fifteen years' duration, and had latterly enlarged. Its surface was unequally resistent. He proposed its excision.

Dr. MURNEY exhibited the foot of a boy, which he had amputated for Osteitis consequent on injury, followed by extensive ulceration and copious haemorrhage. The os calcis was almost destroyed; its texture soft and friable, and the astragalus also was found much diseased within five weeks of the accident. Amputation was performed rather below middle third of leg, to give a long stump. Dr. Murney preferred amputating above rather than at the ankle-joint, as securing a much better stump, and more perfect locomotion afterwards.

Professor REID shewed the brain and kidney of a woman, aged 19, who had died two days previously in hospital. For the first five days after admission she had presented no symptoms of brain-disease. They then supervened, and there was constant screaming for a period of eighteen hours, followed by a rational interval; pain of back had been complained of, and the urine was albuminous. The post-mortem examination revealed thickening of the membranes at the base of the brain, more especially about the optic nerves. The kidneys were decidedly fatty, and there were, moreover, specks or small particles of tuberculous matter in both their cortical and tubular substance. The woman was emaciated, and the cerebral inflammation of a subacute character, and Professor Reid surmised that the latter was dependent on the disease of the kidneys, which he conceived to be the original morbid affection.

SEVENTH MEETING
December 19th, 1857.

The PRESIDENT introduced a man whom he had formerly presented to the Society whilst suffering from Popliteal Aneurism. He had been completely cured. After thinning of the integuments had far advanced, absorption of the tumor had taken place, by means of compression with Carte's instrument.

Mr. JOHNSTON detailed the following cases of Hernia, with Intestinal Haemorrhage.

Alexander Stinson, æt. 50, a weaver, had rupture for above thirty years. He never wore a truss, but always enjoyed good health, and was always able to reduce the hernia, except once, about twenty years since, when he was ill for two or three days. His wife states that at that time he had a large discharge of blood from the bowels, and the rupture was reduced without surgical interference. He went to his work on Wednesday, November 25th, as well as usual, returned to work after dinner,

but about six o'clock he felt unwell, and complained of pains in the bowels. He now found that he could not reduce the rupture. He reached home about eight o'clock; Surgeon Hanna saw him about one o'clock, and found that he had a very large scrotal hernia. The tumor was tense, painful, and irreducible. He advised him to go to hospital, but he preferred remaining at home, and taking some castor-oil, and using a fomentation. During the night he repeatedly tried to effect the reduction of the hernia, and, not succeeding, he fell asleep. About three or four o'clock, a.m., when he awoke, he was greatly gratified in finding the tumor reducible; but his wife now observed that he was very much changed, being pale and faintish. The pains were gone, but he was thirsty, and complained of soreness and "heart-weakness." In a short period he felt inclined to get up to the night-chair, when he had a very copious evacuation of blood. I saw him during the day, and found the tumor reducible, but the patient in collapse. His pulse was scarcely to be felt; his extremities were cold, his features pinched, eyes sunk; one sound only of the heart audible, and an anaemic bruit over apex; little or no tenderness of the abdomen, which was slightly tympanitic. I ordered a mixture of acetate of lead, and administered some opium, and directed whiskey punch. The bowel was reduced with ease. Dr. Wheeler saw him with me in the evening, and we both regarded him as in a dying state, there being as yet little reaction. The following day I was surprised to find a decided improvement. Pulse could be distinctly felt; surface was warm; the second sound of the heart was audible; no vomiting, nor further discharge of blood by stool; no abdominal tenderness; tongue thickly coated; complete anorexia. This day Dr. Moore saw him with me, and to neither of us did there appear any evidence of peritonitis, but the weakness seemed attributable to other causes. The case was one for stimulants and nourishment. For a day or two I had some hopes of his recovery; hiccup, however, now annoyed him very much, and he had some tympany of the abdomen. He took no nourishment, his bowels became relaxed, and he died from asthenia on Tuesday, December 1st, at half-past six o'clock, p.m.

At first, on visiting this patient, I asked myself, if the complete state of collapse could possibly indicate any rupture of the bowel; but at that time the absence of vomiting, hiccup, or tenderness or swelling of the abdomen, contra-indicated such a conjecture, as well as the idea that there was any extensive peritoneal inflammation. I therefore attributed the collapse to the haemorrhage; and here I was again at a loss as to the cause of the latter—whether it was owing to the attempts at reduction, or to an effusion of blood in consequence of extreme congestion of the capillaries of such an extensive surface of strangulated intestine, the hernia being very large. I examined one evacuation he had a few days after the haemorrhage, but did not discover any blood; it was rather of a thin, fluid character, and of a greyish colour. Did the hiccup and tympany towards the end indicate a low form of peritonitis? At no time was there any considerable degree of tenderness. The circumstances of this case reminded me of another which came under my obser-

vation when resident in the Richmond Hospital. A healthy, middle-aged man was admitted about noon, with strangulated hernia. I was directed to try the taxis, and administer an enema. Repeated efforts were made to effect reduction, but without success. I was directed to summon a consultation of the surgeons for eight o'clock, p.m., and to let the patient have a warm bath at the same time. When the patient was in the bath I found he was becoming very weak; still the hernia could not be reduced. I had him immediately removed from the bath; yet such was his state of prostration, that the surgeons agreed it would be wrong to operate. He never rallied, but died from asthenia before morning. I made a post-mortem examination, and was much surprised at finding a considerable portion of the small intestine filled with a large quantity of clotted blood, evidently an effusion from the venous capillaries. A protracted discussion followed, in which different opinions were expressed as to the cause and seat of the haemorrhage in such exceptional cases as the foregoing. Some members regarded the incarcerated portion of intestine as furnishing the blood; others, that it issued from a more extensive mucous surface. Some thought that it was the consequence of ulceration or abrasion, and others that it was an effusion from the congested capillaries.

ORDINARY MEETING

January 16th, 1858.

The President in the Chair.

Dr. GRAVES, V.P., read a paper

On a New Mode of Treating Strumous Abscess of the Superficial Glands of the Neck.

He must be a bold man who, in these days of science and of progress, claims for himself the discovery of a new method of treatment. At the risk, however, of being, perhaps, considered egotistical, I am induced to publish a plan which I am satisfied has, in my own practice, proved useful, and to which I have been unable to find any reference in the books at my command; nor have any of the medical friends with whom I have discussed the subject been more successful than myself. All surgeons are familiar with the class of cases to which I would draw attention, and few but have heartily wished them removed from their care. I allude to subcutaneous abscess, occurring in patients of a strumous diathesis, chiefly met with in the superficial cervical glands—tedious and insidious in their course, and generally, after months of suffering, ending at the best in elevated cicatrices, with wheals and scars; under the most careful and judicious treatment bringing unmerited discredit on the practitioner, and disgust to the patient. I have had recourse to various expedients—free incisions, valvular openings, poultices, and spontaneous evacuation, with a like uncertain result; some, presenting the worst appearance, healing without trouble, while others, in every respect hopeful, have baffled all my exertions for months. Several such were, in dispensary and private practice, under my care during the past year; and seeing that iodine, cod liver oil, iron, &c., &c., applied

externally and internally (administered with, when it could be obtained, a generous diet, warm clothing, &c., &c.), produced little benefit, I determined to try the effect of a counter-inflammation; and observing that a thickening and adhesive process followed vaccination, it occurred to me, that if this was satisfactorily established in one of these abscesses, the sac would probably be obliterated without much difficulty. We all know that, in secondary vaccination, a pustule is produced by the introduction of the virus, after the lapse of a definite number of days; and though the result may not prove a true vaccine pustule, still the inflammation will, in the majority of instances, possess a specific character. Be the result successful or otherwise, I will feel deeply obliged to any gentleman who will kindly furnish me with the particulars of any cases which he may determine to treat on this principle.

In January, 1857, A. B., a mill-worker, æt. 14, of strumous habit, applied at the Cookstown Dispensary, suffering from an abscess of the cervical glands on the right side of the neck, about the size of a nutmeg. The skin was but slightly discoloured, but fluctuation evident. I gave exit, by a free incision at the lowest part, to a small quantity of matter; then charging my lancet with cowpock infection, introduced it in the usual way, by a few slight scratches at either side of the wound, taking care that it should come as little as possible in contact with the discharge from the wound. On the eighth day it had evidently "taken" well; there was the well-marked inflammation surrounding the vesicles. "On the ninth," as Maunsell and Evanson describe it, "there was formed round the base an inflamed ring, with an areola of an inch and a half or two inches in diameter." In this case the redness was more extensive. On the twelfth there was considerable inflammation and hardness all over the surface of the tumor, and very little discharge from the original opening. On the sixteenth this had in a great measure disappeared; and when, in about three weeks afterwards, the crust had dropped off, there was no trace of the abscess, and very little more scar than is left after an ordinary vaccination. I should mention that this patient had not been previously vaccinated.

In March, E. M., æt. 21, a person in comfortable circumstances, consulted me. The history and progress of this case is so similar to that just related, that I need not enter into particulars. The result was alike satisfactory.

September—In the third case, that of C. R. æt. 16, in not good health, there were some circumstances that may require notice. She had a tumor on the left side of the neck, about the size of a horse-bean, very red-blush red—and evidently about to break. Altogether this appeared an unfavourable subject. For some time I hesitated as to the expediency of treating her in a similar manner. The two former cases had given me confidence, and I determined to risk the experiment. Matters went on well till the ninth day, when a considerable amount of inflammatory action had set in. From the wound escaped an unhealthy ichoros discharge. I administered an aperient, and ordered quiet, but on the second day after, the eleventh

from vaccination, there was well-marked erysipelas of the neck and side of face, but, as first observed, I think by the late Dr. Graves, limited by the median line. A linseed meal poultice was ordered, salines and diaphoretics given, and within a week the girl was walking about. In this instance I cannot say what was the effect of the vaccine inflammation "per se," inasmuch as it was complicated with the erysipelas—it is not easy, among pauper patients, to obtain accurate accounts; but this I do know, that at the end of four weeks the abscess was obliterated with very trifling deformity.

Dr. RUSSELL, of Bangor, presented a small warty excrescence which he had excised from a man's uvula.

Mr. BROWNE exhibited a similar specimen in the early part of the season. Dr. HALLIDAY referred to a growth from the same part, which he lately met with in a partially detached, and apparently sphacelated condition.

Mr. MULHOLLAND showed a small brass button which he had removed from a child's nostril, after it had remained there for thirteen months, and had induced fistula lachrymalis.

The PRESIDENT showed the anterior portion of the right cerebral hemisphere of a boy, aged 13, who was admitted into hospital three weeks before his death, with a fracture of the cranium over the right temple. He was then labouring under symptoms of concussion. His pulse was 120 the first night; afterwards falling to 100. The integuments were unbroken, but there was a movable portion of bone at the site of injury. In four days, under the employment of mercurial treatment, he began to exhibit returning consciousness, and subsequently seemed to recover completely from the effects of the accident, manifesting at no period, either paralysis, rigidity of the muscles, or intellectual disturbance. On the lapse of a fortnight, however, there was a recurrence of feverish symptoms, and forty-eight hours after, being sized with rigor, he died comatose. A portion of the internal plate of bone, of about an inch in length, at the seat of the fracture, was found depressed one-eighth of an inch, and projected against the dura mater. An irregular cavity, containing thin ichorous matter and surrounded by clotted blood, occupied the subjacent portion of brain.

ORDINARY MEETING

January 23rd,

The President in the Chair.

The PRESIDENT presented a boy who had received a gunshot wound in the late riots. The ball had entered in front of the masseter muscle of the left jaw, and made its exit behind the sternomastoid muscle of same side, passing in its subcutaneous course, close to, if not actually opening, the sheath of the great vessels. The carotid felt quite exposed by the finger introduced through either aperture. There was very trifling suppuration, and the wound healed without surgical

interference.

Dr. MOORE showed a tumor of irregular form, but as large as an orange, which he had removed from the thigh of a man, æt. 45. It was of fourteen or fifteen months' growth, had increased rapidly of late, and was, in Dr. Moore's opinion, of a malignant nature: appearing fixed when the limb was extended, it became movable upon flexion. On exposure it was found superficial to the facia lata, but partially adherent to the inner edge of the sartorius muscle, and the saphena and femoral veins were laid bare by its excision. It presented, on its removal, the appearance of a congeries of varices, seeming to consist of a fibroid blastema, including cells or cysts, which contained a quantity of dark greenish matter. (A tumor of this kind is described by Paget, p. 46 of his work on tumors.) The adjacent glands were unaffected, and the wound has healed by the first intention.

Another tumor was also exhibited by Dr. MOORE of fibro-cartilaginous character, which he had removed from the right side of the hard palate of a mulatto woman. It was of many years' formation, had never been painful, nor induced other inconvenience than partial stoppage of the corresponding nostril. On her admission into hospital, the woman was in a feeble state of health, and attempts were accordingly made to strengthen her by nutritious food and tonic medicines before proceeding to operation. Chloroform was employed in the preliminary incisions, which were made through the angle of the lips. A bicuspid tooth was extracted to admit of the working of the saw, and a chisel and mallet afterwards employed to detach the alveolar portion of the maxilla, from which the tumor sprang, and which was removed with it. Copious haemorrhage occurred, both during and after the operation, and was restrained at the latter period by the actual cautery. A compress of lint was left in the wound, and there was no return of the bleeding.

Dr. MOORE also presented for inspection the tibia of a lad, fractured in several places by the passage over it of a railway train. The boy had fallen asleep with his legs across the line, and whilst one of them had suffered a comminuted fracture, the other had undergone a compound dislocation of the ankle joint, and an extensively lacerated wound of the soft parts. The former limb was amputated by Dr. Moore soon after the accident; but the latter, though so severely injured, has been preserved, and now manifests a wonderful degree of strength and efficiency.

ORDINARY MEETING

January 30th.

The President in the Chair.

Dr. DILL read the following case of
Irritable Uterus.

Isabella Farrell, aged 25, unmarried, has been ill for upwards of a year. She complains of pain in the abdomen, over the hypogastrium, and in the back and

loins, varying in intensity, but from which she is never quite free. It is greatly increased when in the erect position, or in moving, and she expresses herself as easier in the recumbent posture; yet although she has retained this for a considerable time, she is still subject to recurrences of more than ordinary suffering; in other words, paroxysms of pain occur. The menstrual discharge returns regularly, and neither in quantity nor quality has it varied from the ordinary standard. When she came first into hospital there was some leucorrhœa, which has since ceased. A vaginal examination was made at different times, but no organic disease discovered. The cervix and body of the uterus were somewhat swollen and tender, but the os did not appear to be indurated. Dr. Dill then distinguished the disease from dysmenorrhœa, by the constancy of the pain; from prolapsus, by the state of the parts; and from inflammatory or malignant disorder, by its persistence for so long a period without aggravation. He considered it to be a case of irritable uterus, as described and designated by Dr. Gooch. Dr. MURNEY stated that the woman had been at one time under his care, for hysterical affection of the knee-joint, which fact, he thought, threw some light on the nature of her present disorder. Dr. HALLIDAY observed she had been a patient of his also, with the same symptoms as she now exhibits, but that neither from a tonic nor an antiphlogistic plan of treatment had she seemed to derive any benefit.

Mr. JOHNSTON presented a child, three years old, in whom scarlatina had been followed, after the lapse of a fortnight, by extensive swelling of the neck, together with the formation of a large post-pharyngeal abscess, protruding over and pressing on the base of the tongue. Some purulent matter apparently exuded from this whilst being examined; and Mr. Johnston alluded to the possibility of sudden death from suffocation being sometimes occasioned by the rupture of such abscesses during sleep, without the cause being suspected.

Dr. MURNEY exhibited a hypertrophied labium which he had removed from a woman who had, five or six years before, been affected with syphilis. He remarked upon the subjects of that malady being almost exclusively liable to this local disorder. The other labium of this woman had been formerly excised by Dr. Moore.

Dr. DILL exhibited a heart, the left ventricle of which was somewhat hypertrophied, and the mitral valve ossified and greatly contracted. The man (aged 21) from whom it was taken was received into hospital a few days before. On admission, there was much dyspnœa, with troublesome cough. The veins of the neck were turgid, and the lips and face very livid. The action of the heart was found to be tolerably strong, but the pulse at the wrist was very soft and feeble. Ascites and general anasarca were present to a great extent, and had existed for several weeks. He had enjoyed good health until about two years ago, when he was attacked by what his friends called rheumatic fever, from which he made such a recovery as enabled

him to return to his work as a labourer. Afterwards he had what they called attacks of the chest, and the one from which he sank about twenty-four hours after reaching hospital, came on about five weeks since. Percussion indicated very extended dulness over the praecordial region. A very rough bellows-murmur with the first sound, was heard loudest over the apex and to the left side of the heart. These signs were sufficient for the diagnosis that there was hypertrophy, and that the mitral valves were diseased. The post-mortem verified the diagnosis.

ORDINARY MEETING

February 6th, 1858.

The President in the Chair.

Asphyxia from Abscess of the Pharynx.

Dr. MURNEY, V.P., reminded the members that at the last meeting Mr. Johnston had presented a child, three years old, in whom scarlatina had been followed by extensive swelling of the neck, together with the formation of a large post-pharyngeal abscess, protruding over and pressing upon the base of the tongue. The part affected was examined by several members, and some stated that they observed pus on the tongue, as if the struggles of the patient (for he was very violent) had caused a rupture of some thinned portion of the wall of an abscess. It was deemed advisable that the patient should be admitted into hospital, and for the purpose of examining the swelling, Mr. Johnston placed the extremity of a wire-nipper, covered with lint, between the teeth, while Dr. Murney introduced his little finger. This he had not succeeded in doing (for the patient struggled very violently) when both gentlemen observed the lips becoming blue, and the respiration to be suspended. The wire-nipper between the teeth was immediately removed; cold water was dashed upon the surface; a window was opened, and a current of air allowed to play upon the surface of the body. As the respiratory function was not restored, tracheotomy was performed; some blood was sucked from the wound and from the trachea, and a cut portion of a good-sized flexible catheter introduced. Artificial respiration was carried on for a considerable time, but without success. Dr. Murney considered that the fatal result was produced by spasm of the glottis; and observed, that had operative interference of any kind been carried out, the operation would have been looked upon, by the friends of the patient at least, as the cause of death. Fortunately, however, nothing was done, save an attempt to examine the part. The time occupied in this was not more than from five to eight seconds, when the cessation of respiration required prompt attention.

Mr. BROWNE, V.P., introduced a woman having a *large Scirrhous Tumor of the Breast*. The patient was aged 55, had married late in life, and was mother of one child. The tumor was first observed two years since, and had been open for three months. Mr. Browne had declined all operation, it being his opinion that no case of scirrhous should be interfered with by the knife. He

contrasted with this case one of pure epithelial cancer, which he had lately removed from the lip of a man aged 56 years, and which he considered not at all likely to return.

ORDINARY MEETING
February 13th, 1858.

Dr. GORDON presented a specimen of
*Cartilaginous Tumor, removed from the region of the
Parotid Gland.*

The patient was a female, æt. 50. About seven years ago the tumor was first noticed; it was not painful then, nor did it become so at any subsequent period. Six weeks ago, when Dr. Gordon saw the patient for the first time, the tumor was firm, almost hard in some points, while in others it gave the impression of tensely-filled cysts. The surface was slightly knobbed. When the patient was admitted into hospital, previous to operation, the tumor had increased about a third, and felt much softer, but did not cause any uneasiness, except from its bulk, which was considerable. It was removed on Thursday, the 11th, and on removal it was found to be enclosed in a strong fibro-cellular envelope, and in a dense, firm external or proper cyst. The contents consisted of a hyaline substance, containing finely granular nuclei, about $\frac{1}{2000}$ th. of an inch in diameter. The enlargement of the tumor, which had been progressing for some time previously to the operation, seemed to be due to a serous infiltration, rather than to any increase in the solid contents, as, on section of the tumor, a large quantity of fluid oozed out, diminishing it in bulk materially.

Impetigo of the Scalp.

Dr. WALES introduced a child, æt. 3 years, of strumous habit, who had been placed under his care nine days before. About two months since the child was attacked with an eruption, which Dr. Wales believes to have been eczema. The eruption commenced behind the left ear; pustules formed in the neighbourhood, extended rapidly over the entire head (not, however, crusting it over in their progress); and ended in ulcers, which gradually deepened and extended. Almost simultaneously, but subsequently, pustules appeared, in limited numbers, on the trunk and extremities, pursuing a similar course. When presented, the child's head was covered with deep, circular, unhealthy ulcers, surrounded by a narrow inflamed border, of a dusky-red hue, discharging pus and blood, and occasionally coalescing. The hair was quite absent in the ulcerated spots (seemingly from the extensive destruction of substance), but was present on the intervening ridges, and unaltered in appearance. The forehead, sides of the face, neck, back, abdomen, and extremities, also presented a few large, but superficial ulcers. Some of the ulcers on the scalp penetrated almost to the bone, and some on the upper and lateral parts of the neck, were so deep as to endanger the vessels. After a careful microscopical examination, Dr. Wales could not discover any parasites, and thought that the disease was, probably, that described by Willan

and Bateman, as "impetigo rodens," and named by Neligan, "lupoid ulceration of the scalp." This idea was strengthened by the fact that the disease had commenced as eczema, probably merging into eczema impetiginodes, and ending in consequence of the cachectic state of the system in destructive ulceration. The treatment adopted by Dr. Wales consisted in the administration of cod liver oil and syrup of iodide of iron, and meat broths. Nitrate of silver was applied to the ulcers, and subsequently warm poultices. A healthy clean surface was thus obtained, and then the soda wash was applied, together with an ointment composed of soda, oxide of zinc, and lard. Under this treatment the case is progressing most favourably.

ORDINARY MEETING
February 20th, 1858.
The President in the Chair.

M. GROUX,¹ of Hamburgh, who is the subject of an extraordinary congenital fissure of the sternum, was introduced to the society.

ORDINARY MEETING
February 27th, 1858.

Mr. BROWNE, V.P., detailed the particulars of
A case of Amputation at the Hip-joint,
and presented a portion of the limb removed. The patient, æt. 21, was of strumous appearance, though possessing considerable muscular development. In July, 1857, he had sustained a fracture of the left femur, at the junction of its upper with its middle third. At the end of nine weeks the fracture was so far united as to permit him to walk without pain, by the assistance of a crutch, although some swelling still remained at the seat of fracture. In the following November, in consequence of a fall, pain was set up in the injured part, and he was confined to bed. Three weeks after, on turning in bed, he felt the fractured part give way. On 24th. December he was admitted into hospital. Symptoms:—Complete mobility at seat of fracture, no eversion or softening, and considerable hard swelling where the bone had been broken. For six weeks no visible change took place, except a gradual progressive increase in the size of the swelling. On his admission it had been carefully bandaged and put up with Liston's long splint. An examination of the limb, on February 5th, was followed by pain and increased tumefaction, which was much softer than the original swelling. On the 14th. an exploring trocar was introduced; blood flowed freely from the puncture; the blood was pronounced by Dr. Murney to be healthy. After several consultations of the surgical staff, amputation was resolved on. On operation, it was found the entire end of the femur, from point of fracture to the acetabulum had disappeared, leaving the cartilage of incrustation, and that a large sac existed, containing several pounds of fluid and coagulated blood. The patient never

¹ See Appendix 1 at end of session.

completely rallied, and died twelve hours after the operation. Dr. MURNEY had examined the mass removed, and believed that it could not be pronounced malignant on microscopical evidence. Dr. CUMING stated that he had discovered cancer cells in a portion of the mass which he had examined microscopically.

Mr. BROWNE also exhibited the head and neck of a femur, removed from a man who had fallen from a height of seventy feet. The specimen was removed after death. The great trochanter had been separated from the shafts, and the bone at the trochanter completely comminuted. Mr. Browne observed, that even if the man had not received other injuries precluding his recovery, amputation at the hip-joint would have been his sole chance for life; but independently of the injury to the hip, he had received a fracture of the skull and of the clavicle, of the humerus in two places, and had the feet lacerated.

ORDINARY MEETING

March 6th, 1858.

Cystic Tumor of Neck.

Mr. BROWNE, V.P., introduced a woman affected with a tumor on the anterior surface of the neck, in the median line. Mr. Browne believed it to be a cyst, and unconnected with the thyroid body. There was no enlargement of the lateral lobes of the thyroid. The patient stated that the tumor had suppurated about nine months since. Mr. Browne proposed to tap, and then throw in an injection containing iodine; and stated, that if this proved unsuccessful, he would employ a seton.

Case of Traumatic Tetanus.

The PRESIDENT read the following case of tetanus:—W. Lee, æt. 35, coachman, was admitted into General Hospital December 30th, 1857. A fortnight before, he received a lacerated wound, about one inch in extent, on the upper and back part of the head, in consequence of a fall from a horse. The wound had been dressed with adhesive plaster, and was not yet healed. On December 26th. he first felt occasional slight pains under the right shoulder, which he attributed to a blow received on the back, on the previous day. On the 27th. he felt worse, with pain and spasms all over the back and shoulders, with difficulty of deglutition, and pain about the jaws and throat, and inability to expand the chest. The day following he was obliged to go to bed, being unable to move his legs or to open his mouth. He had lost all power of flexion of the muscles, and suffered from rigidity and cramps. On admission into hospital, he complained of violent and highly-painful spasms of the neck, cheek, abdomen, and lower extremities, occurring every ten or twenty minutes, and causing opisthotonus. There is permanent muscular rigidity. He describes the spasms as commencing at the epigastrium. The arms are completely free from spasms and rigidity. A turpentine enema was administered, which caused a copious and very foetid evacuation; and the patient expressed

himself much relieved. Calomel and opium were then administered. The day subsequent the enema was twice repeated, and the calomel and opium continued; the spasms were not so frequent, and he had slept pretty well the previous night. On January 1st, decided signs of salivation having appeared, the calomel was discontinued. During all this time he suffered from profuse perspirations, and there was a peculiar foetid odour from the body. Opium, with beef-tea and nutritive enemata, were now administered; but he gradually sank, and death took place on January 6th. It was afterwards elicited that he had been intoxicated on Christmas-day, and that he had been much exposed to cold and moisture.

Dr. DUNLOP stated that he had seen tetanus treated successfully by morphia and chloroform, and had observed the happiest results from the topical action of vapour of chloroform.

ORDINARY MEETING

March 13th, 1858.

The President in the Chair.

Cystic Tumor of Neck.

The PRESIDENT introduced a woman who, fifteen years before, had become the subject of a tumor of the neck. About four years since it had been tapped, and more than a pint of fluid, containing cholesterine, withdrawn; and the cyst had been injected with a quantity of solution of iodine, which had the effect of diminishing its bulk. It was tapped a second time, when about half a pint of fluid was taken away. About two years since it was again tapped and injected, after which it was reduced to about the size of a hen's egg, when the President proposed to open and treat it as an ordinary abscess, which the patient declined. The base, as it were, of the original tumor remains, from which an elongated cyst projects, larger than a turkey's egg. On the inner side of this, and resting on the side of the trachea, there is a separate cyst, of almost equal size, but distinct from the original one. The tumor does not interfere with deglutition or respiration; and its attachments are indurated, and embrace the great vessels. The President proposed to again tap both cysts, and inject with iodine, and afterwards to treat them in the manner of an ordinary abscess.

The PRESIDENT also exhibited a

Calculus extracted from the urethra of a boy,
and observed, that calculous affections were at present more frequent in this neighbourhood than in former years.

Case of Urinary Abscess.

Mr. WARWICK detailed the case of a man of strumous habit, aged about 26, who had been attacked, six or eight weeks since, with inflammation and enlargement of the scrotum, which reached the size of a large cocoa-nut. In the first instance it was looked on as suppurative inflammation of the testes. The patient had suffered severely, and was much reduced. The ordinary remedies—comprising leeching, rest in the

horizontal posture, &c.—were resorted to. An abscess at length pointed in the median line, broke, and discharged a quantity of ichorous, sanious fluid; the swelling was thereby much reduced, and both testes could be felt in their normal condition. Two days afterwards urine began to flow from the orifice of the abscess, and has since continued. There exists considerable thickening of the parts anterior to the bulb. Merely a drop of urine flows through the meatus urinarius. Several efforts had been made to pass an instrument, but as yet without success.

ORDINARY MEETING

March 20th, 1858.

The President in the Chair.

The PRESIDENT exhibited the fluid contents of the cyst which existed on the neck of the patient exhibited at the previous meeting of the Society. The fluid resembled bloody serum; and the presence of cholesterine was not evident, as in the fluid removed from the same cyst on a previous occasion.

On the use of Chlorate of Potash in Infantile Stomatitis. A communication from Dr. BABINGTON (Londonderry), V.P., was read, on the value of chlorate of potash as a remedial agent. Dr. Babington observed, that the efficacy of chlorate of potash in cancrum oris was brought under the notice of the profession by Mr. Hunt, about ten years since, in the London Medical Gazette for October 12th, 1849. Dr. B. published a notice of its efficacy in about thirty cases of ulcerative stomatitis, which had occurred in the Coleraine Union Workhouse, in August of same year. In the Medical Times and Gazette for August 16th. and 23rd, 1856, there is a valuable clinical report, from Mr. Hutchinson, of the Metropolitan Free Hospital, on the use of this medicine; and in the same Journal, for September 20th, 1856, Dr. Speer, of Cheltenham, gives some conclusions, arrived at by M. Isambert, on the use of this salt. Its efficacy has been frequently noticed in mercurial salivation, and in the ulcerated throat frequently accompanying scarlatina, from Mr. Hunt's introduction of it up to the present time; nevertheless, Dr. Babington believes that its value has not been sufficiently appreciated. Dr. Babington is constantly in the habit of prescribing it in ulcerative affections of the mouth and throat. In stomatitis, as it occurs in children, he believes it to be a specific, as he has noticed, in every case, marked improvement after the exhibition of a few doses. It possesses an advantage for children, that, when sweetened with syrup, it has no offensive taste. The dose is from three to eight grains every four or six hours. A good way of administering it, in scarlatina, is, to dissolve a drachm in the patient's drink, to be used in twenty-four hours. Applied externally, it excites healthy granulations in sores of an unhealthy character; and when there are sloughs, and even a tendency to take on a phagedenic character, under the constant application of the solution, in the proportion of two drachms to a pint of water, Dr. Babington has seen the previously unhealthy surface

rapidly change its character, and a healthy healing action established.

ORDINARY MEETING

March 27th, 1858.

Dr. MURNEY, V.P., in the Chair.

Case of Dislocation of the Radius forwards.

Dr. GORDON detailed the case of a girl, æt. 11 years, who, four months before, had sustained a dislocation of the radius forwards, which had been overlooked by the medical men to whom she was taken. When the arm is fully extended, a distinct and prominent swelling may be seen and felt in front of the flexure of the elbow; and, from its form, and obedience to the motions of rotation of the radius, it is easily recognized to be the upper-end of that bone; and on examining the arm, below the angle of the humerus, a distinct depression is felt. The displaced head of the radius is restored to its normal position by moderate pressure; but when the pressure is removed, it is immediately drawn forwards and upwards by the biceps, and may be felt and seen on the outer side of the tendon of that muscle. Firm pressure was made over the head of the radius, when in its normal position, and a thick pad and gutta-percha splint applied; but these measures were ineffectual to retain it in its position. Indeed, no bearable amount of pressure would be, in Dr. Gordon's opinion, sufficient to retain the head of the bone in its normal situation.

Contraction of the Palmar Fascia.

Dr. GORDON also presented a patient, æt. 14, affected with permanent flexure of the ungual phalanges of the middle and ring fingers. The deformity had commenced when the boy was five years old. Both phalanges were flexed at right-angles. The contraction was mainly due to chronic induration, and contraction of the fibro-cellular tissue of the sides of the fingers. This has occurred in the sides which are opposed to each other, and there is slight rotation of the bent phalanges on their axes, so that the nails look towards each other. There was, however, real shortening of the flexor tendons, but this Dr. Gordon regards as a secondary effect. Dr. Gordon observed, that subcutaneous section of the shortened tendons, and of the contracted fossa, would be necessary. In one finger these means had been adopted about four weeks ago, and permanent extension had been maintained since that time, with the effect of removing the deformity, except a slight lateral inclination, or rather rotation, of the phalanx.

Mr. JOHNSTON detailed the particulars of a case in which he had observed the spontaneous cure of favus in an adult, the disease having completely destroyed the hair, and so worn itself out.

ORDINARY MEETING

April 3rd, 1858.

Dr. M'GEE, V.P., in the Chair.

Dr. FERGUSON, V.P., detailed a case of
Phthisis Pulmonalis, combined with and masked by
Emphysema,

and presented the affected lungs. The patient, a woman advanced in life, had been admitted into hospital, under Dr. Ferguson's care, presenting strongly-marked signs of emphysema, accompanied by a profuse catarrhal discharge from the lungs. The chest had undergone an extreme amount of the modification in shape usual in this disease; there was tympanitic sonorousness over the greater part of it, and universal mucous râles, mingled with craquements, were audible. There was no hectic, no auscultatory phenomena of the voice; nor was there any symptom leading to a suspicion of phthisis. The disease was accordingly pronounced to be emphysema, and treated upon that view, with great and rapid benefit; but the improvement was quickly followed by greatly increased debility, violent dyspnœa, and death. On examination, two large cavities were found in one lung, and one cavity in the other, all of which were lined by distinct false membranes. There was little congestion, universal emphysema, and there existed intimate adhesions of the pleuræ. The chief points of interest were, in Dr. Ferguson's opinion, the unfrequency of the occurrence of extensive emphysema with tubercular disease in the same lung, and the difficulty of diagnosing the tubercular cavities caused by the presence of the emphysema and the accompanying catarrh. Dr. Ferguson suggested, that possibly the explanation of the latter might be, that the expansion of the lung produced an amount of pressure which obliterated the cavities during life, and that the altered state of the pulmonary tissue interfered with the conduction of the sounds, and consequently prevented the production of the physical signs. The administration of extract of larch-bark had been followed by marked diminution in the catarrhal discharge, and relief to the dyspnœa. Dr. Ferguson observed, that this remedy (which had been brought under his notice by Dr. Frizell, of Dublin) was, however, of questionable utility in cases of this nature.

ORDINARY MEETING

April 10th, 1858.

Dr. MURNEY, V.P., in the Chair.

Dr. GORDON presented the bladder and kidneys of a man, æt. 65, who died in consequence of retention of urine. The bladder was hypertrophied, its muscular fibres forming thickened bands (some of which were more than a line in thickness), standing out in bold relief in the interior of the organ. The mucous membrane was reddened; the ureters and pelves of the kidneys were considerably dilated; the kidneys themselves were a good deal enlarged; and the cortical substance was studded over with small abscesses, some of which had burst, and diffused themselves beneath the capsule, which was considerably

thickened. None of these abscesses had made their way into the pelvis of the kidney. On making sections of these organs, some of the abscesses were found to occupy the centre of the cortex, but most of them were on the outer surfaces. The patient, when he presented himself for admission into hospital, three weeks before death, was very much emaciated, tottering in his gait, and had the mental faculties slightly impaired. There was œdema of the lower extremities, extending to the knee, and his person exhaled a strong urinous odour. On admission, about a quart of urine was drawn off by the catheter, and a few hours afterwards a second quart; and on the following morning a similar quantity. The catheter was introduced twice daily, but this was not sufficient to prevent the stillicidium; it was therefore used three times. He did not gain strength, but became daily more and more enfeebled, and at length sank.

ORDINARY MEETING

April 17th, 1858.

The PRESIDENT introduced a boy, æt. 15, who, on several occasions recently, had been attacked with sudden œdema of the hands and feet, without any ostensible reason. The œdema was accompanied with great lividity, and there was intense pain when either of the affected extremities was touched. This condition of the parts lasted but for a very short time, and passed away, leaving no trace of morbid action. There was no irregularity of the heart, nor any appreciable sign of disease in any organ.

Dr. Thomas READE had seen a gentleman in whom the contact of cold water produced great œdema of the hands, and in whom the use of the bath had been followed by deliquium. The disease had yielded to the administration of tonics, and the use of remedies calculated to improve the health generally.

The PRESIDENT also introduced a patient who had received a *Comminuted Fracture of the Arm*, a little above the elbow-joint, which had not united. The patient, who had been under the care of Dr. Jamieson, of Newtownards, stated that numerous portions of the bone had come away. The fragments were readily moveable on each other, and a fistulous opening existed. There was considerable loss of substance of the bone.

ORDINARY MEETING

April 24th, 1858.

The President in the Chair.

Dr. MURNEY, V.P., exhibited a finger which had been removed by Dr. M'Laughlin, of Lurgan, from a man, æt. 55. A tumor had formed upon it, twelve years before, in consequence of an injury received by the patient. This tumor gradually increased, and had recently attained the size of a small orange, but was perfectly painless, and did not interfere with his employment as a weaver. About a fortnight previous to the operation he had

injured the tumor by a fall, and ulceration had set in. A large fungus had formed, which bled profusely every day, reducing the patient to a state of great anaemia. Under these circumstances the finger was removed by Dr. M'Laughlin. Dr. Murney stated that he had no doubt that the growth was of a malignant nature, as he had ascertained the presence of numerous cancer cells, by the aid of the microscope.

Mr. BROWNE, V.P., introduced a woman, the subject of *Diffused Carcinomatous Growth*, affecting the head, neck, breasts, &c. These growths had commenced two years previously, but only two months ago had begun to increase rapidly.

Dr. HALLIDAY introduced a boy in whom the gum of the lower jaw had become adherent to the cheek, in consequence of ulceration which had arisen during an attack of small-pox.

The PRESIDENT exhibited a tumor, the size of a large bean, which he had dissected out from the forearm of a nurse, æt. 28. The median nerve was imbedded in the tumor, and pressure caused severe pain, extending to the fingers.

Dr. CUMING detailed some experiments on fowls, which he had made by the direction of the Society, for the purpose of ascertaining if the South American arrows in the museum of the Society possessed active poisonous properties. He stated, that the poison was still, after the lapse of several years, quite efficient; and that its effect—namely, the production of muscular paralysis—agreed with the accounts of the properties of the wourali, as described by Humboldt and Schomburgh.

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ANNUAL MEETING
May 1st, 1858

At the annual meeting of the Belfast Clinical and Pathological Society, held at the General Hospital, on Saturday, 1st. May, after a highly satisfactory statement of the finances for the past year, the following officers for the ensuing session were declared:—President, Mr. Browne; Vice-Presidents (*resident*)—Dr. Thomas Reade, Dr. Murney, Dr. Seaton Reid. Vice-Presidents (*non-resident*)—Dr. Graves, Cookstown; Dr. M'Mechan, Whitehouse. Treasurer—Dr. Halliday. Honorary Secretaries—Dr. Cuming, Dr. Wales. Council—Dr. Pirrie, Dr. Dill, Dr. Patterson, Dr. Heaney, Dr. Bryce, and Dr. Gordon.

Dr. James MOORE, the retiring President, delivered the following address: —

GENTLEMEN—At the close of each session, according to our usual custom, and as a proper mark of respect to the members, a few observations may be permitted from your President, who trusts, in their imperfect delivery, to your usual consideration and indulgence. Our proceedings during the present session have been

such as might have been expected from the high professional character and large experience of the gentlemen composing this body. The attendance of members and of students has been indeed good; the mutual interchange of valuable information has been considerable; the advantages of friendly personal intercourse, produced and perpetuated by our meetings here, it is superfluous to enlarge upon. The specimens of morbid structure exhibited, the number of patients presented with interesting forms of disease or malformation—amongst the latter, the remarkable case of Monsieur Groux, the action of whose heart was visible, owing to a deficiency in the anterior wall of his chest—the numerous instructive cases from our country correspondents read, and the results of chemical examination detailed to you, will suffice, without eulogy of mine, to convince the profession at large of the practical utility and business character of this Society. It is from the collated results of each succeeding session that our growing importance and increasing professional usefulness may be safely inferred. Nothing is of greater importance to us than that every successive session should exhibit an increased amount of pathological and clinical information, collected by individual exertion of your members. In this respect we have good reason to regard the session now about to expire, without fear of it suffering by comparison with any that have preceded it.

On the occasion of opening the present session, I enlarged sufficiently upon the important aid rendered by art to pathological science. I shall here only repeat my request to such of our students who may feel inclined to exert their talents in the application of art to the service of their profession, to lose no time in commencing their labours, since of the fine arts may be emphatically asserted, in particular, what the proverb enunciates of arts in general—namely, that art is long (or, in other words, is difficult), while life is short. It is right to observe, in connexion with this branch of the subject, that our museum is enriched with additional casts of diseased structure, with many models in plaster and in wax, coloured after nature, and admirably truthful, to which I need not more particularly direct your attention.

In hopefully looking forward to the still more enlarged importance and usefulness of this Society, I may take this opportunity to remark on the service our members may individually render to the profession and the public, by their exertions in the several branches of professional inquiry, until we again re-assemble in this room. The strict rule which properly confines our discussions here to clinical and pathological topics, does not exist for us in our individual capacities elsewhere. Elsewhere, therefore, I think it right and becoming in our profession to bestir itself, individually, in matters of moment that concern the public health, that, by so doing, our profession may not merely set itself forth as a humane, liberal, and learned profession, but take the proper rank to which it is fully entitled, as a governing opinion of the State. The various predisposing causes by which public health is endangered are surely proper subjects of inquiry to a profession continually called upon to grapple with the fearful

results of these very predisposing causes. Whether we regard the poisoning of human life by heaping up mounds of scarcely covered dead under the very windows of the living, or the constant streams of pollution emanating from open drains or imperfect sewerage, or the noxious gases of pestilential factories, whose smells and fumes are the warnings appointed by nature to induce man to remove them to a distance from his neighbourhood; all these are very fit and proper subjects for the consideration of professional men, who cannot forget that they are likewise public-spirited citizens. The rescue of human life—especially of the lives of those whose daily labour is our national wealth—from the depressing and destructive agencies of damp, ill-ventilated habitations, of defective sewerage, inadequate supply of pure water, and many other less destructive agencies, is especially our business; and I should insult the Society, were I to do more than express my convictions of their readiness to do all that in them lies to remedy such evils, as far as it is possible, by expression of enlightened, humane, and well-considered professional opinion, to do so. The oppressive voluntary taxation, as I may call it, of habits prejudicial to health, though not immediately or suddenly endangering life, are worthy of our serious consideration. I am led to animadvert upon one of these, from having my attention called to several cases of chronic disease produced by excessive indulgence in the practice of smoking tobacco.

I am not about to enter upon the wide field of discussion which the almost universal use of tobacco invites. I am neither prepared, with Pereira and Christison, to assert that no well-ascertained ill effects have been shown to result from the habitual practice of smoking, nor, on the other hand, to condemn unreservedly the moderate use of tobacco, in all cases, times, and places. A luxury indulged in more or less immoderately by so large a portion of the human race, and which, next to salt, is supposed to be the article most extensively consumed by man, must be able to adduce numerous arguments, more or less tenable, for its extended use. For its abuse, however, no arguments can be tenable; and it is with its abuse that we are called upon professionally to deal. We find smoking begins with boyish bravado, or weak compliance with absurd solicitation; proceeds by degrees to an offensive custom, and resulting in a confirmed habit, which it is hardly too censorious to stigmatise as a vice. To trace the progress of this deteriorating habit, from the first whiff, productive of uncontrollable nausea or ill-concealed disgust, to the period, not very remote, of the constant craving, demanding the ever-recurring pipe; following it still downward till the habit merges into the vice, the vice into disease, we have especial reason to lament the increase of the habit of smoking among the rising youths of the lower and middle classes in our town. The prevalent practice of smoking is the more especially dangerous in this, that its agency in lowering the tone—mental, moral, and physical—of the animal economy, is extremely insidious. By degrees the disease—for such it must be considered—ripens into various forms, which compel the interference of the physician; and not unfrequently medical assistance is

unavailing to rescue the sufferer from the consequence of habitual indulgence in this, to him, daily luxury of life. In my own circle of friends, a professor of eminence, an original thinker and fine reasoner, and one who had adorned the literature of our profession, fell a victim to the immoderate indulgence in smoking, a resulting cancerous affection of the tongue being, by the victim himself, attributed to this infatuation. I need hardly remind you of the frequency of epithelial cancer among the poor of these islands, the result, as I believe, of the acrid, irritating, empyrhumatic oil absorbed into the system from the short black tobacco pipes in use among the humbler classes. The delicate nervous organization of the eye is injuriously affected by tobacco in two ways—first, by the direct application of irritating vapours to so delicate an organ; secondly, by the participation of the optic nerve in the depression of the nervous energy throughout the frame. In rude and primitive conditions of life—as that of the hunter, whose high-wrought nervous actions may require to be toned down—or in cold, damp, or hot climates, in marshy districts, or with insufficient food or shelter, and under other exceptional circumstances of daily life, the use of tobacco may be comparatively innocent, and in some cases may supersede the habitual resort to wine, opium, or spirituous liquors, and thus may claim the privilege accorded by common consent to the lesser evil. As a means of assuaging the pain of excessive fatigue of labours, of mitigating the pangs of hunger, or of subduing mental distress—among those, especially, not over-burthened with the good things of this life—there appears much to be forgiven in the use of tobacco. At all events, an indiscriminate censure of it, even if it were just, would be ridiculous. In most countries where tobacco is now extensively used, its use was prohibited by the ruling powers, at one period or another, under stringent penalties; and wherever its use has become almost universal, we find, on consulting historical records, that the prohibitions were the strongest and the penalties most severe. But in town life, and among our rising youth especially, none of the conditions which render the habit of smoking excusable, under certain extenuating circumstances, can be said to exist. There is not even the excuse of want of variety, or that sinking of the spirit, as in remote and solitary places, which makes smoking partly a sedative, and partly a mechanical habit of passing away the tedious time. It is not necessary for our rising youths to dissipate mind and body in this manner. Self-respect will suggest some more active and ennobling employment for mind and hand, or at least will induce the well-disposed to refrain from countenancing, by presence or participation, the bad example of others. When we consider that in the act of smoking of one quarter-ounce of tobacco, there may be imbibed into the system two grains, or more, of one of the most subtle of all known poisons—scarcely inferior in virulence to prussic acid, a single drop being sufficient to kill a dog—one might as certainly expect immediate symptoms of disease from tobacco smoking, as from any other poison, did not nature come to the rescue, by adapting the system to the unnatural conditions imposed upon it. Nicotine, however, is not the

only poisonous principle of tobacco; the oil distilled through the tobacco-pipe, as in a retort, is not only disagreeable and acrid, but narcotic and actively poisonous. Under its influence reptiles die instantaneously, and some of the wild people of the earth wisely employ it for that purpose.

I shall dismiss this disagreeable subject, and refer to a matter more immediately connected with the dignity and interests of our body. In contemplating the progress of the profession at large in public estimation, we cannot fail to be struck with the increase of individual pursuit of special branches of medical, surgical, and pathological science. This division of professional labour has reached such a pitch in our metropolitan cities—Dublin, London, and Edinburgh—that the profession and the public are equally advantaged thereby. In consultations, as we have constant occasion to know, certain great names are appealed to, as of the highest authority, in the last resort. Individual members of the profession, it is also observed, who are shining lights in their speciality, are frequently the most generally accomplished in other respects. This is only what may be expected, since he who confines himself to one chosen department of his profession, will not only be more likely to excel in that, but have more leisure for excellence in other things. This town, though large, and rapidly increasing, may not yet be large enough to admit of that metropolitan division of labour which we see in great cities; and it must be admitted that we, who depend on general practice, must be content to practise generally. Yet I would wish to observe, that I think a tendency to special pursuit, in such of our body as are of my way of thinking, must be of signal advantage, alike to the individual, his professional brethren, and the public. Medical men can have no motive to refuse acceptance of that leading truth of our age, that progress in the arts and sciences is a direct result of the division of labour. As special eminence in particular branches becomes more general, our profession, in theory at least, might be expected to become, if not less competitive, more co-operative, since it is but reasonable to suppose, that as each became an authority in his peculiar walk, his professional brethren would defer to his authority therein, and a mutual deference and respect arise from special individual eminence. Of course we must expect that this devotion to one speciality will be limited, and in some degree hindered, by the circumstances of our individual positions. I only repeat, that the division of professional labour, where practicable, is desirable, and tends to the advancement of the dignity in which is involved the interests of our profession.

Gentlemen—for the honour you have done me, for the uniform courtesy and kindness which you have always shown towards me—I heartily thank you. I now leave this chair to an able and worthy successor; and my sincere hope is, that this Society may continue to prosper—prosper it must—because it is useful, and useful because it is practical.

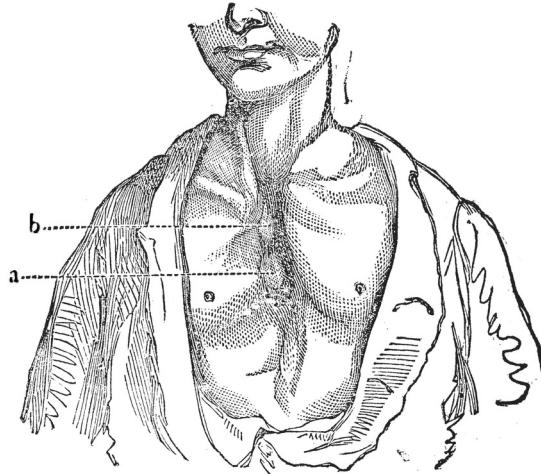
Dr. Moore then left the chair, which was taken by Professor Ferguson; and thanks were voted to the President and the other officers of the Society.

APPENDIX 1

A CASE OF CONGENITAL FISSURE OF THE STERNUM.
BY F. W. PAVY, M.D.¹

E. A. Groux, the subject of this defect, is a native of Hamburg, 25 years of age, below the average height, and although a little thin and pale, yet appears in the enjoyment of pretty good health. I will first sketch you an outline of his history, which I am sure you will consider not altogether devoid of interest. He tells me that he just remembers, when about four or five years old, being taken by his family doctor to a Medical Society at Hamburg; but for what purpose he scarcely then understood, nor did the interest of his case fully occur to him until within comparatively a recent period. He was aware that his chest was not exactly like other people's, but he did not know that there was any special interest connected with this malformation. About 1850 he was over in London, residing with a relative moving in a comfortable sphere of life, and was attacked with cholera. His recovery was protracted, he was for some time under medical attendance, and then it was that his defect was made known to the profession. He was taken about as a curiosity to our leading physicians, amongst whom was Dr. Babington, who brought him down to Guy's, and had a couple of models made of him by Mr. Town, which are preserved in our Museum. I took him across to Mr. Towne's room the other day, and we compared his present condition with these models, to see if any change had taken place. We noticed that the clavicles and the lateral margins of the sternum had slightly approximated, so as to render the groove narrower than it formerly was, during a quiescent condition of the chest. To proceed with our sketch. He afterwards returned to Hamburg, and being seized with an attack of hæmoptysis he was recommended to leave the situation he held in a house of business which kept him confined all day, and to go into the country for a time. It now occurred to him to put in practice the suggestion, which, he says, had often been made to him, viz.: to travel, and show himself to the medical celebrities of the different countries. Starting for Hanover in 1851, he found his expectations realized; and since then he has been visiting all the principal places on the Continent, including France, Germany, Belgium, Holland, Spain and Russia, and to judge from his appearance, one would certainly conclude that he made it thoroughly answer his purpose. He was in London for a short time, about two years ago, and after a short stay now, he intends to proceed to the provincial towns where medical schools are attached, and then to Scotland and Ireland. He carries with him an album, in which he gets one to insert one's opinion of his case and to sign one's name. So that, having been to nearly all the most distinguished men of our age, his album presents a most interesting collection of autographs, and at the

same time testifies the interest his case has elicited.



as to allow him under the influence of the pectoral

muscles, when the upper extremities are fixed to open the groove to an extent of very nearly three inches; it being only a little more than half this width, at its widest part, which is opposite the third and fourth ribs, when the parts are in a natural state. By approximating the arms the end of one clavicle may be made to overlap the other. The muscles of the neck have their normal attachments, although it seems when he takes a deep inspiration, from the cutaneous fold that is produced, as if the sterno-hiod and -thyroid muscles of the right side of the neck crossed over to be attached to the left piece of the sternum. But if these muscles be called into action by the process of swallowing, they may be seen to pass down to be attached on their proper side. If he be requested to cough the right lung suddenly protrudes from the chest through the groove, and ascends a considerable distance above the right clavicle into the neck.

The great point of interest, I conceive, connected with this case, is the exposure of the action of a portion of the heart, which is normally hidden from our view. We know well enough: upon examining our own bodies, the exact moment the ventricles are contrac-

¹ Extract from the Medical Times and Gazette, Nov, 21, 1857.

ting, from the shock communicated to the thoracic parieties: but we have nothing similarly to guide us with regard to the auricles. A case, therefore, in which the action of an auricle is to be witnessed cannot fail to merit our deepest interest and attention. Now on looking at the groove a pulsatile swelling is discernable opposite the third and fourth ribs (*a* in the accompanying sketch). In its ordinary state it scarcely forms a projection except at the moment of pulsation, but if the respiration be suspended it rapidly rises to an enormous extent, measuring then even three inches from above to below, and remains full and tense until the breathing is restored, when it soon subsides. The tumour distinctly pulsates with the contraction of the ventricle and the production of the first sound of the heart. It rises rapidly and suddenly, and instantaneously afterwards falls with that peculiar thrill, wave or vermicular movement proceeding from above to below, which I have pointed out, as, at this period of the heart's action, running through the parieties of the auricle of the dog. It then remains at rest until again distended by a fresh contraction of the ventricle.

From the behaviour of this pulsatile swelling, so precisely corresponding to the action of the auricle in the dog, there is not a shadow of doubt in my own mind of its being formed by this portion of the heart: its position, however, would also lead us to a similar conclusion. You will perceive, therefore, admitting such, how this case corroborates what I have stated about the action of the mammalian heart (the contraction of the auricle immediately following, instead of preceding that of the ventricle), and stands in opposition to what we are ordinarily taught.

Between the clavicles (*b* in the sketch) there is another pulsatile swelling, which can be scarcely seen, but may be easily felt. It is doubtless formed by the arch of the aorta, and when the fingers are placed on it, a double shock synchronous with the distension and the recoil of the vessel, or the opening and the closure of the semilunar valves is perceived.

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY

SIXTH SESSION
1858 – 1859.

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THE FIRST MEETING.
30th October, 1858.

At Three o'clock, the President, Surgeon S. BROWNE, R.N., took the chair, and proceeded to deliver his inaugural address¹ to a large and attentive auditory of members, students, and visitors.

GENTLEMEN,—Having been called to the presidency of this association, my first duty is to return you my sincere thanks for the respect and confidence thus manifested, and the honour conferred—an honour which I deeply feel and appreciate.

The sixth session of the Belfast Clinical and Pathological Society will, I trust, tend to our mutual improvement, the advancement of medical science, and the good of our fellow-men. This earnest wish, I am sure, animates each of us, and will stimulate us in our researches and in our inquiries after truth. The aim and great object of every such association should be to endeavour to examine carefully, dispassionately, and without prejudice, every question of practice submitted to our notice; to inquire as far as practicable into the natural history of every disease discussed

here, and to ascertain as accurately as we can those elements in each which have tended to functional disturbance, or arrest of function—to permanent change of structure, or death; and, on the other hand, to determine, as far as our knowledge and experience permit, how much nature or how much art has been enabled to counteract, the workings of these morbid elements, to prevent their fatal tendencies, to remove structural change, to restore the natural functions—in other words, to produce in the system that condition which, we denominate 'health.'

These, gentlemen, are glorious objects, noble aims—the promotion of the welfare and happiness of the human family; and if, in our inquiries and labours, we are able to throw one mite of sound practicable value, one incontrovertible truth, into the treasury of medical science, our society will not have laboured in vain. Let us, then, earnestly and deliberately set to work.

Each of us should think and examine for himself; and, not relying alone on early teachings, early prejudices, and empirical doctrines, bring the force of reasoning and individual experience to bear on every dogma, every question concerning disease. Every question must be tried in the strong light of reason, for every principle of practice must admit of a rational solution, otherwise we cannot admit it to be of practical value, or an unquestionable truth.

It has, I fear, in all ages, been the habit of our profession to vaunt overmuch certain powers which we undoubtedly possess, and to trust nature too little. That is, when cure of disease has been effected, they have given all the credit to the means used, and have almost, if not entirely, ignored the healing powers of nature. This distrust of nature, and this over-confidence in the powers of medicine, still, to some extent, prevail; and we all, I admit, are still too prone to consider that drugs do more than they really can accomplish in disease. But, while I say so, I do not mean to affirm that our *materia medica* does not possess many inestimable medicines which have great curative powers, whose efforts in aiding the system to struggle with and to repel disease are not most palpable and beyond question. But I do believe and assert that, in all times, the trust in drugs has been too great—the confidence in nature too little. At one period, indeed, in the medical profession—and that not very remote—this reliance on medicaments became so overweening that special drugs were considered to be quite specifics in the cure of certain complaints, and that every symptom almost required a separate medicine—every manifestation of disease a new medicament; hence the unhappy patients were drenched and re-drenched, under the impression, it seems, on the part of the practitioner, that the *materies morbi* could be thus, as it were, washed out of the system; and hence, too, our *pharmacopœia* became laden with multitudes of simples and compounds, many of which were inoperative, or worse than useless.

Now, a social evil of such magnitude—even maintained, as it was, by the professors of the healing art—could not have been endured by the community had it not been for the extreme ignorance which

¹ Samuel Browne's Presidential address was supplied by the National Library of Medicine, Bethesda, USA. It was discovered in the catalogue by Mr David Crawford, once Librarian at Queen's University, Belfast, and a copy was forwarded by Mr Stephen Greenberg.

existed in the public mind regarding questions of medicine, and had not the most absurd notions prevailed with respect to the causes of disease, and the means that were believed to be capable of removing them. Even at this day the same indefinite and foolish notions prevail among all classes not of our profession, regarding the powers possessed by the physician over disease, so that any amount of boasting—any extravagant assertion—is received by many, even of learning and station, with implicit confidence, and the man who lauds his cures and extols his specifics most is often considered a person of pre-eminent abilities.

But, to return to the period when the drug and heroic systems most prevailed in the treatment of disease. Such a state of matters as that to which I have referred could not long exist, when enlightened members of our profession began to look into the nature of diseases, their causes, mode of production, their progress and natural issue. Such inquirers very soon ascertained that many of their former dogmas and speculations were based on false principles, and that many of the means they had adopted in practice were calculated more to disturb or arrest the efforts of the system in throwing off disease than to promote a cure, and that many of the then boasted remedies were either inert, had very little effect, or were even injurious—while few, very few, of them, indeed, could be considered as specifics.

Hence commenced a revolution in the practice of medicine—a revolution which has progressed up to the present day, and which was originated and has been carried on by the legitimate professors of the healing art—not as has been supposed, and has been asserted, by Hahnemann, his disciples, and successors—who have produced and maintained the most irrational system, the shallowest charlatanry that was ever imposed upon the understandings of men. No, gentlemen, long before the promulgation of his absurd and untenable doctrines, the revolution in medicine which I have noticed had commenced; and the observant members of our body had discarded much of the prevalent heroic practice, and the drugging system, and had seen the necessity of trusting more to nature, and less to the articles of the *materia medica*. And, in proof of this statement, in opposition to the assertions of the homoeopaths, I have merely to refer you to the writings of Gideon Harvey and Ernest Stahl, published more than a century and a-half since.

It is true that, long since that period, the heroic practice has been taught in our schools, and carried out by the profession, but it is not less true that, even antecedent to that date, many physicians, distrusting the efficacy of medicine, had pursued a partial or complete expectant system in their practice. I make these remarks simply to show that the reformers of practical medicine were long antecedent to the promulgator of the infinitesimal nonentity—that most miserable fallacy, the most wily yet shallowest pretence that ever duped mankind. To this system it is my intention to refer more specifically presently; but I shall premise that inquiry by stating what the legitimate medical art is—and what it is not; what it professes to do—and what it does not profess; what it

can accomplish—and what it never can.

In making these observations, I shall confine myself to the subject of medical art, as exemplified in the practice of the physician. The science of surgery is of a less occult character—its power and efficiency admit usually of easy illustration, its manifestations are generally more positive and unquestionable, and hence cannot be used by the quack juggler in his medical legerdemain. Regarding it, the accomplished author of “Nature and Art; in the Cure of Disease,” has written:—“Surgery, indeed, must be always admitted to exhibit the least equivocal successes, and the most splendid triumphs of the art.” Then, having enumerated several of these triumphs, he continues:—“It is, indeed, to such facts as these—it is to surgery, even taken as a whole—that the practitioner conversant only with internal diseases, and possessing no other meatus of combatting them but the feeble and uncertain armoury of drugs, must often look up for consolation in his difficulties. It is a perpetual comfort for him to know with certainty that in one of the fields of its display, at least, the noble art he professes leaves no room for doubt as to its vast powers, or as to the incalculable good worked by those in the cause of humanity; and this knowledge yields, moreover, a perennial and lively stimulus to his exertions, by fostering the hope the time may yet come when the treatment of internal diseases may attain something of a like certainty and power.” This, certainly, is a “consummation devoutly to be wished,” and may we not look forward to its almost complete accomplishment, when we remember the vast strides which physiological research, pathological investigation, and chemical analysis have made within our own day, all tending to the illustration of diseases, their nature and origin, their progress and products, their probable results, and the means by which they are best prevented, mitigated, or cured?

These aspirations, these researches, are ours; they constitute, or should constitute, the daily duties of the physician; they are the foundation of the noble science of medicine, whose divine object is to alleviate distress and pain, to mitigate the penalties of disease, and to restore health, and, consequently, happiness, to every afflicted son of man. This is legitimate medicine, and, when practised, can claim the power of preserving and continuing life when all other arts fail to do so; when all other appliances are unavailing; and can render life still enjoyable when, without the relief and support it supplies, the world and all of its pleasures, would only be distasteful, and the prolongation of existence would be but one long-drawn scene of suffering and distress. This is medical art—the prevention, mitigation, or cure of diseases by those means which reason and experience point out, but it is not the part of legitimate or rational medicine to say that every disease can be certainly remedied by certain special means, and that too, independent of nature. That this medicine, or that appliance, will surely cure certain morbid conditions of the system, and that, too, without any reference to the sthenic or asthenic condition of the body in which the disease has been manifested—such would be mere empiricism, and closely allied to the very worst species of quackery.

Now, what does the legitimate medical art profess to do? It claims the power of preventing, mitigating, and curing diseases, under certain conditions, always having due regard to the efforts of nature, and especially taking care not to disturb her sanative course by using heroic, and, consequently, injurious means. This regard of nature—merely watching her progress in the effort to cast off disease, and aiding her when these efforts seem unequal to the struggle, or when they fail—is the distinguishing characteristic of the physician of the present day, who, while he has due faith in those remedies which experience and the demonstrations of pathology have taught him rightly to apply, has also due faith and confidence in that vital principle of the living body which, from the first manifestation of diseased action within it, till the final cessation of that disease, ceases not to resist or repair the inroads made, and only ends that struggle when it has conquered or has been overcome.

With regard to the preventive powers of the medical art, no one who knows anything of medical history can entertain a feasible doubt. Every one who has paid the slightest attention to ordinary sanitary operations, public or private, must have been impressed with their efficacy in preventing disease. There cannot be any question of the potency of hygienic medicine in eradicating the prolific causes of most of our febrile and inflammatory complaints, thereby saving life without the risk and struggle for it, and hence benefitting society in a twofold manner. This is a vast field, as yet but little cultivated; but the results, so far as tried, have been most satisfactory, and lead us to believe that we could calculate upon vast, and almost inconceivable, benefits, were hygienic operations carried to their utmost practical extent. That they have not been so pursued is not the fault of our profession; we have the power to demonstrate and recommend, but we cannot always enforce even the most salutary and imperatively required sanitary operations. Ignorance, apathy, narrow-minded interests, and numberless other antagonistic elements, meet the medical reformer at every step, and too often thwart his best hopes, his ablest and most philanthropic designs.

The second principle which the legitimate medical art professes is the power to modify and mitigate the manifestations of disease; and this it is enabled, every day, to accomplish, in allaying internal or outward pain—in soothing wounds, bruises, and burns—in relieving headache, sick stomach, heartburn, stranguary, constipation; and the like—by plain, rational, and demonstrable remedies, suited to the object in view. It would be mere impertinence on my part to specify these special remedies, as every one of you is aware of their proper application; and no man of observation or experience will, for a moment, doubt that, in the list of our pharmacopeia, he has many medicines which do, when duly exhibited, at once alleviate any of those morbid manifestations which I have named. This, then, is a positive and undeniable power which medical art possesses, and is as capable of proof as that fire applied to water will cause it to disappear in the form of vapour, or that the same water, under different circumstances, by the application of cold, will be converted

into the solid material of ice.

The next principle which we maintain is, that legitimate medicine possesses the power, not only to modify, but, under certain conditions, to cure disease. There cannot be a question that nature uninterfered with by drugs, and having fair scope for the exercise of her innate sanative power, will, especially in many acute diseases, overcome the morbid perturbations of the system, restore the normal functions, and bring about that comparative state of the body which we denominate health. But how seldom is it that nature has this fair play—this requisite, uninterrupted exercise of the restorative functions. Few, if any of the sick, are so circumstanced that they may not be said to be placed in a condition unsuitable, in many respects for the wholesome action of the *vix medicatrix naturæ*, and this may arise from necessity, ignorance, or the pseudo-medical knowledge of the patient or friends.

Take, for instance, a case of measles, scarlet or ordinary fevers, and see how much necessity, ignorance, or pseudo-medical skill may complicate the complaint, and retard, if not entirely nullify, the efforts of nature to shake off the disease. Then it is that the first display of the curative powers of the medical art comes into operation. The experienced physician at once sees what it is that interferes with the natural progress of the malady. Necessity, in one case, compels the unhappy patient to be in a low, damp, badly-ventilated situation, without nourishment—without the means of cleanliness; ignorance, in another case, excludes the light and air, and heaps on loads of bedclothes, and pours down floods of warm drinks; while, in a third case, the pseudo-medical knowledge of the patient or his friends employs all the domestic remedies, from a teaspoonful of sulphur, to a glass of whiskey punch, or from the hot posset, drugged with saltpetre, to the cold and nauseous draught of Epsom salts. Now, what are the curative means which the experienced physician first employs in the instances I have just related? He merely vindicates the rights of outraged nature. He removes the first case into a pure, dry air, administers proper nutriment, gives a cleansing bath, and supplies fresh linen; in the next, he admits a due supply of light, ventilates the apartment, reduces the clothing, forbids the tepid inundations, and allows the use of pure cold water; while, in the third, he employs similar conditions, and strictly excludes every portion of the previous domestic drenching. Having done so, he quietly watches the progress of his cases, and, in almost every instance, he finds that he has done all that art requires him to do. Nature accomplishes the rest. Yet, in all these instances, though he never has exhibited a single drug, will any reasonable man say that, by his knowledge of medical science, he has not accomplished all that could have been done—namely, by having put his patients in the right road to recovery, the disease has been cured? Nay, more, has he not thus simply proved the first principles of the curative power of medical art, by his having removed the impediments which obstructed nature in her struggle with disease?

But let us now inquire whether there are not instances in which medical art can do more—namely, effect the removal of disease by the due administration

of drugs, and in which, without their exhibition, the morbid action must continue—nature being unequal to the contest—until either the complaint had destroyed life, or had effected such changes of normal structure as to prevent, for the future, the due performance of the proper functions of the organ or organs so injured! Every member of our profession, of even limited experience, will at once be able to point out a large number of diseases, both acute and chronic, in which the exhibition of medicinal remedies of undoubted powers is essential to their cure, and which, without such remedies, would unquestionably lead either to disorganization or death. For example sake, permit me to refer to one or two of these. Let me instance acute inflammation of a large joint, acute dysentery, inflammation of the cornea, specific or ordinary Iritis. In all of these cases we have palpable ocular demonstration of what is going on; we know, in each case, what the result is likely to be; and, while we see that nature, as in every other instance, battles with the morbid affection, step by step, we no less plainly perceive that her unaided efforts must end either in death or destruction of the functions of the part affected. We apply known suitable remedies, and we just as plainly see that the diseased action ceases, the morbid products are removed by a natural process, and the healthy condition and functions of the part are restored. Here, then, gentlemen, we have positive examples of the curative powers of the medical art, and in which it acts as the potent ally and subservient handmaid of kindly nature, which ever responds to every judicious effort in her behalf, but which as surely resents every interference which disturbs her operations, or which tries to act contrary to her established and unalterable laws.

For there cannot be any doubt that the functions of all organised bodies are guided by laws as certain and unalterable as those which compel the planetary system to observe their special orbits; and if so, it is clear that whatever interference we make with organised bodies must be in consonance with their peculiar laws. This it is which creates the greatest difficulty of medical practice. Observation and research require to be constantly exercised, and the precepts of experience to be ever kept in view, to enable the physician to judge aright of those disturbing causes which constitute disease, and to select those remedies which will not increase the existing disturbance, or set up more dangerous perturbations in the system.

That we are still very far from being able to select the remedies most suitable for every diseased condition we must all admit. We do not profess to be able to remedy every disorder. We cannot contend successfully with many; in the presence of several we are almost helpless; yet we do not despair. It is our duty humbly to estimate our powers—the curative powers of medical art. But, knowing, as we do, the value of preventive and palliative medicine, whose operations are evident, and usually unquestionable, we do hope that to the undoubted curative means we already possess, accurate observation and experience will add many others, so that we shall be better prepared to contend with disease, under every form, and to afford to nature, when disturbed, and when assistance seems essential

to the well-being of the individual, a succour more certain and consonant with nature's laws.

The principles which I have thus endeavoured to enunciate may not commend themselves to all of you. Some of my brethren present may have a higher estimate of the curative power of medicine than I profess; but I believe that the greater number of those who have passed more than twenty-five years in arduous practice, and who will calmly sum up individual experience, will admit that many views of the powers possessed by curative medicine have been considerably modified since the time we first embarked in professional life.

But, gentlemen, in making all the preceding statements, I must not be supposed to yield—nor do I—one iota of the principles which guide and ennable the legitimate exercise of medical practice. I have merely endeavoured to show cause for our still being hard students: that we yet have much to learn; that we have but little cause for boasting regarding the curative powers of our art; and that, while we know that we have learned much from physiological, pathological, and clinical investigations, we must still be humble observers of the laws of nature, and be content to keep pace with the progressive knowledge of a progressive science, and not attempt "to vindicate for our art the heroic character of a controller of nature and a conqueror of disease."

And now, gentlemen, having expressed my individual opinion of what legitimate medicine is, and what it is not, what it professes to do, and what it neither professes to accomplish, nor, in our present state of knowledge, can accomplish—having fairly and, I believe, moderately, put forward a few of its claims to be regarded as a noble and invaluable art, and having also honestly pointed out its imperfections, I may, with every propriety, claim your attention while I endeavour to expose the fallacies of some of those systems which have been pitted in antagonism to sound, rational, legitimate medical science. In this review, I shall be, I trust, the exponent of your individual sentiments; for I have every reason to believe that every one of you regards these heresies in the same light that I do—namely, irrational and untenable as sound and comprehensive systems!

Homœopathy, as being the oldest of these fallacies—as being the most irrational and untenable of these heresies—as affording evidence of the greatest delusion, claims our first notice; and, as it has lately been brought before us under the title of "What is it?" I shall consider, and endeavour to prove, "What it is not!" Besides, this method will be but simple justice. As I have already reviewed legitimate medicine under similar heads, and as I have moderately and honestly shown what medical science professes to do—what it can accomplish, and what it cannot—I may fairly devote like attention to homœopathy, merely promising that, while legitimate medical science is slow to assert anything regarding its powers, and boasts not of its cures, nor vaunts its infallible specifics, homœopathy is a system of illimitable assertion throughout—it boasts its wonderful (and impossible) cures, and has a specific for every human ill! And, certainly, if it do not succeed

with the public, it is not from any lack of trumpeting forth its delusions as the very embodiment of "rational medicine!" "Rational medicine," as exhibited in the form of a decillionth of a drop of the tincture of belladonna, being gravely pronounced a specific in scarlatina!

It is scarcely possible to believe that any medically-educated man, possessed of even very moderate reasoning powers, could conceive, much less believe, such a monstrous proposition; but as I must charitably suppose, there are some honest men who are sincere followers of Hahnemann, I am bound to accept the confession of their faith; yet must exclaim, O! the immeasurable extravagance of man's credulity! Alas, poor human nature! In the review which I am now about to take of the doctrines of homœopathy, I shall be specially careful not to state anything of "what it is" beyond what is contained in the writings of Hahnemann and his followers, even down to the latest blast that has been blown on a provincial penny trumpet. To the homœopaths I say, "Out of your own mouths shall ye be judged!"

It is evident that time will not permit me to do more than briefly refer to some of the leading doctrines of homœopathy, as I cannot inquire into the Hahnemannic assertion that itch, *psora*—common itch—is not only the cause of all diseases, but even of moral degradation and sin; that the shakings and titurations of the medicaments and infinitesimal divisions not only increase the dynamic force, but even spiritualise them; that the decillionth of a grain of any of their specifics not only effects the cure of disease, but that its presence can be positively demonstrated—that is, that one grain of sulphur can be detected, by physical signs, in a mass of water larger by some million times than the entire planetary system! Any inquiry into such extravagant assertions, which shock common sense, neither my time nor your patience would permit. I will merely say, that the instrument—the magnetoscope—which the homœopaths declared capable of detecting the decillionth of a grain of sulphur in a universe of matter turned out to be an acknowledged failure. An instrument, however, of a somewhat similar kind, enabled Farrady to expose the humbug and deceptions, of table-turning—a simple deception indeed, when compared with the extravagant and injurious delusions of homœopathy.

But to my text—"The theme neglected long!" "What is homœopathy?" Hahnemann, the founder of the practice, and his followers, tell us that it is based upon the principle that like cures like—that is, that anything taken into the healthy system, and which produces certain indications of functional disturbance, will, in a disease which exhibits a like disturbance—that is, symptoms like the perturbed indications produced in the healthy body—remove the disorder, when exhibited with the view of curing it. And they instance Peruvian bark, sulphur, silex, charcoal, and various other substances, which, they assert, have been proved—that is, tested—on the healthy body, and which, having universally produced certain sensible effects, when thus tested, are known to possess wonderful power in the cure of disease. *Credat Judæus! Non ego!*

This little system seems beautiful and simple—very

simple; but, then, it wants the main element which would render it of any value. It wants the essential element of truth. Who is there of us that has not tested the absolute untruthfulness of those pretences over and over again? How often has each practitioner here exhibited Peruvian bark, and its several preparations, in full doses and in moderate doses, for weeks together, and that, too, in the individual who seemed in ordinary health, without ever producing an attack of ague, or anything "like" ague? Has any one here ever seen sulphur produce itch, or create an evil moral propensity? Has any one here ever seen anything "like" the itch produced by the use of sulphur? or, has he ever observed any evil moral tendency generated by its administration?—an effect which it should have, according to the homœopathic system;—for Hahnemann expressly stated that, after twelve years of close and anxious observation, he fully believed *psora*, or itch, to be the germ from which all diseases had sprung; and some of his sapient followers improved upon this, by asserting it to be, also, the basis of moral turpitude!

Hence, if infinitesimal doses of sulphur cure the itch, it should, surely, remove the effects of the itch, moral or physical! It should, in fact, by a parity of reasoning, regenerate the world!—a hitherto, I believe, unexpected result, which must rejoice the benevolent heart of every moral reformer in the community, and for the discovery of which the discoverer, in justice, should be made perpetual president of some great reformatory establishment! The remarks I have made relative to bark and sulphur apply equally to the alleged "provings" of belladonna, aconite, arsenic, mercury, copper, and every other of those remedies which are said by the homœopaths to cure on the principle of *Similia similibus curatur*. No one who had not formed a foregone conclusion could have observed any such effects in the healthy body.

Imagination has a wonderful effect upon the human frame—a fact which every one of us is constantly in the habit of observing. Make a powerful impression on the mind, and the most marked results will ensue. This is one of the secrets of the homœopathic treatment. The homœopaths never stumble at the most extravagant promises; unlimited assertion and unhesitating promise can effect a great deal, and well they know it! and fully carry out, at least, that knowledge in their treatment of disease. They adduce the example of the efficacy of their treatment in infantile diseases, and triumphantly say, "See what effects are produced by our globules—pillules is now the fashionable term—or drops in cases where imagination has no influence!" But they must recollect that in no case does Nature so fully demonstrate her healing powers as in these very instances. This fact every observant medical man knows, and hence, in the treatment of the diseases of children, he has the greatest confidence that the natural action of the vital principle will, in most cases, overcome the disturbing cause, and restore the disordered function. In the severest attacks of infantile diseases, as well as in those of adults, do the homœopaths ever resort to the remedies you or I would likely adopt—clothing these remedies, however, in the mystified garb that conceals all their administra-

tions? They cannot deny that they do: some of them have admitted the practice; hence, who can ever be aware whether he is taking an infinitesimal, and, consequently, perfectly inert, dilution, or swallowing, in a concealed form the most powerful and dangerous of our pharmacopœial drugs? This may be honesty, but it seems to me very like old-fashioned assurance, not to say knavery.

But, to return to their *Similia similibus curantur*. The homœopathists say that all the medicaments they use have been tried on the healthy body, and their effects noted; so that any disease having symptoms "like" the disturbance caused by the drug in the healthy body will be cured by the administration of the self-same drug; and they furnish us with a long list of articles that, they say, produce such and such effects in the healthy individual, and, consequently, will, or "should," cure such and such complaints. We say they cannot shew us any instance of the truth of these assertions, and that the supposed effect upon the healthy individual is the impression made on the imagination, and that alone. Can they adduce any instances in healthy children—children's diseases being quoted as showing the curative powers of their treatment, uninfluenced by the will—where quinine, sulphur, belladonna, arsenic, aconite, or any other of their medicaments, inert or poisonous, produced ague, itch, scarlet fever, measles, cancer, or anything "like" these diseases? Perhaps they could tell us whether a healthy infant, if given powdered coral, would have heat, redness, and swelling of the gums?—symptoms very "like" teething—and that, hence, in teething, the best cure would be found in rubbing the gums with "a coral"? The suggestion, I believe, is new. The fact has not, that I am aware, been "proved." The substance in question, however, is as well worthy of the "proving" process as either silex or charcoal. I hope the homeopathists—especially the young and enthusiastic, members—will value and act on the hint. I trust they will not feel themselves my debtors for it. They need not be uneasy, as, I assure you, I make them a free-will gift of the suggestion.

The next assertion, on the part of homœopathy, is, that having selected the proper drug, and having regard to "like curing like," they can administer it in any quantity, from the third dilution—the millionth part of a grain or drop—to the 30th dilution, the decillionth of a grain! Some even go on to much higher divisions, and state that they can produce the most powerful effects and perturbations in the system of the patient, and thus cure the disease. Nay, more, they further assert that the more infinitesimal the dose, the greater becomes the dynamical value of the drug! Can the force of credulity, the arrogance of folly, and the assumption of impudence carry men farther? They can, as homœopathists, with a fearlessness that borders on blasphemy, assert that their system is a substitution for nature, that it takes her place, and, despite of her efforts, is the conqueror of disease! "The decillionth of a grain of sulphur causes such fearful perturbations in the system that some days must elapse before it can be safely repeated." So says the propounder of the homœopathic doctrine. A grain of sulphur dissolved in all the water that has ever been upon the face of this

globe, since creation's dawn, according to the homœopathist, causes fearful perturbations in the human body, when diseased! And, as it is said thus to cure the itch, it must, of necessity, cure all bodily diseases, and insanity, and moral turpitude, which the homœopathists assert, originate in the itch. Itch, in fact, being the germ whence all diseases have sprung, it is the true type of original sin!

Gentlemen, I will not tire your patience or insult your understanding by pursuing these monstrous absurdities further. But, were I addressing the public, I would consider it my duty to go more into detail, and hold out a beacon to warn them of the shallows, and quicksands, and dangerous reefs, which surround the barren soil whence homeopathy has sprung. And yet, perhaps, it would be labour in vain, for the history of man, from the earliest ages down to the present time, shows that the "many-headed monster," the public, has vast numbers of empty crania that are ever ready to receive any doctrine, howsoever absurd—any *canards* that have mystery enough about them to be totally beyond comprehension; the greater the deception the more compliant the public—the firmer its belief. We have had demonolatry, witchcraft, palmistry, the royal touch, the hanged man's touch, spirit-rapping, table-turning, clairvoyance, electro-biology, mesmerism, and Pulvermacherism, worshipped, or followed, or believed. We have Kinesopathy and hydropathy contending for the curing of all diseases, each vaunting its peculiar powers—that is, whether the system of pushing and shoving, of pounding and shaking, or that of sluicing and "packing" and rubbing, shall be most fashionable and most patronised. And then, above all the rest, we have homœopathy pre-eminent in assertion, boasting, and promise, taking the lead of all other quackeries, and simply because it has the triple pre-eminence I have named, and is, above the rest, totally beyond comprehension.

One or two more inquiries, and I have done. The homœopathists say that we abuse them and the system—themselves without a cause, and the system without trying it. One would suppose that they have been made martyrs of—the most submissive of martyrs—too good, too "spiritualised," too conscientious—to retort at all; while the truth is, that from Hahnemann to the latest disciple that has felt himself "dumbfounded," every abusive epithet has been heaped upon us by the homeopathists, who have never ceased to revile in public, but especially in private, a profession which most of them were bound to honour and revere—a profession which many of them would have never left had they studied or known it—a profession in the ranks of which some who have left it would still be found had they been able, by the practice of legitimate medicine, to succeed. The latter, however, are more to be pitied than despised. Then, again, they tell us that they have forsaken legitimate medicine "for conscience sake"—actuated by its dictates alone—they have courted what they lead the public to believe is nothing less than professional martyrdom! It may be so; and, yet, I have seen some of these martyrs looking very lively, and carrying themselves with a rather jaunty air! Perhaps, that is the way that homœopathic martyrs exhibit their

afflictions. Of course, I believe they feel they are martyrs. Maybe it is that there must be "Mawworms" to the end of the world, and that these men but fulfil their destiny. Does the *unit*, however, when he boasts of his "conscience," believe that the *ninety and nine*, from whom he has retrograded, possess any of that principle? Let us hope, in all charity, that he does. Still, the fact remains behind, that Hahnemann and his followers have usually stated that those of the "old school" are "insensible to the stings of conscience."

In connexion with this part of the subject, I may say that the causes assigned by some of the conscientious converts to homœopathy may strike them as very conclusive, but, in my opinion, are the silliest and most puerile causes—reasons I cannot call them—that were ever adduced in support of a conscientious movement; in fact, they are such as to leave very serious doubts that "conscience" was not the sole or principal impelling motive. The homœopathists occasionally boast of the intelligence and learning and high status of the members of their body. That there are learned and intelligent and clever men who have apostatised from legitimate medical faith I do not question. We have seen learned and intelligent men, in all ages, embracing and practising every species of deception; therefore we cannot suppose that homœopathy should present an exception; but that they had attained high professional status I most emphatically deny. Where are their great men—great in the eyes of the profession before their conversion to homœopathy? They may boast of them; but I confess I am not aware of their existence.

Now, let me sum up what I conceive homœopathy is, and what it is not. In the first place, then, the system, being based upon a false assumption, must of itself be false; it is erroneous in principle, and irrational in practice. It is a system of extravagant assertion, rich in promise, but excessively barren in results—save dead failures. It pretends to place value upon physiological investigations and researches, while, in practice, it entirely ignores their teachings, and sets itself up in direct opposition to all who are guided by the information which pathology and physiology supply. It is professed and practised, I believe, by some sincere, but, certainly, silly men, who cannot understand that *Nihil ex nihil fit*—that, in fact, in giving their infinitesimal dilutions, they are exhibiting nothing, and are unwittingly practising, it may be, a harmless, but, as likely in the case of disease, to be a fatal delusion; while on the other hand, I am persuaded, from what I have seen, that there are many men who have no faith in the so-called science of homœopathy, but have a strong faith in the deception that can be practised upon the public, and thus make it available in a pecuniary point of view. Such are the men who practise, in conjunction with a clairvoyant, and prescribe according to the revelations of a "medium!" Such are the men who give full pharmacoepic doses, concealed in their pills and infinitesimal-like globules. Such are the men who have faith in nothing beyond the powers of extracting money from the pockets of the community. These are my views of homœopathy—"what it is," and what it is not; and I leave it to all honest men—to all rational men—to say if, in its revelations, they can see any cause "why it should be

adopted?"

One or two more words, and I have done. In inaugurating the sixth session of the Belfast Pathological Society, I felt it my duty to draw a contrast between the science which is based upon pathology and some of those systems by which its doctrines are ignored. Time and the proper limits of an address have permitted me to refer only to a few of those principles which distinguish legitimate medicine from all spurious and antagonistic systems; but, in addressing gentlemen of scientific attainments, intelligence, and experience, like these whom I have the privilege and high honour to address, I feel that I have said enough. We are associated for the purpose of scientific research and the investigation of disease. Let us, then, pursue these investigations with earnestness, and in the spirit of free and impartial inquiry. We are associated for the interchange of thought; let that interchange all tend to the advancement of the noble and generous art we profess; and, while we feel that this advancement is for our individual good, let us remember that it has much higher results—mightier tendencies. For, by the progress of the healing art, the health and social happiness of the world must be materially enhanced and promoted.

In conclusion, let me, once more, gentlemen, thank you for the honourable position in which your kindness has placed me. I cannot hope to equal some of my distinguished predecessors in the ability with which your deliberations have been conducted; yet, by your aid and forbearance, and by sincere devotion to the intention and interests of your society, I hope I shall fill the presidential chair so as to merit your approbation.

At the end of his address the president was greeted with prolonged applause, and he was unanimously requested to have the address published.

The PRESIDENT next introduced an infant, aged six weeks, affected with aneurysm, by anastomosis engaging the left orbit and eye-lid. He promised to give the history and his views of the case on the next meeting.

SECOND MEETING. 6th November 1858.

The President in the Chair.

Extensive Caries of Femur.

The SECRETARY exhibited a portion of a femur forwarded by Dr. Babington, of Derry, the history of which is briefly as follows:—A girl, aged 20, by a fall, fractured the femur high up. She was admitted to the Derry Infirmary in December, 1857. In seven weeks union had taken place, and she could move about on crutches. While thus favourably progressing, she got another fall. Pain and swelling in the limb succeeded, producing disinclination, rather than inability, to move. After improving for some time, she again, in February following, became worse, her health failing, and the local symptoms increasing, and so continuing till July. At this period the limb was becoming swollen and tense, exhibiting on its surface several greatly enlarged veins. On July 14th an ulcerated opening appeared at

the upper part, through which a small quantity of unhealthy pus escaped. No palliation ensued. She was now exhausted, and her nights were marked by sleeplessness and occasional convulsions. On the 4th of August there was considerable haemorrhage from the opening, and on that night she died.

Autopsy:—Cutting into the thigh, an enormous quantity of grumous blood and sanies escaped. A large bloody tumor occupied the entire of the upper part of the thigh, and communicated with the external opening. In the site of the tumor there was no muscular or osseous structure, except a small, thin portion of bone, adherent to what seemed to be the remains of periosteum. The acetabulum contained two thin bony plates, the remains of the head of the femur. Its articulatory cartilage was absorbed, as were also the ligaments of the joint, and its surface was rough. The portion of femur remaining (exhibited) embraced the lower two-thirds, the upper half of which presented extensive caries, partial absence of periosteum, and recent bony formations. The lower portion was normal, as were also the surrounding structures. Dr. Babington, in his note with this case, called attention to its being very similar to a case of Mr. Browne's, detailed in *Dublin Quarterly Journal* for May, 1858.

The PRESIDENT and Dr. MURNEY concurred in Dr. Babington's view.

Professor GORDON thought differently, as he and Dr. Cumming, in examining the contents of the tumor, in the case referred to, found characteristic cancer-cells and structure; while in Dr. Babington's case the presence of pus opposed the view of identity, however like the history in each case. The one case Professor Gordon considered true medullary sarcoma; the other he thought non-malignant.

The PRESIDENT could not agree with Professor Gordon in forming opinions as to the malignant or non-malignant nature of a tumour by the presence or absence of pus.

In Dr. Babington's case it was felt that a microscopic examination, and some further details in history, would have added much to the certainty and value of this otherwise most interesting and important case.

The PRESIDENT referred to the case of aneurism by anastomosis, exhibited by him at first meeting, and read a history of it, the particulars of which are as follows:—At the time of birth there was not any mark observed on the child, but, in ten days after, a very minute bright-red spot was noticed upon the left upper eye-lid, near the inner canthus, unaccompanied by any swelling. When the child was about three weeks old, some swelling was noticed under the mark, which had spread considerably. When Mr. Browne first saw the case, after the 26th ultimo, the tumor had increased so much as to impede the motion of the eyelid, and had pushed the globe outwards. On the surface was a bright-red naevus, fully three-fourths of an inch in length, by half an inch in breadth, and this was surrounded by a bluish tint, to the extent of a half inch or more all around. The swelling felt soft, elastic, and without pulsation; it could be made less by pressure. The child was first exhibited to the Society

on the 30th of October, and when again shown to the Council, on November 3rd, they were satisfied that both the naevus and tumor had increased in size, even within that short time.

Mr. BROWNE then referred to some cases of aneurism by anastomosis about the orbit, and observations of distinguished authorities bearing on the case in question; one in particular as very similar, and detailed in Walters's Ophthalmic Surgery, S. 259, and in which Mr. Browne had himself assisted in the deligation of the carotid. The child, in this instance, was nearly five months old when operated on, and it, in common with the rest referred to, succeeded. He then mentioned the suggestions of members—pressure by collodion, and injection of per-nitrate of iron; but he had no confidence in any treatment save deligation of the common carotid; and from the success which attended the cases instanced, he believed the operation justifiable and demanded.

Dr. MURNEY hesitated to recommend deligation in a child so young.

Dr. T. READE thought the operation the proper course, but recommended delay, on account of the infant's extreme youth, the age being only six weeks.

THIRD MEETING.
13th November, 1858.

Cancer of the Rectum.

Dr. MOORE exhibited a coloured cast of cancer of the anus and adjoining parts, and gave the following particulars of the case:—A gentleman, aged 42, became affected, four years since, with a hard warty excrescence at anus, which subsequently increased, and at a later period became stationary. Ten months since he came under Dr. Moore's care; the case then exhibited extension of the warty formation, so as to form a fringe round anus. The finger, on being introduced into the rectum, discovered considerable induration. The introduction caused much pain. The patient's nights were now sleepless, and defaecation difficult from increasing closure of anus, at the edge of which a swelling appeared, which, after gradually increasing, at length gave way, forming an artificial anus. The natural aperture becoming quite impervious, the new opening now began to ulcerate, the ulceration extending so as to engage the whole of the perineum, and eventually forming a deep, rugged, granular cavity (5 inches by 2½ inches), with elevated broad margin. There was no pain in micturition, and no haemorrhage.

Extensive Cardiac Disease.

Professor REID exhibited the heart and kidneys of a female, aged 19, who had died a few days previously in the Union Hospital. As the foundation of her disease was an attack of acute rheumatism, he regretted being unable to give any particulars respecting that attack, as she had not been treated for it in the Union Hospital. Four years ago, however, it was entered in the casebook of the hospital, that she had sought relief, suffering from cough, bloody expectoration, dyspnoea,

and some oedema of the feet. On examining the heart, there was heard a single systolic murmur in the region of the aortic valves, along the aorta, subclavian, and carotid arteries, and a double murmur in the region of the mitral valves. She soon obtained so much relief that she insisted on leaving the hospital.

Dr. REID remarked that there was no class of diseases in which the discipline, rest, dietetic and medicinal treatment of an hospital were more markedly beneficial, in their early stages, than in that to which her ailment belonged; but that the moment relief was obtained, it was impossible to get the sufferers to remain quiet in hospital. To this general law she was no exception, as she was in the habit of paying two or three visits annually, and leaving as soon as relief was obtained. The winter before last, a change was observed in the murmurs that had been heard in the region of the mitral valves; the double murmur being now replaced by a single systolic one, which was heard all round the side, to the spine. The aortic murmur remained the same, but there was now jugular pulsation. The symptoms became steadily more severe at each successive visit, and she entered the hospital, about two months ago, with her sufferings greatly increased by a considerable amount of ascites and anasarca, from which she obtained but partial relief. About a fortnight ago all her symptoms became much aggravated; her urine scanty, high-coloured, and of specific gravity 1,030, and albuminous; and all the remedies tried for her relief having failed, she died with extensive anasarca and ascites. The heart was found greatly enlarged, and, with its pericardium, weighed fully twenty-two ounces. Dr. Reid remarked that the pericardial surfaces were intimately adherent, so that she had suffered from pericarditis, as well as endocarditis during her attack of rheumatism. The hydrostatic test proved that no regurgitation could take place from the aorta into the ventricle. On slitting open the aortic orifice, it was found hard and constricted, without vegetations, but the valves so much altered, that there was but a mere fissure through which the blood could pass into the aorta. The mitral orifice was patent, and the valves considerably hardened by a deposit of atheromatous matter on their external surface. The walls of the left ventricle were greatly hypertrophied, without its cavity being dilated. The right auricle was greatly dilated, and there was considerable constriction, with hardness of the right auriculo-ventricular opening, and the walls of the ventricle slightly hypertrophied. The kidneys were found intensely congested, but quite free from disease. Dr. Reid remarked, that although albumen existed in the urine, the healthy state of the structure of the kidney proved that it must have been owing to transudation from the congested vessels, caused by the impeded circulation through the heart; and that when we found the urine high-coloured, and of such high specific gravity, as in this case, we need not refrain from administering mercury, which we would hesitate to do, were we certain Bright's disease was the cause of the albumen. He added, that as the best authorities now agreed that an adherent pericardium exercised little influence in the production of either atrophy or hypertrophy, the

hypertrophy in this instance must be ascribed to the great impediment that existed to the propulsion of the blood through the aortic orifice, and in part to the regurgitation through the left auriculo-ventricular orifice. Although pulsation in the jugular vein had been observed, and indicated disease in the right side of the heart, he admitted that constriction of the auriculo-ventricular orifice had not been diagnosed during life.

Professor REID, in connection with this case, went on to state the result of his observations on the relative merits of solid and tubular stethoscopes in detecting endo- and pericardial murmurs. He referred to the difference of opinion as to the media whereby sounds were transmitted from the chest to the ear of the observer; the air contained in the stethoscope, its solid portion, or both; and to the solid whalebone stethoscope recently introduced by Dr. Corrigan. He said, with reference to endocardial or bellows murmurs, he had found, that when the solid and tubular stethoscopes were successively applied on the same spot, and the ear brought in contact, the sound was more distinctly conveyed by the tubular. In one case he had detected a murmur through the tubular, which was quite inaudible through the solid instrument—thus proving the superiority of the tubular for the early detection of disease. To test whether the air in the cylinder had any part in conveying sound, the stethoscopes were applied in the same way, but held by a third party; and on bringing the ear near to, but not in contact with, the instruments, a distinct murmur was heard, but more distinct through the tubular. With respect to their relative value in pericardial or friction sounds, the solid stethoscope had enabled him to detect to-and-fro friction sounds, when the tubular one had only revealed a single sound; and when the double friction sounds became unequivocally established, they were intensified by the solid, but the superiority was not so well marked as that of the tubular in the endocardial murmurs.

Professor FERGUSON expressed himself in favour of the solid stethoscope in all cases, and thought that the *bruit de soufflet* could not be heard unless the ear were brought directly in contact with the instrument. He had heard the *bruit de rape*, metallic tinkling, and amphoric resonance, when his ear was not in contact with the chest, but never the bellows murmur.

Dr. PIRRIE observed that Dr. Stokes had a patient who could hear the bellows murmur in himself.

Dr. W. M'GEE related a case in which the same sound was heard by the patient and his wife.

Professor REID, in reply, invited members to visit him at the Union Hospital, for the purpose of testing the accuracy of his observations.

[Letter subsequently published in the Dublin Hospital Gazette by Professor Seaton Reid.]

Sir—It will be in the recollection of your readers, that some time since I detailed before the Pathological Society of Belfast my observations on the relative value of solid and tubular stethoscopes. Further experience has confirmed me in the opinions then expressed, and I will feel obliged by your now publishing the following remarks on the subject.

With respect to endocardial murmurs, it is known that they may be divided into feeble and loud. When either of these was heard at the base or at the apex of the heart, a trial of the two stethoscopes led to the following conclusions:-

First patient, a male, aged 16, admitted to the hospital, suffering from third attack of acute rheumatism. A feeble systolic murmur was distinctly heard at the apex of the heart, through the tubular stethoscope, which was inaudible through the solid one. No change took place in this murmur during his four weeks' stay in the hospital, nor was any murmur heard, at any time, in the region of the aortic orifice. I considered that this mitral murmur had originated in one of his previous attacks.

Second patient, a male, aged 22. on entering the hospital, with his third attack of acute rheumatism, he was found suffering from endo- and pericarditis—the endocardial murmur heard along the aorta and subclavian arteries. The tubular stethoscope alone was used, till the treatment of this case had nearly terminated, and the pericardial murmur had ceased to be heard. A feeble systolic murmur was then distinctly heard at both the base and the apex of the heart, through the tubular stethoscope, but could not be detected by the solid one.

Third patient, a female, aged 35, admitted to the hospital in consequence of an attack of bronchitis, had suffered from an attack of acute rheumatism some years previously. The tubular stethoscope revealed distinctly the existence of a systolic murmur at the base of the heart, which could not be heard through the solid one. She had no appearance of anaemia.

Fourth patient, a male, aged 16, had suffered from an attack of acute rheumatism six years ago, when his medical attendant, in Newry, informed his father that his heart had not been involved. I saw him within twelve hours of the commencement of his second attack, and made a careful examination of his heart, without finding in it any evidence of disease. A minute examination was made daily, with both stethoscopes, without detecting any indication of a cardiac complication, till the morning of the fifth day, when a feeble systolic murmur was heard distinctly at the apex, through the tubular, but not through the solid stethoscope, which continued to be the case till the eleventh day.

An alarming complication, which I had never met with before in acute rheumatism, appeared on the eighth day, when I requested Professor Ferguson to see him with me. He carefully examined the heart with both stethoscopes, on that and the two next days, and agreed with me in the opinion, that a systolic murmur could be heard distinctly at the apex through the tubular stethoscope, which was inaudible through the solid whalebone one.

On applying the tubular stethoscope on the eleventh morning, I found the murmur had become so much louder, that I remarked at once to Dr. Ferguson, that we would now be certain to hear it through the solid one also, and on using it we heard it distinctly. No murmur was heard at any time at the base of the heart in this patient.

From the foregoing observations I consider that I am justified in stating, that the tubular stethoscope is superior to the solid one in detecting the existence of feeble endocardial murmurs; the last case especially shows its superiority, where it indicated the presence of a murmur six days earlier than it could be detected by the solid one.

When however the murmur is a loud one, then will be heard through both the solid and tubular

Having had only one opportunity of comparing the value of the two stethoscopes in pericarditis, I do not feel justified in giving a positive opinion respecting them; as it is well known pericardial friction murmurs may vary much in intensity within a very short period of time.

Yours, &c., Seaton Reid.]

FOURTH MEETING.

20th November, 1858.

Surgeon BROWNE, President, in the Chair.

The PRESIDENT introduced the child affected with aneurysm by anastomosis in the orbit, already before the Society. The tumour had increased in all directions, the surface becoming stretched and ulcerated.

Dr. WALES read a communication from Dr. Russell, of Bangor, detailing the case of a child eight months old, affected with Aneurism by Anastomosis between the Nose and Orbit. The tumor was seen by Dr. Russell four months since; he describes it as partly cutaneous, partly subcutaneous, and rapidly enlarging. He vaccinated the tumor in several places, the result of which was, the immediate arrest of increase, and subsequent diminution. He says it is now shrunk, and he expects progressive contraction and cure. He thinks a like proceeding in Mr. Browne's case worthy of consideration, before resorting to tying of the common carotid.

The PRESIDENT observed, that Dr. Russell's case and his differed in nature as well as site, the latter circumstance alone rendering vaccination in his patient inexpedient. He again referred to deligation of the common carotid as the only chance.

The PRESIDENT introduced a lad from whose bladder he had removed a stone by the mid-perineal section, revived by Mr. Allarton, and described in Braithwaite's Retrospect, vol. XXXI., p. 417. In this publication Mr. Allarton speaks of a work on Surgery by Dr. Joseph B. de Borsa, published at Verona, in 1843, in which is described this mode of operation, and the amazing success attending it, in ninety-nine cases out of a hundred.

A Case of Lithotomy in which Allarton's Operation was Performed.

The subject of the following remarks is a young lad, named James Magee, aged 13 years. He was born at Lurgan, but resided for the last seven years in Belfast. About two years ago he felt a sharp intermittent pain in the right side of the abdomen, which troubled him for

some six months; after this the seat of pain, or rather uneasiness, became fixed in the bladder. These pains were manifestly caused by the passage of a calculus along the right ureter into the bladder. For some time before his admission he had suffered considerable pain, had frequent desire to micturate, with occasional stoppage in the flow of urine, and a general failing away in his health. He was admitted into the General Hospital, under my care, on the 17th of September. At that time he suffered great pain behind the symphysis pubis. On passing a No. 5 steel sound, I struck a stone in the right side of base of bladder, the sensation conveyed to the hand being that likely to be caused by a smooth, hard calculus, of moderate size. I directed him to be kept quiet in bed, to have some aperient medicine, and a sedative at bed-time. There was nothing abnormal to be discerned in the urine. I found, on subsequently sounding him, that the stone had changed its situation. The rest and medicinal treatment greatly improved the patient's health, and it was then determined to perform lithotomy. I determined to adopt Allarton's method. The operation revived by Mr. Allarton is a modification of the Marian, which, Mr. Coulson states, has been abandoned for more than a hundred years, but is similar in many respects to that which Dr. Willis attempted to re-introduce to notice some time back. On the 14th of October my patient, having been properly prepared, was put under the influence of chloroform—no easy matter to be accomplished from the excitability of the lad. When fully under the influence of the anaesthetic, I injected four ounces of tepid water into the bladder, and introduced the sound. The existence of a stone being satisfactorily proved, I withdrew the sound, and introduced a No. 7 grooved staff, which was retained in the proper position by Dr. Murney. I then introduced my left forefinger, well oiled, into the rectum, and carried the point on, so as to discover the end of the staff, as it lay in the bladder, beyond the prostate; having done so, I fixed the tip of the finger against the prostate, just at the junction of the membranous and prostatic portions of the urethra. And here I may remark that the patient was held in the usual position for lithotomy by two assistants, without any binding whatever. The next step in the operation was to pass a sharp-pointed bistoury into the mesial line of the perineum, the back being next the rectum, about half an inch in front of the anus, and carrying it steadily on till its point struck the groove in the staff, a little in front of where the tip of the finger pressed against the prostate. The knife was then moved along the staff for three or four lines, so as to open the membranous part of the urethra, and then being withdrawn, so as to lay open the superficial parts of the perineum, for about an inch up towards the scrotum. I then withdrew my finger from the anus, passed it into the wound, and carried a probe-pointed bistoury above it, into the groove in the staff, so as to fully open the membranous part of the urethra without interfering with the prostate gland. This step, though not advised by Mr. Allarton, I thought right to adopt, so as to be certain the membranous part of the urethra was clearly incised. Still retaining my finger in the wound, my nail

in the groove of the staff, I carried a long ball-pointed probe into the bladder, along the ground. The staff was then withdrawn, and the index finger, well greased, was passed by a gentle rotatory motion along the probe or director, into the bladder. This was accomplished without any violence, the prostatic portion of the urethra yielding readily to the dilating power of the finger, without conveying any sensation that the parts were being torn. So soon as the finger was in the bladder, its point touched the stone, lying behind the prostate. I then passed in a fine pair of forceps, withdrawing the finger at the same time, and at once seized the stone, which was easily extracted. In the operation a small artery, a branch of the transversalis peritonei, was cut, which bled freely for a few minutes; the haemorrhage was, however, easily arrested by a dossil of lint, wetted with strong infusion of matico. One hour afterwards the lint was removed, a little cold water injected into the wound, and the slight oozing ceased. I ordered an opiate and perfect quietude, with light farinaceous diet.

15th—Rested well after the opiate had been repeated. Urine passed freely, half per urethram and half through the wound. Pulse 120. Doing well.

16th—Pulse 84; has slept well; has not any thirst or pain since. Some smarting caused by urine, one-fourth of which came off by the urethra.

17th—Pulse 78; had an excellent night; half of the urine coming off by the urethra; bowels not open since the operation. To have two drachms of castor-oil.

18th—Pulse 74; bowels freely opened; rested well. To have chicken soup. Urine flowing all by incision.

19th—Still improving. To have a chop.

20th—Improving. The wound looks healthy, with a secretion of pus. To have castor-oil.

From this till the 27th he continued to improve; the wound closing, and the quantity of urine flowing through it becoming less every day.

On the 28th only a drop or two of urine came through the wound and I permitted my patient to walk about the ward. He was discharged, quite well, on the 12th instant, twenty-eight clear days after the operation. The stone is of the oxalate of lime, and measures one inch and seven-eighths in its greatest circumference, and one inch and a half in its smallest circumference.

The most remarkable feature in the operation is the ease with which the prostatic portion of the urethra dilates. Even in the dead body I found I could pass in the finger and afterwards the largest-sized lithotomy forceps, without tearing any parts. This I proved by dissecting one case carefully myself; and in another Dr. Murney kindly made the dissection for me, and remarked that not a part was torn, although I had passed in my finger and moved it freely about, and then the large forceps had been introduced.

Dr. MOORE exhibited a small tumor which he had removed from the scrotum of a gentleman, a week since. It had existed six months, and was of a sebaceous character, and had originated in simple enlargement of a sebaceous follicle.

Dr. HEENEY read a case of Extensive Serpiginous Ulcers. A young man, pale, thin, and anaemic, applied to Dr. Heeney, three months since, for the cure of five large serpiginous ulcers on the thighs, the largest of which was seven inches by three inches. He had been two years ill, notwithstanding clever aid. He did not recollect having had syphilis, but might have had it. The disease commenced with a swelling in the groin, which slowly suppurated, and became a spreading sore. Never was salivated. Took sarsaparilla and the mercurial acids without effect. Dr. Heeney, on seeing him, was inclined to think that the intractable nature of the sores depended on other than syphilitic causes, and commenced by ordering good diet, iron, and a solution of caustic to the sores. In three weeks there was marked improvement in health; the sores were improved, the discharge lessened, and the central parts healing. Soon after, the edges began to spread, to stop which applied caustic, and gave iodide of potass, with the effect of checking further ulceration for two weeks; then tried creosote, and administered the bi-chloride of mercury internally in one-twelfth grain doses. These and other applications to the sores were tried with variable effect, but still with some success, the ulcers having greatly diminished. Dr. Heeney, however, observed that the protracted use of any remedy rendered it powerless in keeping back the disposition to the spread of ulceration; he therefore had recourse to a mixture of cod-liver oil, Fowler's solution, and pills of iodide of sulphur, with the effect of checking further spreading of the sores, though they still remained not entirely healed. Dr. Heeney asked the opinion of members as to the best remedy for this case. Dr. HALLIDAY thought mercury, given to salivation, would have a good effect. He referred to Dr. Colles's treatment of such cases by the persistent use of mercury.

Dr. MURNEY recommended fumigations with the vapours of mercury and water, as did the President also, who coincided in Dr. Halliday's view as to the necessity for prolonged mercurialization in such cases.

FIFTH MEETING.
27th November, 1858.

Dr. MOORE exhibited a *Scirrhous Tumor*, which he had removed from the breast of a woman, aged 40. She had felt occasional sharp pain in the part fifteen months before, but did not perceive any tumor till within the last six months. It was movable, did not engage the entire mammary gland, nor implicate the axillary glands. Dr. Moore removed the entire gland, which he considers the proper course under such circumstances, and the case has so far done well; the woman, however, is of a cancerous aspect.

The PRESIDENT exhibited a *Scirrhous Gland*, which he had removed from the breast of a soldier. It commenced twelve years before, in a tumor the size of a pea. For many years he had suffered acute lancinating pain in the part. The man had a healthy appearance, and the friction of the cross-belt was considered to be

the cause.

A conversation ensued as to the propriety of operative interference in cancer; the extent of removal of glandular structures, only a small portion being diseased, and on the chances of the patient after operation.

Professor REID had known the disease to return after the lapse of twelve years from operation.

Dr. HEENEY had removed scirrhouus glands from the breast and axilla; after twelve months the patient died, from what seemed to be idiopathic hydrothorax, but which was most probably the result of cancerous development internally.

Mr. SMYTH had seen the disease return in two years after operation.

Dr. DILL remarked, that two years since he questioned the propriety of operation, as a rule, in cancer; his opinions were then strongly opposed. He thinks they would now be more favourably received.

The PRESIDENT said he believed that surgeons were pretty well agreed as to the general return of cancer after operation; he was, however, in favour of early operation, which, he said, apart from other considerations, relieved the mind from a constant source of dread and despondency—strong provocatives to the development of the disease.

Dr. MURNEY took the same view.

Dr. WALES said the question had been discussed at one of the meetings of the London Medical Society, last session. In the report of that meeting it appeared, that in 207 operations at the Cancer Hospital, the disease returned in the average period of fifteen months, and the recurrent tumor was more difficult to control than the original one. Further, that in cancerous growths there was a natural ebb—a spontaneous degeneration—and that by removing such growths dyscrasia was induced and the disease thereby promoted. Further, that the reservoir being taken away, the cancer-cells were diffused throughout the body; and that, except in epithelial and some forms of medullary cancer, operation did harm. Dr. Wales went on to say, that the microscopic detection of so-called characteristic cancer-cells was till recently considered proof of malignancy. Such were the views of Lebert, Robin, &c. Virchow, Weal, and other distinguished pathological histologists, however, deny the specificality of cancer-cells, and show that exactly similar formations will be abundantly met with in the examination of transitional normal structures. Therefore, amongst the successful results of operation, it is probable that many benign tumors, appearing to possess the microscopical characters of cancer, have been included—a circumstance detrimental to the value of data of results in favour of the knife.

The PRESIDENT read the particulars of a case in which he had removed calculi by the lithotrite. He said that stone was rare in this part, and that his operations of lithotomy and lithotripsy were the first performed in the Belfast Hospital. The patient in this case was a strong, healthy, Carrickfergus fisherman, aged 42. At the beginning of 1857, he first experienced calculus symptoms. In August he passed a stone; and in

November he came under Mr. Browne, who, on examination, discovered a stone, and dilated the urethra. The stone subsequently passed, which, with the former, were of the mulberry kind. In February last, owing to a return of symptoms, he again applied for relief. Mr. B., on sounding, discovered a large stone, and admitted him to the hospital on the 19th, in a somewhat emaciated condition, and worn down by irritation. One week after, he was again sounded, and the stone was found fixed near the opening of the right ureter. Repeated soundings afterwards found it in the same position; and Mr. B. fearing that it might be engaged in the coats of the bladder, deferred operating, hoping for, and expecting, its detachment from its position in front of the ureteral stream. On the 17th March, he again sounded, and found his expectations realized. The stone was free in the bladder, and seemed, from sensation, to be about the size of a walnut, rough, and somewhat hard. The bladder was not irritable, and its soundness was indicated by the absence of an excess of mucus in the urine, or other abnormal product, save oxalate of lime. The prostate was not enlarged, and the urethra was large and dilatable, so that it was a very suitable case for lithotripsy. Accordingly, prepared by castor oil and enema, the patient was, on the 8th April, put on the table, his bladder was injected with tepid water, and after one or two attempts Mr. B. succeeded in grasping the stone with a No. 14 lithotrite. The instrument being well pushed in to avoid injuring the vesical neck, the stone was broken, and the large fragments subsequently crushed. The index of the lithotrite showed 1 $\frac{3}{4}$ in. separation of its blades when the calculus was first seized. The patient, on standing up, passed off the injected fluid, and a considerable number of fragments and detritus. His bladder was again injected, and he was ordered daily hip baths, draughts of liquor of potass, and tincture of hyoscyamus, together with enemata and castor oil, when necessary. Beyond slight irritation of the bladder he progressed favourably, passing fragments and detritus occasionally. On the 11th, a small fragment was crushed; and on the 15th, the same operation was repeated, after which all irritation ceased,—the urine losing the mucus, and becoming clear and retainable. On the 20th he left the hospital, and has since enjoyed excellent health, and immunity from all calculus symptoms.

Dr. MOORE differed from Mr. Browne as to the rarity of stone in this neighbourhood.

Dr. MURNEY remarked the suitableness of Mr. Browne's case for lithotripsy, as evidenced by the gratifying result.

Dr. WALES said that caustic alkalies, combined with any of the forms of henbane, and medicines of that class, completely destroyed their sedative and narcotic effects, while the alkaline carbonates did not, and were as useful as the caustic alkalies. The observations and experiments of Dr. Ganord and others were most conclusive on these points.

The PRESIDENT said he had been in the habit of using liquor of potass and tincture of hyoscyamus in combination, and had found them efficacious.

Professor REID thought that the benefit attributed to the two medicines combined, might be due entirely to the action of the caustic alkali. He also made some important observations confirmatory of the conclusions to which he has been led by his experiments with solid and tubular stethoscopes; which were followed by corroborating statements of a general character from Dr. Murney, Dr. Halliday, Dr. Dill, Dr. Wales, and the President, all of whom had examined the cases on which Professor Reid's observations had been founded.

SIXTH MEETING. 4th December, 1858.

Dr. WALES introduced a patient suffering under what he considered to be an advanced stage of *Suppurative Nephritis, merging into Fatty Degeneration*.

The man was 56, a mill-mechanic. He looked pale and thin, and in answer to questions, stated that he had passed small calculi some years since, and had occasionally felt pain in region of right kidney from childhood. He applied to Dr. Wales on the 30th ult., for relief from an attack of six weeks' duration. Till the period of this attack he had always enjoyed fair health. His illness commenced with acute pain in site of right kidney (which still continues, but in a less violent degree), and with slight general febrile symptoms. Throughout his illness he denies having had sickness, vomiting, rigors, or any of the symptoms of vesical irritation. He could not bear pressure over right kidney. He was concerned for his health by the continuation of the pain, by increasing emaciation and weakness, by want of appetite, and by the muddy aspect of his urine while escaping from the urethra. The patient having retired, Dr. Wales made the following observations:—This case demonstrates very emphatically the value, and even the necessity, of chemistry and microscopy in medicine. Without these aids we could not become certain of the existence of special morbid products in the urine, and without this knowledge our diagnosis, our prognosis, and our treatment must be somewhat speculative and unsafe. The characters of this patient's urine are as follows. *On escaping* it is quite muddy, of a pale dirty white and reddish colour. Its specific gravity is 1,025. After a short time a deposit forms, occupying one-third of the entire bulk of the urine. This deposit is readily miscible with the fluid portion, without the slightest appearance of tenacity. The urine is acid. On heating it a deposit forms, which remaining unaltered, on the addition of nitric acid is shown to be albumen. Other tests for albumen confirm this result. I next tested with *acetic acid*, which caused a precipitate insoluble in an excess of the acid. I was thus informed of the existence of another morbid product, which I inferred to be *pyin*, one of the elements of *pus*. The presence of the latter in the urine I confirmed by the addition of caustic potash to a little of the fluid previously agitated, which immediately converted it into a dense gelatinous mass. It is only to the presence of *pus corpuscles* that this coagulability is due; therefore, I lay stress on the necessity of shaking up the deposit before using the tests. So far, by the aid

of chemistry alone, I was enabled to discover and to identify the matter to the presence of which the morbidity of the urine was due. The next consideration was to know the source of the pus, and the state of the part from which it came. The microscope then became of material service. With a power of 400 diameters I could perceive nothing but pus corpuscles of a very granular and irregular aspect. On the addition of acetic acid, there was not a sharp, clear appearance of the nuclei and nucleoli, which, together with the absence of a generally perfect circular outline, would lead to the view entertained by Vogel, that this pus did not result from a mere catarrh of the mucous membrane, but from purulent destruction, endangering the integrity of the organ affected. To ascertain if the granular aspect of the pus cells were due to the presence of granular fat in the interior, I heated some of the deposit with warm ether, which, after being separated and evaporated, yielded fat largely. Now, this fatty condition of the pus cells appears frequently where matter has been encased for a time in the interior of tissues; but in this case we have had no rigors, which might have been expected with the formation of an abscess. The matter, to the naked eye, had not a purulent aspect, neither could any of it be forced to appear by pressing the urethra—proofs of its not having originated in the urethra; the excessively large quantity of pus present in the urine prevented this supposition too, and also that of its having been formed in the ureters. Then, if it originated in the bladder, mucus and alkaline urine, together with symptoms of irritation of the bladder, should have existed. I was thus driven to look for the source of the pus in the kidney, and there the history, symptoms, and microscopical characters all harmonized. It is true there was no appearance of tube casts, or tubular epithelial debris mixed up with the pus cells; only the latter; but nothing else could be expected if the tubuli of the kidney were already destroyed. The acute stage had passed, and I think during its progress tube casts and other indications of destructive inflammation of the kidney might have been observed. From all these considerations, looking particularly at the excessive quantity of pus, its very fatty character, I am inclined to consider one kidney disorganized from acute suppurative nephritis, and in a state of incipient fatty degeneration.

Professor GORDON said that Dr. Wales had been very careful and minute in his observations, but he thought he had drawn too fine distinctions. He thought the pus had its source in the bladder, rather than the kidney; and he could not see what the presence of pus corpuscles had to do with fatty degeneration of the kidneys.

Dr. WALES, in reply, said that he could not see on what evidence Dr. Gordon referred the suppuration to the bladder. There had not been a single symptom referable to that viscous throughout the whole history of the case, while, on the other hand, the kidney had been the seat of pain all through. He referred to the absence of an excess of mucus in the urine, which almost invariably exists in affections of the bladder, and with regard to the relations of pus-corpuscles and fatty degeneration, he said that the latter was not an

uncommon consequence of acute suppurative nephritis.

Dr. BRYCE exhibited a

*Membranous Fleshy Mass, the size of an orange,
containing an Undeveloped Fœtus.*

It had an intra-uterine existence of eleven months. He also referred to another similar case, in which twelve months had elapsed from the period of conception until the expulsion of the foetal mass.

Dr. MOORE placed before the Society a leg, which he had amputated in the morning, for

Pulpy Degeneration of the Knee Joint,

from a young man æt. 22. About five years ago he complained of pain first in the inner side of the knee, at the top of the tibia, then on the outer side, and shortly afterwards at the lower part of the patella—the usual parts and in the usual order, almost invariably, that patients point to, and express the pain to be located. The knee was very much enlarged—twice its natural size; had a soft resistance, and had a tumor about the size of a goose egg on its outer side, extending downwards along the fibula and communicating with the joint. For this disease he had been in another hospital, and had been from time to time under medical treatment, and the usual leeching, blistering, ointments, mercurial strappings, &c., had been employed. Some nine months ago his health was very much impaired—he suffered from hectic and great local pain. The operation was performed under chloroform, and the artery compressed in the groin (which he prefers to the tourniquet, there being less loss of venous blood), five arteries were tried, and during the operation not two ounces of blood were lost. The circular operation was proposed as giving a neater stump, less bleeding, from the vessels being cut directly across, and less chance of secondary haemorrhage. He looked upon this as a true pulpy degeneration of the joint, and was glad to state that the patient, now five hours after operation, was going on favourably.

The PRESIDENT said he preferred the flap to the circular operation, as, in his opinion, it made a better stump, and had other advantages.

Professor FERGUSON having expressed a desire to ascertain the pathological condition of the joint.

Dr. MOORE afterwards opened it, and exposed the pulpy degeneration. Some matter flowed, and on pressing the tumour on the side of the leg, the joint became filled with matter. He remarked that this case would not at all have been suited for resection, the injury to the parts around the joint, their altered structure, the abscess, and the previous bad health, were against such a proposal, or a favourable result.

Dr. MURNEY presented a series of cases of injuries of the head. From the great obscurity which surrounds the diagnosis of injuries of the head, particularly fractures of the base of the skull, he considered it most desirable to record the history, and in case of death, the post mortem appearances of all cases which have been carefully observed, so that future writers may be

enabled to obtain important statistical conclusions as to the frequency of particular symptoms, or more extended information as to the occurrence of certain lesions. He believed the cases he was about to lay before the meeting were also interesting, from their progress during life, or from the nature or extent of the injuries as shown on examination after death. One was an example of fracture of the lateral region of the head; it proved fatal. Three had fracture of the base; one recovered, two died. And one had a fracture of the superior region of the skull; this patient recovered. He did not deem it necessary to give the history as it appears in his Hospital Case Book. He had, therefore, extracted the important points connected with each in as brief terms as he possibly could. He also omitted allusion to the treatment, as the indications were of the most obvious character.

I.—Fracture of Parietal Bone—Wound of Meningeal Artery—Compression—Rupture of Kidney.

A boy, aged 19, was admitted at 1 p.m., on the 26th August, 1856. He had fallen a height of twelve or fourteen feet. He distinctly recollects falling, being carried into his master's place, and subsequently being brought to Hospital. He was not insensible at any period. The surface was cool and pulse quick. He complained of pain in the right side of the head. His right eye was blackened, and there was some contusion and discoloration over the right temporal muscle. There was trifling epistaxis. At three, p.m. reaction had fully set in. In the evening he passed some high-coloured urine. On the 27th he was reported to have slept a little during the night. Pulse 80, moderately soft. Complained only of pain in the head. His answers to questions were correct and satisfactory.

On the 28th, he passed some bloody urine. For the first time, he now complained to some of the other patients of pain in the right side as well as of the pain in the head; slept well during the night, not too heavily. Was visited by the house surgeon at 9 a.m., and again at 1 p.m., who reports he was perfectly sensible, and progressing favourably. About 2½ p.m. he became stupid, and gradually sank into a condition of complete insensibility. When visited at 5 p.m., the pulse was so rapid it was scarcely possible to count it; the respiration very much hurried; the right pupil, fully dilated, fixed; the left was also immovable—not so large; a good deal of swelling and tympanitis of the abdomen; pressure on this region seemed to cause pain, he died at 7 pm.—53½ hours after admission.

Post-mortem Examination.—Some blood was extravasated into the substance, and on the surface, of the right temporal muscle. A fissure of the cranium, without depression of either table, extended for about one inch nearly horizontally along the anterior inferior angle of the right parietal bone. On removal of calvarium, a firm clot of blood, which, when measured, was rather more than two ounces—almost spherical in shape, about the size of a boy's hand-ball—was placed between the dura mater and the skull; the base rested on the roof of the right orbit; inwards, it extended almost to the crista galli; above, it reached to the frontal eminence; and backwards, it compressed the

anterior lobe, so as to remove it almost completely from the anterior fossa of the base of the skull. Haemorrhage had come from the lacerated arteria meninge media. The veins on the upper parts of both hemispheres were congested. The arachnoid membrane and brain were normal.

Abdomen.—The right kidney was completely lacerated across its centre. From the ruptured vessels a large quantity (about one pint) of blood was extravasated behind the peritoneum; it extended as far as the liver, and down to the iliac fossa. A considerable quantity was also poured out between the layers of the mesentery and beneath the peritoneal coat of the bladder.

Thorax.—The lungs were healthy; no marks of injury. There was complete union of the visceral and parietal layers of the pericardium.

I consider this case presents the following features of interest:—A fracture of the skull was produced, yet the patient was never insensible; he was at all times cognizant of events passing around him, replied to questions, and seemed to possess an average amount of mental acuteness.

Until the last few hours of life, the effects of the fall were so very trifling, we can but say he laboured under the mildest form of concussion.

From the gradual assumption of the symptoms of compression, I infer the blood extravasated from the lacerated middle meningeal artery was not poured out until half-past two, p.m., on the day of his death. It is interesting also to observe, that he passed urine different times during at least thirty hours after his admission, without any peculiarity having attracted attention; and at least forty-five hours elapsed without any complaint of abdominal pain. The haemorrhage from the renal arteries must have occurred shortly before the termination of the case, as I believe, had it taken place early, the symptoms of its presence would have been developed.

II.—Fracture of Base of Skull, passing through petrous portion of temporal bone—Other extensive Injuries of Skull—Laceration of middle Meningeal Artery.

October 11th, 1856—A middle-aged man admitted at two, p.m. A few minutes since, fell from a second loft to the ground. He is described by the lookers-on to have gone down head foremost, the part coming in contact with the flagged flooring being the upper portion of the left parietal bone. He was taken up completely insensible, and brought to hospital. On examination, a wound about an inch and a half long is found on scalp, corresponding to upper and anterior part of left parietal bone. Bloody serum wells up from the left ear. When the head is turned to the right side, it no longer flows, but when resting on the back or left side it dribbles continuously. A surgeon who saw him immediately after the accident, states blood flowed from the mouth and nostrils; none at present comes from those parts. A few drops of stimulant were poured into his mouth, but there is complete inability to swallow. The respiration is slow (about fourteen), without stertor, almost entirely abdominal; pulse seventy-six, compressible. The pupils are greatly

dilated, and quite insensible. About half an hour after admission the following changes were noticed:—Slowly the intervals between the respirations became prolonged; the pulse became very weak. After a little time the breathing ceased altogether; the pulse could no longer be felt; the jaw dropped; all present considered he was dead. In this condition he remained for a short time, supposed to be three-quarters of a minute; then the respiration and pulse gradually and slowly returned. He died eight hours after admission.

Post-mortem Examination.—On removal of the scalp, an extensive bloody extravasation was found; it was fully three-quarters of an inch thick, and extended from the frontal eminences to the occipital protuberance, and lay between the pericranium and the aponeurosis of the occipito-frontalis muscle.

The coronal suture was found completely started, the serrations of the bones no longer interlacing. On attempting to remove the calvarium in the usual fashion, the frontal bone separated from the two parietal, although considerable care was used in the attempt. The skull-cap showed, in addition to the separation of the fronto-parietal suture, 1st, a fissure stretching from the left parietal protuberance forwards, and upwards to the anterior fontanelle, about three inches in length. 2nd, apparently a continuation of this, on the adjacent surface of the frontal bone, about an inch and a half long. 3rd, a fissure passing from the occipital protuberance upwards towards the lambdoidal suture, about an inch long. A large quantity of blood was found extravasated between the skull and dura mater. This occupied the whole of the upper surface of the right hemisphere. It was in greater quantity in the region of the right middle meningeal artery, which had been lacerated. Before the removal of the calvarium, upon every motion of the head, some of this blood oozed through the coronal suture.

The brain was removed, and found healthy and firm, with the exception of almost universal venous congestion. There were two slight lacerations on the inferior surfaces of the cerebellar lobes, corresponding to the situation of two fractures. Stellate fractures occupied the roofs of both orbits. Stellate fractures were also found in both inferior occipital fossæ. Following down the open coronal suture, on the left side, one fracture passed through the great wing of the sphenoid bone, as far as the foramen ovale; a second ran backwards from the beginning of the last across the centre of the petrous bone, and terminated in the cuneiform process of the occipital bone. On the right side, beginning at the anterior inferior angle of the parietal bone, the fracture passed through the great wing of the sphenoid into the foramen sacrum medius; thence it passed into the cuneiform process, where it met with the fissure from the opposite side. It followed, by grasping the anterior part of the base of the skull with one hand, and the posterior part with the other, a hinge-like movement was most easily produced; in fact, the surfaces were retained in contact only by the soft parts. Neither chest nor abdomen were examined. In this case, *post-mortem* confirmed the diagnosis of fracture of the base, passing through the petrous bone of left side. The other extensive injuries could not have

been anticipated.

I was very forcibly impressed with the cessation of the vital functions, and their resumption. I have not observed anything of the kind before, and must say I am at a loss for a satisfactory explanation. I can readily understand the retardation and cessation of the circulating system produced by pressure; but I do not see why these duties should recommence, the compression on the nervous centres being unrelieved.

III.—*Fracture of Base of Skull—Laceration of Kidney—Recovery.*

A man, aged twenty-one, was admitted at 9.15 a.m., on 5th July. Half an hour before, he had fallen a height of twenty-four feet, alighting almost horizontally on his right side. His head struck against a block of wood, fracturing the zygoma. The bye-standers reported that the blood gushed from the nostrils and right ear. On admission, he was completely insensible; blood was oozing from right ear; pupils were dilated, right more than left; and there was general collapse. At times he was quiet, at other periods he moaned and tossed, so that it was with difficulty he could be kept in bed. During the day he vomited frothy blood, or blood mixed with bile, and blood continued to flow from right ear. In the evening he was more conscious, and complained of pain in the region of liver and right kidney. The catheter was passed, and eight ounces bloody urine drawn off. On the 6th he was almost perfectly conscious. Bloody serum oozed from the ear. He complained of extreme pain in the right side, and especially in the region of the kidney, with sharp shooting pains all over the abdomen, increased by pressure. Catheter being passed, bloody urine was drawn off on two occasions. On the 7th he was perfectly conscious, pupils natural, serum flowing from the ear. On the 8th and 9th he continued to improve. On the 10th he began to experience extreme uneasiness in the hypogastrium and right lumbar regions, with a constant desire, accompanied by inability, to urinate, unless when sitting on the close-stool; in this position he passed small quantities of bloody urine. The catheter was introduced, and six ounces of bloody pus and fibrinous-looking clots, mingled with urine of a high ammoniacal odour, was drawn off. On the 11th he passed, *per urethram*, two pints of almost pure blood, containing a great number of casts, supposed to have been formed in the ureter. Large quantities of blood were mingled with the urine, until the 19th, from which day until the 23rd it gradually diminished. On the 24th it again appeared in the urine in considerable amount. In twenty-four hours he passed three and a half pints of bloody urine. This condition gradually declined, and finally disappeared on the 30th July. On the 14th August he was discharged in tolerable health. I have since learned he was enabled to resume work a month after he left hospital.

In all, he was forty days under treatment. I consider we have evidence to warrant the diagnosis of fractured base of the skull and laceration of the right kidney. The progress of the case was most interesting and instructive, as, I need hardly observe, entertaining such an opinion of the injuries, the prognosis was most

unfavourable.

IV.—Fracture of Base of Skull, passing through each of the three Fossæ.

A man, aged twenty-six, was admitted on the 20th November, at ten, p.m. Half-an-hour previously, while intoxicated, he fell backwards down stairs, a height of eight or ten feet. The weight of the frame was received on the occipital region. He was rendered completely unconscious, and bled freely from the nostrils. On admission, there was a small scalp wound to the left of the occipital protuberance; the pericranium was exposed; no inequality of the bony surfaces could be detected. A little blood continued to ooze from the nose, but ceased in a short time. Pulse seventy, very intermittent; respiration stertorous, with sobbing; pupils dilated, right more than left; both were unaffected by light. The stomach-pump was used, to remove any spirits or other contents from the organ, but it was quite empty. He never rallied, but died at seven, a.m., on the 21st.

Post-mortem Examination.—An ounce to an ounce and a half fluid blood lay on the surface of the dura mater. On removing this membrane, the veins of the brain were greatly distended with blood. Fluid and coagulated blood surrounded all parts of the organ, especially the base. Two large clots were situated immediately in front of the anterior lobes, resting upon the roofs of the orbits. The haemorrhage came from the cavernous sinus of right side, which was lacerated. On being measured, at least sixteen ounces fluid blood had compressed the encephalon. The brain, cerebellum, &c., were quite healthy, except the grey substance on the inferior aspect of the anterior lobes, which was softened and torn by the pressure of the blood. The base of the skull presented a fracture passing through each of the three fossæ, in, to me, an unusual direction. It commenced about one inch to the left of the occipital protuberance, and ran down into the inferior occipital fossa, where it divided into two; one branch passed into the foramen lacerum posterius, the other into the foramen magnum. The continuation of this ran through the basilar process, a little to the right of its centre, onwards to the right side of the body of the sphenoid, close by the petrous bone, lacerating the cavernous sinus, then turned inwards and forwards, terminating at the cribriform plate of the ethmoid bone.

In this case I must acknowledge my inability to give a satisfactory diagnosis. That the injury was most serious, was quite evident from the symptoms enumerated; but yet we had no indication of fracture of the base. There was no bleeding from the ears, and that from the nose was most trifling; even had it been considerable, I would have been slow to expect a fracture taking the direction I point out. I have not seen any example of it before; and judging from the strength of the parts involved, I am sure it must be very rare. Neither chest nor abdomen were examined.

V.—Fissure of Cranium—Paralytic Symptoms—Recovery.

A man, aged about forty, was admitted on the 21st July of this year. About one hour before admission, while engaged hoisting goods with a large crane, the machine became reversed, and he received a severe

blow on the forehead from the handle, while revolving with considerable rapidity; was slightly stunned at the time, but does not now show any constitutional symptoms of the injury. A transverse wound extends for about four inches across the forehead, immediately above the frontal protuberance; the bone is exposed for nearly the same extent. A fissure in it is seen, about two inches in length, internal to the left frontal eminence. No inequality on the bony surface. The greater part of the wound united by the first intention. On the 28th the adhesions broke down, and the lips of the wound gaped as at first. It was also noticed his articulation was not so distinct as formerly. He seemed to have trouble in the pronunciation of some words, and he occasionally paused in the middle of a sentence. On the 3rd August he had numbness of the left lower limb, beginning below, and extending upwards; later on, a similar condition of the left arm was complained of. This was succeeded by incomplete paralysis of that side; at the same time the mind became weak; he frequently muttered to himself, attempted to get out of bed, &c., &c. Slowly the paralytic symptoms declined, and he was discharged on the 3rd September, forty-four days after admission into hospital.

In this case, the complete absence of symptoms even of the slightest concussion, for several days, showed there was no necessity for active treatment; accordingly, low diet and an occasional purgative were the only measures carried out. When the wound became unhealthy, more active treatment was resorted to. Increased action evidently caused deposit, most probably at the site of fracture, and hence the symptoms of pressure within the head. Although the bone was fissured, we had no indication that the inner table exercised the slightest compression.

Dr. WILLIAM MACCORMAC exhibited the lungs and heart of a man who had died suddenly. He gave the following history:—

J. C., aged fifty, admitted into hospital 7th of December, 8-30 a.m. On admission, his pulse was very feeble—about 100—his respiration was much oppressed, and there was considerable venous congestion of the countenance, along with great general prostration. He was perfectly sensible, and quite able to state his residence. Apparently, there were no symptoms present, except those referable to the cheat. On making a physical examination, I found dulness beneath each mamma, greater on the left side. The respiration was free in the apices, together with loud crepitating, and large mucous rales in the inferior portions of both lungs, especially the left. The heart sounds were completely obscured by the loud respiratory murmurs.

The history of the patient, as subsequently obtained, was incomplete. His occupation was that of waiter, and he had been long ailing from cough and difficult breathing. He had fallen down in Donegall Place, while proceeding to his work. Neither his wife nor he himself anticipated the fatal termination to his illness. It was thought by those who first saw him that he had fallen in a fit, but they altered their opinion on seeing him quiet and sensible.

It so happened that this man had consulted my father on the morning previous to his death. My father informed me that he was a pale, sallow man, with great anxiety of countenance and oppression of breathing; also swelling of the lower extremities. He stated that he had suffered from those ailments for years. My father looked on the case as one of emphysema, probably combined with heart-disease in an advanced stage, and prescribed a palliative merely. The treatment on admission into hospital was not likely to prove of much service. Mustard was applied to the chest and back, and aromatic spirit of ammonia was administered internally. In ten minutes he became totally collapsed, and in ten more expired. The lungs were greatly congested. The heart was much enlarged, and presented an abnormal quantity of fat. The pleural cavity on the left side contained half a pint of serum. There were extensive adhesions, apparently of different dates. While in the act of dividing the root of the lung, after having separated the adhesions, I observed a small quantity of pus to issue from the posterior mediastinum, beneath and behind the arch of the aorta. On the right side the pleural adhesions were diaphragmatic, but no serum had been effused. The bronchial glands at the roots of the lungs were greatly enlarged, and filled with cretaceous masses. On examination, the lungs presented great emphysema in the upper lobes, with air-bullae scattered over the pleural surface. On section of the upper lobe there was found a considerable amount of frothy mucus, while the lower lobe was greatly congested, and I observed three or four of the bronchi from which there issued purulent mucus. There was no tubercle in the left lung. There was considerable emphysema of the upper portion of superior lobe, while the other two-thirds of the lung were gorged with blood and inferiorly, in a state approaching hepatization. There was no blood extravasated in the substance of the lung.

So much for the lungs. The heart, however, presented still more interesting appearances. This viscus, as I stated before, was much enlarged. The left ventricle was hypertrophied, and the right dilated. In the latter cavity I found a clot almost devoid of colouring matter, and undoubtedly attached in several places to the walls of the ventricle, insinuating itself among the musculi papillares. It sent off two distinct branches, one extending into the auricle, the other into the pulmonary artery. In the left ventricle I discovered a clot much smaller and redder than that on the right side. It was distinctly connected through the auriculo-ventricular opening with a small clot in the auricle. Whether it extended into the aorta, I cannot positively state. The valves of the pulmonary artery, together with the mitral and tricuspid valves, were healthy. On examining the aorta, which I had cut out for about eight inches, I found the coats extensively thickened, but otherwise healthy. There was a notable fusiform dilatation of the arch, and situated in this enlargement was a clot of almost pure yellow fibrine, which I here present. It has a curious shape, thick at one end—that next the heart—the other dwindling into a thread four or five inches long. This mass of fibrine was situated in the dilated portion of the aorta. I cannot state,

however, whether it had or had not a connection with the ventricular clot. On employing the hydrostatic test, the semi-lunar valves failed.

This case, gentlemen, is interesting, as showing what a large amount of disease is compatible with life; and the question at issue is hardly so much the cause of death as the reason for the continuance so long of life. For, in all deference, I submit that the post mortem appearances were the sequel of long-continued diseases. I reserve, however, the question of the cardiac polipi clots, or whatever else may be the appropriate designation, opinions are so diverse on the point. Still, I think that the fibrinous concretions of the right side of the heart and the one contained in the aorta were too tenacious and too free from the colouring matter of the blood to be post mortem. It was clear, also, from the enormous amount of congestion in the lungs, that the current in the pulmonic circulation would be greatly retarded, a circumstance favourable to the coagulation of the blood. To account for the aortic embolus, if we may so term it, we have the fusiform dilatation of the arch. With regard to the pus, I think it was the contents of an abscess in the posterior mediastinum, for that was the region whence it issued. The proximate cause of death we may fairly ascribe to the cardiac clots. Death also, according to Copeland, frequently takes place suddenly in abscess of the posterior mediastinum.

SEVENTH MEETING.
11th December, 1858.

Professor REID exhibited to the Society the brain, heart, liver, spleen, kidneys, and intestines of a female, aged 36, who died a few days previously in the Union Hospital.

Dr. Reid then said—I regret that I am unable to communicate to the Society any accurate history of the patient's illness, in consequence of her being insensible on admission, and that I had no opportunity of conversing with her friends.

All that I have been able to learn is, that she had suffered from dropsy some three or four months ago, and that on its disappearance she was attacked with "bowel complaint," which, I may remark, continued till her death. Six days before her death she was attacked with headache, restlessness, and delirium, and in two days was unable to recognize her friends. On admission to hospital, two days before her death, she was screaming, apparently from pain; was unable to give any history of her illness. Both pupils were dilated, the left one more than the right; the upper extremities were quiet, but the lower in constant motion. At my visit, the next morning, no improvement had followed the treatment adopted. She was still quite insensible; the pupils fixed in the same state as on admission; the pulse 120 full; pinching produced movements in the lower limbs, but none in the upper; the abdomen was flat, and there was no anasarca. She had passed urine and bloody faeces unconsciously, and she was evidently dying. Some urine removed by catheter, for the purpose of examination, was found of sp. gr. 1,018, and

free from albumen.

No improvement took place, and she died the next morning.

On examination after death, there was no effusion into the peritoneum, pleura, pericardium, or beneath the dura mater. The heart was healthy, weighed 7 ozs., and perhaps a little smaller than natural. The liver was much contracted, and presented a well-marked example of cirrhosis, or the "hob nail" degeneration. The gall bladder contained some ounces of bile. The spleen greatly enlarged; its capsule considerably thickened, with striæ passing towards the interior. The kidneys were smaller than natural, and the tubular structure in a few parts encroached upon by fatty deposit.

The mucous membrane of the small intestines was quite pale till within three or four inches of the cæcum, when it became inflamed or congested in patches, which state continued through the entire length of the large intestines to the anus. There was no ulceration. The brain, on being removed, was found opaque on the upper surface and base, and when dissected by Dr. Murney, in the presence of the Society, its substance was found healthy, and there was some effusion into both ventricles, particularly the right. Professor Reid then said that the cause of death in this patient was evidently the affection of the brain, and that, as the ascites had been cured, had the brain not become involved, this woman's life might have been prolonged for some time, notwithstanding the large amount of organic disease that was present.

He added, that as yet no satisfactory explanation had been given why, when the obstruction to the return of blood from the intestines was seated in the liver, the congestion should almost invariably be confined to the large intestine, and the small intestines remain pale, as in the present instance.

Dr. HEANEY said the woman had been treated by him before her admission into the Union Hospital. She had suffered from dropsy, with scanty urine, cough, and constipation. He gave her acetate nitrate, and iodide of potass, together with compound jalap powder and palliatives. The dropsy yielded, diarrhoea supervened, and continued spite of appropriate treatment. Dr. Heaney thought that retention of urea in the system might have had something to do with the form of death.

Professor REID observed, in answer to the supposition of ureal poisoning, that the urine had been freely secreted towards the close of the case.

Dr. M'GEE thought that the action of the jalap administered might have originated the diarrhoea, and the state of the bowels then apparent.

Professor FERGUSON thought not, as he said that jalap acted principally on the small intestines. He considered the congestion visible in the bowels due to the hepatic obstruction which existed in the case, and he was inclined to assign the operation of gravitation as the cause of the location of the congestion and irritation in the large and not in the small intestines.

Dr. PIRRIE concurred in Professor Ferguson's view as to the cause of the location of the congestion, and instanced the common occurrence of haemorrhoids in

hepatic obstruction as an example. Dr. MURNEY said if such were an explanation of the cause of the morbid appearance being confined to the large intestines in such cases, the transverse colon ought to be from its position as exempt as the small intestines. This, he said, was not the case, the transverse colon showing congested and irritated patches, the same as other tracts of the large bowels.

Dr. WALES said he thought the form of death, as observed by Dr. Heaney, and also the irritation visible in the intestines, and the diarrhoea, most readily explained, by the supposition of urea being retained in the blood. He said he thought that urea might be retained, notwithstanding a large watery secretion from the kidneys, and he regretted that no examination of the blood, had been made to ascertain if urea existed in that fluid.

Professor REID said that Dr. Wales's remarks might explain the case, but the symptoms were not those he had observed in several cases of ureal poisoning. He contrasted the symptoms in these and in this case, which led him to think there had not been poisoning by urea.

EIGHTH MEETING. 18th December, 1858.

The PRESIDENT introduced a man, W.G., aged 56, labouring under a large cancerous eroding ulcer of the forehead. The disease had commenced six years since in a small warty-like growth—about the centre of the part now ulcerated. For three years the little excrescence increased but slowly, it then ulcerated, and since has spread rapidly. At the present time the ulcer occupies a space four inches square, having destroyed the coverings of the centre and left part of the frontal bone, down to the periosteum, and having passed deeply into the left orbit. This man (who still enjoys good health) stated that he had never suffered any pain in the part until recently, and even now the pain is confined to the points where the ulceration has attacked the structures upon the margin of the orbit. He also made the remarkable statement, that until he applied, last week, to Mr. Browne, he never bad sought any medical advice.

The PRESIDENT remarked that the case before the Society very much resembled one formerly exhibited, and of which he presented a photograph. In that instance the disease progressed until the substance of the brain was attacked, and the patient sank from exhaustion and irritation. Of course nothing could be done to effect a cure in the case now brought forward.

The PRESIDENT next introduced a man affected with melanosis of right eye, of which the following is the history, as detailed by Dr. Maddin, of Portglenone:—"J. M'L. was seized, thirteen years since, with amaurotic symptoms of the right eye. From that period until about twelve months since, he was occasionally seized with severe pain in the eye and whole side of the head, with a highly congested state of the conjunctiva and neighbouring parts. By proper treatment, those symptoms were always got under without leaving any

apparent disorganization of the eye. About twelve months since he was struck with a cow's horn; some inflammation followed, on the subsidence of which a small tumour was discovered, protruding from the cornea. From that time, he has had frequent seizures of violent inflammation of the parts, still leaving the eye further disorganized, until it has reached its present state."

The PRESIDENT said the case was suitable for extirpation, and remarked that the removal of the globe itself, without any other structure of the orbit, would be sufficient.

Dr. PATTERSON read the following case:—

Mrs. ___, aged 48, mother of nine children—eight living, youngest nine years old—dark complexion, of very active habits, enjoyed remarkably good health up to the last twelve months, when she began to complain of occasional pains in the abdomen, attributed to flatulency. Last March she believed herself pregnant, though her husband, a medical man, did not think so. On the 10th July, the pains in the abdomen became so severe that, in the absence of her husband, she sent for medical advice. Surgeon Aickin, who then saw her (in my absence), found her complaining of severe abdominal pains, without any inflammatory symptoms. She was treated by castor oil and turpentine internally, and hot turpentine stapes externally. In a few days the urgent symptoms abated, and at the end of the month, when I saw her, her husband suspected ovarian dropsy. The abdomen was enlarged, most evident on the right side. As she believed herself pregnant, she refused all medical treatment. In August, she went up to Dublin, and was under the treatment of a physician eminent in female diseases who, on the 7th September, gave the following opinion of her case:—"I can detect no evidence of pregnancy, nor of any form of dropsy. I believe the history of her case to be that in July she had an attack of inflammation, under the influence of which the peritoneum, the subjacent areolar tissue, and the mesentery became thick and consolidated, and hence the dulness over all the region below the umbilicus; and I suspect some induration in the mesentery. I consider this condition will yield to moderate aperients, external frictions, the warm bath, iodide of iron, but the process will be slow." On the 15th September she returned to Belfast, and continued this treatment for two weeks, during which time her size increased and urine became scanty. The most active remedies were then used to counteract the dropsical symptoms, without the slightest benefit. Previous to this, there was tympanites. There was great irritability of the stomach with vomiting, but no thirst; the bowels were constipated, and continued so throughout the entire disease. Notwithstanding the immense size she attained, there was not the slightest dyspnoea during the entire continuance of the disease, nor did the urine, though repeatedly examined, possess any trace of albumen. Towards the end of October, as she had not benefitted by any treatment, and at the earnest solicitation of some friends, she placed herself under the treatment of a homœopathic practitioner, under whose care she was for upwards of two weeks, during

which time, of course, I ceased attendance. On the 10th Nov. she again requested Surgeon Aickin and myself to see her. On visiting her we found her much enlarged and weaker. We recommended tapping, to which she readily agreed, and on the following evening Dr. James Moore drew off about five pints of matter, consisting of glairy, reddish fluid, and a considerable number of masses of clear, gelatinous matter. Although her size was not much reduced, still she was considerably easier for a time. On the 5th December, at her own urgent request, as she was then larger than when the operation was before performed, an opening was made by Dr. Moore, but not more than half a wine glass full of viscid gelatinous matter obtained, notwithstanding the opening was so large as to admit the little finger readily. The operation was performed in bed, she was so extremely weak. From this time she gradually sank from exhaustion, without any new symptom; and expired on the evening of the 13th inst. without any apparent suffering. The post mortem of the body was made forty three hours after death by Surgeon Aickin. Present also, Drs. Moore, Cumming, and myself.

Dr. Patterson also called attention to Dr. M'Gee's opinion of the colloid nature of the disease in this case, as expressed by him during the life of the patient.

Dr. CUMING exhibited the diseased parts, and read the following account of the autopsy and of the subsequent microscopical examination which he had made:—

Sectio Cadaveris, December 14th, 2 p.m., 43 Hours after Death.—Head and thorax not examined.

On opening the abdomen, a large mass was seen extending from the pelvis to the ensiform cartilage, and completely concealing the intestines.

On the anterior surface of the mass, the opening made into its envelope, in the operation of tapping, was observed to be still patulous. At the sides, and covering a portion of the surface of the tumour, was a quantity of semi-transparent, viscid, gelatinous matter, varying in tint from a light amber yellow below to a brown above.

The mass was constituted by an encysted tumour springing from the site of the right ovary; consisting of several enormous cysts, united together by their walls, composed of a tolerably firm vascular, fibrous membrane containing a clear-yellow, tenacious matter, similar in character and consistence to that which had been found external to the tumour. At the base of the large mass several smaller cysts were noticed. The entire quantity of the tenacious matter was roughly estimated at about a gallon. The left ovary was enlarged to about four times its normal dimensions, was perfectly smooth on the surface, and on section was found to have undergone similar cystic degeneration. Both the visceral and parietal layers of the peritoneum were perfectly healthy, with the exception of some old strong adhesions on the superior surface of the liver, and an indurated growth in the substance of the omentum.

There was a congested state of the intestinal canal, but no trace of disease, except at the junction of the ileum with the colon, where there existed a tuberiform induration, above which, in the lower portion of the

ileum, was a mass of extremely hard laminated faeces.

The liver and spleen were congested, and apparently diminished in bulk from the compression to which they had been subjected. The other viscera healthy.

Minute Examination.—The substance contained in the ovarian cysts was found, on microscopic examination, to be composed of—

Minute filaments.

Large irregularly shaped nucleated cells.

A large number of granular corpuscles about the size of pus cells.

A considerable quantity of minute granules.

There was distinct fibrillation on the addition of acetic acid. On the surface of the diseased omentum, but covered by the serous membrane, a considerable number of minute cysts were visible to the naked eye, varying in size from that of a millet seed to that of a small pea, and filled with a substance similar to that contained in the large ovarian cysts. The diseased mass itself was of almost cartilaginous hardness, presenting on section a white glistening surface, from which, on pressure, exuded a pale yellow viscid substance, in all respects analogous to that which formed the contents of the larger cysts, but much less rich in cell-forms. Under the microscope the indurated substance was seen to consist of the so called colloid cancer, viz.:—a fibrous stroma forming very distinct loculi of various sizes, in which the gelatinous material was contained.

The induration in the ileum was identical, both in external appearance and in minute structure, with that in the omentum.

Remarks.—Mr. President,—The most noticeable feature in the pathology of the specimens before us is, I think, the evident identity in type of formation of the hard, solid mass in the omentum and ileum, and of the large cysts in the ovary: the great difference in their ultimate structure depending clearly on the fact that, in the one case, the development of the cyst-contents forms the prominent character of the new product: while in the other the predominance of the fibrous or enveloping element gives rise to an essentially solid, though alveolar structure. And from the fact that the cysts are largest and most typically developed in those situations where pressure is least, and where, consequently, the evolution of the morbid growth has been least impeded and interfered with, namely—on the surface of the omentum, and towards the anterior parietis of the abdomen in the ovarian disease—would it not seem that here the nisus of the diathesis has been towards the formation of determinate hollow structures? I think the most probable view of the nature of the disease before us is, that it has originated in a growth of cysts of the same character as those we see in the ovary: that these, possibly in consequence of pressure—possibly from some unknown influence of tissue or seat, have formed the solid alveolar tissue by the apposition of their walls and the increase of the fibrous element.

If this view be correct we would have here, not a cancerous growth associated with cysts, nor cysts developed in a cancerous structure, but cysts constituting what possibly is cancer.

I offer these remarks, Sir, by no means as embodying

a theory, but merely as speculations, into which I was led by an attentive study of the specimens before us, and on which I would be glad to hear the opinion of gentlemen of much greater pathological experience and information than I could pretend to.

Dr. HEANEY read the following case:—

W. H., a stout-looking man, 60 years of age, and of temperate habits, sent for me to visit him on the 15th October last. He stated to me that he had always enjoyed good health till about three weeks ago, when he began to feel weak and troubled with unusual chilliness, but was still able to follow his employment as a carman, till about four days before, when he became so weak and annoyed with pain and soreness throughout the whole extent of the right side of the abdomen, that he was obliged to remain within doors. On that day he was unable to leave his bed, and his appetite for food had completely left him; his tongue was dry, like a person in fever, but there was no headache or chilliness; his pulse 96 and weak. On examination, I could find nothing wrong with his side beyond slight tenderness on pressure. I ordered a dose of castor oil and a large sinapis to the side. On next day the oil had acted, and the pain he complained of was somewhat abated. On the following day he complained that the pain was rather worse, and I found the abdomen tympanitic, for which I ordered castor oil and turpentine, with a reapplication of the sinapis. On my next visit, the day after, the tympanitic affection was removed, and the pain slightly abated. Up to this time he was able to take a little beef tea and some gruel, but for the three succeeding weeks I could not prevail on him to take either, and he was supported principally with wine and water, which was the only nourishment he could or would take. On the sixth day of my attendance, discovered a small round tumour in the right hypogastric region, near to the site of the ilio-caecal valve, more tender upon pressure than the surrounding parts, which continued to increase for five or six days. It was not at all connected with the integuments, and evidently lay beneath the peritoneum. It was not diffuse, but well circumscribed and immovable. About this time an oblong swelling, with inflamed appearance, began to show along the upper part of thigh, running below, but parallel with Paupart's ligament, extending from the femoral vessels outwards. At first view there appeared to be no connection between the tumours, as there was a complete sulcus between them, the centre line of which was Paupart's ligament. As my patient was very weak, unable to take nourishment, and the nature of the tumour in the abdomen not a little obscure, I became apprehensive for his safety, and demanded a consultation. Dr. Wales was called in, who, after due examination, recommended a continuance of the treatment, which consisted of poultices and warm fomentations, and in about five days after we were enabled to open the longitudinal tumour below Paupart's ligament, from whence there issued about 24 ozs. of good healthy-looking pus, causing the tumour in the abdomen to nearly disappear. It continuing to discharge moderately for about a week, and then gradually healed up. Although immediately relieved of the pain and tension

by the discharge, his health and appetite did not improve for a week, his first meal being a small water cracker on the fifth day, after which he could take gruel and arrow-root in small quantities. During the whole of his illness, for three weeks, he got no sleep, unless from hypnotics, which I was obliged to administer every second night. The point of interest, Mr. President, in this case, is to ascertain the exact site and nature of this abdominal abscess; and how, and by what channel, it made its way to the top of the thigh about two inches outside of the femoral vessels. The man declared he got no hurt for the last four years, and the matter did not appear of a scrofulous character. He is now restored to health, and following his usual occupation as a carman.

Dr. READE considered the case one of iliac abscess.

Dr. M'GEE asked if the limb of the affected side had been drawn up during the patient's illness, and being answered in the negative, he said he could not consider the case one of iliac abscess, as both in that disease and in psoas abscess the limb of the affected side was drawn up.

Dr. MOORE said he had seen cases of iliac abscess in which the limb was not drawn up.

Dr. M'GEE said he could not be satisfied with positive opinions as to the nature of such cases, unless post mortem proof of the site of the disease could be adduced.

Dr. READE understood Dr. M'Gee to say that in iliac abscess the limb was drawn up. He had seen the limb thus flexed occasionally, but he had seen twenty cases in which there was no flexion of the limb of the affected side; he, therefore, could not consider the drawing up of the limb a necessary accompaniment of iliac abscess.

The PRESIDENT was of opinion that the abscess was situated in the iliac fossa. He did not consider drawing up of the limb absolutely a necessary accompaniment to either psoas or iliac abscess.

Dr. HALLIDAY said he never saw psoas or iliac abscess in which the limb was not more or less flexed.

Dr. HEANEY adverted to the direction of pointing of the abscess in the case, as opposed the view of its being either psoas or iliac abscess.

NINTH MEETING. 1st January, 1859.

The PRESIDENT said he would be glad to bear the observations of members on Dr. Murney's cases of injuries of the head.

Dr. M'GEE said the cases reported by Dr. Murney offered several points of interest. In the third case he considered there had been fracture of the base and rupture of the membranes, and he formed this opinion in consequence of the serous haemorrhage from the ear.

The second case he considered interesting, from the cessation and resumption of the respiration and pulsations, and he ventured a supposition that the heart might have been in a state of fatty degeneration—such condition, according to Dr. Stokes, being a cause of

apnoea.

The first case he considered singular, for the lateness at which coma set in—49 hours after the fall. He pointed out, as a possible cause of extravasation and consequent coma, the occurrence of laceration of the middle meningeal artery by its own pulsations against the margin of the fissured bone;¹ and he related a case of gun-shot wound in which a similar occurrence took place, and extensive haemorrhage, followed by friction of the femoral artery against spiculae of the comminuted femur, six days after the injury.

Professor GORDON said, in the case of the boy, he did not agree with the opinion expressed by Dr. Murney as to the time at which the effusion of blood took place. He thinks that it occurred shortly after the accident, and gradually accumulating, had not attained sufficient magnitude to produce fatal compression until a short time antecedent to death. He looked upon this case as having a very important practical bearing on the treatment of severe injuries of the head. It points very distinctly to the injurious consequences that might result from the early exhibition of stimuli; for, if the amount of injury the intra-cranial mass be such as likely to lead to the extinction of life, the early exhibition of stimuli will not prevent a fatal result, but in cases in which recovery from the collapse supervenes they will rouse prematurely vascular action, and determine to haemorrhage. It is, therefore, our duty to prolong the collapse rather than to shorten it. A turpentine enema at such a time will do good. As to the use of the stomach pump, he could not comprehend the principle which would justify its use. The introduction and pressure of the tube in the oesophagus would unquestionably induce spasm of the glottis, and, as a consequence, venous congestion in the right side of the heart, in the veins of the neck and head, and determine to haemorrhage. He, therefore, regarded the use of the stomach pump as decidedly injurious, entailing much more serious consequences than any that might result from the contents of the stomach. In forming a diagnosis and prognosis in severe injuries of the head, the vital symptoms are generally vague and unsatisfactory as to the real nature and extent of the intra-cranial lesions. The physical conformation of the cranium, and forces acting on it, have been too much overlooked. Thus, when a man falls from a height and alights on the upper part of the head, the vertex is depressed and approximated to the base, whilst the lower borders of the parietal bones are thrown outwards, frequently detaching the squamous from the

¹ When this report was published in the Dublin Hospital Gazette, the Editor added:—"We are cognizant of a case in which a similar occurrence took place. A gentleman was riding about four miles from town, when his horse fell, but not seeming to be much hurt, he remounted and rode home. When near home, he observed the horse to be gradually becoming weaker, and at last to stagger under him. He had barely time to leap off, push the animal from him, when it dropped dead. Post-mortem examination showed that at the time of the first fall the animal had fractured a rib, and that the aorta, pulsating against the point of fracture, had gradually torn itself, and that a sudden burst of haemorrhage had proved fatal." [The order of the three cases has been reversed to allow this footnote to be displayed.]

petrous portion of the temporal bone. When a person falls in this manner, and from no great elevation, from the force and conformation of the skull we may naturally expect fracture of the temporal bone, and its consequences—effusion of blood between the dura mater and anterior inferior angle of the parietal bones from rupture of the middle meningeal artery; also haemorrhage from the ear, frequently from laceration of the lateral sinus, and also welling of a clear fluid from the ear, mixed or un-mixed with blood, from the sac of the arachnoid being opened. Effusion of blood from the ear has been regarded as indicative of a fracture of the base of the skull, but to give to it its true signification, it is only a strong presumptive evidence of a fracture of that part of the base of the cranium corresponding to the juncture of the squamous and petrous portions of the temporal bone. This is true as regards the generality of such cases, but rare instances have occurred in which there was in some cases haemorrhage, in others welling of clear fluid, without fracture. Let us carry our reasoning a little further; let us suppose that the height of the fall has been considerable, and the man weighty. The violence will, therefore, be greater, and we must expect more extensive injuries; fractures of the vertex, disjunction of the sutures, fracture of the basilar process, and fractures radiating from the condyles, taking different directions, according to the relative strength of the several parts of the cranium. Dr. Gordon, therefore, infers that if Dr. Murney had taken these various circumstances into consideration, he might have anticipated the extensive injuries met with in one of his cases. The man falls from a considerable height upon a flagged flooring, alighting upon the upper part of the right parietal bone. The vertex thus first reaches the flags, the whole weight of the body impinges upon the condyles, and comminutes the base. From the very nature of the forces brought into operation, so are we to expect fractures. Hence valuable information may be gained as to the diagnosis and prognosis from the physical conformation of the cranium, and from the forces acting on that structure. In blows and falls upon the head, the most frequent seat of separation of the dura mater from the skull is unquestionably at the anterior inferior angle of the parietal bone, and the reason of this is, that the connexions of the dura mater, especially the tentorium, does not permit this membrane to follow the sides of the cranium, when thrown outwards by force acting on the vertex. As regards the treatment of injuries of the brain, Dr. Gordon expressed himself as opposed to exhibition of mercury pushed to salivation. He says that injuries of the brain depress vital energies and the reparative process, and determine to unhealthy action in the part of the brain injured. A person who is under the influence of mercury is not in a fit state to undergo a surgical operation, as unhealthy inflammation is almost certain to attack the wound. He, therefore, recommended the head and shoulders to be well elevated, cold applied to the head, and a mild but continuous action to be kept up in the bowels, by the exhibition of the neutral salts, so that the patient may have at least three or four motions daily, at distant intervals. He does not object to the exhibition of

mercury as a purgative, for he looks upon it as a most valuable remedy for the removal of mucous secretions and other unhealthy matters from the intestinal canal.

Dr. Ross wished to ask Dr. Murney if in his first case, he had observed layers in the clot effused from the lacerated meningeal artery, as such a constitution of the clot would show that the effusion had not taken place suddenly.

The PRESIDENT said that while he fully concurred in several of the remarks of Professor Gordon, he must dissent from one or two of his propositions. In the first place, as to the non-exhibition of stimuli in bad injuries, under any circumstances, he could not agree, as he had seen several cases of concussion in which life seemed hanging in the balance, and when both alcoholic and diffusible stimuli had been given with the happiest results. In fact, he felt certain that such cases would have succumbed had stimuli been withheld. He also could not subscribe to the Professor's doctrines regarding mercury in the cases under consideration; he had seen many cases of very severe injury of the head, where the grave symptoms were at once relieved when the patient came under the influence of that most valuable drug, and one of the cases reported by Dr. Murney fully illustrated this. In conclusion, he felt it his duty to express the pleasure he had experienced in listening to Dr. Murney's lucid and able paper, and the interesting discussion which it had elicited; both were exceedingly valuable in a practical point of view.

Dr. MURNEY said—Observations have been made on the cases I have brought before the Society, by Dr. M'Gee, Professor Gordon, Dr. Ross, and the President. As the last-named gentleman has addressed himself to the remarks of those who immediately preceded him, I do not consider I am called upon to do more than express my concurrence generally with the opinions he has just stated. If I mistake not, Dr. Ross asks, "Was the clot, formed in the first of my cases, carefully observed, to note if it had all been poured out at the same period, or if there were any lamellae of fibrine to indicate a series of extravasations," as appearances of this character had fully warranted the opinion of a number of haemorrhages in a case which had been examined by him. In reply, I beg to say, not anticipating a clot of the magnitude I described, I examined it with the utmost care, and am perfectly satisfied all the blood was poured out in a very few hours.

Professor Gordon has stated—

1st. He considers the tentorium cerebelli officiates as a "beam" to hold the lateral portions of the dura mater in their places, and in case of violence from above, that portion of the membrane in which the arteria meningea media is placed, will be stretched or torn according to the amount of force.

2nd. He considers too little attention is devoted to the mechanism of the head, and seems to think if I had studied that subject more carefully, I would not express surprise at the direction of the fracture in one case.

3rd. He most emphatically disapproves of my having administered stimulants in one case, as he believes such are always inadmissible in injuries of head.

4th. He objects to my having used the stomach pump in one case.

5th. He disapproves of the use of any mercurial preparation, with the object of producing the constitutional effects of that drug.

1st. The arteria meningea media is placed on a plane anterior, and the tentorium is posterior to the petrous bone. To no part of the base of the skull is the dura mater more intimately adherent than the upper and anterior surface of the petrous portion of the temporal bone; for a strain applied to the tentorium to influence in any degree that part in which the trunk of the meningeal vessel lies, would require the membrane to be separated from the bony surface to which it is so intimately attached, and as I cannot think of any force which would produce this result, I consider the first statement is not correct.

2nd. I believe no surgeon can form a proper estimate of injuries of the head unless he has studied the mechanism of the skull. If Dr. Gordon will again refer to my cases and observations he will find to my fourth case the following—"I would have been slow to expect a fracture taking the direction I point out. I have not seen any example of it before, and, judging from the strength of the parts involved, I am sure it must be very rare." I confidently repeat this expression of opinion, and am satisfied fracture in this direction must be very infrequent.

3rd. I think no surgeon can be more strenuously opposed to the indiscriminate administration of stimulants than I am. I consider it my duty, however, to protest against the sweeping rule as laid down by the Professor. I believe stimulants are not only admissible, but absolutely necessary in those most serious cases of head injury in which the collapse is extreme, and the very life of the individual is hovering in the balance. In milder cases, experience teaches us excitants are absolutely prejudicial.

4th. Reference to the case in which the stomach-pump was used, will, I consider, readily explain my reason for applying it. The man was intoxicated when he received the injury, and I believed it was most desirable to remove, if possible, any whiskey or other drink. Nothing was found in the stomach. Most probably as the patient had not partaken of dinner, absorption from the digestive cavity occurred with considerable rapidity. Upon this subject I have not heard any argument to change my view, and indeed cannot understand how, if stimulants are at all times inadmissible, there can be such serious objection to the use of the stomach pump in cases such as mine.

5th. I do not this moment recollect any exception to the rule that some of the preparations of mercury should be used in *all* cases of injury of the head—in the milder forms, as purgative, alterative, or both—in the more serious, with the design of producing the full constitutional effects. We all know that, with the exception of some head cases, general bleeding is now rarely practised by surgeons, and in no class of cases are we more imperatively called upon to pursue antiphlogistic treatment and regimen than in those under consideration. Now, mercury is an admirable antiphlogistic, and, therefore, do I use it. In addition, I believe it is impossible to say, in any given instance, we have an unmixed case of concussion or compression,

and as mercurial preparations are pre-eminently useful in promoting the action of the absorbents, and thereby facilitating the removal of deposited blood, lymph, we have a second and most cogent argument for its administration.

Dr. M'Gee asks, at what period I calculated the fatal haemorrhage in the head had commenced in the first case. I think I have given an explanation most in accordance with the circumstances. I made careful inquiry to know if the patient had made any exertion—as getting up from bed, urination, defecation—prior to the stupor which preceded death, but I was unable to obtain satisfactory information. I believe a clot was formed in the lacerated artery at the time of the accident. From some cause this was dislodged within five hours of his death, and bleeding, of course, ensued. I cannot answer Dr. M'Gee's second query, as to the condition of the muscular fibres of the heart in my second case, as I was not permitted an opportunity of examining the thoracic, or abdominal contents.

TENTH MEETING. 8th January, 1859.

Mr. Johnston exhibited some fine specimens of tubular lymph casts of trunks of the bronchial tubes with their ramifications, which had been expectorated by a patient under his care, suffering under a combination of pneumonia and bronchitis. He read the case as follows:—

Ellen Harrison, aged 15 years, slender figure, pale, anaemic appearance, and nervous temperament, became unwell on Sunday, December 12th, being seized with rigor, sickness of stomach, loss of appetite, and stitch in right side. On Monday, 13th, she was feverish, and had a teasing cough. Tuesday and Wednesday, in addition to the symptoms mentioned, her expectoration was rust-coloured. I visited her on Wednesday evening, fourth day of her illness, and on examination found the usual physical signs of pneumonia of the right lung, passing into the second stage; the greater portion of posterior surface of the organ was engaged. The physical signs were dulness, where crepitus was passing in to bronchial respiration, rusty sputa, and difficult breathing. There was a considerable amount of bronchitis of left lung and anterior portion of right. This might in part explain the great difficulty of breathing present, which was out of proportion to the extent of the pneumonia. In all its characters the case bore a very urgent aspect. I ordered powders, with one grain of calomel, two grains of grey powder, and three grains of Dover's, every second hour. On Friday, 17th, thirty-six hours after the first exhibition of the mercury, there was evidence of its action on the system, and at the same time an immediate improvement in the symptoms. On this day and Saturday, coincident with the action of the mercury, there occurred what I regarded as a feature of interest in the case, viz., the expectoration of lymphy membranous casts of the bronchial tubes, and their ramifications, similar in character, I presume, to those occasionally thrown off from the trachea in cases of

croup; I have not known, however, of such membranous excretions being of usual occurrence in cases of pneumonia. You have here one or two specimens. Upon examination you will find these hollow; indeed, shortly after being thrown off we were able to inflate them, so as to represent a bronchial tube of the second or third order, with its minute divisions. I need not follow up the details of the case. She continued to improve from this date, and when I saw her on Thursday, she was sitting up, her chief complaint being in regard to her mouth. We must attribute the rapid and favourable progress of this case to the salutary action of the mercury, one scruple of calomel and less than one drachm of grey powder was the entire amount given. She was neither blistered nor bled. I mention these facts, as I consider it is instructive as well as satisfactory to point to the unaided and salutary action of such a small amount of mercury. Are we to regard these cylinders of membrane as identical with the false membranes thrown off from inflamed serous membranes; and as, therefore, affording us an example of adhesive inflammation in a mucous membrane? We know that such an event of inflammation does take place in early life, but I believe it is rare after puberty, so far at least as regards the pulmonary mucous membrane. I was led to consider the casts as emanating from the pneumonic part of the lung, from the fact of the bronchitis not being intense, and from the improvement in the lung affected by pneumonia being coincident with the expectoration of the casts.

Watson, in his last editions, points out two points of distinction between such membranous excretions and those false membranes that are formed on serous membranes, viz., that such an example as I here present is more of an *albuminous* nature, brittle, and less fibrous; and secondly, that it is not *plastic*; that is, that it never becomes organized, never connects itself with the surface from which it proceeds, but, as in this case, becomes detached, and if the patient progress favourably, is thrown off. The last point that crossed my mind in reference to this case is, whether, with the occurrence of such membranous excretions in a case of pneumonia, we have any more need to fear the supervention of phthisis, than in ordinary cases of pulmonic inflammation.

Professor FERGUSON said he wished to ask Mr. Johnston the physical signs of pneumonia present in this case, and their extent.

Mr. JOHNSTON said the physical signs were dulness, where crepitus was passing into bronchial respiration, rusty sputa, and difficult breathing.

Professor FERGUSON next enquired whether Mr. Johnston considered the casts the product of pneumonia or bronchitis.

Mr. JOHNSTON said he believed they were thrown off from the tubes penetrating that portion of the lung affected by pneumonia.

Professor FERGUSON said that, at the present time, the pathological indications of such formations deserved special attention. He adverted to the probability of the tube casts being the result of a diphtheritic state of the bronchial lining, rather than of pneumonia; and also to a case brought under the

notice of this Society, in which similar formations were expectorated by a person in health (a cast of which he exhibited.) He further said, that he was not aware of such casts accompanying pneumonia, though not uncommon in bronchial and catarrhal affections.

Professor REID said that such casts had occurred in pneumonia as well as in bronchitis, and according to Stokes, they had been thrown off more frequently by the aged than by the young. In the case before the meeting he considered it difficult to say from what part the casts came—whether from the pneumonic or bronchitic part of the lungs.

Dr. PATTERSON said the substance of the casts under notice very much resembled that of exudations from the fauces in a case of diphtheria under his care.

Dr. ROSS said the casts, in his opinion, indicated inflammation of an active character. He expressed surprise at Dr. Reid's statement as to the more common appearance of such formations in the old than in the young.

Professor REID said that statistics bore out his statement.

Professor FERGUSON remarked the disproportion between the dyspnœa and the extent of pneumonia in Mr. Johnston's case. He asked if the former was not relieved by the expectoration of the bronchial casts, and he said he did not think the exudations the result of pneumonia.

Dr. HEANEY said he considered the relief to the dyspnœa in this case due to the expectoration of the casts, and its previous existence chiefly to their presence in the bronchial tubes.

The PRESIDENT said he believed such formations may result from asthenic as well as acute action. In cases of diphtherite he had seen patches of exudation, but no tube casts like those under notice of the Society.

Mr. JOHNSTON said he was quite alive to the importance of considering the prevailing type of disease, in coming to conclusions as to the nature of his case. He had recently had exudations on the pharynx in cases of typhus and hydrocephalus. In the case before the Society he was led to consider the casts as emanating from the pneumonic part of lung, from the fact of the bronchitis not being intense, and from the improvement in the lung affected by pneumonia being coincident with the expectoration of the casts.

Professor FERGUSON wished Mr. Johnston to explain how crepitus could be heard in the pneumonic lung, if the trunks leading to the smaller tubes and air cells had been obstructed by casts, such as these exhibited.

Mr. JOHNSTON observed that a similar difficulty would stand in the way of the Professor explaining the presence of bronchial rales in the bronchitic part, supposing that to be site of the exudations.

Dr. M'GEE said that Professor Ferguson's objection could not weigh, as the tube casts were tubular, and therefore pervious to air.

Professor FERGUSON said that the object of his remarks was to ventilate the subject thoroughly, and he had succeeded.

Case of Abscesses in the Brain, by Dr. Harkin.
Robert Elliot, aged 35, unmarried, of temperate habits,

and recently returned from America, called on me upon the morning of Thursday, 23rd December last, complaining of intense headache, debility, and pain of the back. He had never been subject to headache or any cerebral affection in his youth, but about fifteen years since had a severe attack of haemoptysis, and more recently suffered from three prolonged attacks of "fever and ague." Since his return from the United States, in October last, his friends state that he had become irritable in temper, lost his accustomed cheerfulness, and avoided all society. It was not, however, until the 14th December that he exhibited any symptoms of illness, when, after taking saline medicine to relieve some uneasiness in the stomach and bowels, he was seized with a rigor which continued for three-quarters of an hour, followed by a hot fit and by vomiting. On the 15th and 16th he complained of violent pain in the back, extending along the greater part of the spinal column; about the 17th it extended to the loins, the groin, and the lower part of the abdomen; at this time his urine was found to be loaded with lithic acid deposits, and the chamber utensil stained as if with red paint. He continued in this state till the 20th, becoming very restless at night, when he first discovered weakness and loss of power in his right arm; on the 21st it became completely paralyzed. He remained in this condition, still taking food, and his bowels acting, after mild purgatives, till 23rd, when, becoming alarmed at his state, he called on me. I advised him immediately to return home and lie down, and saw him soon after in his bed, when he presented the following symptoms:—His principal complaint was of intense pain of a dull throbbing kind, which extended all over the head from the forehead to the occiput, constantly present, but aggravated at intervals, and at night becoming unendurable. He was very giddy when he attempted to stand, and his pulse was about 100 in the erect position, lower when in bed, very small and compressible. The forehead and temples hot; the eyes natural; the pupils obeyed the stimulus of light, but slowly, especially the left. His tongue dry and brown; sense of hearing unimpaired; speech occasionally indistinct; had also transient fits of incoherence. The right arm was completely paralyzed, and a little colder than the other; the fourth and fifth finger bent; no other sign of contraction; no lesion of sensation in the arm. The application of leeches to the temples, cold lotion to the forehead, occiput to be shaved, and a blister to the back of the head and neck were then ordered. He had also ten grains of calomel administered, to be followed by two grains every alternate hour, and warm applications to the feet. The leeches were applied, and procured an interval of ease for about three hours; he, however, peremptorily refused to permit the application of the blister. He passed the night of the 23rd in a very excited state, having dressed and undressed himself three times. His sufferings were intense and his screams very loud. Finding on the 24th that he still persisted in refusing to have the blister applied, and that his friends had lost all moral control over him, I recommended his removal to the General Hospital, whither he was taken same evening. From the first moment I had seen the man, it

was quite evident disorganization of the brain had set in; that the inflammatory period had gone by, and with it the time for active treatment and hopeful interference, and that in the presence of abscess or softening of the brain, medicine had no effectual remedy.

Dr. W. MacCORMAC, in continuation of Mr. Harkin's case, said the man was admitted to the General Hospital, on the 24th December last. He complained of headache and motor paralysis of right arm. Pulse normal, vision and hearing perfect. On the 25th he was worse, the pain in the head occurred in violent paroxysms, and mercurial foetor set in. On the 26th the pain was still worse. No sickness. Suspicions of the pain being of a neuralgic character were entertained at this time. On the 27th the pulse was slow and irregular. The pupils, one natural, the other dilated. The right leg became paralyzed. He complained of ringing noise in the left ear, and remained sensible till the 2nd of January, when he died.

The post-mortem examination was made by Dr. Murney, on Sunday last. On removing the dura mater, he found pus on it. He exhibited the brain, and demonstrated its condition to the Society as follows:—An abscess in the anterior part of the right hemisphere; another in the same part of the left; one in the left lobe of the cerebellum; together with several smaller abscesses in the upper part of both cerebral hemispheres, but none whatever in the base of the brain. He adverted to Rokitansky's observation on the rarity of circumscribed abscess of the brain, and said the present case afforded well-marked illustrations of such.

Dr. M'GEE said the impairment of hearing on one side, and the loss of motive power on the other, were points of interest in the case.

Dr. ROSS said the large abscess in the left cerebral hemisphere might have been primary—the other abscesses resulting from it by absorption. He said the supervention of loss of power on the right side bore out that view somewhat.

Mr. HARKIN said he believed rigors had only occurred once.

Dr. MOORE exhibited a left testis greatly enlarged by medullary disease (of which it was a good specimen), which he had removed ten days previously from a man aged 42. The disease commenced about 12 months since, and originated in a hurt. The symptoms were those of hydrocele, and a practitioner, supposing it to be such, had tapped the part, but only blood flowed. After this the tumour became painful and rapidly increased. The spermatic cord was, however, free. The wound healed by the first intention, and the man was able to leave hospital in a week.

The President said his experience of such cases made him fear the disease would return.

ELEVENTH MEETING.
15th January, 1859

The PRESIDENT exhibited the recent parts after

amputation, and made the following observations.—

Case of Resection of the Knee-joint.

The subject of the following brief remarks is a man aged 27 years, named Samuel Goudy, a painter by trade, and a native of Belfast. He is of phlegmatic temperament, and of the strumous diathesis. Some seven years since he first came under my notice, with the usual symptoms of inflammation of the right knee-joint, as seen in a person of scrofulous habit. From time to time these inflammatory attacks were subdued, recurring, however, from very slight exciting causes, the joint remaining stiff and swollen, but without pain, in the intervals. This state of things continued up till the period of his last admission into hospital, in July, 1858. He then complained of pain on any attempt at motion, and on pressure over the patella and condyles of femur, especially the inner. The parts were infiltrated and considerably swollen, giving the knee all the appearance of a joint suffering from pulpy degeneration; and the severe pain on motion pointed out the probability that erosion or ulceration of the cartilages had taken place. His general health was deranged, the vital functions much depressed, and his total aspect demonstrated bodily suffering and imperfect nutrition. The treatment adopted was with the view of improving the health, and it did improve for some time, when confinement and hospital air began to tell against the system, and it was determined, in consultation, to remove the diseased part; and I wished to give the patient the chance of a good limb, by performing excision of the knee-joint. This operation of resection I performed, accordingly, on the 25th of August. The patient having been brought fully under the influence of chloroform, I made an incision four inches on either side of the joint, well back, and united these by a cross-section through the soft parts and the *ligamentum patella*, so as to open the joint. The flap thus formed was turned up, the ligaments were divided, and the ends of the bones exposed, and freed from the soft parts, and were sawn off. An inch and half of the femur, and about three-fourths of an inch of tibia, were removed, and the face of the patella was likewise removed, by means of a metacarpal saw. Upon attempting to bring the cut bones into opposition, it was found requisite, in consequence of the contraction the joint had assumed, to saw off another thin slice from the femur. The limb was then put up on a modification of Mr. Butcher's splint. Some hours afterwards these bleeding vessels were tied, five points of suture introduced into the flap and opposing parts, and the wound was dressed with strips of wet lint. The shock after the operation was trifling, the reaction not at all great, and everything promised well. The wound was dressed first on the fifth day, and every second day afterwards. In a week the cross section had healed, and the wounds looked well, a healthy suppuration having been established.

Up till November everything seemed prosperous, save that I experienced considerable difficulty in retaining the parts *in situ*, more especially as the patient was impatient of restraint, and his skin became abraded by the necessary bandages. For some ten days I had to allow the limb to be removed from the

apparatus, and after the re-adjustment suppuration set in very copiously, the patient's health suffering from the drain. Every means likely to improve matters were resorted to, but beyond the constitutional improvement, no advance was made towards cure. Under these circumstances, I most unwillingly resorted to amputation, which I performed on the 8th instant, by the rectangular flaps, as recommended by Mr. Teale, of Leeds, and sawed the femur through, a little above the middle part, having been obliged to go so high, in consequence of the sinuses of the soft parts above the knee. I put the flaps together with a few points of suture, and a very few narrow strips of adhesive plaster, and did not disturb the stump till the eighth day. I then removed the points of suture and strips, and the ligatures, save that on the femoral artery, and found adhesion had taken place, without any tendency to suppuration; and the case bids fair to progress to a satisfactory termination, as regards the patient's life.

In conclusion, I beg to offer one or two observations—first, as to the state of parts at the time of the resection. The soft parts had largely degenerated, and the bones showed erosion and ulceration at several points of their cartilages, the patella alone being free from disease. The end of the femur, when cut through, presented a softened state of its cancellated structure, and on the whole did not look well, though not actually diseased beyond repair. Second, as to the steps of the operation, I feel satisfied that I should have divided the hamstrings by subcutaneous section, and I ought also to have removed the patella. Were I to operate again in a similar case, I think I would proceed differently from that I followed in this instance, or that which has been usually recommended. Dr. Murney, who has kindly made a dissection of the amputated parts, will be able to give a report of what he observed, and also to express his views on the whole case, and also the statistics of resection of the knee-joint.

Dr. MURNEY remarked—This patient was under my care for about a fortnight or three weeks in July of last year. At the 1st August he was transferred to Mr. Browne. When first examined there was evidence of ulceration of the cartilages of the knee, of a chronic character. On consultation it was agreed, in the absence of any acute symptoms, that mercurial strapping, perfect rest, and a course of one of the preparations of mercury gently introduced into the system, should be tried.

As in this my colleagues expressed the opinion I entertained myself, I gave the patient the only chance of saving his limb (without operation), by endeavouring to procure ankylosis. In a few days the constitutional effects of mercury were manifested; and after continuing its use as long as was considered necessary, without any beneficial result, it was omitted, and every effort made to improve his general health, preparatory to the operation which has just been described. Altogether he was under the influence of mercury about a fortnight; after that time the management devolved on my successor.

At the examination of the limb, I found fatty degeneration of all the muscular textures in the neighbourhood of the knee. A great number of sinuses

passed in various directions, but some of the principal ran to large exfoliating surfaces on the tibia and femur. The hamstring tendons, which were divided a short time since, were connected by organized lymph, and were being united in the usual fashion.

The patella was connected to the anterior surface of the lower end of the femur by bone. A considerable part of the upper end of the tibia was removed by ulceration. Similar action existed on the femur. On the former bone the fore part, on the latter the posterior portion, was affected. A good deal of new bony tissue was deposited on the femur, so as to spread out or expand that bone to a breadth fully as great as before the removal of the condyles. The opposing ends were coated, except the carious portions, with a velvet-like membrane, of a highly vascular character. The two bones did not form a right line, for fully one-third of the femur was in front of the tibia, so that a glance at the specimen suggested the idea of incomplete luxation of the leg backwards.

This case verifies an anatomical objection which frequently occurred to me when considering the operation of excision of the knee—viz., on making the customary incisions, the ligamentum patellæ is cut, and the action of the vasti-rectus and crureus muscles is unopposed, so that the patella must be drawn upwards, and rest, as in this case, upon the femur only. In this situation it does not in any way strengthen the knee. Now, I consider the transverse incision should be made above the patella, cutting through the attachments of the muscles already named, that bone thrown down, its posterior surface cut away, if necessary; and when the operation would be terminated it could be replaced, when it would lie in front of both bones, would become united to both, and of course strengthen materially the parts to be ankylosed.

Some observations have been made as to the results of this operation, contrasted with amputation of the thigh. I find in Mr. Butcher's paper, "On Excision of the Knee-joint," published in the *Dublin Quarterly Journal*, for February, 1855, that since 1850, "31 operations are recorded. Out of this number, 5 have died;" and of these latter, one was carried off by epidemic dysentery; another died of pyæmia, sixteen days after operation; and a third was killed by diarrhoea on the twenty-fourth day. Again, in a second table by the same writer, in February, 1857, we have the statistics of 50 additional cases:—16 cures with useful limbs; 15 recovering; 1 relieved; 1 in a precarious state; 9 died; and 7 required amputation; total, 81 cases, followed by death in 14 instances; and if we add to this list 7 amputations, we have non-success in 21, out of 81 persons subjected to excision.

Dr. MOORE exhibited a diseased knee, the opening of which, exposed ulceration of the cartilages, degeneration of the synovial membrane, and a curdy deposition in the joint. He said—

"The subject of this amputation is a man, aged 40, who, four years since, became affected with pain in the knee, which yielded to leeching and ordinary treatment. Three months ago he was admitted to hospital. His knee was swelled and painful, and his system participated in the derangement. Alterative and anodyne

medicines, together with rest, speedily improved him. He became able to sustain pressure on the joint, and ultimately to walk, when, of his own accord, he went home to the country. In the course of a month he returned, with the joint in a much worse condition, and all blistered over, by the direction of some country adviser. Examination satisfied me as to the propriety of amputation, which, at the end of three weeks' preparatory treatment, I performed by antero-posterior semicircular incisions, and subsequent circular muscular cuts down to the bone. While being put under chloroform, I bandaged the limb upwards from the toes, and the femoral artery being well commanded by thumb pressure, I completed the operation with haemorrhage not exceeding 3 drachms, which was chiefly venous. The flaps came well together, and were retained by six or eight stitches, and the wound is healing by adhesion."

Dr. MOORE said his case was not suitable for resection, but anyhow, he was opposed to that operation; and Mr. Browne's case, he said, did not tend to alter his opinions with regard to it.

Dr. MOORE next exhibited a foot which he had removed by Syme's operation, the patient having since done well. He said—

"The subject of this amputation is a woman, aged 28. She was admitted to hospital with *talipes varus*, the foot much swelled, and a large gangrenous ulcer between the great and adjoining toe, extending upwards on the dorsum of the foot. The whole lower limb up to the groin was swelled nearly twice the size of the other, representing, in fact, in most of its characters, the disease known as *Elephantiasis*. The cellular tissue, however, was the part chiefly engaged. There was no pitting on pressure. Rest and suitable treatment reduced the painful swelling of the foot. The history of this case is this—About 15 years ago the patient received a prick of a thorn on the inner side of the foot, which, producing great pain, caused her to walk on the outer part of her foot. The wound from the thorn not healing, and the pain remaining, obliged her, for relief, to continue to walk on the outer side of her foot, until ultimately *talipes varus* was induced, for which, at her own request, amputation was performed."

Dr. MOORE next introduced a young man, 22 years of age, with an extensive tumour extending from the posterior part of the neck to the front of the thyroid cartilage, and from behind the ear close to the clavicle, tilting the ear upon it. It is half as large as his head, with a flat irregular circular ulcer on the front. The general colour of the tumour is of a bluish red. He states that about two years ago, a small tumour formed at the angle of the jaw, which was leached, rubbed with ointments, leached again, and poulticed, and so on, till it reached about the size of his fist, when, feeling soft in front, it was opened, and a small quantity of thin watery fluid, with a few curdy flakes, escaped. Since then the tumour has increased rapidly. Dr. Moore looked upon it as a malignant growth, and one that would go on increasing, and involving as it does the important part of the neck, he considered it to be

beyond surgical art.

The PRESIDENT remarked that the case of knee disease, presented by Dr. Moore, fully justified its removal. He could not agree with him, however, that it was unsuitable for resection; had it been his, he would have given the patient the chance of saving the limb, which, if preserved, is always better than a wooden pin: Moreover, he could not agree that resection of the knee-joint was to be cast aside because some cases had failed—as fail some must—for the statistics of the operation, as already published, give very great encouragement indeed to surgeons to perform the operation in suitable cases. For his own part, his personal experience, like that of Dr. Moore, was not great regarding this operation, but he felt satisfied that the published statistics were correct, and such as to induce him not to abandon it.

He also said he did not consider the second case related by Dr. Moore one of "Elephantiasis" as he had described it. He looked upon the affection before them as one of thickening and infiltration of the sub-cutaneous tissues, without hypertrophy of the skin at all; therefore, not one of elephantiasis. He had seen the disease in a vast number of instances, both in the West Indies and all over the East. In reply to a query from Professor Ferguson as to the advantage of metallic sutures, he said he approved highly of them, and recommended annealed iron wire, No. 32.

The members generally concurred with Dr. Moore in his view of the nature of the tumour in the neck, and in the hopelessness of surgical interference in the case.

Case of Labour, complicated with accidental Hæmorrhage. By Dr. DILL.

On the 13th ult., at 5 o'clock, a.m., I was sent for to attend in her confinement Mrs. C., aged 37. She was the mother of six children. She had one or two miscarriages, and she believed herself to be about a fortnight from the full period of pregnancy. Before I saw her she had one or two faintish fits; however, on reaching her, she had improved, and labour had commenced. She was pale, pulse was under 80, and feeble, and the skin was considerably under the natural temperature. She was under the impression that the membranes had given way, and that the waters were discharged, but an examination satisfied me that this was not the case. The os uteri had dilated to the extent of half-a-crown, and the presentation was natural. The pains were feeble, and the progress of labour slow; however, in about eight hours she was delivered of a dead male child. The placenta was expelled in a few minutes afterwards, and with it a great mass of very dark coagulated blood. The uterus contracted perfectly; the bandage was applied, when a few additional clots came away, dark as before. The stomach, which was very irritable from the first, continued so, with retching and vomiting. Opiates were administered with but very temporary relief.

I found, next morning, that she had some rest through the night, but the sickness continued, and there was considerable pain in the epigastric region. No pain or uneasiness whatever over the uterus; pulse under 80 and feeble; skin dry and very cool, tongue

pale, dry, and glossy. A sinapism was applied to the epigastrium. The bowels were opened by means of an aperient and an enema, and the opiate was repeated at bedtime. On the 15th, I found Mrs. C. a little improved; she had had some sleep; the sickness was not so distressing; the pain at the stomach was nearly gone, but had shifted towards the right side. I could not ascertain that she had passed any urine since her confinement, and the renal secretions appeared to be suspended. She had been taking a mixture of minderous and sweet nitre, and she was now ordered, in addition, half-a-dozen pills, each containing half a grain of opium and three grains of blue pill. She took one of these every three hours, until she had taken the fourth. She had, besides, a blister applied to the side. On the 16th, the pain in side was somewhat relieved, but the sickness continued. She passed some urine, but the quantity was so small, and being mixed with other discharges, it could not be examined. From the first there was occasional giddiness, with indistinctness of vision. In the evening I was sent for in a hurry, when I found her sitting up in bed, the mind wandering, and she was totally blind. The pupils were fixed and dilated, and she appeared as one in amaurosis. Her head was placed upon the pillow, and in a short time she became tranquil, and her sight and mental facilities were restored. The pain had now shifted from the side to the back and loins, to which parts a sinapism was applied, and a mixture containing Rochelle salts and a little sweet nitre, was ordered. An involuntary jerking motion of the muscles had been observed for some time, which was becoming worse.

On the 17th I found the pain in the stomach and side quite gone, but some uneasiness in the back and sickness continued. On the 18th a very small quantity of urine was secured, and being tested with heat and nitric acid, it was found to be highly albuminous, and continued so under repeated examinations up till the 20th, just eight days after her confinement, when she sank rapidly, and to some unexpectedly, though not to myself.

Although we were not allowed a post-mortem examination, which no doubt, would have added greatly to the interest in this case, yet I think we should look upon it as one possessing some features of practical instruction.

1st, The complications of labour with accidental hæmorrhage, at first recognised by the fainting fits, and afterwards corroborated by the large quantity of dark coagulated blood which was discharged with and after the placenta; and 2nd, the giddiness in the head and indistinctness in vision, which were observed from the first, and appeared to be increased when in the erect position, struck me as being naturally chargeable to the loss of blood and weakness, although at a later period these aggravated symptoms, as exhibited in the total blindness and mental wanderings, plainly indicated something worse. 3rd, The suspension of the renal secretion was at first accounted for by the fact that no drink, and indeed nothing, had been retained upon the stomach, and of course did not get into the circulation, and hence no secretion by the kidneys. 4th, As the symptoms became more developed, as seen in

the jerking motions of the extremities, the total blindness, state of the mind (though but for a brief period), the albuminous urine, too plainly showed that at least the kidneys were the organs primarily affected, and that we had to deal with as pure a case as is on record of blood-poisoning, and at the same time one of a most intense character—or uræmia, which is the result of albuminuria. 5th, The jerking motion reminded me very vividly of the effects produced when strychnia is introduced into the system. And 6th, that disease of the kidneys should have existed, with such an amount of albumin in the urine, is rare in the puerperal state, unless accompanied by œdema, anasarca, and convulsions, which did not at all exist here, and without one or more of which the case was considerably masked at first; and that the latter symptom did not take place can only be accounted for by the poison expending itself in the eccentric, in place of, as is more usual, the concentric form.

Some unimportant observations on this case brought the proceedings to a close.

TWELFTH MEETING.
January 22nd, 1859.

Dr. MOORE introduced a lad about 18 years of age, having a large venous cutaneous nævus, about nine inches by seven, on the outer part of the thigh, and scarcely elevated above the surface. About four years ago he was admitted into hospital with an ulcer about the size of a halfpenny on the lower part of the nævus, which healed. He was again admitted about three weeks ago, with another ulcer higher up in the nævus, from which there was a great amount of bloody discharge. The ulcer was large enough to contain half a walnut. It was cleaned out repeatedly, touched with solid caustic, and is now healed. From the toes up to the middle of the thigh the whole limb is surrounded (when in the erect position) with a perfect plexus of enormously distended veins, some of them an inch in diameter, and would be supposed to contain, in their distended state, close upon three pints of blood. If the patient suddenly raise himself from bed and stand up, Syncope is induced. Dr. Moore remarked, the wound having healed, there is nothing to be done but judiciously to apply a laced stocking for support.

Queries were put by members to ascertain the duration of the nævus, whether it, and the varicose condition of the limb had come on and progressed simultaneously? and whether or not any tumour or other obstruction to the venous reflux could be discovered above the nævus to explain the cause? In answer to these it was stated that the nævus was congenital, and had but slightly increased; that the enlarged veins were the result of gradual and progressive development; and that the most careful examination had failed to discover any mechanical or other cause for the varicose condition of the limb below the nævus.

Professor GORDON next read the following case:—

"Jane O'Hara, aged 40, admitted into the General Hospital on November 12th, 1846. She says that about

eight years ago, a small tumour, not larger than a pea, formed in the left mamma. This tumour remained almost of the same size for three years, when the skin covering it became discoloured, and on its being punctured, fluid resembling jelly escaped. After that the wound healed, but the fluid re-accumulating, a second puncture was made, and a discharge of a like description came away. Since that time the tumour has been frequently opened, always followed by the escape of a fluid of the same clear, gelatinous character. About eight months before her admission into hospital I saw her for the first time. The left mamma was considerably enlarged, but not painful, and there were several cicatrices on its surface.

"On admission into hospital the size of the mamma is somewhat smaller than when I first saw her, the tumour in the interval having been opened. It is very moveable on the surface of the pectoral muscle; the nipple is perfectly healthy, not in the least degree retracted, but immediately below it there is a fistulous opening leading into the interior of the tumour, and giving exit to a sanious discharge. External to this, the skin is, for a small extent, ulcerated, but otherwise not unhealthy. The remainder of the surface of the mamma is slightly uneven, firm to the feel, but not hard, and presenting depressions and cicatrices, the results of former incisions.

"On the 16th I removed the tumour and mammary gland. On making a transverse incision in the tumour, through the fistulous opening, the appearance presented by the section was that of a ripe peach, but external to this it resembled amber-coloured jelly, traversed by widely separated, but extremely delicate bands of fibro-cellular tissue.

"On the day succeeding the operation, the patient was attacked by unhealthy inflammation in the wound, followed by sloughing of the cellular tissue. Three weeks after this the wound was nearly healed, with great improvement in her complexion and general health. A short time after this she left the hospital, and went to America to join her husband, who had emigrated a few months previously. In 1856, O'Hara called on me. On exposing the front of the chest, there was a large cancerous ulceration 8 inches by 6 over the lower part of sternum and upper part of epigastrium; the edges were hard, everted, and prominent, and immediately around it the skin was firm and discoloured. The cicatrix of the operation was healthy."

Dr. WALES introduced a boy with an ankylosed condition of the shoulder-joint, and relaxation of the sterno-clavicular ligament, permitting free luxation of the sternal end of the clavicle. Motion in this case (which was curtailed and somewhat painful), produced singular frictional phenomena, the source of which was a matter of some doubt, and gave rise to considerable discussion, some considering the grating due to a supposed partial motion in the shoulder-joint, others to the condition of the sterno-clavicular ligament, and most to the friction of the muscles and bony surfaces about the part. The disease commenced seven years since with pains of a rheumatic or neuralgic character in the shoulder and arm, particularly the latter, and

gradually motion became impaired. The boy is of a scrofulous habit.

Some unimportant discussion followed this case, with which the proceedings terminated.

THIRTEENTH MEETING.
29th January, 1859.

VASCULAR TUMOUR OF LIP.

Dr. CUMING stated that he had examined a portion of a lip which had been removed by Dr. Babington, of Londonderry.

The diseased structure was entirely composed of an immense number of small dilated blood-vessels, interlacing in areolar tissue. There was no evidence of any malignant growth. The following notes of the case had been furnished by Dr. Babington:-

"The patient stated that some two years since she was sucking a thimble, which adhered so tightly to her upper lip that it had to be filed off; that soon after she experienced an unusual pulsation in the lip, and that it gradually increased in size. When first under treatment the pulsation occupied the whole labium. Injections of per-chloride of iron were tried, and it was hoped successfully, as the swelling became solid and all pulsation ceased. She again came under treatment, the pulsation was at this time limited to the right side of the lip, the other side was cured.

"Injections were again tried as before, but without benefit, and as the lip was increasing rather rapidly, it was deemed advisable to remove the whole diseased mass.

"The wound healed by first intention, and the patient suffers no inconvenience."

ARSENICAL POISONING BY WALL-PAPER.

Dr. WALES read a paper on this subject. He said-

Mr. President, the first notice on the circular of today is a "Case of Arsenical Poisoning by Room-Paper." That case, Sir, I have the honour to bring under the notice of this Society, and I would substitute for the startling announcement the less alarming, though perhaps not less true title, "Supposed Deleterious Effects of Green Flock Paper."

Is bright green flock paper on the walls of our sitting-rooms prejudicial to us? This is a question, Sir, that people are beginning to ask. It has been answered in the affirmative and in the negative by high authorities on the one side, and official authority on the other.

Conceiving it to be the object of our high calling to endeavour to prevent as well as to remove disease, I deem it a question demanding our careful consideration. It is, however, one which nothing short of experimental evidence can decide; consequently, it is our duty cautiously to examine the cases adduced as examples of arsenical poisoning, before receiving them as such; but being satisfied, it is equally our duty to make known our opinions, that the community may benefit by them. I will now, Sir, read my case-

"BELFAST, January 26th, 1859.

"DEAR SIR,—At your request, I have pleasure in stating the particulars of my health, since August, 1856, when I first occupied my present sitting-room, and for a while experienced no change in my naturally robust health.

"For the first time that I remember, however, I was, the following winter, affected with a sore throat, which I attributed to the dampness of the house, with north-east aspect; but as the warm weather returned, I gradually got better, and was comparatively well in the summer.

"As the winter again approached I was, as before, affected, but to a far greater degree; I had pain in evacuating the bowels, and extreme soreness of the anus; the latter was allayed by your application of nitrate of silver.

"Having at this time occasion to visit the north of England for a few days, I there heard that similar effects were attributed to the poisonous colouring matter in bright green wall-papers, and as my parlour was papered with a rich green flock, immediately, on my return, I removed to the drawing-room, which is covered with a simple gray and gold pattern, and, very strange to say, I was for the rest of the winter perfectly well.

"In the summer of 1858, I was induced, for convenience, to again occupy my parlour, and in a few weeks my throat became sore, and the sides of my tongue most painful from small vertical openings or cracks, as if cut with a knife, which led me to suppose they arose from the teeth, which were accordingly filed, but with little effect; and the tip of the tongue was so sore that to touch my gums was painful. The parts thus affected were treated, as before, with nitrate of silver with little benefit. I removed to my upper room, and in a week or two I was quite well; but wishful to fully satisfy myself, I again returned to the parlour for a few days, but feeling my tongue beginning to be affected as before, I had the green flock paper at once removed, since which I have occupied this sitting-room only, without the slightest return of any one of the previous symptoms; and I now enclose a piece of the green paper, for your analysis, that if found poisonous, others may benefit by my experience.—Dear Sir, very truly yours,

"Dr. Wales."

"V. Z."

The first point, Sir, in this case is—Does the paper contain arsenic? I enclosed a portion of it for examination to my coadjutor, Dr. Cuming, and I have examined another portion of it myself, and found it to contain arsenic.

I will now mention other cases in which injurious effects are recorded as resulting from a similar cause.

In the *Medical Times and Gazette*, of May, 1857, Dr. Hinds, of Birmingham, writes, showing the danger to which people are exposed by arsenical paper-hangings. In his case, the symptoms of chronic poisoning by arsenic were produced, viz., prostration, headache, tightness across forehead, a low febrile state of the system, inflammation of the eyes, and soreness of the mouth and throat. In the same journal, in January,

1858, Dr. Halley writes, saying, "In Autumn, 1856, my study was papered by an emerald-green flock. I worked in it every evening five or six hours, the room being lighted by a single burner. Within a few days I began to suffer from headache, dryness of throat and tongue, and internal irritation. In three weeks I was prostrated, almost losing the use of my left side. Somewhat recovered, I returned to my study, and, after a few days, the symptoms returned and obliged me to desist, until at last I found that whenever I worked for any length of time in this room I invariably suffered from the same sort of symptoms, which did not come on if I remained in other rooms not so papered."

Dr. Halley's attention was directed to the cause of his illness by reading Dr Hinds' letter, and, on examining the paper, he found arsenite of copper in it in the proportion of nearly one drachm to the square foot. He also obtained crystals of arsenious acid on paper saturated in ammonio-nitrate of silver, after exposure in the air of the room for ten hours.

Dr. Alfred Taylor, Mr. Kesteven, and Mr. Gay have detailed similar cases equally convincing, which will also be found in the *Medical Times and Gazette*, but which I need not here enter on, as the history of one is nearly the history of all. Suffice to say, that the fact of such cases occurring in the persons of medical men whose attention has been called to the subject, leads to the inference that many similar cases of disease exist, the result of slow arsenical poisoning, which are ascribed to other causes, and which, were the real cause known, might swell the list of examples of the injurious effects of arsenical green paper to an alarming degree.

So much, Sir, in the affirmative response to the query introducing these remarks. The negative rests chiefly on the testimony of Mr. Fletcher, a paper manufacturer, who says that his workmen enjoy perfect health, though for years they have constantly handled arsenic; and on a Report of the Board of Trade founded on the experiments and observations of their chemist, which sets forth the innocuous characters of bright green flock paper, as regards atmospheric contamination, and which, when published, allayed the apprehension excited by Dr. Hind's letter, and produced the impression that his, Dr. Taylor's, and Dr. Halley's observations might be erroneous. Recently, Dr. Taylor has given reports of cases, and indisputable experimental evidence in support of his former statements and opinions; and I think those who have read what has been written on the subject, will be strongly disposed to answer the query I have put in the affirmative.

Presuming, then, on the injurious influence exercised by wallpapers containing arsenic, it becomes interesting, Sir, to enquire how the poison is conveyed from the walls into the system—in what state, and by what channels.

Dr. Halley says, that at ordinary, or even higher temperature, with common air, the amount given off is inappreciably small. That the products of the combustion of gas passed through an aspirator filled with arsenical paper, gave distinct evidence of the imbibition of arsenic in the passage of the air through to the paper—crystals of arsenious acid being obtained

from it; and that no arsenic was found in the gas supplied for the experiment. In other words, the arsenic in the wall-paper is vapourized, but mere temperature alone is not the chief agent in separating it from the copper with which it exists in combination, but that such vapourization is due to the action of the products of combustion of carburetted hydrogen on the arsenite of copper, by which the former element is separated and vapourized.

Under these circumstances, the pulmonary mucous lining would be the channel by which the poison would be conveyed into the system, and it happens to be a ready and effective one in this very case.

The poison, however, acts on the body, beyond all doubt, in another way—whether only locally, or locally and generally, I cannot say. The dust of the paper (i.e., arsenite of copper with the fabric of the paper), carried from its rough surface by currents of air, or by brushing, will eddy through the room's atmosphere, and will come in contact with, and adhere to the exposed mucous surfaces of the body, and will also be inhaled. May not, therefore, the affections of the eyes, mouth, tongue, throat, &c, be due only to direct irritating contact of the poison, rather than to preceding systemic contamination by it; and may not these differences in the condition of the poison also explain that while in all cases reported we have affections of the mucous surfaces, in some and in the one I have brought forward, we have no constitutional symptoms.

Mr. President, I will conclude these observations by saying, that in this country, where liberty is so extensively enjoyed, that all kinds of poisoning, save malicious, is permitted, the thing being done on a scale of respectable magnitude, diffusion of the knowledge of the danger of papering our rooms with green flock is the mode best calculated to remedy the evil. In Prussia there is a special prohibition to the use of arsenic in the manufacture of papers and paints, arising no doubt from the knowledge of the injury likely to result to the public health therefrom.

FOURTEENTH MEETING.

5th February, 1859.

The President in the Chair.

Amputation of Leg.

The PRESIDENT exhibited a leg which he had amputated that morning; it was a case of secondary amputation. The patient L.J., aged 48, came into hospital in September last, suffering from disease of the astragalus of left foot. This disease had existed from the preceding July. On the 25th of October, Mr. Browne removed the foot, commencing the operation as that of "Pirogoff;" but finding the os calcis carious, he completed it by "Syme's." On sawing through the end of the tibia, the structure was found to be rather softened. The wound healed rapidly, though extensive suppuration occurred in the sheaths of the extensor tendons, a result, Mr. Browne remarked, which occasionally follows Syme's operation at the ankle-joint. After the parts had quite healed up and were regaining their natural appearance,

the tibia took on disease which necessitated the removal of the limb below the knee. This was done by the double flap, three vessels were ligatured, and the wound was united by metallic sutures. The pathological specimen exhibited a beautiful illustration of the excellent elastic pad which the soft parts of the heel form in cases where Mr. Syme's operation has been adopted; and, as the President remarked, it has yet to be proved that, while Pirogoff's operation gives an additional inch, or a little more, to the length of the limb, it will also afford an equally good point of support, and be as useful as the limb after Syme's operation.

Case of frequent serous discharge from Uterus.

Dr. BRYCE read the following case:—The patient whose case I am to bring before you, is the mother of eight children; the youngest was a year old at the first of September last, and still on the breast. At this period she had a severe attack of haemorrhage. I may mention that for the previous ten months, she had smart attacks of menorrhagia, occurring at intervals varying from one to three weeks, from the effects of which her health had suffered considerably, and she had become nervous and hysterical. She had a second attack about the middle, and a third about the end, of September. During the last attack there was discharged a gelatinous-looking mass, very much resembling frog's spawn, but firmer, which was studded with vesicles filled with a light straw-coloured fluid. After the discharge of this mass, there was no return of haemorrhage for four weeks, and the patient was rapidly recovering strength, and I believed that this substance, by distending the uterus, had been the cause of the haemorrhage. However, it again returned, but now mixed with a serous fluid. After two or three attacks of this kind, the blood disappeared, and there were discharges about once a week, for five or six weeks, of a clear watery fluid, in quantities varying from one to two pints. On one occasion she succeeded in collecting a pint of this fluid. There was sometimes a slight discharge of fluid blood, and at others a clot was expelled before the water. The uterus could not be felt externally, and to the touch internally and when viewed through the speculum, it appeared quite healthy, only there was seen a softish substance plugging up the os, which required to be pushed aside before a sound or other instrument could be introduced. I at first considered this a case of hydatids, but am now inclined to believe that this fluid was secreted by a false membrane lining the cavity of the uterus, and discharging its contents occasionally. About four weeks ago, I ordered her the carbonate of iron, (by double decomposition); since this period she has greatly improved in health and appearance. There has been no return of the watery discharge for three weeks, but there was, on two occasions, a slight sanguineous discharge which continued for a day. I had tried the injection of the sulphate of alum, but without any apparent good effect.

Scirrhous of the Pylorus.

Professor REID exhibited some morbid parts removed

from the body of a patient who died recently in the Union Hospital. The woman, aged 56, was in hospital about three weeks, and gave the following history of her illness:—She stated that, about August last, she began to vomit her food about an hour after taking it, but that the interval gradually became shorter, until now that she rejects it almost immediately. The matters vomited are very sour; she suffers much from thirst; the urine is scanty and the bowels constipated. Her eyes are much sunk, the malar eminences flushed, the skin of the body sallow, and she is greatly emaciated. The abdomen was flat, and a distinct hard tumor was at once detected in the right hypochondrium. Three days after her admission she passed a large quantity of urine, which had been previously scanty. The sp. g. was 1,018, and contained no albumen. With the presence of such symptoms, there was of course no difficulty in concluding that she was the subject of scirrhus pylorus; but on some subsequent examinations, it was not so easy to confirm this opinion, because the tumor was not to be felt in the right hypochondrium, but had shifted into the locality of the cardiac orifice, and on other occasions was to be found below the umbilicus. Combining this last locality with where it was first found, I had no doubt of the pyloric orifice being affected; but the vomiting immediately after taking food, and the hardness felt in the region of the cardiac orifice, led me to believe in the possibility of the cardiac end being also involved. The mobility of the tumor, when the pyloric end is involved in cancer, should never be forgotten, as cases have occurred where non-attention to this has led to the disease being undetected. An instance of this fell within my observation about two years ago, in which an eminent physician in another town had for many months been in attendance on a lady suffering under the usual symptoms of scirrhus pylorus, but had failed to detect the disease in consequence of not searching for the tumor sufficiently low down, where there was no difficulty in detecting it below, and to the right of the umbilicus. Some days she would reject everything; again she would take and retain large quantities for a period of 48 hours; and again the quantity rejected appeared far in excess of what she had taken into the stomach. Latterly the matters vomited had all the characteristics of what has been described as "coffee grounds." In this, as in several previous cases, I found a combination of sweetmilk, whiskey, and lime water, to be retained when taken in small quantities at stated intervals, when all other kinds of nutriment had been rejected. There was present in this woman what I had observed in a few other similar cases, viz., that when commencing to examine the abdomen, its parietes would be found flat and retracted to the spine, but soon after the withdrawal of the hand, the stomach would be observed to swell up, raise the parietes, and contract like a worm from end to end. She required aperient medicine and enemata till the 26th ult., when diarrhoea set in, and continued till death, on 3rd instant, the evacuations resembling coffee grounds, and being very foetid. On post-mortem examination, it was found that the stomach had contracted no adhesions to any neighbouring organ, and, as is

generally the case when the pyloric orifice alone is diseased and greatly contracted, the cavity of the viscus was greatly enlarged, capable of containing several quarts, which at once explained how the tumor was to be felt in different localities. The pylorus was surrounded by a hard ring of scirrhus, and so contracted that it only allowed a No. 10 catheter to pass into the duodenum. There was no scirrhouous deposit in the liver or mesentery. The small intestine was natural to within about one foot of the cæcum, when it was found invaginated; the upper portion being inverted into the lower. The uterus was found very small, it and the rectum healthy. The spleen unusually small, and free from any morbid deposit. The kidneys large and healthy in structure. The supra renal capsule enlarged considerably; there was, however, no discolouration of the skin during life, as has been observed by Dr. Addison in connection with disease of these organs.

Case of Chlorosis—Anæmic Murmur at Apex of Heart.
Professor REID then stated that a chlorotic girl was, three weeks ago, admitted into the Union Hospital, in whose case there were some points of interest, and who gave the following account of her health:—About two years ago, the catamenia had been too profuse, which medical treatment, however, soon restrained, without her strength or usual ruddy complexion being at all diminished. About twelve months since she complained of pain in the epigastrium, suffered from vomiting, and found her strength, appetite, colour, and catamenia gradually diminishing, the latter still appearing at the regular periods. About eight months ago, she began to suffer from palpitation and breathlessness on going up stairs, or on making any exertion, with throbbing in the back of the head, noise in the ears, and often pain in the right side of the head. She was certain that, from the attack of menorrhagia two years previously, there had been no debilitating discharge of any kind; neither epistaxis, haemorrhoids, haematemesis, nor leucorrhœa. She sought hospital treatment on account of palpitation and debility. On admission, her eyes, naturally large, were very bright; the conjunctiva, the lips, the gums, and tongue bloodless. The skin of the face and body was pale yellow, and free from oedema about the ankles, although the stethoscope leaves a slight depression on the chest. There was no evidence of organic disease of either the lungs, the liver, or spleen, and she had never had intermittent fever; and as she had always been well fed, and clothed, and kindly treated in a gentleman's family, I had no difficulty in making my diagnosis that she suffered under chlorosis, fairly attributable to the affection of the digestive organs, which appeared one year previously. When the hand was laid over the heart, its action was found irritable; percussion did not detect any enlargement. The stethoscope revealed the existence of a distinct systolic murmur in the second left intercostal space, and extending towards the left shoulder, in the locality of the pulmonary artery. A murmur very much fainter was heard over the sternum, rather lower down, or in the position of the aorta. The second sound of the heart was quite

distinct. Over the body of the ventricle, no murmur was heard, but finding the apex of the heart, and placing the stethoscope over it, a distinct murmur was also heard at the period of the heart's systole. There was also heard a continuous murmur in the jugular veins, most distinct in the right; but I could detect none over the site of the longitudinal sinus or the torcular herophili, where in similar cases a murmur has been heard. This girl was positive that she had never suffered from rheumatism in any form, nor had any symptom that would indicate the presence of a previously inflammatory state of the heart; and as she is remarkably intelligent, and gave a most connected account of her illness, I have every confidence in her statement. My reason for bringing this case before the Society, is the presence of murmur at the apex of the heart, in a chlorotic female; and I have been compelled to go more fully than I wished into the history of her health, and the symptoms present on her admission, because the existence of such a murmur, independent of organic disease, is still a disputed point, and the bare possibility of its occurrence has been only recently, and indeed but very partially admitted—as may be learned from the following extracts on the literature of the question:—Dr. Hope "considers that an inorganic murmur is confined to the aortic orifice." Dr. Latham appears to hold the same opinion. Dr. Davis states, "that functional murmur is exclusively situated at the base of the heart." Dr. Bellingham writes, "that the systolic bellows murmur in organic affections of the heart, has its seat at the aortic orifice, and is not audible at the apex of the organ." Dr. Hughes states a similar opinion. Dr. Markham "believes that mitral systolic murmurs invariably indicate a defective condition of the mitral valves and are never inorganic—he is not prepared to admit or deny, that spasmodic contractions of the papillary muscles, the tendons of which are inserted into the mitral valves, may occur, and so prevent the closure of the mitral valves for a certain period." Dr. Walshe states "that haemic murmurs are invariably basic in seat, systolic in time, only in exceptional cases audible below nipple, and never perceptible as far as left apex." He admits "that a dynamic murmur," that is, a murmur dependent on some "abnormal state of the heart's action, as in chorea, and probably in other nervous disorders, is heard at left apex, owing to a disordered action of the muscular apparatus of the valve." He has "never seen a murmur at left apex of purely blood origin, and has never heard, in a purely chlorotic woman, a murmur having all the characters of a mitral regurgitant one." Dr. Stokes advises us "to be cautious in rejecting the opinion," that inorganic murmurs may not be seated in the mitral orifice, "as he believes that he observed cases of inorganic murmurs, which, so far as physical signs went, were closely similar to those of ordinary regurgitant disease." Dr. Stokes has recorded two most instructive cases, in which organic disease of the mitral orifice was associated with chlorosis. In one there was marked lividity of the lips, until the chlorosis was cured, the systolic murmur at apex remaining, the lady dying suddenly some years afterwards. The other had previously suffered from an attack of pericarditis, and

post-mortem examination proved the existence of organic disease of the mitral orifice. Dr. Barclay "is quite certain that an anæmic murmur is occasionally heard of greater intensity towards the left apex." It would thus appear that Drs. Stokes and Barclay are the only authors who admit that a blood murmur may exist at the apex of the heart, independent of organic disease. It is strange that, notwithstanding many sudden deaths in chlorosis, we have no record of any post-mortem examination in a case in which a murmur at the apex had been heard in chlorosis, except where there existed during life evidence of organic disease.

Dr. REID remarked, that as there was neither cough, nor hemoptysis, nor lividity of the lips, nor any symptom that would indicate regurgitation through the mitral orifice, he was disposed to believe that the murmur at the apex was caused by the friction of the spanæmic blood against the columæ carneaæ of the ventricle, the sound being conveyed to the surface by the apex of the heart when in contact with the side; and that from this case we should draw the practical lesson, that we are not hastily to decide, that when a murmur is heard at the apex, therefore organic disease of the mitral orifice must be present, always bearing in remembrance that Dr. Stokes has proved that such disorganization may co-exist with well-marked chlorosis, and remain and cause death after the chlorotic murmurs had been removed. This patient derived marked benefit from the administration of iron, the colour of the lips and tongue improving greatly; the murmur much less distinct at the second intercostal space, and not constantly heard at the apex.

FIFTEENTH MEETING.

12th February, 1859.

The President in the Chair.

Porrigo existing only on the Chest.

Mr. H. M. JOHNSTON having, at the last meeting of the society, introduced a child, aged 2 years and 4 months, on whose chest a solitary spot of disease existed of six weeks' standing, which he believed to be porrigo; and some diversity of opinion having arisen as to its nature, in consequence of no trace of eruption having appeared on the scalp, it was ordered that the crust should be examined microscopically. Accordingly,

Dr. CUMING stated, that, having examined the crust, he had been able to identify the parasite, so that the disease was undoubtedly porrigo.¹

Dr. WALES exhibited the *achorion schœleinii*, the vegetable parasite of the crust in question, under the microscope.

Case of Placenta Prævia.

Dr. HERNY read the following case:—On the 8th of November last, I was hastily summoned by a junior

member of the profession to render assistance in a case of excessive haemorrhage from the womb, occurring in a parturient woman in the ninth month of her pregnancy. On arriving at the bed-side, I found the patient in a state of extreme debility, and it was with great difficulty that any pulsation at the wrist could be found; her extremities were cold, and her face quite pallid, although her head was placed low. The patient was too weak to give me any information at the time, but I was informed that she had previously several attacks of flooding. I afterwards learned from the patient herself, the following details: She is about 35 years of age; the mother of six children; and there was nothing unusual in the present pregnancy beyond a constant pain in the back, which, however, disappeared on the occasion of the first haemorrhagic discharge, which took place on Monday, exactly sixteen days before her delivery. She found occasion to empty the bladder, and, whilst doing so, she remarked upon the unusual quantity of fluid which was passing from her, and was surprised and horrified to find that the chamber utensil was literally overflowing with blood. She lay down, and the haemorrhage ceased till the second day afterwards, when it again returned without pain or warning of any sort, and there issued, according to her own estimation, about three or four pints. She now felt very weak and alarmed, and sent for an accoucheur, who, upon visiting, found the haemorrhage had ceased, and ordered the continuous use of a mixture, with a view to bring on labour pains. He then left her and did not return. She drank the entire of the mixture, but without the desired effect. On the Sunday following she had another attack, then on Tuesday, and finally, on Wednesday, two other attacks—the first at two o'clock, p.m. This left her in a very alarming state, when another accoucheur was summoned. He found it necessary to administer stimulants, and some local applications to the genital organs, and, I believe, not suspecting unavoidable haemorrhage, resolved on waiting the efforts of nature for the expulsion of the foetus. He left the patient to repose, as the haemorrhage had ceased, but was summoned in two hours afterwards, as it had returned with force, and he was so alarmed at the quantity lost, and the great prostration, and almost moribund condition of the patient, that he demanded assistance, when I was sent for. Before I arrived the haemorrhage had ceased. I then proceeded to a careful examination. I found the os uteri pretty high up, but dilated to nearly the extent of half-a-crown, and somewhat dilatable; the anterior half of the circular opening of the womb was covered with a fleshy or fibrous substance, which I readily concluded to be the margin of the placenta, and whose presence in this situation was the cause of the previous haemorrhage. I then endeavoured to find out the part of the child presenting, but was unable to do so, as I could touch nothing within but the membranes filled with the waters. The hand, however, I afterwards discovered to be the presenting part, but the water behind, and the placenta attached principally to the cervix anteriorly, prevented me from then ascertaining that point. I found myself now in a critical position. To wait for the efforts of the womb, and another attack of

¹ When this report was published in the Dublin Hospital Gazette, the Editor added: — "On the inaccuracy of this test, see paper by Jabez Hogg, Esq., read before the Medical Society of London, page 110."

bleeding, would be to consign the woman to certain death, and to turn, in her present depressed and anaemic condition, would be attended with considerable risk, and, if unsuccessful, with perhaps no small amount of obloquy. However, a sense of duty compelled me to adopt the latter alternative, which was readily agreed to by my colleague; but, as I have said before, that he was a young practitioner, I thought it prudent to seek the opinion and consent of an experienced accoucheur. As the bleeding had again ceased, there was time to send for one, and I thought it right, in the meantime, to give as much stimulus as she could take, which was little, owing to the difficulty of swallowing. Dr. Wales was the gentleman sent for, who, after hearing the case as far as I could explain, and after due examination and deliberation, concurred with me that immediate delivery was the most proper course. On introducing my hand within the os, and behind the margin of the placenta, I experienced no resisting contractile efforts, but it was with some difficulty that I got the hand introduced. I then ruptured the membranes, and sought the foot of the child. I could not conveniently grasp more than one, and brought it down, and there was no difficulty till the breech came low enough to pass the os, the passage of which occupied a considerable time, as there was a steady passive, though not active resistance. However, by steady perseverance and repeated tractile, though not violent, efforts, the delivery was accomplished. The placenta immediately followed, and I never saw a delivery where there was less loss after the expulsion of the foetus, which was stillborn. She had no labour pains from first to last, but I thought I perceived some slight bearing efforts on her part during the latter part of the delivery. The woman is now perfectly well, but it was several weeks before she could leave her bed from debility alone. She had no subsequent inflammatory symptoms, but the pulse ranged high for a considerable time after delivery; it however gradually improved under the use of haemastics and nutritious diet.

I am happy to think, that cases of *placenta prævia* do not often occur, as, although I have practised pretty extensively for many years, I never met one before. I adduce this instance to illustrate the danger of leaving cases to nature where the loss and weakness have been so alarming—a course advised by some authors, and as confirmatory of the views of those who deprecate delays. Such cases are extremely perplexing even to the experienced practitioner. My opinion, however, corresponds with the teachings of those who recommend delivery as soon as the *dilatable* state of the os uteri will permit, and not to be deterred from interfering even where the loss and debility have proceeded to an extreme degree, (whether from neglect or ignorance of the consequences, as in the present instance,) as immediate delivery affords the best, if not the only, chance of rescuing the unhappy patient from the jaws of death.

Bigg's Orthœpede.

Dr. WALES next exhibited an instrument, invented by Mr. Bigg, for use in equino-varus. He said he had been using it for some time, and with modifications had

found it to answer the purpose for which it was intended. The mechanical merit of the instrument consisted in the simplicity and ingenuity of the arrangement by which three distinct movements of the foot-piece could be produced by acting on one centre; these movements were eversion, rotation, and elevation of the anterior portion of the foot, and consequent depression of the heel, such motions as were requisite for the restoration of the foot affected with equino-varus to the normal position. In slight cases, the use of this instrument would suffice for a cure, without surgical interference; but when the latter was necessary, it became still more useful. The instrument being adjusted to the deformed position of the limb, and section of the tendons being performed, it maintains the foot immovable, until the new bond of union safely admits of elongation, which can be so gradually and steadily accomplished that all risk of loss of power from imperfect or weak union is avoided. To keep the stem of the instrument, however, firmly in the middle of the lateral aspect of the leg required extension of the short thigh stem to the hip joint, and its pivot attachment there to a pelvic band. This addition renders the instrument very effective. He further said, that though the instrument answered exceedingly well for very young children, he preferred, where a child is about walking, dispensing with it altogether, and operating at two distinct periods. His plan was to convert *equino-varus* into *equinus*, by section of resisting structures and immediate extension on a common straight splint. Eversion being complete, he next divided the tendo-achillis, and by simple mechanical means, brought up the foot gradually to a right angle with the leg, which position, with proper and common appliances to the foot, will be maintained by the weight of the child's body in its attempts to walk or support itself.

Fractures of the Acromial End of the Clavicle.

Professor GORDON read the following case:—As the following case and specimens of fracture of the clavicle, near the acromial end, have an important bearing on the present knowledge of such accidents, I have, therefore, been induced to bring this matter before the Society, more especially as the conclusions at which I have arrived are different from those of Dr. R. W. Smith, whose work on fractures and dislocations embraces, with some trifling exceptions, almost all that is known on the subject. A carpenter, aged 30, whilst assisting in carrying a heavy piece of timber, on the 19th January, 1859, fell at least from a height of 20 feet, in his descent striking the side of the wall, and alighting on the posterior and outer part of right shoulder and axilla. About an hour after the accident I saw him. He was in a shed adjoining the place where he had fallen; he was sitting on a form, leaning slightly forwards and to the right side. His sole complaint was of severe pain in the right hypochondrium and upper and back part of axilla. On passing my hand beneath his clothes, and desiring him to take a deep inspiration, I was unable to make out any fracture of the ribs; but as the attitude in which he sat and the way in which he had fallen, led me to suspect fracture of the clavicle, I next proceeded to

examine that bone. On carrying my finger along its upper surface, when I arrived within $\frac{3}{4}$ of an inch of its acromial end, the continuity seemed to be lost, and pressure here caused him to wince; but the pain was very trifling indeed when compared with that experienced when the trapezius was pressed forwards against the seat of fracture. He was directed to be taken home and to go to bed for a further examination. On visiting him shortly afterwards, I found him sitting up, being unable to lie down from the severe pain in the right hypochondrium and back part of axilla; but as the most careful examination of these regions did not reveal either crepitus or inequality of the external surface of the ribs at the seat of pain, I regarded it as proceeding from muscular contusion. I now requested him to raise the arm, which he did slightly, at the same time flexing and extending the fore-arm upon the arm with tolerable freedom, and without complaint of pain. On exposing the shoulder, it was found to be more depressed, and the spinal border of the scapula more prominent than that of the opposite side. When measured from the acromion to the sternal end of the clavicle, there was shortening to the extent of half-an-inch. On carrying my finger along the anterior border of the clavicles, on arriving near the acromion, the anterior concavity was much deepened; the outer, or acromial fragment formed almost a right angle with the sternal portion, which seemed to be displaced backwards. On the upper surface both fragments were on the same level. Pressing the trapezius forwards opposite the fracture caused very acute jagging pain. No crepitus was detected by slightly raising or depressing the shoulder. However, as he suffered very acute pain in the right hypochondriac and axillary region on the slightest motion of his body, and as the signs of fracture of the clavicle were quite conclusive, no further attempts were made to elicit crepitus. A large pad was placed in the axilla, and a figure of 8 bandage applied, which removed almost completely the inclination forwards of the acromial fragment of the clavicle. Dr. Smith, to whom we are indebted for pointing out this displacement forwards of the outer fragment, says—"From an examination of these preparations, we learn that the outer end of the clavicle may be broken either between the coraco-clavicular ligaments, or between the trapezoid ligaments and the acromion; and that fracture in the former situation is of comparatively rare occurrence, and attended with scarcely any displacement of either fragment of the bone; but that in the latter, contrary to what is usually stated, there is generally a considerable amount of displacement. The specimen of fractured clavicle which I now exhibit, and which I shall call No. 1, resembles so accurately that of No. 3, page 22 of Dr. Smith's work, that if we had a like horizontal section in it, it might almost be said that the drawing was a faithful representation of it. But was this a fracture external to the trapezoid ligament? Unquestionably not. The trapezoid ligament was attached, in any dissection made by me nearer to the acromial end than $\frac{3}{4}$ of an inch. From half-a-dozen of examinations recently made, half-an-inch would represent the average distance between the trapezoid ligament and the

acromio-clavicular articulation. In this specimen the fracture is a little more than one inch from the acromial end, and yet the acromial fragment forms almost a right angle with the sternal. This specimen, which I shall call No. 2, I dissected to-day (Feb. 12th, 1859). The acromial, or outer fragment, is on a plane, about a line above the sternal portion; it is so much displaced forwards as to form an angle of about 43° with it. The fracture is oblique from before backwards, and from above downwards and outwards; it commences four lines internal to the acromio-clavicular articulation, and running obliquely backwards and inwards, terminates opposite the posterior and outer border of the root of the coracoid process; and yet the most careful examination shows that, although from its obliquity the line of fracture is nearer to the acromio-clavicular articulation on its under surface than above, there is none of it external to or between the trapezoid ligament and the acromio-clavicular articulation. The conclusions to be drawn from the case related, and from the two specimens exhibited, are—That in many instances of fracture between the coraco-clavicular ligaments, the outer or acromial fragment is so displaced as to form a right angle with the inner or sternal portion, the upper surfaces at the same time maintaining the same horizontal level, or, as in No. 2 specimen, with the acromial fragment, on a plane somewhat above the sternal fragment. When the clavicle is broken between the attachments of the coraco-clavicular ligaments, the scapula rotating on an axis nearly corresponding to its anterior border, falls forwards and inwards. The acromial fragment is thus brought into relation with the anterior border of the sternal portion, and, if the accident has been overlooked, unites at right angles with it. That the attachments of coraco-clavicular ligaments do not oppose any obstacle to the outer fragment being applied to the anterior surface of the inner, and, when we have fracture between these ligaments without displacement, it must be referred to some other cause rather than to the resistance offered by these ligaments. That the chief agents in causing displacement are the same as those in the ordinary fracture in the middle third of the clavicle, excepting the subclavius muscle. That the outer end of the inner or sternal fragment seems to be displaced backwards, but this is more apparent than real from the shoulder falling forwards and inwards. From the inclination forwards and inwards of the shoulder, the outer end of the sternal fragment comes into more close proximity to the trapezius. Hence, when we press on that muscle opposite the fracture, it becomes applied against the broken end of the sternal fragment, causing a jagging pain, much more acute than when pressure is made over any other part of the fracture. That, from the shape of the clavicle, fracture is most likely to occur at the centre of, or a little external to, the centre of the posterior concavity, than between the trapezoid ligament and acromio-clavicular articulation. That, from the attachments of the coraco-clavicular ligaments and the two specimens exhibited, I am of opinion that many of the cases of fracture of the clavicle described by Dr. R. W. Smith as external to the

coraco-clavicular ligaments, are really between them, and that his observations apply more correctly to the fractures between, than to those external to, the coraco-clavicular ligaments.

SIXTEENTH MEETING.
19th February, 1859.

Fatty Tumour of Back of Neck.

Dr. MOORE exhibited a cast of a fatty tumour of the back of the neck, extending from the occipital protuberance to the first dorsal vertebra, and measuring in its transverse diameter about 6 inches.

About twelve years ago Dr. Moore had been consulted by the gentleman who was the subject of this growth, who was then in his 72nd year, with regard to its removal. Dr. Moore at that time advised, considering his age, non-interference, remarking that it would be a tumour to him all his life. His death was caused by a railway accident, necessitating the removal of both legs below the knee four days after the receipt of the injury. Dr. Moore believed that he would have recovered from the effects of the amputation but for an injury of the spine, which he received at the same time, causing paraplegia.

Chopart's Operation.

The PRESIDENT exhibited a foot, which he had amputated that morning, by Chopart's operation, for disease of the internal cuneiform and cuboid bones. The only remarkable feature in the case was the small evidence there was, at first, of such extensive disease as was exhibited by the tarsal bones, and the rapidity with which they had become disorganised; the internal cuneiform especially was almost completely transformed into tubercular softening. The soft parts in the dorsum of foot had also taken pulpy degeneration. Three vessels had been ligatured, and the edges of the flaps had been brought together by metallic sutures. The patient was a young countryman, aged 24 years.

Uterine Tumour.

Dr. MURNEY placed before the Society a specimen of a uterus, which he considered was an example of the fibrous tumour of that organ; it was taken from a subject in the anatomical rooms of Queen's College. He said—Unfortunately, I am not able to give any history of this case. On inquiry, I have been able to learn only the two facts, that the woman was 40 years of age, and has been an inmate of the idiotic ward in the Union Workhouse for some time past. She was very much emaciated. There was complete absence of mammary development; no fatty deposit at the region of the mons veneris, and there were extremely few hairs about the pubis; altogether, a superficial examination would have led to the inference it was the body of a girl about 18 years of age, who had never menstruated.

The brain was normal in every respect; the viscera of the abdomen were also healthy, with the exception of the uterus, which was somewhat spherical in shape, nodulated, about the size of a cricket ball and half. The tissue of the organ was not of uniform density; some

portions of it were of a natural firmness, others much harder. The "os" was transverse and the margins cicatrized, having evidently been ulcerated at some period. In two instances the nodosities were connected to the tumour by very narrow peduncles. The whole weight of it was 8 oz. 6 drachms, the average weight of healthy specimens being, for the virgin 6 to 10 drachms, and from 1½ to 3 ounces in females who have borne children.

Having cut into the specimen in the presence of the Society, Dr. Murney called attention to the fibrous deposit which had taken place in the two customary situations—viz., on the surface of the uterus, beneath the peritonæum, and in the interior, close to the lining mucous membrane. From the appearance of parts of the section, and the manner the knife cut through it, he was inclined to think portions of the new deposit were undergoing malignant change. Parts of the suspected structure were taken for microscopic examination by some of the members.

Fracture of Neck of Femur.

Dr. MURNEY then showed an example of intra-capsular fracture of the neck of the femur, also met in the anatomical rooms of Queen's College during the past week. The specimen consisted of the articulating part of the bone, connected by a quantity of fibrous structure to the upper end of the shaft between the trochanters. Every portion of the neck had been removed by absorption. The capsular ligament was very greatly thickened, and the muscles around the joint, particularly the glutaei medius and minimus, had undergone fatty degeneration from non-use. The presence of intra-capsular fracture had been recognised when the body, that of a female, was received for dissection, as there was eversion of the foot, shortening of the limb to the extent of one half inch, and upon rotation the trochanter rolled upon its own axis.

Dr. MURNEY remarked—On looking at this specimen, I find the portion of the head which remains exactly corresponds to the superior epiphysis of the thigh. It may be recollect that in the case in which the President performed amputation at the hip joint, and about which case some difference of opinion existed as to the pathological changes, one portion exhibited was precisely similar to this one; also, in a case forwarded to the Society by Dr. Babington, of Londonderry, the same extent of bone occupied the acetabulum. These instances, and others I have seen, lead me to conclude that at all periods of life the epiphysary, and perhaps the apophysary parts of long bones, receive their nutrition independent of the supply given to the shafts. We know, of course, that, during the development of the bones, the progress of each centre is in a great measure independent of those parts to which it is as yet imperfectly connected, but about the age of 25 years, ossification is completed. This person, a woman, was 65 or 70; Dr. Babington's patient was, I think, 40 or 50; and Mr. Browne's case was 26 or 27 years of age. In two at least of these we might have expected the circumstances which caused removal of the neck of the thigh would also have carried off the head, had both

those parts been nourished from the same source; but as I believe they derive their supply of blood from different vessels, we can readily explain why certain parts are so frequently to be found cut off from the remainder of the bone at precisely the same situation.

SEVENTEENTH MEETING.

26th February, 1859.

Deformity of Hand, with Operation.

Dr. GORDON presented a boy, 8 years of age, on whom he had operated eight months ago, for a deformity of the hand from a burn. The boy was two years of age when the accident occurred, and being weak and delicate, his mother said, "I did not pay sufficient attention to him, thinking he would not live long." Shortly after the commencement of last session, Dr. Halliday brought him before the Society. After that this cast was taken, on his admission into hospital. The hand is flexed at an acute angle with the forearm, and the proximal, or upper end of the carpus, and its dorsal surface, projects downwards, so that when he falls forwards the upper and back part of the carpus comes in contact with the ground. The palmar aspects of the ulnar side of the hand, and a considerable portion of the little finger, are united to the anterior surface of the lower fourth of the forearm. On the radial side, the ball of the thumb is approximated to the forearm, but the cicatrix does not extend so high by an inch as on the ulnar side. The hand is thus not only greatly flexed, but also very much adducted and slightly rotated, the palm looking upwards and towards the radial border. The thumb is so much bent backwards that its phalanges form an acute with its metacarpal bone, the dorsal surfaces looking towards each other. The band of skin which has thus bent the thumb backwards proceeds from the root of the nail, burying, as it were, the whole thumb except its apex. The fore and middle fingers are free, but the ring finger is held very much flexed, whilst the little finger is greatly adducted, and held against the ulnar surface of the forearm. The boy was put under the influence of chloroform, and a V incision, its apex upwards, was made through the band uniting the ulnar side of the hand to the forearm. The angular flap was next dissected downwards, until the hand formed an obtuse angle with the forearm. A similar V incision was made on the radial side. After that the two sides of each of the V incisions were approximated transversely by sutures, the water dressing applied, and extension maintained by a splint passing along and beyond the back of the forearm and hand. When these incisions had cicatrized, and when the hand had been brought on a line with the forearm, a V incision was also made in the cicatrix, which held back the thumb. The state of the parts at present are—The hand is on the same line as the forearm, with the exception of a very slight inclination towards flexion. The thumb is inclined backwards, but not to the same degree as before operation, its extremity, as high as the second joint, being free. The ring finger is considerably flexed by a contracted band. The little finger is so flexed, deformed, and incapable of motion, that it would not be possible to make it of any use to him.

Cases of Placenta Prævia, by Dr. DILL.

It will be admitted by all who practise obstetric medicine and surgery, that there is no one complication in midwifery attended with more danger to the patient, and difficulty to the practitioner, than those cases wherein the placenta presents, and unavoidable haemorrhage occurs. Under circumstances of such extreme peril to the patient, the accoucheur may be said, indeed, to be actually combating death.

With such facts before us, and acknowledging the serious responsibility that presses upon us, we are imperatively required to be not only intimately acquainted with the symptoms, but to analyse thoroughly and impartially, and examine carefully, the different methods of treatment which have been from time to time recommended by the various authorities, so as to come to a safe and satisfactory finding regarding the management of placenta prævia. It is not necessary for us here to pause and inquire how it comes to pass that the placenta is occasionally to be found planted over the os uteri, and at times in its immediate vicinity. It is only required of us, at the present time, practically to know that such cases do exist, and that we may be suddenly and unexpectedly called upon to deal with placental and partial placental presentations. Placental presentations are to be diagnosed, first, by the sudden attacks of discharge of blood from the uterus, usually commencing with the sixth month of pregnancy, and recurring occasionally until the full period of gestation arrives, or until the approach of labour. Second, by a vaginal examination, when a firm, fibrous, and fleshy sensation is communicated to the finger by the part presenting. Third, by the body conveying such a sensation being attached to the inner side of the os uteri; and fourth, by a loose membranous-like substance hanging down through the os, when the placental presentation is partial. The different modes of managing cases of placenta prævia, may be briefly stated in the following order:

The first plan proposed may be said to be the use of the "tampon," or the plug. This practice is only indicated when the os is not dilated sufficiently, or dilatable. Under these circumstances, I have used the "tampon" with advantage. The only objection to it is, that haemorrhage may go on inwardly.

The second is the puncturing of the membranes, which has been practised from a very early period, and I would merely allude to one very formidable objection, viz., that should turning be the practice required at any future period, it is found to be much more difficult, if not dangerous, in consequence of the evacuation of the waters, and the contraction of the uterus.

The third is the partial separation of the placenta. With this proposal, which originated with Dr. Robert Barnes, I shall not occupy your time, as it does not recommend itself to my mind in any case; I shall only say, that in most cases of partial presentation, we have at a certain stage a partial separation of the placenta without any good results following.

The fourth is the complete separation and extraction of the placenta before the child; and the fifth is what I would consider the grand and the chief operation in placenta prævia—viz., the turning of the child.

The fourth and fifth plans of treatment appear to me to be the modes of managing cases of placenta prævia, with which we have principally to do, and which have occupied the minds of the profession as rival or antagonistic operations since 1844, when Dr. Simpson revived the plan as proposed by Mr. Wood and Dr. Radford, viz.:—the separation and extraction of the placenta before the child. We have now to take up and carefully inquire into the merits and demerits of that proposal which has been made, of artificially separating and bringing away the placenta before the child. And this practice having had the advocacy of Wood, Radford, and latterly of Simpson—men of such high standing—we are bound, before condemning it, to give it our best attention. Dr. S. appears to think that this operation should supersede the operation of turning; but the theory and arguments which have been advanced in its favour, and which he makes the basis of his practice, are not (as I shall show) to be relied upon. The recommendation is founded upon the hypothesis, that the flooding comes from the cells in the placenta—not from the uterine vessels—and if this can be sustained by facts and arguments, then, indeed, should the placenta, the source of the discharge or haemorrhage, be the body first removed. No satisfactory proof can, however, to my mind be given, that the great quantity of blood which flows in these cases, proceeds altogether from the placenta. Is it at all likely that this large quantity of blood should come from such a small portion of detached placenta as is usually at first separated? Besides, if the extremities of the blood-vessels on the surface of the placenta be open at all, they must of necessity be very minute. Some anatomists and physiologists assert that they have not open mouths, and Dr. H. Madge, who instituted a series of experiments, established the fact that the vessels on the surface of the placenta are shut sacs. The experiment was this: he injected the umbilical vein with a quantity of coloured fluid, and in place of escaping at the surface of the placenta, the fluid returned by the arteries. On the other hand there are strong and valid reasons for believing that the mouths of the vessels on the inner and stripped surface of the uterus, are the principal sources of haemorrhage in placenta prævia. The size of these vessels in the mouths of the sinuses which will expand at the mouth and neck of the uterus with each pain, at which time an increased quantity of blood is discharged, furnish satisfactory arguments in favour of the opinion that the flooding comes directly from the uterus. Moreover, Dr. Simpson himself states, that there is a greater development of the uterine blood-vessels in the neighbourhood of the placental attachments, and also a larger determination of vital fluid to this quarter. And hence, we must most naturally infer, that when the placenta is separated, the flow of blood from this part of the uterus becomes excessive.

As often as I have examined the portion of separated placenta, so often have I observed that the surface and cells were coated and filled with coagulated blood. The fact is also on record, that although the placenta has been separated and expelled, the flooding has continued. We may also adduce post-partum

haemorrhage, as a very strong argument in favour of the opinion that it is from the uterine vessels the discharge comes. No doubt haemorrhage has occasionally ceased by extracting the placenta before the child; but this is to be ascribed to, and accounted for, by the fact that the head of the child is pressed down, and shuts up the mouths of the uterine vessels. But admitting that this may occur, and although the placenta may become spontaneously detached and lodged in the vagina, from which of necessity it must first be removed, yet this does not satisfactorily prove the propriety of artificially separating and extracting the placenta in all cases before the child is delivered. Nay, more, I believe I have advanced arguments strong and sufficiently numerous to deter the practitioner from such a mode of procedure. We now have arrived at that point at which we shall consider the most important operation in placenta prævia, viz., turning, which operation, if performed judiciously, and at the proper time, gives us the best chance for preserving the lives of both mother and child, as I shall endeavour to show, in the favourable results which flow from this practice, in the relation of a few cases which lately came under my own observation:—

Case 1.—Mrs. C., aged 30, April 21st, 1858, Keegan-street.—Mr. J. called me to see this patient, who was far advanced in pregnancy, and had been attacked with profuse uterine haemorrhage once or twice during the eighth month, and now again towards the close of the ninth. The placenta was felt adhering at the neck of the uterus; the os was about the size of a crown piece, and dilatable. The woman was weak, but there were symptoms of a living child. She was put under the influence of chloroform. I introduced the left hand, the os easily yielded, passed onward, punctured the membrane, got a hold of one foot, turned, and delivered her, in the usual way, of a living child. The placenta very soon followed; the haemorrhage ceased; the woman did well; the child died within a week.

Case 2.—In June, 1858, I was called, by Drs. S. and J., to a woman residing in Fourth-street, who had been attacked with profuse haemorrhage at the close of the ninth month of pregnancy. She had been ill for nearly two days when I saw her. The edge of the placenta was protruding through the mouth of the womb. The waters had been discharged some hours. The woman was weak, and life in the foetus could not be detected. It was agreed that turning was the proper course. Dr. J. introduced his hand, got hold of a foot, turned, after some difficulty, and brought away a dead child. Marshall Hall's plan of treatment was vigorously instituted, but without effect. The mother did well till the tenth day, when she died, but as I did not see her after being delivered, I cannot state the particulars.

Case 3.—Mrs. M. was brought into the Lying-in-Hospital in a very weak and exhausted state from haemorrhage, about the full period of gestation. The placenta presented. Dr. Pirrie, whose patient she was, finding the os but slightly dilated and rigid, thought it better to introduce the "tampon." It remained in for four hours, during which time the pains had increased. The "tampon" was removed. The os was found to be farther dilated. She was placed under chloroform. Dr.

Pirrie introduced the hand, turned, and delivered; the child was dead; the woman made a good recovery.

Case 4.—On the 10th of September, 1858, Mrs. F., aged 33, took ill of flooding at 5 o'clock, a.m. I was with her at 6 o'clock. She had completed the sixth month of pregnancy. She had lost a good deal of blood, and the discharge was continuing. The placenta presented; os, size of half-a-crown and rigid. I introduced the "tampon," applied cold, and admitted cool fresh air into the room. Mrs. F. was a delicate woman, and she had become rather weak. I was soon afforded the assistance of Dr. P., when we agreed to administer chloroform, and deliver. I introduced the right hand into the vagina; found the os more yielding, so much so as to enable me to introduce two fingers; found it to be a cross birth; hooked one of my fingers into the groin of the foetus, and soon brought it away; being premature, the foetus was of course dead, but the mother made an excellent recovery.

Case 5.—On the 12th of July, 1858, at two o'clock, a.m., I was sent for by Mr. Moore, resident pupil in the Belfast General Hospital, to see Mrs. L., whom he had brought into the house the night before. She had now reached the full period of pregnancy, and during the last three months she had been attacked frequently with profuse haemorrhage. I found her very weak; pulse nearly gone. On examination discovered a complete placental presentation. The haemorrhage continued. The child was found to be alive; but both mother and child were in extreme danger. She was placed under chloroform. I introduced my left hand, separated the posterior edge of the placenta from the uterus; passed onward; punctured the membranes, got a hold of the child's foot, turned, and brought away a living child. Although the mother had a severe attack of puerperal fever, both she and the baby did well.

I was present when a member of this Society, in a case of placenta praevia, turned. His patient did well; but as I was only in the room, and did not make an examination, I am not in a position to say more.

I would conclude by stating that I know of no case in which the use of chloroform is more indicated, and in which the good results arising from it are so apparent, than when turning is practised.

Lastly, Dr. Simpson's statistics show that where turning is practised, there is a mortality of one in three and a-half, and consequently argues against it; whereas, I have brought under the notice of this Society six cases in which turning was the practice, and in some of them under very unpromising circumstances, with only one death, and which, I believe, was not to be ascribed to the operation. I may add, that in this case, at her own request, chloroform was not administered.

EIGHTEENTH MEETING.

March 5th, 1859.

Foreign body in Bladder.

The PRESIDENT exhibited a piece of bone, two inches and one-eighth in length, thickly incrusted with phosphates, so as to make it one inch and a-half in

circumference, which he had removed from the bladder of a male patient in the hospital that morning. The operation performed was that recommended by Mr. Allerton, and which had been recently adopted successfully by himself, in the case of stone which he had brought under the notice of the Society at the early part of this session. The history of the case, he said, might be stated in a few words. The patient, a man of 50 years of age, looking now, however, much older, some few months since, while labouring under an extraordinary state of morbid feeling, had introduced into the urethra a pin of turned bone, a part of a crochet-needle handle, which, finally, had either slipped, or had been pushed into the bladder. From that time, of course, a good deal of suffering commenced, and continued to increase up to the period of his admission to the hospital, near the end of January last. During all the time he was under treatment he never divulged what he had done, save to the first surgeon whom he had consulted, and who told him that the foreign body could only be removed by some operative proceeding. Even after he was admitted into hospital, and when sounded for a calculus, which was suspected, he did not once mention the peculiar circumstances of his case; and it was only on Monday last that he hinted at the true nature of the exciting cause of his symptoms. On Wednesday Mr. Browne introduced a sound, and then believed he felt a foreign substance; but on Thursday, having injected the bladder with six ounces of tepid water, the body was easily detected lying in the left side of the base and near the neck of that viscus. An operation was then of course the only remedy for the poor man's most painful sufferings; and consequently, on Saturday, at ten o'clock, the patient was brought into the operating theatre, placed upon the table, and subjected to the influence of chloroform. When he was fully under the effect of the anaesthetic, the bladder had six ounces of warm water injected into it, and the sound having been introduced, the foreign body was appreciable to the touch of the surgeons present. The sound having been withdrawn, and a No. 11 grooved staff having been substituted, the patient was secured in the usual position for lithotomy. Mr. Browne then introduced the index finger of the left hand into the rectum, so that its tip rested against and fixed the staff at the prostate. A straight sharp-pointed knife was then thrust into the centre of perineum, half an inch anterior to the anus, and carried horizontally on till it struck the groove of the staff, immediately in front of the prostate gland. The membranous portion of the urethra having been divided, the knife was withdrawn, and the external wound was extended anteriorly towards the scrotum for an inch and a-half; the staff, it should be remarked, was held perpendicularly, and hooked up under the pubis. A long ball-pointed director was next passed along the staff; the staff was withdrawn, and the left index finger, well greased, was carried along and above the director with a slow rotatory dilating movement, till it entered the bladder, and the tip of it rested against the foreign substance, which lay obliquely across, and a little to the left side of the neck of the bladder, one point being firmly fixed in behind the prostate, and the other held

in a fold of the mucous membrane of the anterior part, and it was only after repeated attempts that the points of the bone could be freed from the structure of the bladder in which they were imbedded, every application of the instruments proving fruitless, till Mr. Browne having pushed the upper point backwards with his finger, was enabled to seize the other with the forceps, and to extract the body exhibited. The bladder was then well washed out with warm water, the patient was removed to bed, and an opiate was exhibited. Some twenty-five minutes elapsed after the section of the bladder before the bone could be extracted.

The PRESIDENT concluded by observing, that from the long-continued irritation and injury of the bladder by the pointed body grasped by, or rather imbedded in, its structure, and from the great difficulty experienced in the extraction of the foreign substance, he considered the patient in imminent peril; however, what had been done was imperative, and as little injury was inflicted as, in the circumstances of the case, was possible.

Recent Parts in Case of Dysentery.

Dr. DRENNAN exhibited the transverse colon and rectum of a sailor, aged 32, who had died four days after admission to hospital, in an advanced stage of dysentery. The disease had commenced as diarrhoea, four months previously, after exposure in the Chinese seas to great vicissitudes of weather and temperature, and had been aggravated, he thought, on the voyage home, by unsuitable diet. For the last month there had been copious discharges of blood, tenesmus, and general abdominal uneasiness on pressure. On admission he was in a state of great prostration. Opium was freely given, and on the second day an enema, containing 1 scruple nit. arg. in 4 oz. of water, was administered, with an O'Beirne's tube, and repeated on the following day. Slight relief followed the first—no marked symptoms at either injection. He continued to sink, and for some hours before death, there was very frequent action of the bowels and hiccough.

The post-mortem examination (twelve hours after death) disclosed disease amounting almost to disorganisation of the greater part of large intestine. The descending colon gave way under the hand. The mucous membrane was extensively destroyed, and in several places the muscular coat also. About three inches above the anus a rounded aperture of more than half-an-inch in diameter, and with thinned edges, had given rise to an extravasation of fecal matter into the abdominal cavity. Some soft lymph coated the peritoneum around this opening. The stomach and small intestines seemed blanched; the liver not abnormal; the spleen contracted. The practical conclusion drawn from the case was the necessity of great caution in administering enemata where such a state of the intestines as the foregoing might possibly exist. Whether or not the enema-pipe had in this instance caused the perforation, the state of the intestinal coat rendered such an accident, under the most careful management, far from improbable.

Case of Severe Injury.

Dr. W. MACCORMAC said—The following case is that of a

man who was first knocked down and then run over by a heavy four-wheeled machine. When first seen, about twenty minutes subsequent to the occurrence of the accident, he presented the symptoms of extreme collapse, the pulse and breathing barely perceptible. He died a few minutes afterwards. On a post-mortem examination, the eighth, ninth, and tenth ribs of the left side were fractured, as also the left ulna. On being opened, the abdominal cavity seemed completely filled with blood. The superior surface of the liver presented two fissures, which had not quite divided the capsule. On the inferior surface in the portal region the substance of the organ was most extensively broken up and lacerated, while the portal vein was ruptured. The liver seems to have suffered in this instance from a species of *contre coup*, as the external injuries were all on the left side. As the cause of death—the object in view—was rendered quite apparent, no further examination was instituted.

The recent parts were exhibited.

Removal of Prepuce.

Dr. MOORE exhibited a prepuce which he had removed. The patient, he said, had injured the penis by the introduction of a rusty nail: inflammation had ensued, followed by ulceration, and the glans penis had protruded through an opening thus formed in the side of the prepuce. The larger part of the prepuce, accordingly, resembled a small supplemental penis at the side of the organ. Considering the inconvenience and unsightliness of such an appendage, he had deemed it advisable to remove it.

Artificial Arm.

Dr. MURNEY showed a highly ingenious artificial arm, made by Mr. Bigg, of London.

NINETEENTH MEETING. 12th March, 1859.

The Case of Foreign Body in the Bladder.

The PRESIDENT stated that the man on whom he had operated for the removal of the handle of a crochet-needle from the bladder, and whose case was before the Society at last meeting, had since died. He regretted his inability to procure an examination of the parts, but, from inspection of the foreign body, it was evident (about one-twelfth of an inch of each extremity being free from deposit) that the impaction must have been due to partial penetration of the walls of the bladder.

L'Estrange's Sound.

The PRESIDENT also exhibited L'Estrange's instrument for detecting and measuring calculi in the bladder.

Dr. ROSS eulogised this instrument, pointing to the advantage of the employment of the sense of hearing as well as feeling in discovering the presence, and, in a degree, the character, of vesical calculi.

Recent Parts in Case of Supposed Fatty Heart.
Professor REID exhibited to the Society some morbid

parts, which were removed from the body of a patient who died recently in the Union Hospital. He said, the only portion of his previous history that I can give is, that his age was 62; that he walked into the car that conveyed him to the hospital, and also to his bed, from the chair upon which he had been carried from the bath-room; and then stated, that for the last two months "he had suffered from weakness only," and had slight dropsy of his feet and legs. He was very cold and pale, and on getting into bed, appeared quite exhausted and dying. Dry heat was immediately applied, and he was seen at once by the Resident Surgeon, who very properly gave him some whiskey in hot milk, and prescribed a cordial stimulating mixture, with a sinapism over the chest. Soon afterwards he ceased to speak, although still conscious, and lay in a lethargic state all night, passing a considerable amount of urine in his bed; the bowels remaining quiet.

At my visit in the morning of the 1st inst., he was still cold and pale, opened his mouth when directed to do so, but did not speak. There was slight puffing of the cheeks during breathings, and occasional tremors or writhing movements about the shoulders and arms, such as are often seen to precede a fit of convulsions, or to follow an attack of apoplexy. He could move both arms and legs, which were rather emaciated, free from fat, and with little anasarca. The pupils were of equal size, and not dilated. The lower part of the abdomen was full, and dull on percussion, and on the catheter being passed, about three pints of urine were withdrawn, which was healthy in smell and appearance, free from albumen, and of sp. g. 1,013. The respirations were regular, about 14 each minute, and the pulse in the radial artery 30 or 40. The veins on the temples, chest, arms, and legs were distended. No impulse was to be seen or felt in the region of the heart, and on applying the stethoscope over its base, a distinct cooing or musical murmur was heard, in place of the first sound; followed, after a short interval, by an indistinct second sound; this murmur was also heard in the sub-clavians and carotids, and very distinctly at the region of the apex. It was considered to be systolic, because it was heard immediately after the longest period of repose; although the pulse, at the wrist, was synchronous with the second sound. The radial and brachial arteries felt so full and firm, that I believed their coats to be atheromatous.

Interpreting the symptoms I have just enumerated, as indicative of fatty degeneration of the heart, I gave him at once four ounces of whiskey in hot punch, which was swallowed without much difficulty, but made no change in the frequency of the heart's action. The stimulating plan of treatment was continued during the next twenty-four hours, when, at my visits, I found his pulse to be 38, and of the same degree of fullness. The respirations increased to 18, and regular. He was now unable to swallow, and moaned often, which, with his lungs full of sonorous and mucous rales, rendered it quite impossible for me to ascertain the existence of either the musical murmur, or any sound of the heart; and, although the intercostal spaces were depressed, no impulse was either to be seen or felt. The tracheal rales increased during the

evening, and he died at 2, a.m., on the 3rd instant.

Feeling much interest respecting the pathological state that existed in this case, I requested Dr. Murney to dissect for me the parts that had been removed by Surgeon Rea, which he did with his usual courtesy and kindness. Mr. Rea, when removing the parts, found some fluid in both pleuræ; the lungs distended, and some old-standing adhesions in the left, and that no effusion existed in the pericardium. But that I was wrong in believing him to be the subject of fatty degeneration of the heart, is shown by the following statement of the morbid appearances:—The brain was found free from all indications of inflammation, effusion, or congestion, and was healthy in every part, except one or two specks of atheromatous deposit in the basilar artery. The heart was firm, of natural colour, retaining its natural shape and bulk, and having no disposition to collapse by its own weight. The valves of the aorta and pulmonary artery showed their sufficiency on the application of the hydrostatic test. The aorta, for several inches from its origin, was rough, owing to fatty degeneration, which, in some patches, had become atheromatous. On dividing the aortic orifice, we found a small ridge of soft vegetation on the ventricular surface of one of the valves—all the rest being healthy. A small fourth valve, in all respects complete, was observed at the pulmonic orifice. The walls of the left ventricle, as may be seen, are hypertrophied, being nearly an inch in thickness, and the cavity, if not contracted, is assuredly not dilated. Dr. Murney has examined it carefully with the microscope, and has found no indications of fat. The mitral valves were found healthy in structure, and the orifice natural. The brachial and radial arteries were free from any atheromatous deposit. The right kidney was found large and congested, but perfectly healthy in structure, while the left was found small, and in a state of fatty degeneration. There was no disease of the liver, spleen, or prostate gland.

Dr. Reid then said—Now, Mr. President, there are two points of interest in this case. 1st, Was it possible, under the circumstances I have stated, to have avoided this error in diagnosis? and, 2nd, How can the symptoms be explained?

To the first I reply, that the amount of information I obtained from what is called "the previous history of the patient," was simply, "that he had suffered from weakness alone for two months;" and next, that the pulse continuing under 40 during the two days he was in hospital; the fulness of the radial artery; the first sound of the heart replaced by a murmur; the absence of all impulse to either sight or touch (not to be explained by pericardial effusion); the cold and pallid state of the body; the lethargic state, without paralysis, constituted a group of symptoms that might be considered almost pathognomonic of fatty degeneration of the heart.

To the second query I reply, that, to explain the feeble sound and absence of impulse in this patient, we have to remember that various writers on cardiac pathology have observed such to occur where the ventricle was hypertrophied and contracted; but, should we agree with Cruveilheir and Budd that

contraction cannot take place, we are absolutely certain that in this instance there was no dilatation. The cooing murmur that was present during the systole is sufficiently explained by the vegetation on the ventricular surface of one of the valves, and, perhaps, more satisfactorily by the roughened state of the first four inches of the aorta. The murmur being so distinctly heard at the apex, although the mitral orifice was healthy, must, I conceive, have been owing to the firmness of the substance of the heart rendering it a better conductor of sound. Dr. Bellingham states that this cooing, or musical murmur, is almost pathognomonic of regurgitant lesions of either the aortic or mitral valves. This case, however, proves this opinion to be incorrect, because after a small opening was made into both ventricles, the water test proved that no regurgitation could take place at either the aortic or pulmonary orifice, and the mitral valve is to be seen perfectly healthy. The frequency of the murmur, and of the second sound of the heart when heard through the stethoscope, tallied so accurately with the number of pulsations at the wrist, that it is evident there could not, in this case, have been any of those practical and more frequent contractions of the ventricle that have been observed occasionally by others when the pulse was unusually slow. But of all the symptoms, it is perhaps most difficult, and, at the same time most interesting, to attempt an explanation of the relation that existed between the feeble action of the heart and slow pulse, and the lethargic or cerebral symptoms—or to decide in which of these organs was the first link of the morbid chain. We all know, that disease of the brain will undoubtedly diminish the frequency of the heart's action; and whilst Dr. Bellingham states "that the heart's sounds being slow, are more frequently due to disease of the nervous centre than of the heart;" yet he adds, "that fatty degeneration of the heart appears to be the only diseased state ever accompanied by diminution in the frequency of the heart's action." Now, Dr. Murney, whose experience in examining this organ is unquestionable, is positive, after a most cautious and minute dissection of it, that it presented no evidence of any form or amount of disease, except one or two very small atheromatous deposits in the basilar artery. I believe, therefore, that the first link was furnished by the heart and aorta, and that the lethargic symptoms were due to the blood being sent into the brain in insufficient quantity and force; and that the inaction of the bladder was dependent on the depressed state of the brain; as the state of the prostate and urethra show that there was no impediment to the passage of the urine; while the natural thickness of the coats of the bladder, the smell of the urine, and its freedom from mucus, prove that the bladder had not been habitually distended.

I should, perhaps, mention the absence in this patient of two symptoms, which are often associated with fatty heart; namely, the *arcus senilis* of Cauton, and the *respiratory distress* of Stokes—when these are present, they are valuable aids in diagnosis, but they may be absent, although fatty degeneration exists.

Professor GORDON, in allusion to the fourth pulmonary valve in the heart exhibited, said he never

had seen such before, though he had seen a variety in the aortic valves. He also remarked that a pulse synchronous with the heart's second sound did not argue weakness of that organ.

Dr. MURNEY said he never had seen a variety in the number of the aortic valves, but he had before seen a fourth pulmonary valve. In relation to the symptoms in this case, he considered a distended radial artery and a firm pulse rather incompatible with the supposition of a fatty heart. He further said that the hypertrophied condition of the left ventricle was undoubtedly due to the obstruction offered to the circulation by the deposition on the semilunar valves and aorta.

Dr. ROSS was impressed with the idea, that this was a case of death from ureal poisoning, which supposition, independent of the symptoms detailed, he considered strengthened by the state and diminished size of the left kidney.

Dr HEENEY asked if the spinal cord had been examined. He thought any inference as to the cause of death imperfect without an inspection of the whole nervous centres.

Professor REID stated, in reply to observations, that a distended state of the radial artery had repeatedly been observed in cases of fatty degeneration. The idea of its being a case of uræmic poisoning had not been overlooked by him; but, that when he found one kidney perfectly healthy, and shown by the catheter on two occasions to be capable of secreting 3 pints of urine daily, which was free from albumen, and of a sp. gr. of 1013, he could not satisfy his own mind, that there was any evidence, that a sufficient amount of urea was not eliminated from the system. He said the spinal cord had not been examined; and he further stated, that as the "Respiratory distress of Stokes" was a symptom that was not to be seen frequently, he would be happy to afford any member of the Society an opportunity of seeing it in a patient in the Union Hospital, in whom it was very well marked.

Case of Pemphigus Gangrenosus.

Dr. ROSS read the following case—

Catherine Kelly, aged four years, residing in a very contaminated atmosphere, was seen by me on the 20th of January, 1859. It was stated she had been about a week ill. Constitutionally there were febrile symptoms, and locally, over the upper parts of the thighs, the lower portion of the abdomen, and the internal and external surfaces of the labia, and around the anus, there were several well-marked gangrenous ulcers and vesicles of pemphigus gangrenosus. Dysuria, and pain and tenderness of the affected parts were also present.

As to the treatment, the chlorate of potash was given internally, and the nitric acid lotion was applied externally, with well-marked and immediate good effects.

On the 17th of February, 1859, the child was quite well, presenting no appearance of the attack she had passed through, with the exception of the cicatrices of the gangrenous ulcers.

Case of Anthrax in the Breast.

DR. MOORE exhibited a coloured cast of anthrax in the

breast. The subject was a spare attenuated woman, aged 50. The case was unmistakeably carbuncle, involving a portion of the mammary gland, and the line of demarcation was about to be formed. There was no interference beyond the application of a poultice, and the carbuncle sloughed out. He had never seen a similar case before, and from its rarity he considered it worth bringing before the Society.

TWENTIETH MEETING.
19th March, 1859.

Professor FERGUSON laid before the Society two small bodies, resembling leaves in size and shape, which had passed from the bowels of a young woman, after a dose of castor oil. The patient had long suffered pain in the left hypochondrium, which had ceased since these substances had been passed.

Case of Polypus Uteri.

Mr. HARKIN read the following case:-

Margaret Devlin, aged 50 years, married, and mother of three children; her husband dead for 13 years; of spare anaemic habit, and melancholic temperament. Had enjoyed uninterrupted good health till within six years previous to my visit. At the commencement of that period, however, the menstrual discharge ceased, and her health became much impaired.

For about four years, a copious and constant discharge of thin sanguineous looking fluid took place from the vagina, accompanied, at intervals, by what the patient described as "pure blood." Cold and astringent injections were then used, which had the effect of putting an end to the discharge; but its disappearance was followed by severe attacks of pain in the hypogastric region, and general constitutional irritation, from which she very slowly recovered. After this time, she consulted several practitioners, who treated her for various diseases of the uterus, with little relief.

I was called to see her at eleven o'clock, p.m., on the 10th February, 1842,—the messenger stating that "the woman's bowels had all come out" I found her lying upon her back, her legs widely extended, and a large firm globular tumour, as large as a good sized turnip, protruding from the vagina. The tumour very much resembled an inverted uterus, and great difficulty was experienced in introducing the finger to make the necessary examination—the os externum being completely plugged by the tumour. The woman's pulse was very feeble, her extremities cold, and the bedding was quite saturated with blood; I immediately administered a stimulant, which had the effect of rousing her from a state of syncope, and sent a messenger for Dr. Burden, who kindly favoured me with his advice.

After as careful an examination as was possible, and after obtaining from the patient the history of the case, we concluded that we had a pediculated polypus to deal with, attached to the os uteri; and determined upon its removal by means of the ligature and double canula. However, on grasping the tumour firmly for the purpose of passing the tube and ligature around it, the mass separated, the connecting fibres having given

way, and without haemorrhage or any other unfavourable symptom, the woman recovered.

The tumour weighed 1 lb. 9 $\frac{1}{4}$ oz.; its smaller circumference measured 11 $\frac{1}{2}$ inches, its greater 15 inches.

Upon cutting into its substance it appeared to be composed of fibro-cartilage, deposited in layers of a circular form, and white pearly colour.

The great point of interest in this case, irrespective of its unusual dimensions, was the difficulty which we met in making an exact diagnosis, and this applies to many uterine tumours; but the globular shape, the density and the weight of the tumour, and the absence of any trace of the fallopian tubes, and the history of the case which completely shut out any idea of its being an inverted uterus, decided our opinion. The converse, however, might occur, and it would be a sad misfortune, and one not at all unlikely to happen, to mistake an inverted uterus for a polypus, and not discover our error until it was too late to rectify it.

On Extra Capsular Fracture of Neck of Femur.

Professor GORDON read the following paper:-

William Mitchell, aged 58, but apparently older, a pensioner, admitted into the Belfast General Hospital, February 12, 1859. He states that his habits are temperate, and also for some time past he has been subject to a chronic cough and shortness of breathing. On the evening previous to admission when passing along a dark lane, he was tripped by a rope, fell against the curbstone, and broke his thigh. On admission into hospital, the long splint was applied. On visiting him on the following day, there was no deformity, no shortening of the limb, nor complaint of pain in the thigh or hip.

15th—As the difficulty of breathing had increased, obliging him at intervals to assume the sitting posture, he removed the perineal band to be enabled to sit up. To permit him, therefore, to do so with greater facility and comfort, the long splint was taken off, and the limb placed on the double-inclined plane. This did not cause him pain, at least he made no complaint, nor was the fracture apparently disturbed.

16th—His expression is maniacal; he is talking incoherently. During the night he made several attempts to rise out of bed. The upper fragment of femur can be felt distinctly, about three inches below the trochanter major, causing the thigh at this part to be much bowed outwards. Measurement along the convexity does not show any shortening of the limb, but that of the concavity, or inner side of thigh, is shorter by two inches at least. Pulse 88, soft; skin moist; bowels open; tongue slightly furred; respiration 40. The limb was extended, and a pad and splint applied to the outer side of thigh, which was still kept on the double-inclined plane, and a broad piece of linen, with straps attached, was laid along the outer side of opposite thigh; some of the straps were carried behind, and others in front of the thigh, and being tied, prevented the outward displacement.

20th—Is becoming insensible; the forehead is covered with an abundant perspiration; pulse 108.

He died on the night of the 21st, or on the 9th day after the accident; and on the following day the femur

was removed from the thigh; much blood was effused amongst the various tissues of the limb, even down to the knee. At first sight, the accident seemed to be a fracture of the upper third of the shaft of the femur, running obliquely upwards to the anterior part of the root of its neck; the capsular ligament attached to its end, preventing displacement upwards; but on removing this ligament, and the other soft parts adherent to the bone, it was found to be an extra-capsular fracture of the cervix femoris.

I exhibited at a former meeting of this Society this fracture, when the periosteum was on the cervix; then the line of fracture on the fore and upper part of the neck was so indistinct as to be incapable of detection, either by the sight or touch, and it was only by moving the fragments that the whole of its course could be traced. Now, however, when the parts have been boiled, we are able to perceive the full extent and true nature of the injury. The more carefully I studied the case, the more and more interesting it became, as affording us an example of extra-capsular fracture, which may have an influence in settling disputed points, by corroborating the views entertained by some, whilst at the same time it modifies, or is opposed to the statements or conjectures of others.

The fracture may be said to consist of four main fragments, in each of which may be included several minor ones.

The first consists of the head and neck. The second consists of the trochanter major; the posterior intertrochanteric line; part of the posterior surface of the lesser trochanter; and a triangular portion of the upper end of the shaft, which may be easily determined by a point on its external surface $3\frac{1}{4}$ inches below the base of the trochanters; and from the point thus indicated by drawing two other lines, one passing upwards and inwards, and ending where the base of trochanter joins the neck, the other, upwards and backwards to the lesser trochanter. We have thus a portion of the anterior external, and posterior surfaces of the shaft attached to the trochanter major, and posterior intertrochanteric line. The third portion consists of the lesser trochanter, and a small elongated triangular piece, running obliquely downwards and backwards to the linea aspera. The fourth portion consists of the remainder of the shaft.

Let us now trace the line of fracture. On looking downwards at the centre of the upper border of the trochanter, where the neck of the femur joins it, impaction commences. The fracture from this point runs obliquely downwards and backwards, internal to the digital fossa; after that it corresponds exactly to the junction of the neck with the posterior intertrochanteric line, and on reaching the upper and back part of the root of the lesser trochanter, it bifurcates, the posterior division running along the middle branch of the linea aspera, whilst the other branch runs above the lesser trochanter, separating it from the neck, and having gone forwards so as to be on a vertical plane anterior to the lesser trochanter, it again divides into a descending and ascending branch. The former running in front of the lesser trochanter, and passing obliquely downwards and backwards joins the branch behind it,

or that which is in the middle branch of the linea aspera. Thus we have the lesser trochanter, with a triangular piece of bone attached to it, completely isolated. At the place where the fracture passes above the lesser trochanter, separating it from the neck, there were several comminuted pieces of bone. The fracture after that takes a course upwards and outwards along the inner border of the anterior intertrochanteric line as high as the base of trochanter. There the impaction ceases, the remainder of the fracture along the upper and anterior part of the root of the neck did not suffer the slightest displacement. Anteriorly, where the intertrochanteric line joins the trochanter, the fracture of the upper end of the shaft commences, whence it runs obliquely downwards and backwards, and joins that proceeding from the lesser trochanter, $3\frac{1}{4}$ inches below the base of the greater trochanter. Besides these complete separations, we find partial fractures or fissures, which have, as I shall presently attempt to show, an important bearing on the mode by which fracture of the trochanter is produced. In the upper and external surface of the trochanter major there is a letter H like fissure, the upper limbs of which ascend over the upper border of the trochanter, and join the main fracture opposite to the commencement of the impaction, whilst the lower limbs pass half way down the trochanter. The extent of space within these vertical limbs is nearly one-third of the transverse breadth of the trochanter. There is also another fissure in the upper part of the posterior intertrochanteric ridge, which ends in posterior and superior angle of the greater trochanter.

Previously to the patient becoming delirious, I was fully satisfied with the statement made by our intelligent house pupil, Mr. Moore, that there was merely a fracture in the upper third of the femur; there was not the slightest appreciable deformity, nor did the patient make any complaint; and even when, in his delirium, he had disarranged the relation of the fractured surfaces, and even when I found the point of the lower end of the upper fragment displaced outwards $3\frac{1}{4}$ inches below the base of trochanter, the thought of the fracture being extra-capsular never occurred to me.

As the conclusions at which I have arrived from the study of this specimen of extra-capsular fracture are in several respects not in accordance with those of others, I shall first consider the question of shortening of the limb. Dr. Smith says, "From the opinion, therefore, of Rodet, that there may be no shortening of the limb in certain cases of fracture external to the capsule, I must altogether dissent...for in all such injuries there is impaction, and if so, there must inevitably be shortening of the limb, even though there be no loss of obliquity in the neck of the femur, no separation or displacement of the fractured trochanter, no laceration of the fibrous structure." (Smith on Dislocations and Fractures, pp. 18, 19). Now, the question at issue is this, -Is Dr. Smith right in maintaining that there is, in every instance of fracture of the neck of the femur, external to the capsule, a primary and immediate shortening, and Rodet wrong in supposing that when the trochanter and the fibrous tissue

surrounding it is uninjured there is no shortening? I am fully sensible of the difficulty of giving a positive value to the precise signification of the term shortening. If by the words "primary and immediate shortening," Dr. Smith means a shortening that can only be detected by the most accurate measurement,—a measurement that will detect shortening to the extent of a line, or a line and a half at the utmost,—then I should say that this specimen will corroborate his statements. If, on the other hand, he means to imply a primary and immediate shortening, unequivocally capable of being detected in the living subject, and leaving no doubt on the mind of the surgeon that there is shortening. Then I say that this specimen will not warrant such a positive statement. On the fore and upper part of the neck there is not the slightest displacement, and even behind and below at the base of the lesser trochanter, where the impaction is best marked, it is not more than a line and a half at the utmost. Now, is it possible that such a slight degree of impaction could cause a primary and immediate shortening capable of detection in the living? I think not. I am, therefore, bound to adopt the following inference, that this is an undoubted example of extra-capsular fracture, in which there was scarcely any eversion of the limb, and no shortening capable of being detected by the most accurate measurement. But, in addition to this, it presents us with an example of an extra-capsular impacted fracture, in which shortening might be referred to two different conditions of the same fracture. The first, is that to which I have already referred, viz., the impaction of the neck of the femur. The second, is the oblique fracture through the shaft, which was produced in the following manner. "When the lower part of the neck was driven into the shaft by the shock, it became wedged between the posterior part of the base of the lesser trochanter and the inner surface of the shaft, and instead of detaching the posterior part of base of the lesser trochanter and inferior part of posterior intertrochanteric line, it caused a very oblique and complete fracture of the shaft itself. Although anteriorly and internally the upper part of the shaft is detached from the base of the neck, almost as high as the anterior and internal part of the base of the greater trochanter, and after that running outwards and downwards for $3\frac{1}{2}$ inches, until it meets with that proceeding downwards from the lesser trochanter, still there was no displacement in the vertical direction, as the attachments of the capsular ligament in front, and the insertion of the gluteus maximus behind prevented it.

Another interesting question in connexion with this fracture is the *modus operandi* of the force causing it. With the first part of Dr. Smith's explanation, I entirely agree, but the latter I cannot adopt. He says, (*Ibid.*, p. 17) "What occurs appears, in fact, to be this—the neck of the femur is, in the first instance, broken by the fall upon the hip, and then driven into the cancellated tissue, between the trochanters, by the weight of the body, and the prolonged action of the shock; but as soon as the neck of the bone is broken, the femur is rotated outwards, and even before the action of the first impulse has ceased. Thus the posterior inter-

trochanteric ridge being thrown forwards, is forcibly driven against the back of the neck of the femur; two forces, therefore, combine to produce the fracture through the intertrochanteric space, one of which consists in the impaction of the cervix into the shaft, whilst the other is found in the collision which takes place between the broken neck of the bone and the posterior intertrochanteric ridge." In this, and several other specimens in Queen's College Museum, I do not find that the posterior intertrochanteric ridge lies in contact with the posterior surface of the neck, and, therefore, cannot admit that it is driven forcibly against the back of the neck, and produces the fracture through the trochanter; for if this were the case, would we not find the back of the neck lying against the ridge, and probably a depressed fracture in it? The fracture through the trochanter occurs antecedent to the impaction, and, therefore, antecedent to the inclination forwards of the posterior intertrochanteric ridge; and what seems to me to have occurred, and I think is capable of demonstration in the recent subject, was as follows:—the patient, on being tripped, fell upon the posterior and outer surface of the greater trochanter, which was, therefore, thrown inwards and forwards; the impulse, therefore, instead of being received equally on all parts of the base of the neck, fell, in the first instance, on its posterior part at its junction with the greater trochanter and posterior intertrochanteric ridge, which giving way, impaction occurred, and after that the remainder of the fracture. The extent of the comminution and impaction will vary according to the fragility of the bone, and the amount of violence applied. The impaction of the neck will have unquestionably an influence in determining displacement of the trochanteric fragment; but, from the effects of blows on the trochanters, as witnessed on the dead body, the sequence of events seems to be as follows—direct lateral violence produces primary and immediate comminution of the trochanter, fracture of the base of the neck, impaction, additional fractures, and then displacement. Violence applied from behind forwards, produces primarily fracture and displacement inwards and forwards of the trochanter, impaction posteriorly, fracture of the base of the neck generally, and then displacement and fracture from the impaction. When the trochanter strikes the ground, it will be for the instant fixed, perhaps at this time, the extremity being in projectile force, acts obliquely, as a lever, in breaking up the base of the neck. I think this specimen points to the impaction acting powerfully at two points, viz.—at the upper part of the neck corresponding to the prominent ridge which bounds superiorly the digital fossa. It is at this part and a little in front of it, that the starting point of the fracture of the trochanter originates. The second point is, where the neck joins the lesser trochanter. There the compact tissue of the neck in expanding to form the lesser trochanter, is less thick than higher up, and when it gives way and enters the cancellated structure, it drives backwards the base of the posterior trochanter and the intertrochanteric ridge. The impaction thus occurring simultaneously above and below, causes further detachment of the posterior part of the

trochanter, even before the broken edge of the intertrochanteric ridge could possibly have come in contact with the posterior surface of the neck. Now, in this instance, the wedge-like action of the base of the neck at these two points, acting as it were differently, and instead of mutually contributing to detach the trochanter, have caused two different fractures. That above is the usual fissure or fracture of the trochanter; that below, instead of acting in a posterior direction on the lesser trochanter and posterior intertrochanteric ridge, has splintered the upper part of the shaft of the femur.

TWENTY-FIRST MEETING.
26th March, 1859.

Case of Injury of Head.

E. M_____, aged 20 years, was admitted into hospital on the evening of the 17th instant, from a severe injury of the head which he had just sustained. He stated that about an hour before admission, he had been spoking the fly-wheel of a steam-engine he was starting, while using considerable exertion, the wheel suddenly turned rapidly round, by which he was precipitated with great force into the wheel-pit, five feet deep, alighting on his head upon an irregularly paved surface. He at once recovered himself, and would have proceeded again to his work, had he not perceived that his face and neck were covered with blood, he was quite collected, not at all stunned, and walked a considerable distance to the hospital, to have his head dressed.

On examination, it was found that a portion of the skull at the anterior inferior angle of the left parietal bone was depressed beneath a lacerated wound of the integument, and that this piece of bone was about $1\frac{1}{2}$ inches by $1\frac{1}{4}$ inches in extent. On further examination, this portion was seen to be actually stove in, and depressed fully half an inch. At the posterior inferior part of the same parietal, another fracture, to the extent of about half an inch, was found also to be deeply depressed.

Dr. MOORE, in my absence, saw the case, and very properly elevated and removed the depressed portions of the fractured bone; during this operation, and previous to the patient's arrival at the hospital, there was considerable hemorrhage from the torn branches of the meningeal artery. A dossil of lint was placed upon the bleeding vessel, and a light water dressing applied to the wounds. When I saw the patient at 9 o'clock, p.m., two hours after the receipt of the injury, he was perfectly conscious, and complained merely of the smarting of the cuts in his head. Pulse was then 86. Early next morning I found he had rested tolerably well, and his bowels had been freely opened by the purgative and the enema, which had been exhibited; pulse 112. He told me he was "rightly," and felt little or no pain. On that day, about one o'clock, after he had exhibited some restlessness, he suddenly was seized with a convulsive attack, followed by unconsciousness, which lasted for about twenty minutes. When I saw him immediately after, he had recovered, and seemed calm and collected—pulse, 120; and he only exhibited

some involuntary tremor of the limbs, and slight twitching of the muscles of the face. I had the dressings and dossil of lint removed, and directed cold applications to be constantly kept to the head. In the evening, I found him still quite intelligent, pulse, 126; he had, during the interval from my former visit, thrown off some bilious matter; and, I should remark, that he had had occasional vomiting from the period of his admission.

On the morning of the 19th, Saturday, I was informed that he had passed a fair night, and had vomited only once. He seemed unchanged, save that there was almost constant tremor of the voluntary muscles; he was perfectly conscious and capable of explaining his sensations; he complained of headache, but referred that to the wounds. On visiting him at five, p.m., I found that while he had not had any return of the convulsions of Friday, the muscular tremor had increased; and that, although he was evidently conscious, he could not speak or open his mouth to exhibit his tongue according to his desire, and yet, when requested to take some drink, he directly sat up and swallowed some milk and water. The following day, Sunday, he was dull and could barely articulate "no." He also swallowed with difficulty, pulse, 126; breathing occasionally much hurried, but usually under 30 in the minute; pupils contracted; had strabismus of left eye; still he was evidently conscious when spoken to. That night he became violently delirious, and required restraint. Monday, the 21st, I found him restless, and incessantly straining his eyes in the attempt to look upwards, and to the left side. He had also an increase of that twinkling of the eyelids, that I have often seen in the last stage of fever, when fatal. From an early period, there was the muscular tremors and twitchings to which I have referred, but there never was sign of paralysis in any of his limbs; and the bladder and bowels acted naturally up till a short time before his dissolution. During the night, he gradually sank, and died without any return of the convulsions, at three, a.m., of the 22nd.

Post-mortem.—On removing the scalp, the site and extent of the injuries of the skull came into view. On the anterior inferior angle of the left parietal bone, an aperture to the extent of fully half-a-crown, and with comminuted edges, was exposed, within this the space was filled by a firm clot of blood. On the posterior inferior part of the left parietal an opening large enough to admit the end of the little finger was observed,—it was from this several small comminuted portions of bone had been removed. When the calvarium was removed, it was found that all around the edge of the large anterior fracture, the *dura mater* was separated to the extent of $1\frac{1}{2}$ inches, fully, and was bulged inwards for more than half an inch, by a firm clot. On the inside of the posterior injury, the internal table was driven in to the extent of nearly a square inch, the *dura mater* also separated from the bone, but was not torn. When the brain was removed, the *dura mater* in the occipital fossæ, and in the right temporal fossa, was found to be detached and very easily separable. The brain itself presented on the surface of the left hemisphere a considerable depression, corre-

sponding to the part where the *dura mater* was detached, and bulged in by the clot of blood. The arachnoid was very slightly opaque, and there was a small quantity of sub-arachnoid fluid. The cerebral mass, divested of the arachnoid, seemed paler than natural, and felt firm. On slicing the hemispheres the structure was found to be acutely congested—the vascular puncta being exceedingly numerous, the blood oozing from them in minute drops for some time after the division of these capillaries. The lateral ventricles were natural in appearance. The outer side of the posterior lobe of the cerebrum, at a point corresponding to the posterior fracture, had a portion, about the size of a small walnut, broken up, softened and infiltrated with blood, and, on the cerebellum, immediately adjoining this part, there was a bruised point, of the size of a field-bean. These were the lesions observed. There was not fracture of the base of skull.

Remarks.—The case briefly stated is one of those instances occasionally met with where the brain sustains a most severe and usually fatal injury, without any urgent symptoms being manifested at the outset; and is in striking contrast with others when an apparently trifling injury is attended by the most urgent immediate effects, and finally by fatal results—sometimes recovery. Here we had most extensive injuries, yet, as we have seen, the subjective signs were not manifested for some time, and then, indeed, very slowly. From the first, there had not been any symptoms of concussion, and, throughout the progress of the case, though there was considerable pressure on the brain, first by the depressed bone, and next by the effused clot, there was not any evidence of compression. The absence also of paralysis, was another striking feature in the case.

The post-mortem examination shews that the cause of death was the acute congestion of the entire brain, and the softening and effusion that occurred in the posterior part of the left hemisphere.

The remarkable vascular condition of the brain, (I refer to the multitude of bleeding points revealed by every slice that was made) I have only seen in cases of death resulting from yellow fever, and where head symptoms had prevailed, and when death took place very early in the disease.

TWENTY-SECOND MEETING.

2nd April, 1859.

Extirpation of Eye.

The PRESIDENT exhibited an eye, which he had removed that morning in consequence of long-continued irritative inflammation, and gave the following history of the case:—

J. S., aged 49, a mechanic, upwards of twenty years ago received an injury in his right eye, by a chip of iron having been projected against it with great force. A small portion of the metal was removed, immediately after, from the margin of the cornea, and gradually the eye recovered, so far as to be able to distinguish print, and to see small objects by the assistance of a glass.

This state continued for some months, but at the end of a year and a half after the accident, vision was completely lost in that eye. During the subsequent ten years the injured eye gave no trouble: but since that time, it has been attacked, at intervals, with severe inflammation, during which attacks the patient suffered great agony, and, for the last four months, the distress has been so great as to incapacitate him for any employment. Under these circumstances, it was deemed advisable to remove the diseased globe. This was done while the patient was under the influence of chloroform; the conjunctiva was incised with a knife, and the curved scissors were then carried rapidly around the eye-ball, the muscles, optic nerve, and other attachments being divided close to it. There was not much hemorrhage, a little cold water and the infusion of matico sufficing to allay the bleeding; the part was dressed with a light compress of wetted lint and a bandage.

On laying open the eye-ball, it was found that all of the normal internal structure, with the exception of the choroid, had disappeared, and was replaced by a sepia-coloured fluid. The choroid was thickened, and adhered firmly to the sclerotica by layers of superimposed lymph, and the inner surface of the sclerotica, when these were peeled off, exhibited a beautiful rose tint. On washing the eye in a little water, a small piece of metal as large as a mustard seed was discovered: this was, doubtless, the cause of all the mischief that had ensued to the eye, and of all the patient's lengthened sufferings.

Diseased Mamma.

The PRESIDENT also brought under the notice of the Society a diseased breast, which he had excised a few hours before. The patient, a woman aged 82 years, though looking much younger, had always enjoyed excellent health till about three years since, when she had inflammation, and, as she described, likely suppuration of the left mammary gland. This abscess soon closed, and, for some eighteen months, it gave her no annoyance. About a year since, she felt a small tumour in the centre of the same breast. This gradually increased in size, till the entire gland became engaged, but without giving any pain. Two months ago a couple of vesicles appeared, one on either side of the nipple. These had been opened by a needle, and soon after a fungoid growth sprung forth, since which time the patient has felt a severe burning, shooting pain in the part. She was admitted into hospital on the 29th March, when the tumour was found to be about the size of the largest orange, of a deep puce colour, with many enlarged veins radiating over its surface. The site of the nipple was occupied by a pink fungoid growth, the size and shape of a large mushroom. This was covered by a smooth polished membrane, and was free from any sanguous discharge. The tumour was quite moveable over the subjacent parts, though the integument adhered to the greater part of its circumference. The patient's health being good, the axillary and cervical glands being quite free from any disease; and, as her sufferings were daily increasing, it was resolved to remove the entire morbid mass. As it

was feared that there would be profuse hemorrhage, it was deemed advisable not to add also the depressing effects of chloroform. Mr. Browne, therefore, determined to try the effects of local anaesthesia, and chose cold, with the view both of allaying the pain of cutting, and of avoiding the risk of profuse bleeding. Pounded ice, inclosed in a thin cloth, was therefore applied for about twenty-five minutes, when the integuments were found to be becoming white, and were insensible to the prick of a pin. A couple of sweeps and a few light touches of the bistoury sufficed, in five or six seconds, to remove the diseased structure. During the use of the knife the patient did not complain of any pain, and blood did not flow, but merely trickled forth for a brief period; the venous blood oozing out, thickened and very dark coloured. Cold and then tepid water was applied to the part, and, on the return of the circulation, three vessels were ligatured; the edges of the wound were brought together by three points of metallic suture, strips of dry lint and a compress, with bandage. In an hour after, smart haemorrhage took place, which required the application of firm pressure and exposure for two hours.

This case, he considered, illustrated the benefit to be derived from cold as a local anaesthetic, where applicable, and where chloroform could not properly or safely be used.

A section of the tumour showed it to consist of a series of cysts in the glandular structure, surrounded by a capsule, as it were, of encephaloid deposit. These cysts at first seemed to be filled with colloid matter, but, on closer inspection, they were observed to contain a straw-coloured fluid within the usual lining membrane.

Uterine Hydatids.

Mr. JOHNSTON read the following particulars of a case attended by Dr. Hunter, Townsend Street:-

Sarah Molyneux, aged 21; married one year; four months advanced in pregnancy, as supposed; having menstruated last in November, 1858. Enjoyed good health till menstruation ceased; from that period has suffered much from sickness, without any positive ailment. On Wednesday, 16th inst., hurt herself pushing or lifting a large stone. Same evening was attacked with pains in the back and flooding, both continuing all night.

Dr. H. saw her on Thursday morning, and, finding the flooding slight, directed her to keep her bed, and gave her 30 drops every fourth hour of a mixture composed of three drachms of aromatic sulphuric acid and two drachms of laudanum. On Sunday morning, both haemorrhage and pains had been absent for a considerable time, and neither returning till Thursday 24th, at eleven o'clock, p.m., the patient, in the meantime, expressing herself as very strong and well. Dr. H. saw her about half-past six o'clock on Friday morning. She had flooding and pains all night. On examining, found it difficult to make out more than the situation of the os uteri. The upper part of the vagina was filled with clots, very little escaping outwardly. The loss of blood evidently being by the accumulation of clots, which

were expelled at intervals. Shortly after making an examination, a gush of fluid and clotted blood took place, and, judging from the haemorrhage that it would be useless to arrest the threatened miscarriage, he plugged the vagina, applied cold, and gave ergot and borax. The pains becoming severe, he removed the plug for the purpose of examining, and found the os uteri sufficiently dilated to admit the point of the finger. On introducing the point of the finger, he felt a substance presenting—too firm for a clot and too rough for the membranes. On carefully examining, he came to the conclusion it was a case of *placenta prævia*, and sent for assistance. The patient getting low, he gave a stimulant, and the pains continuing, the plugging was forced out suddenly, and a large mass of hydatids appeared at the os externum, which was soon succeeded by another mass. The haemorrhage ceased, and the patient afterwards progressed favourably.

Professor REID presented the following

Cases of Aneurism; With Remarks.

Having four cases of thoracic aneurism at present in the Union Hospital, in each of which there is some peculiarity in the symptoms, a few observations upon them may be acceptable to the members of the Society.

I shall commence with one in which the presence of aneurism is rather a matter of inference than of proof. When thoracic aneurism has made its way into a locality where it can be seen and examined, its diagnosis is generally easy, and it loses somewhat of its interest. It is otherwise, however, when it is concealed from sight and touch, and when the symptoms it produces may, as in the present case, be caused by other kinds of tumor within the thorax.

This man, on admission, stated his age to be 37, but he looks at least fifteen years older. He has always been employed lifting and carrying heavy goods to his carts on the quay, and for several years past has been subject to cough, and pains about both shoulders, the latter of which often caused him to knock and press his shoulders against bags or posts in the shed, to obtain relief. These pains were felt at all times of the day, and he thinks they immediately disappeared on his putting on flannels; but has observed them to return "with a dart," if he left off the flannels for half an hour. He has never been intoxicated three times in his life, although generally taking stimulants daily, and has never had acute rheumatism. During the last eighteen months his cough and dyspnoea have increased, and the expectoration has been repeatedly mixed with blood. About five months ago he entered an hospital in another town, and remained in it till a few weeks before entering the Union Hospital. During his entire stay there, he says that attempts were made, every few days, to pass a sponge saturated with a solution of caustic, through a tube, into his larynx, and that he believes this did him harm. He has often suffered from pain in his left ear on going to bed, which was immediately relieved by turning on his right side. There has never been any numbness felt in either arm, nor oedema of any part. He felt some difficulty in swallowing, for the first time, about ten days before admission, which required him to take his food in a

softer state than usual. His bowels have been regular, and he has no difficulty in passing urine, which is of specific gravity 1,015, and free from albumen. He says he is much annoyed with flatulence in his stomach.

On admission to our hospital, he complained chiefly of the troublesome cough and dyspnoea, and pointed to the lower part of the trachea as the seat of all his ailments. His face was swollen, his cheeks (especially the left) flushed, his eyelids puffy, the conjunctivæ injected, and both pupils considerably, but equally dilated. There was some fulness at the base of the neck, and over the first bone of the sternum, and both jugulars were swollen. His voice was hoarse, and at times whispering. He had a loud, ringing, stridulous cough, the sound of which indicated that the cause of the stridor was situated low down in the trachea, or behind upper part of sternum, and that it was an instance of Stokes, "stridor from below." His expectoration was composed of a viscid mucopurulent fluid, considerable in amount, and containing much florid blood. The right side of the chest was almost quite immovable during respiration. When a finger was passed in behind the upper bone of the sternum, a rather hard and very indistinctly expanding tumor was to be felt, but no tumor or pulsation was to be felt or seen at any intercostal space at either side of the sternum. When the hands were placed between the scapulæ, and over the sternum, no impulse was to be felt; but when I applied Dr. Green's test, of placing the chest in profile, a slightly heaving impulse was to be seen. The upper part of the right side of the chest, next the sternum, was duller on percussion than the same locality on the left. The stethoscope revealed, over the upper part, and to the right of the sternum, a distinct double sound and slight impulse, but no murmur. This double sound diminished in intensity as we approached the heart, the double sounds of which were feebler than those heard above; and no murmur was to be heard at either the aortic or mitral orifices, or in the subclavian or carotid arteries. A double sound is also heard from the occiput to the sixth dorsal vertebra, and between the spine and margin of right scapula, but no murmur. His pulse is 80, regular, and equal in both radials. At the apex of the right lung the natural respiratory murmur was replaced by a loud bronchial breathing or stridor, which was most distinct during expiration; and a similar condition existed behind. Lower down at the base a feeble respiratory murmur was heard, presenting thus a marked contrast to the puerile respiration heard over the entire of the left lung. His respirations are regular, about 24 each minute. With such a group of symptoms, it is evident that the diagnosis lay between aneurism or the presence of some other tumor behind the sternum. The cough, the stridor, the double sound, the immobility of the side, the dysphagia and impulse, have all been produced by tumors that were not aneurismal, and therefore could not be relied on as diagnostic of an aneurism in this case, especially when he stated that one of his sisters had died of some form of cancer, although he was free from any external tumor.

There were, however, two circumstances connected with this man's history, which, associated with the

symptoms I have just enumerated, warranted me, I believe, in deciding that he suffered from an aneurismal tumor. These were—first, that he always experienced relief from the pain in his left ear by turning on his right side; and the second is, that he now finds the cough, dyspnoea, and stridor so much relieved by lying on the right side, that he almost constantly assumes that position.

These two facts, I think, indicate that the tumor is moveable, to some extent, by its own weight, which could not likely occur were the tumor one of those that occasionally form in the mediastinum.

With respect to the portion of the aorta that is involved—whilst fully alive to the difficulty of deciding such a point, yet I believe, that the pains having been felt in both the shoulders, the stridor and other tracheal symptoms, the double sounds to be heard over the upper portion and to the right of the sternum, the immobility and change of the respiratory sounds, with dulness at apex of right side, all tend to indicate that it is the ascending portion, and chiefly the arch, that are implicated; but both pupils remaining of equal size, with no pulsation at any intercostal space, would, I think, justify the conclusion that the tumor, on either side of the medial line, cannot as yet be very large. This man has been in hospital for ten weeks, and his treatment has consisted in confinement to bed, a nutritious diet, with opiates, and regulation of the bowels. Under this plan almost all his symptoms have been relieved. The cough and stridor are greatly less, the blood has entirely disappeared from the sputa, and he has no difficulty whatever in swallowing; indeed he says he would be quite well, "were it not for the cough and the wind in his stomach." His appetite, he says, is good, but he is steadily emaciating since his admission, without there being any severe pain or waste of any kind to account for it. We might, therefore, infer that the tumor is pressing on the thoracic duct, and thus depriving him of nutriment.

SECOND CASE.

In the second patient, there is no doubt respecting the existence of an aneurism, but still there are some points of interest connected with his symptoms. His age is about 70. He has been several times a patient in the Union Hospital, in consequence of a troublesome cough and dyspnoea, with severe pains about his chest and shoulders, which were sometimes felt on the right side, and at other times on the left; but his intelligence is so much inferior to that of the last patient, that no great reliance can be placed on the accuracy of any history he would give. His employment was that of a turner of wood, and he admits that he lived rather freely.

On his last admission to the hospital, his voice had become so hoarse, and his cough had acquired that peculiar ringing and stridulous sound, that I suspected an aneurismal or other tumor to be the cause of all his sufferings and symptoms. I consequently made repeated examinations with reference to the presence of an aneurism, but failed in finding any symptoms of it, till about two months ago, when I detected a double sound over the upper part of the sternum, without any

murmur. In a few weeks afterwards a pulsation could be felt and seen between the second and third left intercostal spaces, where a double sound was now also to be heard, but without murmur. This double sound became feebler as we approached the heart, and markedly so at one spot. The sounds of the heart were feebler than those heard above, and there was no murmur at either the aortic or mitral orifices, or in the carotids. Soon afterwards a soft puffy tumor appeared above the left clavicle, and the jugular vein on that side was seen distended.

For some months past he has less power in his lower limbs than usual. At present his pulse is about 80, and regular, but feeble in the left radial artery than in the right; it is quite distinct in both carotids. His respirations are quiet and regular, his cough ringing and stridulous, its sound indicating that the cause of the stridor is below. Pressure behind the sternal notch does not reach any pulsating tumor. There is marked dulness at the upper part of the left side, where the double sounds are rendered more distinct by placing the patient erect; and pulsation is to be seen and felt between the third and fourth intercostal spaces, and as far outwards as a line perpendicular to the nipple. Pulsation is also to be felt, on deep and backward pressure, between the sterno-mastoid and trapezius muscles; and there is a distinct double sound between the edge of the left scapula and spine, but none along the spine itself. He has never had numbness or oedema of either of his arms, nor any difficulty in swallowing, nor expectoration of blood; nor is he now much troubled with cough. He says he can lie on either side, but I always find him lying on his left.

Both the pupils are contracted, but the left is permanently more so than the right; and this difference in size is still more marked when both are brought under the influence of belladonna. This contracted state of one pupil in aneurism was first recorded by Dr. Walshe, but a similar state had been described, in the *Medical Gazette* for 1838, to have been produced by a hard, but not aneurismal, tumor in the neck.

The merit of fixing the attention of physicians upon its frequent association with aneurism is due to Dr. Gairdner, of Edinburgh, and it is now invariably looked for in cases of that disease. Dr. Gairdner's first case, and an attempted explanation of its cause, led to a controversy in the *Edinburgh Medical Journal* for 1856, respecting the *modus operandi* of belladonna in producing dilatation of the pupil, to which, as the pupil is contracted in three of my patients, and that I had applied belladonna round all their eyes, I shall allude very briefly.

It is known that the iris is composed of circular and radiating fibres, the former of which contract, whilst the latter dilate, the pupil. It is stated that the circular fibres are supplied with nervous power from the third and also the fifth cerebral nerves, whilst the radiating fibres receive filaments from the sympathetic, which joins the ophthalmic branch of the fifth, after it has passed through the Casserian ganglion; and that these filaments from the sympathetic derive a motor power from anterior roots of the spinal nerves in the lower

cervical and upper dorsal region; and that division of the sympathetic in the neck, or of the anterior roots of the spinal nerves, causes the pupil to contract, by resigning it to the exclusive influence of the circular fibres supplied by the third. Now, it is known, that when the third nerve is destroyed, incomplete dilatation of the pupil takes place, and that a complete dilatation follows the application of belladonna to the eyebrows. It has, therefore, been asked, does belladonna cause dilatation of the pupil by paralysing the ciliary branches of the third pair, which supply the circular fibres, or does it act by exciting the motor filaments which join the fifth from the sympathetic and anterior roots of the spinal nerves, and thus stimulate the radiating fibres to contract, and thereby dilate the pupil?

It occurred to me, that as there was no evidence of disease of the brain in any of my patients with contracted pupils, that if I brought all their eyes under the influence of belladonna, the result might support one or other of the views in the foregoing question; for I thought that if belladonna acted solely by paralysing the third nerve, which supplied the circular fibres with motor power, its application to the eyebrows should be followed by an equal dilatation of all six pupils, as the radiating fibres in what we may call the aneurismal eyes would then have nothing to oppose their contraction. Equal dilatation, however, did not follow the application of the belladonna, for in each of the patients the contracted pupil, although dilating very considerably, was still markedly smaller than the other; nor have I been able to dilate it to the same extent as the sound eye by several days' application of the belladonna.

Now, it has been observed, that when disease or injury had paralysed the third nerve, complete dilatation of the pupil did not take place, but that it would do so if belladonna was subsequently applied; which would certainly imply that it had the power, by its action on the radiating fibres, to cause the latter to contract.

Dr. Benjamin Bell, of the Edinburgh Eye Infirmary, who advocates the stimulating theory of the action of belladonna, considers that in aneurismal cases the pupil is not fully dilated by it, because the circular fibres of the iris are then in unimpaired power, whilst the radiating fibres have their power of contraction impaired by the pressure of the aneurismal tumor, and that therefore the relative power of the circular fibres is increased. In one of the patients, whose freedom from suffering enabled me to observe the effects of belladonna more accurately and continuously, I found that when it was applied equally to both eyelids, the sound eye was completely dilated, and the aneurismal one markedly less so; but when I applied the belladonna for several days around the latter, it dilated to a much greater extent than it had done at the period of the sound eye's full dilatation. Now, if the belladonna acted by paralysing the branches of the third, which supply the circular fibres, as there was no disease of the brain present to prevent its action, ought not the dilatation to have been as great, on the first day, in the one eye as in the other, and is it not therefore rational to suppose that the increased dilatation was due to the

persevering stimulation by it of the partially paralysed radiating fibres? I therefore consider that the results that followed the application of the belladonna, in my cases, tend to support the accuracy of the opinion advanced by Dr. Bell. It is interesting to find, that in the case of aneurism in which the disease appears, for so far, to have chiefly implicated the arch of the aorta, the pupils are both rather dilated, and equally so; whilst in the three other cases, in which there is evidence of tumors on the side of the spine, the pupil is affected on the side where the tumor is; so that a contracted pupil, if it had been previously of natural size, might, in an obscure case, become an important sign of the presence of a tumor on the same side. And again, when both pupils are greatly contracted, as is the case in one of my patients, the application of belladonna would indicate the one that was so from the paralysing presence of a tumor.

As one pupil is occasionally smaller than the other, owing to previous inflammation in the iris, or some other cause, it will be necessary to bear this in mind, when looking for it as a symptom often present in aneurism.

In this man the aneurism appears to be enlarging very rapidly in the direction of the left thoracic cavity; but in consequence of its not coming in contact with any of the bones or nerves, it is really giving him little, if any, annoyance. Whilst in the former patient I considered that it was the ascending portion, and chiefly the arch of the aorta, that was involved, I think that the symptoms in this patient would indicate that it was the arch and descending portion of the thoracic aorta that is implicated.

My next two cases differ from those I have just noticed, in having, I believe, a different vessel in the thorax affected with aneurism; and in both of them there is much interest connected with some of their symptoms. One is a male, and the other a female.

THIRD CASE.

The male patient stated, on admission, that his age was 60, and that for the last six or seven years he has had pain in his right shoulder, and also in the neck of that side for about two years. No pain was felt on the left side at any time. He suffered from dyspnœa since the pain in the neck appeared, but had no cough till within the last six months. During the last four days, only, has he had any difficulty in swallowing, and he thinks the food is stopped about the base of the neck.

He was able to lie on either side till twelve months ago; since then he was easiest on right, till within the last few days, when he requires to sit up; for if he lay down, he would perspire profusely from pain. He has never had œdema of any part, or any expectoration of blood, or any numbness or want of power in either arm. His urine has a specific gravity of 1,025, and is free from albumen. The sternal end of the right clavicle is dislocated by a pulsating tumor behind it, which is felt not to extend across the trachea, or into the sternal notch; but an apparent prolongation of it can be felt distinctly, deep in the neck, between the sternomastoid and trapezius muscles. No pulsation is to be felt or seen in any of the intercostal spaces, and that in

the radial artery on the right side is feebler than in the left; it is distinct in both carotids. The right jugular vein is distended, but no puffiness about neck. His feet, knees, and hands are slightly livid, but free from œdema. His face is sallow, and lips pale. The right pupil is smaller than the left. A distinct double sound is to be heard at the top of the sternum and to the right of it, as also in the neck, and at the supra-spinous fossa. The heart's sounds are feeble, but distinct, with considerable pulsation in the epigastric region. No murmur is to be heard at either mitral or aortic orifice, or in the carotid arteries, or over any of the localities where the double sound is to be heard in the tumor. The respiratory murmur is less distinct at the right apex. His cough is troublesome, and the expectoration difficult; it is muco-purulent, and free from blood. The respirations are irregular in frequency, ranging from 40 to 50 at different periods of the same minute. His pulse is also irregular in frequency, ranging from 70 to 110, when counted at different portions of the same minute.

Next to deciding the site of the aneurism, the state of the respiration and pulse are the two symptoms to which, in this and the next case, I attach the chief interest, and to which I shall now allude.

For about the sixth of a minute there is perfect quietness and regularity in this man's breathing; then the respirations gradually increase in frequency and loudness, till they became so loud, especially during expiration, as to be heard several yards off, and so laboured, that every muscle appears to be acting to dilate the chest. Then the respirations become gradually less loud and less frequent, till they return to the state of quietness and regularity I have mentioned, when he will say, "Now I am quite well." After a few seconds of repose, the same process is commenced again; and this is continued, with more or less intensity, whether asleep or awake.

This man called this state "palpitation," and said that it had annoyed him much for the last three months; but it is evidently an instance of what is called "the respiratory distress of Stokes." The number of respirations would vary from 40 to 58 during a period of distress, and on other occasions from 32 to 37, when six or eight calm respirations will take place. This symptom is the cause of his greatest suffering, as he has now little, if any, pain or cough.

I have stated that his pulse was also irregular, which it is, if felt during a minute; but I found, on closer examination, that both in this man, and in the female whose case I have next to notice, there was a curious regularity to be observed in its irregularity. For example:—counting it during an entire minute, it would be about 90; but when it was counted from about what I may call the mid-way up of a paroxysm of respiratory distress to mid-way down of the same state, it would be found to number about 12, or at the rate of 70 in a minute; then it would rapidly increase to 17 or 20 in the next sixth of a minute; so that, if counted from that time till the "respiratory distress" was again mid-way up, it would be found beating at the rate of 120 or 130 in the minute; and this state of the pulse was found present from day to day.

The symptom of respiratory distress was first

observed by Dr. Cheyne, in 1816, in a gentleman who suffered under fatty degeneration of the heart; and Dr. Stokes, who first directed the attention of the profession to it, states, "that he has never seen it except in examples of fatty heart." I am not in a position to say that fatty degeneration does not exist in this man's heart, but that he is the subject of aneurism there can be no doubt; and that it is the arteria innominata is involved, I am disposed to believe from the following reasons:

1st. There has been pain for years, confined exclusively to the right shoulder and neck. The sternal end of the right clavicle is dislocated by a pulsating tumor immediately behind it, which tumor is also to be felt higher up in the neck, at the edge of the trapezius muscle. The pupil of the right eye is smaller than that of the left. The right radial artery has a feebler pulsation than the left; and the double sounds are heard most distinctly at the right of the top of the sternum, and in the site of the tumor. Again, there has been no stridor or ringing cough; no pulsation in the centre of the sternal notch, or in any of the intercostal spaces. With respect to the peculiarity of the pulse I have mentioned, I have not been able to find, in any work on cardiac pathology, that the pulse had been observed to become invariably slow during the period that the respiratory distress was most severe, and again invariably quick when the distress was least, and, I might say, absent; and as this continued day after day, and was observed also in the female patient, I think it cannot be looked upon as a mere accidental occurrence. It may, perhaps, be found by myself and others so frequently as to prove that there may be (to use an Irishism) a *regularly irregular* pulse as an associate of the respiratory distress.

This patient has now been in hospital for three weeks, and a marked amelioration of his sufferings has taken place. Within the first week he was able to lie down on his right side, with his head resting on his hand, and his elbow on the pillow. Now he is able to lie on his back, and occasionally, for a short time, on his left side. He has no difficulty in swallowing, and has little cough, and no stridor. The respiratory distress has almost entirely disappeared, his respirations being yesterday about 26 in the minute, and now, to a casual observer, partaking more of the character of sighing respiration than of the distress I have described, and which had been seen by several members of the Society during the past fortnight. The pulse has also become all but perfectly regular, and beats about 90 in the minute. This group of symptoms would, therefore, appear to be one that is not continuous in intensity, whatever may be its cause. Since its great diminution, I have observed that the thorax is now more shaken by the impulse of the aneurism, and the clavicle moved forward each time, and I fancy I observe it larger at the sternal notch; the relief to the distress may, therefore, be owing to the backward pressure of the aneurism being less.

FOURTH CASE.

My fourth and last case is that of a female, aged 59, who stated, on admission, that for five years past she

had severe pain in her right shoulder and arm, which was always most severe at night. This pain continued till about three weeks ago, when it ceased entirely. She had also had numbness of right arm. She never had any pain or numbness in left arm.

About two years ago, she had an attack of epistaxis from the right nostril, and about that time vomited a considerable quantity of blood. For years she had been subject to a "winter cough," which is, however, quite free from any stridor or ringing sound, and she is quite certain she never coughed up any blood. She has been a hard-working industrious woman, and ascribes the commencement of her illness to a severe fall. Her face is puffy, and there is also some anasarca of the lower limbs, and ascites, but no fulness about the base of the neck. The right pupil is contracted, being markedly smaller than the left, and this difference continues when both are brought under the influence of Belladonna. Both jugular veins are swollen, but there are no enlarged veins on the chest. There is no displacement of the clavicle, nor any pulsation to be felt behind the sternal notch, although she describes the tumor as being there, which she says she can push aside with her finger, and thus relieve a difficulty in swallowing that is occasionally, but not always, present. An unusual pulsation is to be felt and seen about the inner third of the clavicle, and the carotid artery there feels dilated, as also an artery crossing towards the trapezius. An indistinctly pulsating tumor is felt deep at the back of the neck, between the sterno-mastoid and trapezius muscles. No pulsation is to be felt or seen at any of the intercostal spaces. Pulsation is distinct in both carotids, rather stronger in the right, and the pulse in the right radial artery is feebler than in the left. A distinct double sound is to be heard over the upper part and to the right of the sternum, and louder than at the left of it, or over the region of the heart. It is also heard over the supposed tumor in the neck, and between the scapula on both sides of the spine, but loudest on the right. The heart's sounds are distinct, especially the second, and its impulse is also to be felt. There is no murmur at either the aortic or mitral orifices, or in the subclavians or carotids, or at any of the localities where the double sound is heard. Since her admission, she has at times been able to lie on her back; but, generally, she is obliged to rest on her knees, with her face on the pillow, inclining a little to the left side. This position appears to increase the dropsy of the eyelids, face, and chest; the right mamma is greatly more swollen than the left, and to-day there is a large anasarcaous effusion over the trachea and sternal end of right clavicle, and the ascites and anasarca of the lower limbs are increasing. The urine is acid, of sp. g. 1,020, and albuminous. I have already stated in my review of the symptoms of the last patient, that the "respiratory distress of Stokes" was present in this female also for the last two months; and that it was associated with precisely the same regular irregularity of the pulse. Resting the head with the face to the pillow, and lower than the trunk, is a position, described by Dr. Stokes, to have been assumed intentionally by some of his patients, who had fatty degeneration of the heart. Six days ago, this woman coughed up three or four sputa composed of

blood and pus; and, during the next night, she states she vomited fully a pint of blood. Although the existence of a pulsating tumor could not be so certainly felt as in the last patient, yet the other symptoms present, and the history of her ailment, tallied so exactly with his, agreeing with him also in the absence of certain symptoms, that I am disposed to believe that the arteria innominata is also implicated here, with perhaps a portion of the aorta.

She is in every respect becoming so rapidly worse, that I believe her dissolution to be not far off. When noticing a contracted state of the pupil being present in three of my cases, I already mentioned that the tumor and contraction were on the same side. With respect to treatment—these two last patients have earnestly asked for stimulants, and have reported that they were greatly relieved by them; whilst the two in whom the aorta appeared to be solely involved have shown no such craving for them.

TWENTY-THIRD MEETING.

9th April, 1859.

CASES OF ANEURISM CONTINUED.

Professor REID exhibited the heart, large vessels, and kidneys of the female patient whose aneurismal symptoms had been described at the last meeting of the Society. For several days before death, she was so exhausted as to be compelled to assume the recumbent posture; and that in consequence, the dropsy of the face and eyelids, as also that of the greatly enlarged right mamma, had diminished very much; with, as might be expected, a corresponding increase in the size of the arms and legs. Her pulse had become more regular, and the right pupil had assumed the size of its fellow. Her death was quiet, and apparently from exhaustion.

He said:—Dr. Murney, with his characteristic courtesy, had made a post mortem examination which revealed, as will be seen from his report, fatty degeneration of an hypertrophied and dilated heart, Breschet's cylindrical aneurism of the aorta and innominata, effusion into both pleura and contracted and fatty kidneys, &c.

Dr. Murney found the body was emaciated; upper and lower limbs anasarcaous; and, on dissecting back the skin from the anterior regions of the neck, the external and anterior jugular and other superficial veins were found greatly distended. In the thorax a few unimportant pleuritic adhesions, and a considerable amount of effusion, were observed on both sides. The pneumogastric and phrenic nerves of both sides were traced to the lower part of the chest—the former from the middle, the latter from the lower, parts of the neck. No peculiarity was observed, nor did those trunks appear to have been subjected in any degree to pressure. The thyroid body was at least twice its normal size, and very firm. The subclavian, internal jugular, innominate and caval veins were greatly distended with fluid blood, without any clots. The ascending and transverse portions of the arch of the aorta were considerably dilated, but the descending

portion and thoracic aorta were of normal calibre. The left carotid and subclavian arteries were also natural. The innominate, right carotid, and subclavian were a good deal enlarged, and the two latter were markedly different from the vessels of left side. The increase was, therefore, principally in the aorta and innominate, which latter was at least twice the usual calibre, and a minor degree of increase existed in the branches of this vessel. Only two patches of atheromatous deposit could be felt externally, one at the upper part of the transverse portion of the arch, the other at the termination of the innominate; but when the vessels were laid open, a most copious deposit was found; it was as yet soft, and in no part, save those named above, had undergone calcareous degeneration; it varied from the size of a pin head to even larger than a split bean, in greatest quantity in the dilated vessels, but it also extended into those which did not exceed their natural dimensions. The right coronary artery showed the same diseased action in its coats. The heart was considerably enlarged and very greatly distended with blood, it completely filled the pericardium, and was from three to four times the natural size; large clots and fluid blood were found in each of the cavities: in the right auricle the coagulum was of the amber colour so frequently met with. Both ventricles having been opened, the hydrostatic test showed the perfect competency of the aortic and pulmonic semilunar valves. The wall of the left ventricle was 7-10ths of an inch in thickness; the cavity was very considerably dilated. The heart, with aorta, and other arterie referred to, weighed 20½ oz. Deducting 2½ ozs. for the vessels, will leave 18 oz. as the weight of the central organ of circulation. The firmness and colour of the muscular structure of the heart would not have indicated the existence of fatty degeneration, but microscopic examination showed the presence of a considerable amount of such disease. The liver, which seemed of normal size, was not removed. Both kidneys were small and firm, the right weighed 3 oz., the left 3 ¾ oz., both were highly congested, and had apparently undergone some degree of fatty degeneration; time, however, did not permit of a microscopic examination of their structure, but from the casual observation made, there seemed to be sufficient healthy material for the due formation of the renal secretion. A small abscess existed at the lower portion of the left kidney, situated between the fibrous coat and the secreting structure of the gland, but not communicating with its interior.

Dr. Reid being anxious to let the members of the Society see the morbid parts as nearly as possible in the state in which they were found, the vessels had not been at first opened, and, therefore, as already stated, only two patches of atheromatous disease could be felt externally, one at the upper part of the transverse portion of the arch, the other at the termination of the innominate; but when the vessels were laid open in the presence of the members of the Society, a most copious deposit was found; it was as yet soft, and in no part, save those named above, had undergone calcareous degeneration; it varied from the size of a pin head to even larger than a split bean, in greatest

quantity in the dilated vessels, but it also extended into those which did not exceed their natural dimensions. The right coronary artery showed the same diseased action in its coats.

He then said, I have no doubt Mr. President, that those members of the Society who were acquainted with the literature of aneurism, and who have followed my description of the symptoms present in these several cases, will have observed that in forming my diagnosis I have been chiefly guided by the information derived from the researches of the late Dr. Greene, and also from the labours of Dr. Stokes; and from an able memoir by the late Dr. Holland, of Cork, in which he has carefully compared the symptoms present in Dr. Greene's cases of aneurism of the arch of the aorta, with those reported by various writers to have been observed in 24 cases of aneurism of the arteria innominata. From this comparison, Dr. Holland deduced the following rule:—"That the symptoms and signs of innominata aneurism have a tendency to occur on the right side of the body; whilst those of the transverse portion of the arch, as shown by Dr. Greene's cases, appear on the left."

Having read the abstract he gave of the 24 cases, I considered he was justified in proposing the rule I have just quoted as being applicable at least to aneurism of the arteria innominata; and it was on this rule that I based the opinion that in the woman who has since died, "the arteria innominata and perhaps the aorta was involved." In her case the diagnosis was far more difficult than in any of the others, owing to the absence of unequivocal tumor and pulsation; yet the post-mortem examination shows how much we may rely on Dr. Holland's rule, when meeting with a similar group of symptoms.

I shall briefly review those symptoms, as now interpreted by the post-mortem examination.

1. There was pain felt exclusively in the right shoulder and arm for several years. Now, pain I believe is one of the earliest, most constant, and, perhaps, most frequent symptom of aneurism. But what is its cause? I believe the majority of us associate with its presence the idea of pressure by a tumor on the nerves, or other tissues in its vicinity. But in this woman, although pain was felt during five long years, yet the post-mortem examination showed, that in her there was no circumscribed tumor to produce pressure, and that the enlargement of the aorta and innominata, were only to such an extent as we can readily imagine must be the case when all aneurisms are commencing; at which stage pain is almost invariably present, although tumor to any extent cannot as yet exist. It therefore seems to me that the cause of the pain is owing to the enlarging vessels stretching the filaments of the nerves that surround it, and this view I conceive receives support from the state of the aneurismal parts in this case, in which the disease has taken the form of an equal dilatation of the vessels for several inches, to which the name of cylindrical or fusiform aneurism has been given, and in which a sack or tumor does not exist, to produce pointed pressure on the surrounding parts.

2. Next, there was some fulness and pulsation at

sternal end of the right clavicle; whilst nothing similar was to be seen or felt on the left side.

3. There were the double sounds heard in the same locality, and behind; no doubt conveyed to the latter locality by the vertebræ. During life, I thought these were produced behind by what I considered was a pulsating tumor at edge of the trapezius muscle; but no such tumor was found after death, and I cannot satisfactorily account for my mistake, unless it was owing to the transversalis humeri artery arising, as it did, much nearer the axillary artery, and being, therefore, obliged to cross the locality where I felt this pulsation. It was the three foregoing circumstances that caused me to form the diagnosis I have stated.

4. With respect to some of the other symptoms that were present, I would remark, that we learn from the post-mortem examination that a large tumor is not necessarily present when the pupil on the same side is contracted, and that the current of motor power from the spinal nerves to the radiating fibres may be interfered with by a moderate dilatation of the aorta and innominata.

5. The microscopic examination of the heart supports the opinion of Dr. Stokes, that a connection exists between the symptoms of "respiratory distress" and a fatty heart. Had it not been for the microscope, this degeneration of the muscular fibres of the heart could not have been discovered in this case, as we had no other proof of its existence. The craving for stimulants in my two patients who had the respiratory distress, and who felt relief from their use, might be an indication of this enfeebled power of the heart, and of the propriety and safety of their use in similar cases.

6. I did not detect the effusion into the pleuræ during life; and cannot, therefore, say how long it was in existence; but having examined the right lung about a week previously, to ascertain if the aneurismal symptoms might not be caused by cancer of the lung, I think if the effusion had then been in existence, it would not have escaped my notice, as I examined the base of the lung on that side. I am therefore disposed to believe, that this effusion took place within the last few days; this, however, can be but a matter of opinion, because I was so much on the alert for aneurismal symptoms, that the others might have escaped my notice.

7. Unless we admit, that the right vena innominata was compressed by the dilated artery, nothing was found to explain the extraordinary edematous state of the right mamma—extraordinary because she generally rested on the left elbow. That such was the cause is rendered probable by the fact, that the enlargement of the breast almost entirely disappeared, as soon as the patient was forced by debility to assume the recumbent position, and thus take off the pressure of the artery on the anterior wall of the chest.

8. I have next to notice the state of the kidneys, which, as may be observed, were much smaller than natural; but as their secreting structure was not much impaired, and as the urine on several occasions was of high specific gravity, I am disposed to believe that the albumen, in this case, was due to impeded circulation, rather than to a disorganized condition of these

organs.

9. It only remains for me to allude to the statement of the patient, that she felt, and was able to push aside with her finger, a tumor at the sternal notch; I am disposed to hazard as an explanation of this, that the arteria innominata did occasionally approach too near the trachea, and that she was then enabled, by pressing her finger in behind the sternum, to push it a little aside.

Postscript.—The first of the foregoing cases died on the 22nd May, after two or three days' suffering from increased stridor, dyspnoea, and much increase of lividity. Post-mortem examination refused.

The second patient died suddenly on the 30th June, without any suffering; a small quantity of blood being found on his pillow. On post-mortem examination the left lung was found adhering to the aneurism, with a rent in it and in the pleura, through which a large amount of blood had been effused into the cavity of the latter. The parts were removed for a more minute examination by Dr. Murney, who kindly furnished the following report:

Heart normal, 9 ounces in weight; the walls of usual thickness, except those of the left ventricle, which were slightly hypertrophied. The aortic and pulmonic valves were healthy and competent. The ascending aorta was of greater calibre than usual; patches of atheromatous and calcareous deposit were found along it, at the origins of the three great vessels and also on the descending aorta, which were the only parts submitted to me. None of these patches were large. An irregular-shaped opening, which would readily have admitted the extremities of three fingers, was found leading from the convexity of the aorta to the left side of the left subclavian trunk, opposite the ligamentous remains of the ductus arteriosus. It opened into an aneurismal sac, about the size of a cocoa-nut, which rested across the spine, almost symmetrically, being somewhat more prominent to the left side; in appearance it was not unlike a small double hydrocele. In its general expansion forwards and laterally, the areolar tissue had been spread out into an innumerable series of layers of fascia. On its anterior surface, rather to the left side, a jagged irregular opening communicated with the interior of the aneurism. To this part the left pleura had been adherent, and on the giving way of the tumor, the membrane had also burst, permitting the haemorrhage which preceded death. Behind there was no such protection, as the vertebrae, &c., were in direct contact with the stratified layers of coagula. Pressure had caused the removal of nearly the entire thickness of the bodies of the second, third, fourth, fifth, and upper part of sixth dorsal vertebrae; the heads of the ribs corresponding to these bones, on both sides, were also partially eroded; that of the fifth, on left side, was entirely destroyed.

The trachea, oesophagus, and other parts which must have been more or less displaced or compressed, had been removed when the post-mortem was held; I cannot therefore speak of the effects produced by the aneurism on those structures.

The third case died on the 4th May, after several days' severe suffering. Very great oedema appeared in

region of right mamma (as in the fourth case), followed by oedema of right arm, and base of right side of neck. Considerable puffiness also appeared over sternum, with much lividity everywhere during last 48 hours.

The symptoms connected with the respiration and the pulse rendered a post-mortem examination most desirable, and every influence was brought to bear to obtain one, but without success.

Case of Chlorosis.

Professor REID then added—It may be in the recollection of the Society, that at our meeting of the 5th February, I made a communication to them respecting the symptoms that were present in a girl, who was suffering from chlorosis, in the Union Hospital. I then mentioned, that the reason for my bringing her case before the Society was, that a murmur was heard at the apex of her heart, in addition to the basic murmurs usually present in chlorosis. As soon as I had observed this unusual murmur, I asked several members of the Society to examine her, in order that the accuracy of my observation might be confirmed or not. You alone, Mr. President, had done so, when I made my communication to the Society, and you were satisfied that a murmur was present at both base and apex.

Professor Ferguson visited her a few days afterwards, and also had no doubt that both murmurs were present; although treatment had even then been beneficial to her. At the period of his visit she was suffering from an inflammatory attack of her left lung, chiefly affecting the apex; and, I feared she might, like many other chlorotic girls, be passing into phthisis. I am happy to say that the attack passed off without any injurious results, and her lungs appear now to be perfectly healthy. Her general health has since then been rapidly improving. All the uncomfortable head and chest symptoms have disappeared; her colour and strength are vastly improved; and her general stamina so much increased, that the catamenia have reappeared.

When Dr. Ferguson was in the hospital last week, seeing some aneurismal patients, I asked him to examine her again, when he agreed with me that the murmurs had disappeared from both localities. It will be recollected, that I had heard a murmur at the apex of the heart, in the patient whose hypertrophied heart I exhibited here two weeks ago; and which, during life, I had thought was the subject of fatty degeneration; and that the mitral orifice and valves were found healthy in that heart. That case, and the one whose history I now complete, tend to confirm the opinion of Dr. Stokes, that a systolic murmur at the apex is not necessarily a proof of organic disease of the mitral orifice or valves, in opposition to the opinions of those authors whose views I formerly quoted in connection with this case of chlorosis.

TWENTY-FOURTH MEETING.
16th April, 1859.

Scirrhous of Mamma.

Dr. O'HARE read the following case, and exhibited specimen.—The subject of this disease was a lady, aged 50 years, unmarried; had ceased menstruating for the last seven years; had always enjoyed pretty good health up till seven months ago, when she complained of shooting pains through her left breast and shoulder. About this time I was called in to treat her for a very prolonged attack of gastric fever, which seemed to resist all the treatment I could devise. However, she got well, and at that time she noticed a small hardened tumour in the left mammary gland, in the seat of the darting pain, which never subsided. At this time it was not larger than a small split pea, and very hard. This was in Nov., one month after the gastric fever had subsided. I lost sight of her up till six weeks ago, when I was asked to visit and treat her for an attack of bronchitis, and, upon examining her chest with the stethoscope, I detected a tumour the size of a hen's egg, which I at once believed to be cancerous, and advised its removal. To this she readily agreed, not, however, until I would first acquaint her friend, who is a surgeon of standing in the West of Ireland, He at once gave it as his opinion that the tumour should be removed, and seemed to be quite prepared for something of the kind, inasmuch as four sisters out of six of the family had cancer. The four, he said, had been unmarried; the other two had been married, and had large families, and always enjoyed excellent health, free from all appearance of cancerous degeneration, apparently, though beyond 50 years of age. He operated on two of the four alluded to, both of whom died within the three succeeding years of the operations. The third went up to Dublin, and was there operated upon by Mr. Cusack, of Steeven's Hospital, about two years ago, and still enjoys good health, without any apparent return of the disease. The fourth and last sister I operated upon on Tuesday last, who is now recovering rapidly. The wound is almost entirely healed, and on the whole, the operation appears to be successful.

The only feature in this case, Mr. President, in my mind, worthy of note, is the tendency in certain members of the same family to cancerous degeneration, and still more, in the unmarried portion of that family. It would appear to me that married life in the female is a prophylactic, to a certain extent, to cancerous degeneration.

The appearance of the tumour under the microscope warrants the operation, if operations in this disease be warrantable. Under a power of 450 degrees, the granular cells are very well marked, containing nuclei and nucleoli. A few caudate cells appeared, but not well marked. Upon the application of acetic acid, the cells still appeared more distinct.

Cancerous Growth.

The PRESIDENT exhibited a scirrhouous tumour which he had removed from a female, aged 60 years, that morning. This growth was unconnected with the

mammary gland, though in its immediate neighbourhood, being situated two inches behind the breast, and exactly below the axilla. He stated that he had seen three cases of cancerous growths occurring in the like situation, which very soon invaded the mamma. In two, the parts had been entirely removed by the knife, but the disease returned, and proved fatal within three years. One had advanced so far as to forbid any operation. In the case before the Society, he hoped the very early removal of the growth would be followed by permanent benefit. Local anaesthesia had been produced by congelation. The patient did not suffer pain; but, in some time after, there was, as in the former case he related where cold had been applied, very smart haemorrhage.

In the discussion which followed, some members attributed the bleeding to the active reaction after the congelation, others considered it was accidental, and that by a coincidence both of the growths had been freely supplied with blood-vessels. The President promised to investigate the question farther, upon suitable opportunities offering.

Cystic Tumour Developed in Nævus.

Dr. GORDON read as follows:—

Mrs. P., aged 39, the wife of a respectable farmer, came to me on the 23rd of March, 1859, fully determined to have a wen removed, which, for the last six months, had caused her great pain and mental anxiety. On examination, I found on the left side of head, posteriorly, a tumour of the size of a turkey's egg. Its surface at several points, was of a livid red colour, and prominent, elsewhere it was unequally lobulated, firm to the touch, quite moveable on the parts beneath, and not very painful on being handled. Supposing it to be an ordinary cystic tumour, in which suppuration had taken place, and which would soon ulcerate, I felt no hesitation in assenting to its removal. Having procured the assistance of Mr. Moore, one of the resident pupils of the General Hospital, I proceeded to its removal—the patient lying on a sofa, with the head resting on one of its ends. As the scalp on the most prominent part of the swelling was very much thinned and discoloured, I determined to leave an elliptical portion of it attached to the tumour, of about 2½ inches in length and one in breadth.

The first cut, which was made rapidly, went through the skin, and about a line into the tumour. Haemorrhage most profuse, in fact alarmingly profuse, and to a degree which I had never before witnessed, followed, not only from the vessels of the divided integument, but also from the tumour itself, preventing them being seen and tied. A sponge was pressed into the wound, and pressure made on it and around the tumour. I now requested Dr. Murney's assistance, who arrived in a very few minutes. In the meantime, the patient became faint, the haemorrhage having ceased, partly from the weakness, and partly from the pressure around the tumour. A second incision was made as rapidly as the first, but the stimulus of the knife aroused the patient and the haemorrhage. With my fingers the tumour was almost instantly raised from its bed, and the remaining connections separated by a few strokes of the knife.

Three arteries were secured by ligatures, and yet the haemorrhage was profuse from numerous small vessels. A compress of lint was placed in the wound, and the scalp brought partially over it, and then a second compress and a tolerably firm bandage restricted any farther loss of blood. Nine hours afterwards, the compresses and a small piece of the tumour which became detached during its evulsion, were removed. The edges of the wound were approximated, and the water dressings and bandage applied. During the day, the patient was weak, and the stomach irritable; but, on the next morning, she had recovered sufficiently to be able to go home, a distance of 12 miles.

The history given by the patient herself was as follows:—She first observed the tumour when nine years of age, and, after gradually increasing in size for several years, it was punctured; suppuration supervened and continued for two years. In 1848 she married. Then it was about the size of a large pea; after that it gradually increased, until two years ago it was as large as a hen's egg. During the last six months it was the seat of constant and severe pain, which rendered her existence miserable.

On examination, the tumour was found to be invested by a thin fibro-cellular capsule, oval in shape, and made up of lobes or cysts. On making an incision into it, the knife, as it were, grated through it; and, on passing my finger along the cut surfaces, they felt rough, and this roughness was due to a large quantity of calcareous matter embedded in numerous small cysts. My first impression was that the tumour was sebaceous, which had undergone calcareous and malignant degeneration. But on examining it more carefully, with the object of determining the source of the haemorrhage referable to itself, I found it bore an exact resemblance to those cases of cystic tumours developed in naevi, and which have been described by Mr. Lawrence, in the 22nd volume of the *Medical Times*.

There are two cysts, sufficiently large to admit the point of the finger, which contained blood alone; these communicated with several others, and with a large vessel divided in the first incision. There are several other cysts, one of them of the size of a large filbert, in which there was a slightly yellow serous fluid and a quantity of fibrine; a third set, of which the main bulk of the tumour consists, are entirely filled with cholesterine, granular or molecular matter, free, or irregularly aggregated, resembling corpuscles, and a paste-like or nodulated calcareous matter.

I shall now relate one of the cases of Mr. Lawrence, with a few of his observations, which will show the close similarity of his cases and that now under consideration. There is, however, this difference, that in none of Mr. Lawrence's cases was calcareous matter present; but I regard this as denoting merely a more advanced condition of the same disease. "In the autumn of 1848, I removed from the chest of a child two years of age, a small tumour, partly solid and partly vascular. It had ceased to enlarge at the circumference, but the vessels, tortuous and with thinned walls, were becoming more prominent, and assuming the form of cysts. Upon examination after extirpation, it was found

to be composed of veins, which, after pursuing a short course, became much dilated, and eventually formed cysts. In many situations the continuity with the vessel was completely cut off. The more recent cysts contained nearly pure blood; others contained a yellowish fluid, composed of fibrine, albumen, and altered blood-discs, mixed with a large proportion of water. The older cysts contained a limpid fluid, composed of water, albumen, granular matter, and cholesterine. In all the cases of cystic tumour now brought under your notice, the disease was either congenital, or of so long duration, that the patient could not remember its commencement. In this respect they resemble naevi. The smooth internal surface of the cysts in the three first cases, was more like that of veins than any other structure, while their firm texture, irregular dilatations, and partial constructions presented just such an appearance as might have been expected in veins which had undergone dilatation, and then lost their connection with the corresponding trunks. The venous origin thus assigned to these cysts is not an explanation of mine; *non meus his sermo*. I merely set before you the conclusions deduced by Mr. Coote, whose industry and accuracy you are well acquainted with, from a careful examination of the parts removed in the cases now related."—*Medical Times*, Vol. 22, p. 561.

Scirrus of the Pylorus.

Dr. MURNEY exhibited specimen of scirrus of the pylorus, which he had met with in the dissecting room.

Worms in General, and Tænia in Particular.

Dr. ROSS exhibited specimen of tænia, and read as follows.—While some are inclined to overrate the constitutional injury and disturbance produced by worms in the alimentary canal, others, I have no doubt, underrate the effects they cause. If the ova of worms are ingested, in proportion as the system is below par, there will be a tendency to their growth and reproduction. A favourable nidus, and the introduction of the parasites into the body, are the general conditions of their existence in man. The most practical and useful view to take of the entozoa, is to consider them a complication of a deranged state of the constitution and of the alimentary canal, and that while we hold it to be of primary importance to improve the general health, we have a secondary affection, as in many other cases, requiring special treatment. For the expulsion of the whole tapeworm, I place most confidence in the oil of the male fern. The efficacy of oil and turpentine, however, is un-questionable, as the following case will show—

A girl aged 7, was "fat and lusty" until March 8th, 1859. For the two weeks succeeding this date, her general symptoms were feverishness, thirst, headache, severe umbilical pain, diarrhoea, and cough. Her food was porridge, potatoes, and bread, and her residence was in a wretchedly bad sanitary state. She got a tea-spoonful of spirits of turpentine in the morning, and in the evening a table-spoonful of castor oil, (by which the bowels were freely acted on,) a few days before the 22nd of March, on the morning of which the specimen

of tænia, which I now show you, was expelled.

The only diagnostic symptom of tapeworm, is the appearance of it, or its segments, in the evacuations; and as the segments are shed every three or four months, by keeping a constant look out we may come to an unerring decision. I have only further to say, that unless the head be expelled, we cannot be sure that the animal will not be reproduced.

Labour, with Unusual Complication.

Dr. MADDEN, Portglenone, forwarded the following communication, which was read by Dr. Cuming:—

On the 31st December, 1858, I was summoned to attend Mrs. S. in her third confinement. On reaching the house, the noise made by the patient led me to believe that the child was on the point of being born. On examination, however, I found it otherwise. The os uteri was dilated to about the size of a shilling, and placed right over the symphysis pubis. A large tumour, in the form of a crescent, extending from side to side, occupied the posterior part of the pelvis. The tumour was so large and firm as completely to prevent the descent of the child's head into the pelvis. At first I thought it might be the rectum filled with faeces, and compressed into this peculiar shape. On, however, emptying the rectum and bladder, I found it consisted of a misplaced or a partially retroverted state of the uterus. It was evidently formed by a fold of the uterus that had descended into the pelvis. The pains continued very severe and frequent for four hours after my arrival, without effecting the least change in the state of matters.

During this time, I made two unsuccessful attempts at reduction. Fearing that the uterus might suffer injury from the long continued pressure betwixt the child's head and the sacrum of the mother, I had her placed on her back, with her head low, and the pelvis raised. I then introduced my hand, placed my fingers along the tumour, and, having used considerable force during the absence of the pains, ultimately succeeded in reducing the part to its proper position. The os uteri was then easily brought to the centre of the pelvis, dilatation took place rapidly, and the child was expelled in about twenty minutes after the parts were righted. Mother and child did well. It might be supposed that this woman had a very large pelvis, from a fold of the uterus having thus descended before the child's head, but so far from this being the case, the forceps were used in her two previous confinements.

TWENTY-FIFTH MEETING.

25th April, 1859.

Rheumatic Arthritis.

Dr. DRENNAN presented a man, aged 60, a carpenter by trade, who had been admitted into hospital with chronic bronchitis, and complaining, likewise, of pain in left arm and shoulder. This pain, he asserts, was first felt between two and three months ago, and has persisted since in variable degree. The shoulder joint has undergone a marked change in form, which the patient himself, however, had not noticed. The

acromion is higher than on the opposite side; the roundness of the shoulder is lost; and the axis of the limb altered. The head of the humerus is above and within its normal situation, and crepitus is perceived on moving it. The elbow cannot be brought into apposition with the side, nor the arm raised beyond a horizontal line, whilst its under movements are performed with facility. The other joints seem unaffected.

Dr. DRENNAN considered this an example of Rheumatic Arthritis, as described by Mr. Adams. Its progress to luxation seems to have been remarkably rapid. The man is of intemperate habits, and, notwithstanding his denial, a fall may perhaps have led to, or aggravated, the arthritic affection.

Cases of Uterine Phlebitis.

Dr. BRYCE read the following paper:—

I have proposed to bring under your notice six cases, which I will designate as uterine phlebitis, as they resemble that complaint more than any other occurring in the puerperal state. In order to be as brief as possible, I will detail the symptoms occurring in the first case, and then notice any peculiarities occurring in the other five.

Mrs. O. was confined on the 27th April, 1858, I did not see her again until the 30th; found the abdomen greatly enlarged, especially over the epigastric region; the uterus was tender to the touch and greatly enlarged, as large as the gravid uterus at the sixth month. In none of the other cases was the uterus so large as in this, owing, I suppose, to the length of time that elapsed before there was any treatment. The pulse ranged from 120 to 140, the attacks were not preceded by shivering, nor were there any febrile symptoms of any consequence. There was no peritonæal tenderness. There was little or no pain, except on pressure: in fact, no urgent symptom to attract the attention of the attendants. This patient's labours were always difficult, requiring the use of the forceps. She sank rapidly, and died on the 1st of May, the fifth day after her confinement.

The second case was also delivered by the forceps, in this and the previous labour, although on twelve previous labours she received no assistance. She made a tedious recovery.

The third case differed from the first two in having considerable head affection. She became quite delirious (so that she could with difficulty be restrained), accompanied with hysterical screaming. This might be owing to her having drunk whiskey to intoxication shortly after her delivery, and to being greatly disturbed the night after her confinement. She died on the sixth day.

Case fourth. This patient was considered out of danger on the fifth day, but was seized with excessive haemorrhage about 2 p.m. on that day, and gradually sank, and died on the sixth day. In this case the labour was tedious, in consequence of an unnaturally enlarged and pendulous abdomen.

In the fifth case the labour was easy. On the next day after her confinement, and a few hours after the other symptoms set in, she became incoherent, or rather she

could not find the proper word to express what she meant, and her articulation was indistinct. These symptoms went completely off, but returned again two or three times in the twenty-four hours. When the general swelling had been somewhat reduced, the transverse colon could be traced through its whole length, distended to the utmost degree, and tympanitic. There was no tympanitis over any other part of the abdomen, in this, or in any of the other cases; but when pressed on, it gave the same feeling as a bladder half filled with fluid, although, of course, distended with air. On the fourth day all symptoms of danger had disappeared, and the pulse had fallen to 90, but on the evening of the same day she became suddenly worse, and died on the sixth day.

Case sixth presented no peculiarity, only that the symptoms presented themselves sooner than in the other cases, coming on in six hours after delivery, whereas, the others were from ten to fifteen. The labour in this case was difficult, and the child dead.

I gave 10 grains of calomel with 2 of opium, followed in three hours by $\frac{3}{4}$ of an ounce of oil of turpentine and some castor oil. This reduced the swelling considerably. This was followed by calomel and opium, in small and frequently-repeated doses, until the mouth was affected. At the same time leeches were applied over the uterus, followed by a blister; the leeching was repeated eight or ten times, and the blister applied twice. This patient recovered after twenty days' treatment.

Cases of Diphtheria.

Dr. HALLIDAY read the following—My attention has, within the last few weeks, been directed to a peculiar form of disease, differing widely in its character from anything which I have heretofore witnessed; and, as no reasonable doubt can now be entertained, that the disease which has been termed "Diphtheria," is epidemic in parts of England, and partly so in this country, I thought it might be well to give to the Society a short account of two or three cases which have fallen under my own observation.

The first was that of a boy, aged 4 years and 4 months, of delicate constitution, but in ordinary good health, who took ill on Saturday evening, 29th January, with symptoms of influenza, of which other members in the family had been complaining. His mother gave him a purgative powder, and he appeared to be quite better on the following Sunday, and part of Monday; on this night he became restless and feverish, asking frequently for drink. Up to this time, and even on to Friday, there was no evidence of throat affection; but on this day, his mother enquiring as to the seat of illness, he pointed to his head and throat, and she remarked a stiffness in his neck when turning. He rested very badly on Friday night, and on Saturday morning, at eleven o'clock, she remarked, for the first time, that his breathing was somewhat croupy. He was able to swallow without difficulty. Shortly after this, I visited him for the first time, and, on examination, found the tonsils slightly inflamed, and a whitish yellow slough occupying the back part of fauces; pulse, 120; tongue slightly furred; skin hot; countenance thought-

fully anxious. The solid nitrate was freely applied, which appeared to afford relief. The bowels having been freely acted on, I prescribed a diaph. mixt. Visited again same evening. The breathing, which had been much relieved, was again becoming difficult. Ordered a turpentine stupe and a mixt. containing chlorate of potass. On Sunday morning, the symptoms were much as they had been on Saturday at same hour; he had passed a restless night, and had difficult breathing, with occasional spasm. The caustic in solution was again applied, with slight relief. Ordered a blister round the throat, and a calomel purgative, but without any marked benefit; the symptoms went on increasing. Saw him again at 3 p.m., and at 10 o'clock, and, as there was no improvement, decided, on consultation with Surgeon Browne, on performing laryngotomy, as affording a last chance, but shortly after the operation, he sank calmly, as if from exhaustion, dying on the eighth day.

I have been particular in describing this case, as the two following were very much like to it.

The second, was that of a little girl, aged 3 years and 8 months, who enjoyed good health up to 18th March, when she was observed to be feverish and restless, with slight cough. Saw her in my own house, on Monday, the 21st. There was then slight redness of throat, and also a swelling in submaxillary region, on both sides. At first, I thought it might be scarlatina. I prescribed a couple of aperient powders, and she left. On Tuesday night, dyspnoea set in, and, on Wednesday, I visited her at her own home. She was still feverish, with rapid pulse, and, on examination, I found a yellowish slough situated on the left tonsil. In this case, I prescribed calomel in small doses, applied caustic, and blistered. I also gave the chlorate of potass, and supported the strength with chicken broth. On Sunday, the 26th, she was much better, the croupy breathing had left completely, but on Monday morning, she was much worse. She had coughed severely during the night, and the other tonsil was now affected, having passed an exceedingly, restless night. She died on Tuesday, the 29th, tenth day of illness. Surgeon Browne saw this case also with me, and we agreed that an operation would not be likely to afford any relief.

My third case was that of a female child, aged 1 year and 9 months, who took ill on Sunday, the 10th April, with slight cough and feverishness. On Monday, the 11th, she was much worse, and her mother observed a slight swelling on left side of neck, under the jaw; all this time she made no complaint of throat, and swallowed well, but on this night, her mother became alarmed at what she called a "choking in her sleep."

I saw her on Tuesday, the 12th, at Dispensary, the throat was apparently ulcerated, and the tonsils slightly inflamed. I gave nothing in this case save the tinct. ferri mur. 5 drops every fourth hour, and kept hot stupes constantly round the throat. On Thursday she was somewhat better, but became worse on this night, and died on Friday morning, at 9 o'clock, apparently of croup, on the sixth day. The mode of death in these cases, and the course of the disease, correspond with the description given by Bretonneau, and is similar to what has taken place in England, viz., that it is first

pharyngeal, extending afterwards to the air passages, and very few are stated to have been saved by tracheotomy. In none of these cases could I obtain a post mortem examination, which I regret. Dr. Corrigan has given a description of a case in the *Dublin Hospital Gazette*, for February, in which the post mortem appearance was described, and dwells upon the peculiar form of the swelling in neck, as likely, perhaps, to form a distinguishing mark. I may add, that the throat, in my cases, presented more the appearance of ulceration, coupled with slough, than that of being covered with the pasty exudation described by writers on this disease; and my little patients had all been previously well nourished, and living in healthy localities.

TWENTY-SIXTH MEETING.
30th April, 1859.

Fracture of Clavicle Between the Coraco-clavicular Ligaments.

Dr. GORDON read the following paper:—

This specimen of an old and ununited fracture of the clavicle between the coraco-clavicular ligaments, was taken from the body of a man who died during the past week of traumatic delirium, supervening on an extensive lacerated wound of the scalp. The deformity, from projection backwards of the trapezius muscle by the outer end of the inner or sternal fragment, was well marked. The fracture is oblique from behind forwards, being, posteriorly, 10 lines distant from the acromio-clavicular articulation; but it is, anteriorly, 16 lines. There is no osseous union, and the ligamentous bands which unite the fragments are thick and strong. The articular surface of the outer fragment is applied against the anterior border of the inner fragment; the end of the latter is free, and projects considerably beyond the former, and instead of looking directly upwards, it has undergone a slight degree of rotation, so that its upper surface looks upwards and forwards. The tubercle on its under surface, which lies above the angle of the coracoid process, is surmounted by an osseous process, about half-an-inch in length, to the extreme end of which the conoid ligament is attached. Between this process and the insertion of the trapezoid ligament, there is a space of half-an-inch unoccupied by any of the attachments of the conoid or trapezoid ligaments, but the seat of a considerable amount of ossific deposition, nature having formed a glenoid cavity, with prominent margins on the anterior border of inner fragment, to receive the rounded head of the inner extremity of the outer or acromial fragment. This example, the third which I have met within less than six months, fully corroborates the remarks which I previously made during the present session regarding this form of fracture; and, I am now more surprised, that the true nature of an accident, seemingly so common, should have been hitherto completely overlooked by surgeons.

Osteo-cancer of Shoulder.

Dr. MOORE exhibited a cast of a gigantic example of osteo-cancer of shoulder. The cast had been taken

after the death of the patient, and coloured by Dr. Moore, so as to represent accurately the appearance presented during life. The patient was about 20 years of age. The new feature of the case was the enormous size to which the tumour attained, and its extremely rapid progress, the disease having appeared about four months before the death of the patient.

When seen by Dr. Moore, the disease had invaded the textures connected with the shoulder joint to such an extent as to preclude all operative interference. He remained at home under the care of his ordinary medical attendant. The disease having all the appearances of a malignant growth, advanced rapidly, engaging the entire shoulder, neck, superior part of breast and arm, as far as junction of lower and middle thirds of humerus, and attained the magnitude of an ordinary small-sized bees' -cap. It ulcerated at three points, discharging sanguous fluid, with occasionally clots of blood. By this discharge the tumour was reduced in size, and frequent haemorrhages occurring, the patient succumbed. On cutting down on the shoulder joint, the whole osseous textures therein engaged had almost disappeared, leaving only a mere friable shell.

Dr. MOORE also exhibited a cast of foot after removal, in the case of elephantiasis which he had brought before the Society at a previous meeting.

Cases of Tracheotomy.

Dr. MURNEY read the following—

I propose to bring under your notice, the history and results of some cases which required tracheotomy. The reports are taken from my hospital book, but I have curtailed them as far as adherence to the peculiarities and features of interest would warrant.

On the 6th February, 1854, a girl, 2 years old, was admitted into the General Hospital. Some time previously, when thirsty, she attempted to take a drink from the spout of a kettle which contained boiling water. A quantity of steam, was, of course, inhaled, scalding the mouth, upper portions of pharynx and larynx. She was brought to a practitioner in the neighbourhood, who smeared the parts with oil, and directed her to be taken to hospital if the symptoms became more urgent. Some time, therefore, elapsed, before her admission into this institution. When seen by the resident pupil, her respiration was hurried and laboured; expression of countenance anxious; the uvula large and tense, and the fauces congested. A concentrated solution of nitrate of silver was applied with decided relief, and a mustard synapsism placed over the anterior region of the neck. For an hour the respiration became easier, and the symptoms abated. At a quarter before nine o'clock, I saw her, when I was informed the symptoms were becoming more alarming. Strong ammonia was applied externally, so as to vesicate, and the pharynx "swabbed" with solution of nitrate of silver. At ten o'clock, the temporary advantage resulting from the last treatment having subsided, no prospect remained for the preservation of life, save by the performance of tracheotomy, which was done in the usual mode, eight hours after the inhalation of steam.

The trachea was opened close above the thyroid body, and a part of a full-sized flexible catheter introduced and tied in the wound; not more than half an ounce of blood was lost during the operation. Immediately, after some four or five deep inspirations, the child fell into a placid and refreshing sleep. I need not follow the daily reports, but may mention, until the 9th, she progressed favourably; she had now, however, accelerated pulse, although stated to have slept well. On the 14th, she had general bronchitis, which could not be in any way controlled. She died on the 26th February, twenty days after the performance of the operation. The treatment consisted in placing the little patient's bed close to a fire, so that the atmosphere around her was but slightly influenced by external cold; the administration of small doses of calomel, combined with compound hippo powder, in the early stages; and, during the progress of the bronchitis, carbonate of ammonia, in decoction of senega. Stimulation was also used to the surface of the chest, but without any benefit.

The second case occurred on the 2nd January, 1858. It was that of a little girl, aged two years, who also inhaled steam from a kettle, had similar symptoms, and was brought to hospital 6 hours after the unfortunate occurrence. I saw her shortly after admission; external stimulation and caustic solution were here also applied, but with only temporary benefit. At 7½ p.m., viz.—7½ hours after the accident, I opened the trachea at the same part as in the last case. During the operation I tied two arterial twigs, and from the highly congested condition of the veins, there was pretty smart venous haemorrhage, which ceased after a few deep inspirations.

On the introduction of the gum-elastic tube into the opening, some blood escaped by its side into the trachea, which produced suffocating cough. To remove this I found it necessary to apply my lips to the wound, and suck out the blood. As in the former case the patient fell asleep immediately after the operation.

Bronchitis set in at once, and the patient died on January 7th, five days after operation. I need not particularize the treatment, as in many respects it was the same as that detailed more at length for the first case.

On the 6th November, 1858, at noon, a fine little boy, aged three years, was admitted into hospital labouring under all the symptoms of oedema of the glottis, caused, as in the other cases, by the inhalation of steam from the pipe of a kettle; the occurrence took place at 9 a.m. Again was I induced to try the application of solution of nitrate of silver; and, as the surface was cold and somewhat dusky in hue, partly from incomplete clothing on a cold day, and partly from obstructed respiration, I placed him in a bath at 110 deg. F. for eight or nine minutes; relief of a decided but only temporary character followed. Again the solution of caustic was used, but with the usual result. At half past one, p.m., namely, four hours and a half after the inhalation of steam, on consultation, tracheotomy was deemed necessary and immediately performed. During its progress nothing untoward occurred; two small vessels spouted, but were immediately secured. He continued to improve till the 10th, when he suffered from bronchitis. Till the 13th this gradually became

worse,—on which day and the 14th the severity of the symptoms caused me to fear he would not survive. Steadily, however, the cough diminished, and on the 20th he was convalescent. On the night of Monday, the 22nd November, we had, I believe, the first intense frost experienced this winter. Unfortunately, on the evening of that day the fire in the ward (which was close by the patient's bed, and about which I had been most particular and precise in my directions,) was neglected, and died out about six o'clock. The temperature of the room was gradually sinking, and I suppose about nine was little above that of the lobby or stair. Shortly after the child became restless and fretful, had teasing, irritating, then difficult and croupy cough. I saw him shortly after midnight, and certainly feared all our attention and care were about to prove unavailing; but in a little time he began to exhibit the good effects of a fine fire warming the cold air, and I considered he was also greatly benefitted by a turpentine stufe, which I directed to be applied all round his chest. In the morning he was greatly improved, and in a couple of days he was again convalescent. Considerable caution was exercised in confining the patient, when almost recovered, at first to his bed, after a time in allowing him to play about the ward, and later on, on mild days in permitting him to expose himself to the colder currents of the lobbies and stairs. He was discharged quite well on the 3rd December. The wound in the trachea had completely cicatrized on the 22nd November, so that, had the difficulty of respiration become greater, another opening of the windpipe would have been necessary, which would have been more troublesome in the performance, and assuredly would have been undertaken with a much more unfavourable prognosis than the original operation.

On the 12th November, 1858, a man, aged 31 years, unmarried, was admitted into one of the medical wards, labouring under an attack of laryngitis, which commenced six weeks previously. He had placed himself successively under the care of two practitioners, from whose treatment he derived some temporary benefit; but, the recurrence of his symptoms, in a more severe form, induced his last attendant to recommend him to hospital. When first visited, he had pain on pressure over the region of the larynx, especially between the alae of the thyroid cartilage; hurried and difficult respiration, each inspiratory effort being accompanied by a crowing sound, which could be heard at some distance from the ward he occupied, even when the door was closed. Four years ago, he had a sore on the penis, after connection, which in a little time healed up. Never had any eruption or other constitutional result of syphilis. The sore was never shown to a medical man, but was treated under the advice of some acquaintance, so that the existence of venereal taint, although probable, could not be ascertained with certainty. On Monday, the 15th, the pain about the larynx, and difficulty of respiration, had increased so much, I recommended tracheotomy, but a number of his friends induced him to leave the hospital.

On the 16th, about eleven p.m., I was sent for by my friend, Dr. Heeney, to perform the operation. I found

the man in a miserable apartment, surrounded by a number of his friends—several of the male portion more or less intoxicated. He was much worse than when I had last seen him. His lips were blue, the surface dark, and it was apparent, the quantity of air passing to the lungs was now very small, and momentarily diminishing. My friend and I agreed we could not venture to remove him to hospital before operation, nay, I even feared to leave the house to get a tracheal tube, as I had not one with me, so imminent was the state of asphyxia. Before proceeding farther, I would explain the reasons for choosing another and a more difficult operation than that which was performed in the cases of oedema of the glottis. The connection between syphilis and the present affection being very obscure, it was impossible to form any estimate of the extent of the disease in the larynx, and therefore I would not perform laryngotomy for the same reasons I avoided that part of the trachea above the thyroid body. I therefore determined to open the windpipe at the more difficult, but, *apart from the operation*, the safer locality, immediately below the azygos lobe of the gland. For this purpose, assisted by Dr. Heeney, I made my incision in the usual region, when having, of course, cut some turgid veins, from which a good deal of blood poured, I naturally waited a few seconds to sponge the surface, when I observed respiration had ceased. Nothing then remained but to open the trachea at all hazards, which was immediately done.

In previous operations, the plunge of the knife had been invariably followed by a gush of air into the tube. Now no such pleasant sound was heard. The man was virtually dead, and remained so for at least thirty or thirty-five seconds, during which time I thrice applied my lips to the wound, and sucked from the trachea large mouthfuls of blood, when at first, slowly and imperfectly, then more deeply, the respiration returned; subsequently I introduced a tube and had him removed to hospital, where, having passed through a smart attack of bronchitis, he recovered. There has been complete occlusion of the larynx for more than five months; and I do not anticipate he will ever be able to permit the closure of the artificial opening.

From a consideration of the anatomy of the parts occupying the median line of the neck, I consider there are two situations at which the trachea may be opened—viz., one above, the other below the median lobe of the thyroid body. The former is much the more simple operation, and, I believe, is applicable to the great majority of cases; in fact, at this moment, I do not recollect any instance in which, as I would style it, the low operation should be performed, except a case such as that just detailed, or where a foreign body has passed through the larynx into the trachea, and is, perhaps, situated at the lower part of that tube. The isthmus of the thyroid rests anterior to the third ring of the trachea, consequently, the upper two rings may be reached with some facility, and, when we consider, usually there are no vessels or parts of importance very near to this region, that its depth from the surface is not very considerable in the child, and there are not usually so many turgid veins as exist where the inferior operation is to be executed, there cannot be a doubt as

to which locality should be chosen, unless when special contra-indication existed. A little point in the progress of the operation, I think, is not sufficiently insisted upon by surgical writers. It is—in the dissection of this part of the neck we find four layers of fascia, three of which will be cut through in ordinary fashion, and do not require any special notice. The fourth layer is that which lies between the sterno-thyroid muscle and the trachea. It is of considerable thickness and strength. Now, more than once I have observed, unless care be taken, this membrane was cut, and the trachea not opened until the knife was used a second time. Its position should therefore be borne in recollection, and when cut, I would suggest, the opening should be free, as from the tossing of the patient the orifices in the membrane and the windpipe may not correspond, resulting in impeded respiration to the patient, and some trouble to the operator in the introduction of the tube.

I cannot find any statistics to place before you the results of a number of operations on the windpipe, but I believe I am warranted in saying, at the age of five, seven, or ten, the deaths are not much more numerous than occur with adults, but that during the first two or three years the mortality is very high, and the question naturally arises, Can this be attributed to any source susceptible of removal or mitigation? Now, it is well known, one of the most frequent causes of death after operation for strangulated hernia is having permitted too long a period to elapse before resorting to the knife, and I am fully persuaded the performance of tracheotomy at an earlier period than has hitherto been customary would give the patient a better chance of life; for it seems that by delaying until a condition of venous congestion is produced, and allowed to exist with increasing intensity for a time, we have a lowered tone of vitality induced in the lungs, and perhaps in other organs, but especially the lungs, about to be subjected to various causes which would set up inflammation—certainly a state the most unfavourable. As a probable cause of the greater mortality among young subjects, I would suggest that, as the capillary circulation is so remarkably active, the condition of lowered vitality will be more rapidly induced than in those of more advanced years, and, of course, there is, in addition, that tendency to succumb to any serious disease so invariably exhibited in children.

*Examination of Specimen of "Lusus Naturæ" Forwarded
to the Pathological Society Some Time Since.*

The manubrium of the sternum is natural in all respects. The mucro is developed in the usual fashion by centres of ossification placed laterally; the right portion is larger and more fully ossified than the left; the cartilages of the ribs are connected in the normal manner to the sides of the sternum. A wide interval exists between the lateral parts of the body of this bone through which the heart is protruded, and rests in front of the thorax perfectly destitute of covering. Behind it, and separating this organ from the lungs, &c, &c, is a serous membrane, which, in a more developed condition, I consider, would have formed the serous layer of the pericardium. The heart is natural in shape

except at the apex, from which a conical-shaped process, which might be styled an auricular process, passes towards the left side for about one-half inch in length, and is connected by a muscular bundle to the anterior part of the cartilage of the sixth rib. The only peculiarities observable in the dissection of the heart are, the walls of the right ventricle are very much thicker than those of the left, and from the latter cavity a *cul de sac* runs for about three lines in the interior of the “conical-shaped process,” already referred to.

ANNUAL MEETING.
7th May, 1859.

THE Council and Auditors' Reports having been read, the Office-Bearers for the ensuing Session were announced as follow:—

PRESIDENT.—Dr. J. Seaton Reid.

VICE-PRESIDENTS.—Dr. Murney, Dr. Thomas Reade, Dr. Gorden, Dr. Babington, and Mr. Ferris.

MEMBERS OF COUNCIL.—Dr. Drennan, Dr. Dill, Dr. Patterson, Dr. Pirrie, Mr. Johnston, and Dr. Heeney.

After which the retiring President delivered his closing address, the business being brought to a close by a vote of thanks to the Ex-President, Honorary Secretaries, and Treasurer, separately, and by the installation of the President-Elect.

BELFAST CLINICAL AND PATHOLOGICAL
SOCIETY

SEVENTH SESSION

1859 – 1860.

OFFICE-BEARERS
FOR THE SESSION 1859-00.

PRESIDENT.
PROFESSOR J. SEATON REID, M.D.

VICE-PRESIDENTS.

RESIDENT, DR. MURNEY.	NON-RESIDENT, DR. BABINGTON,
DR. THOS. READE.	Londonderry.
DR. GORDON.	SURGEON FERRIS, Larne.

SURGEON BROWNE, R.N., Ex-President.

TREASURER.
DR. HALLIDAY.

HON. SECRETARIES.

DR. CUMING,	DR. WALES.
COUNCIL.	DR. DILL.
DR. DRENNAN. DR. PATTERSON. DR. HEENEY.	DR. PIRRIE. SURGEON JOHNSTON.

BELFAST
CLINICAL AND PATHOLOGICAL SOCIETY.

SEVENTH SESSION – 1859-60.

THE first meeting of the Society for the Session was held on Saturday, October 29th, at the General Hospital.

The President, Professor J. SEATON REID, M.D., was in the chair.

The following members were present:—Professor Ferguson, Drs. M'Minn, Wales, Dill, Heaney, Mulholland, Ross, Patterson, Halliday, Murray, Reade, Lynch, Moore, Drennan, O'Hare, Dunlop, M'Cormac, Pirrie, M'Mechan, M'Crea; Surgeons Browne, Ross, Arnold, M'Cleeny, &c

Dr. Cuming, one of the secretaries, read the minutes of the previous meeting, which were confirmed.

Dr. DILL then, according to previous notice, moved that an additional country Vice-president be appointed, so that the number in town and country be equalised. Dr. HEANEY seconded the motion.

Professor FERGUSON moved, as an amendment, that the question be deferred till the annual meeting, and being seconded by Surgeon BROWNE, the amendment passed unanimously.

The President delivered the Opening Address as follows:—

GENTLEMEN,—Since the establishment of the Clinical and Pathological Society of Belfast, it has been the custom for the President to deliver an inaugural address at the commencement of each session. It, therefore, now devolves upon me to place before you a few observations of an introductory character.

I have, in the first place, however, to return my most sincere and grateful acknowledgments to the members of this Society, for the very high honour which they have spontaneously conferred upon me by electing me their President.

This Society was established for the high and noble purpose of advancing medical and surgical science in their practical departments, in the hope of rendering them more efficient for the removal or relief of disease. To preside over the deliberations of gentlemen engaged in so important and vital an object requires such varied accomplishments that I would have been disposed to recoil from the office, had I not been certain of the assistance and support of those who had acted so efficiently as my predecessors, and did I not rely on a continuance of that courtesy towards each other which has hitherto characterised the members of this Society, even when challenging the correctness of each other's views.

The subject matter of an address like the present necessarily varies with the person who holds the office of President. The special branch of practice to which he is devoted, the direction of his reading, and the nature of the questions that at the time agitate the

public mind, naturally exercise an influence over the subject he may select for the consideration of his hearers. My professional career having been that of a physician, I have naturally selected for my theme, a subject connected with practical medicine. I have just stated that this Society originated in a desire to contribute to the advancement of medical science; but it is, doubtless, known to you all, that whilst we have claimed for medicine a place amongst the progressive sciences, the validity of our claim has been denied, and it has been asserted, that no progress has been made by it for centuries past. For example, when the late Sir William Hamilton, of the Edinburgh University, reviewed, a few years ago, "Dr. Thompson's Life of Dr. Cullen," he did not hesitate, after calumniating the members of our profession, to ask, in the most disparaging manner—"Has the practice of medicine made a single step since the days of Hippocrates?"¹

Believing that he and others have acted most unjustly, in denying that our knowledge has increased, I shall, in the following remarks, endeavour to show that, even within the last half-century, a large amount of progress has been made, and that no little amount of benefit has been conferred on mankind by the results.

You are aware that medical science may be defined to be an aggregate of the knowledge we derive from the study of anatomy, physiology, pathology, chemistry, *materia medica*, and the practice of medicine and surgery. But, it is evident, that were I to go into details respecting the contributions made by each of these, I would far exceed the limits of an address like the present. I must, therefore, endeavour to find some department in which the contributions made by each would appear to be concentrated, and, by a brief and impartial examination of it, endeavour to vindicate our profession against the charges which have been so inconsiderately brought against it.

Now, I believe that you will agree with me in stating that, as the chief object of medical science is the removal of disease, each case presents to the physician two grand problems to be solved. First, to discover its nature; and, secondly, to devise its cure; so that all the benefits resulting from a study of the various branches I have named must be found centred in diagnosis and therapeutics, and are ultimately valuable to us in proportion as they facilitate the recognition and treatment of diseases. That various maladies attack the human body must be admitted by the most superficial and illiterate observer. The records of medicine, in their most imperfect state, recognise this as a fact, and it is employed as the basis of every treatise on medical practice. Diagnosis, or the power of distinguishing these diseases from one another, lies at the very foundation of our art; and just in proportion to the perfection and accuracy of our diagnosis, and our power of discrimination, will be the certainty of our therapeutics, and the attainment of the grand object for which our profession was instituted. Now, if it can be shown that medical science has made progress in the acquisition of knowledge in these two departments,

even within so limited a period as the last half century, I conceive it will go far to vindicate our profession against the disparaging charge that has been brought against it.

In attempting the fulfilment of such a task, it is desirable to follow some method or arrangement, and I am not aware that I can suggest a better one than to take as a basis the usual anatomical divisions of the organs of the body, and endeavour to ascertain what improvements have been made in the diagnosis and treatment of their respective diseases. By this plan, the diseases of the nervous system; next those of the respiratory and circulating systems; then those of the digestive and eliminative organs, will successively be examined.

I shall commence with an examination of the nervous system, rather out of deference to the important place which it holds in the animal economy, than because it is the department in which the greatest progress has been made. That this has not resulted from any want of zeal on the part of our profession, but from the existence of circumstances beyond their control, may be shown by a brief mention of some obstacles that, so far, appear insurmountable. Chief among these may be mentioned the enclosure of both brain and spinal cord in cases of bone, which remove them beyond the reach of any direct examination of their condition, and thus compel the physician to rely almost exclusively upon derangement of their functions as indications of the presence of disease. But our experience of thoracic disease has taught us how little dependence can be placed on derangement of function alone, and what innumerable mistakes we should commit had auscultation not enabled us to test the correctness of its indications. I need but mention, as examples, that the greatest dyspnœa, the most agonising pain, and the most hurried breathing, may be dependent on either functional or organic disease. Again, if distrusting functional derangements, we are disposed to rely upon the statements of the patient, we know that, in many instances, only a very small amount of disease shall have taken place on the surface of the brain, till the mind becomes so confused that no reliance can be placed on the descriptions of the unhappy sufferers. A third obstacle exists in the peculiar structure of the nervous tissue itself. You are aware that this is composed of two materials, called respectively the grey and the white, and that anatomists and physiologists, in their most recent investigations, have endowed each of these with peculiar powers. But they find these structures so intimately blended together that they have difficulty in deciding the boundaries of each; so that, when the pathologist, after a careful observation of symptoms during life, attempts to explain them by organic changes found after death, he is much embarrassed by this structural intermixture. Although an attempt has been made to overcome the first of these obstacles, by the application of auscultation to the brain, yet it has hitherto been barren in results, and I fear that we must look upon them all as belonging to a class that human skill will never be able to remove.

It was necessary to mention the existence of such impediments, in order to protect our profession

¹ Discussions on Philosophy and Literature. By Sir William Hamilton, Bart. 1852. P. 253.

against a charge of being deficient in zeal; and to account for the want of that precision and accuracy in the diagnosis of diseases of the nervous system which has been acquired regarding diseases in other departments. Still, the investigations and observations carried on during the last half-century have not been entirely without fruit; and we are enabled to point to several discoveries of the greatest scientific importance, which have rendered our diagnosis more accurate, and extended our knowledge in various directions.

In the first place, we have acquired the power of distinguishing from one another several diseases of the brain that were formerly confounded together. By an application of the law which connects symptoms with lesions, and which led to a closer study and record of the former; and by a subsequent comparison of them with the records of dissections, it was found that diseases very dissimilar in their nature and seat, although similar in their more prominent features, had hitherto been confounded under the same name. For example, there can now be little doubt that, under the name of phrenitis and brain fever, several diseases were described and treated that were in their nature totally distinct, while there were also united under the name of inflammation of the brain, several others, which are now well known to be distinct, both in their seat and in their results.

When inflammation is confined, as is occasionally the case, either to the substance of the brain or to the membranes covering it, we are enabled not unfrequently to tell which is involved; and, when the membranes are the seat of it, to decide whether it be those covering the base or the surface that are diseased—a precision in diagnosis which was assuredly unknown to our immediate predecessors. In the diagnosis of these inflammatory affections we have learned the great reliance that may be placed on our opinion, when either persistent vomiting or sighing respiration, or both, may be present. Whilst our forefathers in medicine would have ascribed the first of these to deranged stomach or biliousness, we have been taught the fearful significance that it gives, in either old or young, to apparently trivial cerebral symptoms; and, if sighing respiration be a less obtrusive symptom, experience has taught us all how to interpret its association with cerebral indications, although these may appear to be of little importance. So indicative of serious brain disease are these two symptoms, that their absence justifies us in holding out hopes of a favourable result to our treatment of others in the same region, which their presence would debar us from entertaining. One of these diagnostic symptoms we have seen manifested by a derangement of the digestive functions, the other through the respiratory system; but there is a third, of equal significance, indicated by the organs of circulation, though of rather less value, because it requires the disease to have reached its last, if not hopeless, stage, before it is fully developed. I allude to the varying frequency of the pulse, first mentioned by Dr. Whytt. Repeated observations have confirmed the accuracy of his remark, that in inflammatory affections of the brain, the pulse is first frequent, then becomes unusually slow, and again

resumes still greater frequency towards the termination of life.

Now, it is not without interest to remark, as a corroborative proof of the difficulties connected with an investigation of the diseases of the brain, that the three chief symptoms which modern research has proved to be the most indicative of inflammation of that organ are learned through a derangement of the digestive, the respiratory, and the circulating systems, rather than from a direct interrogation of the brain itself. I may here state a fact that might be of use on some occasion to some of the junior members of our Society, as I have not observed the point noticed by any authors. Before death takes place from inflammation of the brain in children, there appears occasionally a dusky rash over some parts of the body, which has led the attendant to suppose the child was dying from undeveloped scarlatina. I have known this opinion to have been held with such pertinacity, that whilst the symptoms had been persistent vomiting, constipation, screaming, coma, squinting, convulsions, and hemiplegia, extended over ten or twelve days, yet, in opposition to the opinions of two others, death was asserted to have been caused by suppressed scarlatina, and no other certificate would be given. The more correct diagnosis of these inflammatory affections of the brain has caused the term hydrocephalus to be used much less frequently; as it is now known that the coma, the dilated pupil, and squinting, which were formerly believed to indicate effusion of water in the brain, may be the accompaniments of a mere inflammatory opacity or thickening—effusion of fluid being rather the exception than the rule.

Again, paralysis was formerly described and treated of as a distinct disease, and in almost every instance subjected to the same treatment; whereas now it has been proved to be only a symptom, common to various structural lesions of the nervous centres, such as rupture, inflammation, softening, pressure, &c.; each of which requires a variation in our remedies. And with regard to that form of paralysis that appears occasionally in the insane, it was in consequence of the accurate observations of physicians who practised little more than thirty years ago, that we have been taught to predict an invariably fatal result from the association of the slightest amount of unsteadiness or slowness of articulation with the very mildest form even of mental aberration; repeated observations having proved it to be a law, that the slightest delay in the formation of successive syllables or words by the insane is the certain forerunner of that general paralysis in them which invariably terminates life within two or three years. No remedial measure has hitherto been found to ward off the issue, though lowering treatment has been followed by most injurious results. Now, it is extraordinary that not a trace of a description of this peculiar kind of paralysis, is to be found in the writings of any physician prior to the year 1822; though it possessed such peculiar characteristics as to be confined almost exclusively to males, to be most frequently associated with that form of insanity in which the patient is always hopeful, the world prospering with him in every respect, his power of motion and his health, in his own

opinion, always improving, though he can scarce move or speak. Such patients, also, almost invariably become fat, the very opposite result of the presence of other forms of insanity; yet, with such peculiarities, its natural history was only discovered about the date I have just mentioned.

Within the last few years a peculiar inflammatory affection has been discovered, attacking the base of the brain and superior part of the spinal cord, to which the name of cerebro-spinal meningitis has been given. This, although an acute inflammation, appears to prevail at times as an epidemic, and did so some years ago in the Belfast Workhouse. It most frequently attacks boys, or young men recently subjected to the vicissitudes of a military life.

The foregoing statements have indicated the progress of medical science, by showing that we have acquired much greater facility in the interpretation of symptoms; so that we are enabled, not only to distinguish more accurately diseases of the brain from each other, but also to assert with greater confidence the existence of particular diseases from the presence of certain symptoms, though these latter may not appear to be directly connected with the brain.

I have now to adduce proofs of progress of a somewhat opposite character, by showing that certain symptoms, which at the commencement of the present century were looked upon as infallible evidences of serious, if not fatal, disease of the brain, are now to be interpreted in a very different way. We are indebted for this discovery to our celebrated English physiologist and physician, the late Dr. Marshall Hall. At the period I have mentioned, all diseases were ascribed to inflammation, and it was to the discovery and treatment of it that every physician directed his attention. Pain was known to be one of the most certain indications of its presence in inflammation of the bowels and other localities; and when it was complained of in the head, it was at once held to be indicative of inflammation of the brain, which required the most active blood-letting for its removal. Dr. Hall's great powers of observation soon told him that pain was by no means a certain indication of inflammation of the brain; and that it was almost invariably present when that organ was deficient in blood, rather than overcharged. All who have read his invaluable essay on bloodletting, will recollect his instancing case after case, in which severe pain in the head was but temporarily mitigated by bleeding; but at once relieved by nourishment—brandy and ammonia. To the same illustrious physician are we indebted for another discovery of a similar nature, as he was the first to point out that a group of symptoms in children, such as insensibility, squinting, and convulsions, which had hitherto been looked upon as certain indications of hydrocephalus, or inflammation of the brain, and requiring the most decided lowering treatment, were in reality the result of exhaustion; and were most certainly removed by brandy nourishment and ammonia. Dr. Watson, of London, has truly remarked that one of the most trustworthy diagnostic symptoms of this peculiar condition of the brain in infants, consists in depression of the anterior fontanelle, the reverse of what occurs when the brain is inflamed.

When we recollect the saving of life that has resulted from the discovery of the two foregoing facts, we must admit, that apart from his discovery of the "reflex function," Dr. Hall was entitled to be enrolled amongst the most successful benefactors of his race. Few discoveries of modern times are of greater importance than that which has taught us that exhaustion and irritation may originate a group of symptoms in both brain and intestinal diseases having a great resemblance to inflammation, but which would be aggravated and perpetuated by a lowering treatment, and almost immediately relieved by the reverse. Intimately connected with the brain, are to be found the spinal cord, and certain cerebral nerves; each liable to serious diseases, which, if not so destructive to life as those we have been alluding to, are still of such importance as to cause us to inquire what progress has been made in their diagnosis and treatment.

In connexion with the discoveries in this portion of the nervous system, we may well be proud that Great Britain and Ireland have furnished such experimental physiologists and practical physicians as Sir Charles Bell, Dr. Marshall Hall, and Dr. Bentley Todd. Sir Charles Bell's discovery, in 1811, that the anterior and posterior roots of the spinal nerves performed different functions, enabled an explanation to be given why disease in one part of the cord caused a loss of power, and in another a loss of sensation; and, although the recent investigations of Brown Sequard have shown that he had not succeeded in unravelling all the mysteries connected with sensation and motion, still the accuracy of his original discovery remains almost intact. By Sir Charles's discoveries, also, respecting certain cerebral nerves, we are enabled to explain why, in disease or injury of the seventh pair of nerves, certain superficial muscles of the face are paralysed, and others escape uninjured; and, again, when the anterior root of the fifth is involved, how it happens that the temporal and masseter muscles have lost power, whilst others do not suffer. Two kinds of facial paralysis are met with; one is of trivial importance, almost invariably amenable to treatment, and needs cause little anxiety to the patient; the other is of most serious import, generally dependent on disease of the brain, and too often uninfluenced by treatment. Now, you well know that we are indebted to the discoveries of Sir Charles Bell and Dr. Bentley Todd for our capability of distinguishing between them; in the one case warranting words of comfort and assurance to the patient; in the other, demanding those of a less hopeful character. Sir Charles's investigations have explained that when the eyelids are incapable of being closed in facial paralysis the disease soon yields to proper treatment, and a permanent recovery results. Indeed, there are few of us who have not found the value of this knowledge, and the relief from anxiety it enabled us to administer to our patients, whose cheeks had become suddenly paralysed. Whilst, on the other hand, by the investigations of Dr. Bentley Todd, we have been taught that the power of closing the eyelids, in a case of facial paralysis, is an absolute proof that the affection is of a more serious character, and depending on disease of the brain itself.

Again, the discovery by Marshall Hall of the property of "reflex action," and which has immortalised his name in the science of physiology, has furnished us with unerring means of ascertaining whether the cause of the paralysis of the limbs of our patient is due to disease of the brain, or seated lower down in the cord, thus indicating not only the locality to which our remedies should be applied, but furnishing us with the means of deciding on the propriety of using that most powerful remedy, strychnine, which is beneficial when the spinal marrow is the cause of the paralysis, but hurtful when the brain is diseased. Although this knowledge had been acquired within the last quarter of a century, yet some recent investigations of Professor Van Der Kolk have extended our knowledge of the reflex function, by demonstrating that the posterior roots of the spinal nerves divide in the spinal cord into two parts, one of which passes directly up to the brain, and is the channel of sensation; whilst the other penetrates through the white masses of the cord into the grey substance, and becomes the channel through which the phenomena of the reflex action are excited. I might add to the foregoing other examples of improvement in our diagnosis of other diseases of the nervous system, but I have limited myself to a notice of the most important conquests that have been achieved; conquests which have been acknowledged by the most enlightened practitioners in every country, and by them admitted to have contributed to the preservation of human life.

Such, gentlemen, is the reply that an examination of even one portion of the diseases of the human body enables us to present to the detractors from our professional renown. And when we recollect that some of the most important of those discoveries were made by Sir Charles Bell in Edinburgh; that they had procured for him so world-wide a reputation, that no disease of the nervous system could be mentioned without his discoveries being noticed; that he was the co-professor of Sir William Hamilton in the University of Edinburgh; and that Scotchmen are generally not insensible to the claims of their countrymen, we are at a loss to account for the utterance by Sir William of such a calumny on our profession as "that medicine in the hands by which it is vulgarly dispensed is a curse to humanity rather than a blessing,"¹ or for his addressing to us the question, "Has the practice of medicine made a single step since the days of Hippocrates?" When language like this is published by a writer of such unquestionable attainments in philosophy, and attempted to be justified by quoting a statement of the blacksmith Priesnitz, of water cure celebrity, surely we must accuse him of having shown a most unpardonable ignorance respecting the history and progress of medical science, or conclude that his mind had become warped by a most unjustifiable prejudice against it. But, I must remember that Sir William is no more, and that—

"De mortuis nil nisi bonum."

The plan which I had laid down for my inquiry into the progress of medical science, requires me next to ascertain what improvements have taken place in the

recognition and treatment of diseases in the organs of respiration and circulation. I am certain that you will agree with me in stating that it is here that the practice of medicine has achieved its greatest triumphs, and that we are enabled to enumerate discoveries in diagnosis and therapeutics that half-a-century ago would not have been deemed possible by the most enthusiastic member of our profession. It is almost superfluous to state that these have resulted from the application of auscultation and percussion in the investigations of all diseases of the lungs and heart. Auscultation in medicine, you are all aware, is the art of listening to the different sounds produced in the living body; and, as a method of diagnosis, it has for its object to determine the condition of an organ in which the natural sounds are altered. Its application to the study of diseases of the respiratory and circulating organs proved it capable of rendering the diagnosis of nearly every disease of the lungs, of the pleura, and of the heart more certain, and more minutely accurate, than perhaps even those diagnoses established by means of the sound, the probe, or the finger. For the discovery of this valuable and useful art we are wholly indebted to the immortal Laennec, and at a date so recent as 1816. Not only did he lay the foundation of our knowledge respecting it, but, by his indefatigable industry and ardent zeal, he brought it very nearly to that degree of perfection which it has now attained, and which renders it one of the most efficient means ever devised by the skill of man for the elucidation of pulmonary and cardiac affections. The stethoscope enables the physician of the present day, as it were, to see through the body of the patient, and to announce, in the great majority of instances, what alterations of structure exist at the point which is subjected to his examination. No intelligent practitioner can now refuse to acknowledge that the discovery of auscultation, by this eminent Parisian, forms one of the most memorable eras in the history of medicine; nor will its practical utility be denied by any one who has qualified himself to estimate its value. Whilst we have claimed for our countrymen, Sir Charles Bell, Dr. Marshall Hall, and Dr. Todd, some of the most valuable discoveries in connexion with the nervous system, we must, in candour, acknowledge that the entire merit of the discovery of auscultation is due to the illustrious Frenchman, although, as an art, it has been greatly extended and more accurately applied by Drs. Stokes, Williams, Walshe, Corrigan, and Hope. It has rarely happened, however, that there has been an instance of a discovery of equal importance in which so little was left by the discoverer to be performed by others; and we, who have benefited so much by his genius, cannot but rejoice that, as an exception to the general rule, the gratification was enjoyed by Laennec of witnessing the acknowledgment of the value of his discovery, and its adoption by the most intelligent of his countrymen and contemporaries.

Exactly a century ago an Austrian physician had announced the discovery of a new means of detecting the diseases of the lungs and the heart, to which he gave the name of percussion. This discovery attracted little attention, and had fallen into oblivion till about

¹

* Discussions on Philosophy, &c. P. 252.

the year 1808, when Auenbrugger's treatise was translated into the French language by Corvisart. The value of percussion was soon tested, more extensive applications of it proposed, and, under the distinguished Pierry, of Paris, it has been brought to a high degree of perfection as a means of diagnosis. He, however, appears to place too exclusive reliance on this method, and professes to obtain results with his pleximeter which others of equal ability and honesty are quite unable to confirm. Still it must, in candour, be admitted that many who have accompanied him in his visits to his hospital patients have been astonished at the accuracy of his diagnosis. The most ignorant vender of whiskey or beer knows how to estimate the gradual falling of the liquor in a cask, by the different sounds elicited on striking it above and below the level of the liquid. In like manner, every part of the human body, when struck, emits a certain sound, and always the same sound under the same circumstances, and, therefore, when found altered by disease, it becomes a valuable symptom. Ordinary percussion is chiefly used to ascertain the degrees of intensity of sound, or, in other words, the degrees of sonorousness or clearness, and their opposites—dulness or flatness. It, however, reveals only one symptom, and but one element of diagnosis; although that symptom is often of paramount importance, yet it rarely, if ever, is of itself sufficient for determining the nature of the disease. If, for example, percussion discovers dulness at the base of a lung, other means must be employed to discover its cause. In such a case, it merely indicates that a comparatively dense body occupies the place which in health is occupied by a substance of lesser density. If we wish to know more, auscultation and the general symptoms must determine what the nature of that body is, and how it affects the general system. When auscultation and percussion are thus combined, they become invaluable in diagnosis; in fact, they are essential to the successful practice of medicine, nor can either be relied on to the exclusion of the other. Their mutual dependence is so well known to you all that I need not mention many examples. But, having given one illustration of the insufficiency of percussion without the aid of auscultation, I may, in justice to Auenbrugger, give one where percussion is as necessary in aid of auscultation. Certain circumstances cause the stethoscope to be applied over the right lung, but no sound whatever of respiration can be heard. Is the lung solidified, or is the pleura full of fluid? Auscultation cannot furnish a reply, because no respiratory sounds are heard, either healthy or morbid. The aid of percussion is sought to clear up the difficulty, and it finds perfect, or even unusual, clearness of sound; therefore, neither solidification nor effusion can exist. There must be some cause preventing the air passing into or out of the lung, and a reference to the patient's history may furnish good grounds for believing that a foreign body blocks up a bronchial tube, thus rendering the passage of the air through the lung impossible, and, consequently, stopping all sounds. This body may be a "wisdom tooth," as in the late Dr. Houston's patient, or a half-sovereign, as in the case of the celebrated engineer, the late Mr. Brunel. The idea of combining

auscultation and percussion originated with Laennec, proving that he desired progress in medical science rather than fame for himself, by an exclusive advocacy of auscultation.

Percussion, I have said, had been proposed as a means of distinguishing diseases of the chest fully a century ago, but it attracted little notice, and had fallen into oblivion till Corvisart recalled attention to it in Paris in 1808, and it was little practised in England till 1824. Whilst, therefore, it cannot, like auscultation, be claimed as a discovery of the last half-century, still to the physicians of this period is due the merit of its application, and a more accurate and extensive appreciation of its value.

I make no apology for this allusion to the discovery and history of auscultation and percussion; because, in common with every practical physician, I witness daily the incalculable benefits they confer on mankind, and feel that medical science can most truthfully point to both, as discoveries of recent date, which exercise an unquestionable influence in the relief of human suffering and the preservation of life; in this way accomplishing the noble purpose for which our profession has been organised. And if any sceptic wishes to be convinced of the great progress that the practice of medicine has made since the introduction of these methods of investigation, it is only necessary to contrast the facility of discriminating the most frequent pulmonary affections at the present time with the difficulty which confessedly existed prior to the employment of those methods. If we turn to the works of Cullen, in praise of whom Sir William Hamilton could find no language sufficiently eulogistic, or to the more recent writings of Good or Thomas, we will find that these authors acknowledge the inability of the practitioner to distinguish, by means of symptoms, pneumonia, pleuritis, or bronchitis from each other. At the present time, by associating auscultation and percussion with other symptoms, it rarely happens that the discrimination cannot at once be made. And that this improvement is mainly due to these newly-discovered aids in diagnosis is shown by the fact that, to distinguish the affections referred to by symptoms alone, is still as difficult as it was to the physicians I have named. If any one ascribes our success to a more accurate interpretation of mere symptoms, it is sufficient to refer to the mistakes in diagnosis daily made by practitioners who rely exclusively on symptoms; mistakes which might be easily avoided by their practising auscultation and percussion. Bronchitis, pneumonia, and pleuritis, are not unfrequently latent, so far as distinctive symptoms are concerned, and consequently overlooked; or they may be completely masked by the symptoms of other associated affections, and thus escape detection. Of this we have daily examples in fevers and in head affections of both children and adults. But the application of auscultation and percussion at once enables the modern practitioner, if properly qualified, to arrive at a correct conclusion as to their existence.

Chronic pleurisy was habitually mistaken for other affections by the physicians of former times, and still is mistaken by those who do not practice auscultation

and percussion; and yet nothing is now more simple than to determine the existence of this affection by these new methods of investigation. In illustration of how much we are indebted to these methods for improvement in the accuracy of our diagnosis, let us examine for a moment the value of the definition given of acute pleurisy, by the late Dr. Good, in these words:—"Acute pain in the chest, increased during inspiration; difficulty of lying on one side, hard pulse, short distressing cough." Is there a physician who would now accept this as a definition of the disease, or from the presence of these symptoms state that it existed? You all know that he would not, and for the simple reason, that the use of his stethoscope and percussion have taught him that the disease may exist without any of these symptoms, and, what is of more importance, that if they were present, they may indicate the existence of pericarditis rather than pleuritis. How different is the accuracy of our diagnosis of acute pleurisy, as revealed by auscultation and percussion. This will be best shown by a rapid sketch of what they indicate as taking place in such a case. A patient complains of his left side. The symptoms I have quoted from Dr. Good may or may not be present. His physician immediately applies his stethoscope, and through it hears the sound, as of two rough surfaces rubbing over each other; percussion at first finds no dulness. In a few days the rubbing sound ceases to be heard, and it might be supposed that the disease had disappeared, were it not that percussion now detects dulness, owing to effusion of fluid, where clearness previously existed. Day after day this is found increasing in extent. The sounds of the heart now cease to be heard through the stethoscope in the region of the nipple, but are heard underneath, or to the right of the sternum, and can be traced daily passing gradually across till they are heard on the margin of the right arm-pit. In a few days more, the patient has been brought under the influence of medicine, and the fluid which had dislocated the heart begins to be removed; then, day after day can the heart's progress back to its natural position be traced by auscultation, till in a short time, by means of auscultation and percussion combined, we can assert that all fluid has been removed, and the lung has been enabled to resume its natural functions. There are few present whose experience could not verify the description I have given, and all are aware that the information thus obtained may be implicitly relied on, even should the patient's mind be so utterly prostrated as not to be able to answer a single question. It is known to you all that, for any such accuracy in diagnosis, or history of a case of acute pleurisy, we would search in vain the works of either Cullen, Thomas, or Good; yet this accuracy of knowledge is now possessed by every well-educated physician, though he should only have just completed his education.

It is unnecessary to make similar special remarks regarding the accuracy of our diagnosis of pneumonia, bronchitis, and other diseases of the lungs. Indeed, the value of auscultation and percussion might be illustrated by almost innumerable instances, but I shall only notice a few general examples of their utility. By them

we are enabled to distinguish at once between organic and functional disorders of the respiratory organs; to detect serious lesions, while their functions seem almost unimpaired; to determine the precise situation of the lesion, its stage, and extent; to indicate the proper place to which our remedies ought to be applied, as well as to prevent error in their selection, by establishing that essential preliminary to all successful treatment—a correct diagnosis.

Acknowledging, to the fullest extent, the discoveries that have resulted from the application of auscultation and percussion to the investigation of the diseases of the lungs, we are constrained to admit that they have been surpassed in novelty and extent, if not in accuracy, by those that have resulted from the use of these new methods in recognising and distinguishing diseases of the heart and large blood-vessels. These diseases were imperfectly understood until within a comparatively recent period—almost within the last quarter of a century. Formerly, they were thought to be very rare, and, because not recognised till their advanced stages, were considered to be almost uniformly fatal—a popular impression which has still such hold on the public mind as to require extreme caution in announcing their existence. They often escaped detection altogether, in consequence of the attention of the practitioner being directed to other prominent morbid affections, such as congestion, and haemorrhage from the lungs, cerebral apoplexy, and different forms of dropsy, of which they were in reality the primary cause; but which, from an ignorance of auscultation, there was no means of detecting. For, if it has been successfully shown that general symptoms are insufficient to enable us to detect diseases of the lungs, we may, with tenfold accuracy, assert their incompetency with respect to diseases of the circulating organs, as every practical physician is aware that, where they would seem to point unerringly to the presence of organic disease, it may not be present; and, even when it is present, no general symptom might indicate its existence.

Formerly, as I have said, the diseases in question were considered to be rare, and almost uniformly fatal; now they are known to be very frequent; but, if treated in their early stages, they are found, though dangerous, to be by no means uniformly fatal, nor entirely beyond the control of medicine. The facility with which the stethoscope enables us to detect these diseases, and to announce their presence, has caused non-professional persons to imagine that diseases of the heart were surely becoming more frequent. Recently they have been ascertained to be so associated with, and dependent upon, certain diseased conditions of the fluids of the body, that the early application of therapeutic measures to the latter has repeatedly been successful in preventing them.

Great as we have found the revolution produced by the application of auscultation and percussion to diseases of the lungs, it is undoubtedly greater and more important in connexion with diseases of the circulating organs; for these methods have revealed to us diseases, the very existence of which was previously unknown, and enabled us to detect them in their very

earliest stages, and before a single feeling on the part of the patient or a single constitutional symptom had given warning of their presence. And if there be here to-day any member of this Society who is disposed to disparage the value of auscultation, I would ask him could any of our forefathers in medicine have detected in a single instance the existence of acute inflammation in either the lining or the covering membrane of the heart? We know well they could not; and that, even with reference to the most frequent cause of inflammation in both these localities, the only extent to which observation of symptoms through thousands of years had increased their knowledge was, that disease of the heart followed so often on acute rheumatism that they appeared to stand towards each other in the relation of cause and effect. But to tell at what period the heart became diseased, with what morbid process it commenced; in what texture of the organ it had originated, or how its presence was to be detected, was to them impossible.

How entirely has the application of auscultation removed this professional ignorance and incompetency! If we see a patient at the commencement of an attack of acute rheumatism, before the heart becomes involved, we can, by the aid of auscultation, tell almost the very hour in which inflammation will commence. We can tell, in the overwhelming majority of instances, whether it is seated in the interior or the exterior covering of the organ. If in the interior coating, we can tell whether it is the orifice through which the blood enters, or that through which it leaves the heart, that is involved. We can tell whether the disease only obstructs the passage of the blood from the heart, or whether it has so disorganised the valves as to render them incapable of preventing the regurgitation of the vital fluid.

For this precision in our diagnosis, we are chiefly indebted to the labours and observations of Bouillaud, in France, and in England, to those of Williams, Hope, and Latham.

Again, if the exterior covering be attacked, the same sound of two roughened surfaces passing over each other which auscultation detected in acute pleurisy, is found to exist here also. This friction sound may, as in pleurisy, disappear in a few days, and the same erroneous conclusion might be formed as to the cessation of the disease, did not percussion inform us that the natural dull sound over the heart had become extended over a larger space, indicating an accumulation of fluid round the heart. In a few days the patient has been brought under the influence of medicine; the removal of the fluid commences; and when it has so far disappeared as to allow the roughened surfaces to approach each other, we have a return of the rubbing sounds for a short period, and then, by the conjoined application of percussion and auscultation, we learn that all morbid indications have ceased, and that all immediate risk to life is over.

Now, this knowledge has been acquired within the last quarter of a century, and it is with feelings of no little gratification that we can point to it as the result of the genius and industry of our illustrious countryman, Dr. Stokes.

But the value of auscultation is not confined to acute cases alone. Many of you, like myself, have been asked to visit a patient who thought "he had caught cold." Every portion of the lungs is explored with the stethoscope, without finding any disease. At last a faint murmur is heard over one of the large arteries; it is traced to its origin in the heart, and reveals the existence there of deadly disease, of old standing, the patient being all the while ignorant of its existence, and unconscious of any illness in which it originated. If asked of what value is the discovery of this incurable disease, which is causing no inconvenience? I reply that, apart from the scientific interest connected with its detection, it may be of vital importance to the patient. With a knowledge of its existence no intelligent physician would apply those debilitating remedies which, under other circumstances, might be applied with propriety. Nor could he forget, in the treatment of such a patient, that

Hoerit lateri lethalis arundo.

The examples I have given have shown the value of auscultation in the detection of diseases of the heart; but it is of no less importance in a group of cases in which certain symptoms and sensations in a patient lead him to believe that he is the subject of disease, when in reality he is not. These symptoms often imitate very closely those of real disease, and occasion much mental distress and anxious apprehension to the subject of them, lest he may be labouring under an incurable affection. I am certain that there are few members of this Society who have not had opportunities of removing such mental disquietude by the application of the stethoscope, which enabled them to assure their patients that there was no evidence of organic lesion.

Time will not permit me to furnish illustrations of the great improvements that have taken place in our power of detecting those diseases of the substance of the heart and of the large blood-vessels, which are developed in the enlargement, the softening, or the conversion into fat of the former, and in the dilatation into aneurisms of the latter. In the discovery of these, our countrymen, Dr. Stokes, Dr. Corrigan, Dr. Greene, and Dr. Bellingham, have all borne a most distinguished part, having extended our means of diagnosis, and contributed rules for their treatment, that in practical utility could not be surpassed. I am certain that you will not have forgotten how unhesitatingly the indebtedness of our profession and of mankind to Laennec, as the discoverer of auscultation, has been admitted, and also the great perfection to which he had brought its application in investigating diseases of the lungs; but truth compels us to acknowledge that he was not by any means so successful in his application of it to the diagnosis of diseases of the circulating organs; inasmuch as many of the diagnostic symptoms and rules which he inculcated have been found by his successors to be quite incorrect. This, you are aware, was owing to the inaccuracy of the knowledge of his day respecting the motions and sounds of the heart, and not to a want of accuracy of observation on his part. In fact, the order in which the contraction of the various parts of the heart took place, and the cause of

the sounds that were heard, were not ascertained till many years afterwards; and in their elucidation Professor Carlisle of Queen's College, Belfast, took a most active part.

The high state of perfection that has been reached in the diagnosis of diseases of the heart and large blood-vessels has resulted from the researches and discoveries of Laennec, Corvisart, Collin, Louis, and Bouillaud, in France; of Hope, Williams, and Latham, in England; of Stokes, Corrigan, Green, and Bellingham, in Ireland. Nor do I consider that I am detracting from the merits of British stethoscopists, if I assign a pre-eminent position amongst them to our countryman Dr. Stokes. He has shown himself to be a master in the diagnosis of disease of both the heart and of the lungs—in the former discovering almost all that we know of pericarditis and fatty degeneration; in the latter, the differential diagnosis of intra-thoracic tumours. Indeed, by his discoveries and published works on the diseases of the respiratory and circulating organs, he has earned for himself a position in the history of auscultation, only second to that of the immortal Laennec.

Whilst referring to what we owe to distinguished men in our own and other countries, in this department of medical science, we may observe, that we are not aware of any contributions Scotland has furnished to it by any of her physicians, or the professors in her universities or colleges. Dr. Hope, who wrote so ably on diseases of the heart, was, indeed, born in Scotland, but he pursued his investigations into cardiac diseases in England; so that we think it will be found, that all the really valuable additions which have been made, out of France, to the diagnosis of the diseases of the lungs and heart, have resulted from the researches of either Englishmen or Irishmen, in which investigations, Ireland's sons have borne no inglorious part.

We must not, however, forget how much our therapeutic knowledge has been advanced by the zealous and judicious manner in which Dr. Bennett, of Edinburgh, has introduced cod-liver oil as a remedial agent in the treatment of thoracic and other diseases.

I have now terminated my inquiry into the progress that has been made in our knowledge of diseases of the lungs and of the heart; and I believe that I am justified in stating that if medical science could indicate no other discoveries than those I have mentioned, they are abundantly sufficient to prove that the slander that has been published against us was unfounded and unjust. More numerous proofs of advancement could have been given, had I not been compelled to limit myself to an enumeration of some of the most prominent, the value and accuracy of which have been admitted by the most intelligent and trustworthy physicians in every country. I must add that the largest exercise of charity cannot reconcile us to the opinion that a discovery like auscultation and the stethoscope, which was the theme of conversation amongst all classes in the community, and which had its aid invoked by the highest and wealthiest in the land, as well as by the poorest of the poor, could have been so utterly unknown to the reviewer I have named, as to warrant his asking the

disparaging question—"Has the practice of medicine made a single step since the days of Hippocrates?"¹

I have next to inquire into the improvements that have been effected in the diagnosis of the diseases of the digestive and eliminative organs. Many asserted discoveries in this department have not yet received the assent of the majority of physicians; and as in my examination of the nervous, respiratory, and circulating systems, I only noticed such discoveries as had met with general acceptance, a similar course here will render my notice a very brief one. Notwithstanding the increase to our knowledge of the physiology of digestion that resulted from the observations and examinations made by Dr. Beaumont, through the valvular opening in the stomach of the Canadian, St. Martin, we are still compelled to admit that little, if any, improvement has taken place in acquiring a more accurate diagnosis in the diseases of the stomach. Some progress has, however, been made in distinguishing the inflammatory diseases of the intestines. The researches of the late Dr. Abercrombie have shown that inflammatory pain, when associated with a loose state of the bowels, may be, in the majority of instances, accepted with considerable confidence as indicative of the mucous coat of the intestines being involved; that pain, if accompanied by a constipated state of the bowels, may be interpreted as symptomatic of inflammation of the muscular coat; and again, that when the inflammation is limited to the peritoneal coat there will be pain, soon followed by dulness on percussion, and that the bowels may be either loose or constipated. Previous to those investigations of Dr. Abercrombie, all the inflammations of the bowels were included under a common name, and the peritoneum supposed to be frequently involved, when the mucous membrane alone was affected, it being now well ascertained that the serous and the mucous tunics of this organ are rarely involved in the same acute inflammation, except when occurring in the puerperal state.

With respect to chronic inflammation of the peritoneum, an interesting application of the law of tubercular development was found to apply. Louis had observed, during his researches into tubercular disease of the lungs, that if, after the age of fifteen years, tubercles, or grey semi-transparent granulations, were found in any organ, they existed at the same time, in a more advanced stage in the lungs. And, as chronic peritonitis, occurring subsequently to the age of puberty, is always tubercular, an application of the law just stated indicates that that disease is always associated with tubercles in the lungs, although their numbers or development may not have intimated their presence. The well known accuracy of Louis's observations requires us to admit this as a fact, and it should never be forgotten in the treatment of chronic peritonitis, for it at once prohibits the use of mercury, which has been found of such unquestionable value in the treatment of the acute disease. The only eliminative organ in the abdomen, in which the diagnosis of its diseases has made undoubted progress, is the kidney. About a quarter of a century ago, Dr. Bright discovered

¹ Op. Cit. p. 253.

that this organ was very frequently the subject of disease, which gave origin to a number of other secondary diseases that, previous to his investigations, had never been supposed to be in any way connected with the kidney. This state of the kidney he considered capable of being ascertained by a diminished specific gravity of the urine, but especially by the presence of albumen in it. A considerable amount of discussion and investigation, continued even to the present day, followed his announcement of this hitherto unknown disease. Some have differed with him respecting its nature, others as to the pathognomonic value of the diagnostic symptoms he had announced. All, however, are unanimous in acknowledging the kidney to be liable to a disorganisation previously unknown, and that its detection depends on an examination of the urine. In honour of the discoverer, it has received the name of "Bright's Disease," which will perpetuate the name of this distinguished physician, like that of Mr. Pott, through all future ages of our profession, and mark him as one of the most accurate observers of symptoms during the lives of his patients, and a successful tracer of them to their cause after death.

It is not without some interest to remark, in passing, that notwithstanding Dr. Bright's unlimited zeal in examining patients when alive, and their bodies after death, yet he possessed so little moral courage, that when ill himself, he would permit no minute investigation to be made into the nature of his disease; so that, although he had the advice of some of the most eminent physicians of the metropolis, yet from compelling them to rely upon mere symptoms in the formation of their opinion, he died without his disease being detected, although the examination of his body after death proved that the application of the stethoscope would have revealed it in a few seconds.

But, to return to the diagnosis of Bright's disease of the kidney. If some recent statements be verified, there would at last appear a means of reconciling the conflicting opinions and statements I have alluded to, and of establishing some most valuable symptoms for diagnosis. The researches of Dr. George Johnston and Dr. Wilkes, some years ago, conjoined with the recent investigations of Mr. Dickenson into the particulars of a large number of cases treated at St. George's Hospital, appear to have proved that there are two forms of diseased kidney to be met with under the name of Bright's disease, and that each of these possesses peculiar diagnostic symptoms, amongst which Mr. Dickenson now wishes us to include the age of the patient. First, there is an enlarged kidney with a smooth surface, in which it is the secreting surface of the tubes that is deranged. The diagnostic symptoms of this form are stated to be scanty urine, with a specific gravity above 1,015, much albumen and coarse granular tube casts; considerable dropsy; the average age of fatal cases being 28 years. In the other kind, the kidney is contracted, granulated or lobulated on the surface, and the disease seated in the tissues between the tubes. The diagnostic symptoms of this form are stated to be a rather abundant secretion of urine, with a specific gravity below 1,015; little albumen; some transparent tube casts, loaded with fat or oil; little

dropsical effusion, and the average age of fatal cases 50, the patients being often gouty. My own experience leads me to believe that this new classification and indication of the symptoms peculiar to each may be relied on in practice, if we take care to separate those cases in which the urine contains albumen, in consequence of impeded circulation through the heart.

Here, again, we have another example of the discovery of a new disease and its diagnostic symptoms, resulting from the observations and researches of physicians within a comparatively recent period. Nor must we forget that Dr. Christison, colleague of Sir William Hamilton in the Edinburgh University, took a very distinguished part in indicating the secondary diseases that most frequently appeared during the progress of Bright's disease; whilst Dr. Geo. Johnston, and, more recently, Dr. Basham, have most successfully applied the microscope in detecting the various kinds of casts and transudations that are found present in the urine during the course of this disease. Indeed, the latter asserts that greater dependence can be placed on the revelations of the microscope than on those other diagnostic marks hitherto relied on.

The recent researches of Dr. Addison, of London, have directed the attention of physicians to a diseased state of the supra-renal capsules, and to a frequent association with it of a peculiar discolouration of the skin, and a state of great constitutional langour and debility. As yet, however, it has not been proved that these exist in the relation of cause and effect; nor has much practical utility resulted from the discovery.

I have now passed in review the more important discoveries that have been made during the last fifty years, in connection with the diseases of the three great anatomical divisions of the human body. In all of them we have found evidence of additions to the knowledge of the practice of medicine, that could not have been anticipated at the commencement of this century. There are few amongst us who have not read the terms of derision in which all the leading journalists received the announcement of what auscultation and percussion proposed to effect; and we now know that they vie with each other in proclaiming their success. Notwithstanding the physical obstacles opposed to a minute investigation of another department, we have found discoveries effected of the very highest importance, and conjoined with a more accurate interpretation of symptoms in their diagnostic, therapeutic, and prognostic relationships; all contributing to the preservation of life. And, lastly, we have had revealed the existence of a most fatal form of disease in one of the eliminative organs, and its diagnostic symptoms established on a most certain and accurate basis. With such indisputable evidence of progress in the practice of medicine, are we not justified in appealing to every impartial mind, whether a satisfactory reply has not been furnished to the defamatory remarks which a high name has circulated against us.

Had time permitted, I might have alluded to the glorious termination to the investigations of the physicians of the last century in the discovery of vaccination by the immortal Jenner, in 1796, which is estimated to save at least 500,000 lives each year, and which, if

unacknowledged by the reviewer I have named, had elicited from the savage chief of the Indian tribes, the following most striking language:—"We shall not fail to teach our children to speak the name of Jenner, and to thank the Great Spirit for bestowing upon him so much wisdom and so much benevolence." I might have alluded to the labours of Howard, the philanthropist, a member of our profession, who has effected such an annual saving in human life by his reformation in the management of jails and lunatic asylums. I might have instanced the saving of life that has resulted from the practice of medicine in its obstetrical department, so that the mortality from child-bearing has been reduced from one in fifty to one in two hundred; and that, from a better management of children's diseases, and attention to hygemics, 100,000 lives are now annually saved, when compared with the mortality that prevailed among children less than two centuries ago. And, finally, I might mention the prolongation of human life generally in these countries, resulting from a more successful treatment of diseases, and from the adoption of various sanatory arrangements, first suggested, by our profession; so that, whilst it is known that one in every twenty-one of the inhabitants of England and Wales died annually about a century and a-half ago, now the bills of mortality only indicate one in every forty-five.

I had originally intended to have entered more minutely into these subjects, and to have reserved a portion for a closing address. I feel compelled, however, to condense both addresses into one, and to indicate only the more prominent discoveries in our science. I trust that enough has been said to establish for medicine a valid claim to an unquestioned position amongst the progressive sciences. I have only to regret that the enumeration of the proofs of its advancement, and the defence of its practitioners from the slanders that have been published against them, had not devolved upon one more competent to the task.

Gentlemen, the value of a society like this to ourselves, as well as to the public, the spirit that should influence our proceedings, the necessity for each member exerting himself to promote its success, have all been so well placed before you by others, that it would be a work of supererogation did I dwell on them again. Aware that my position as President renders it undesirable that I should be a frequent contributor to your proceedings, I have to hope, that the Session we now enter upon shall be productive of such varied and valuable communications from you all, as to prove that your zeal, industry, and anxiety for the prosperity of this society have in no degree diminished. I enter on my duties, pleading for an extension of your forbearance, in consideration of my many shortcomings, and with unfeigned anxiety, lest anything should occur that would in any way check the hitherto prosperous career of this society.

Need I add, how desirable it is that all possible courtesy should be extended by you towards each other during debate, so that when the session closes we shall separate with those feelings of mutual esteem and respect which it is desirable should exist among the members of a profession that has been organised in

harmony with the commands of the Great Physician to His disciples, when He said—"Into whatsoever city ye enter, heal the sick that are therein." Having such an authority for the practice of a profession which exercised the sympathies of even Divinity itself, I shall close in the not inappropriate language of an eloquent historian of medicine, who says—"Who of us shall forget its ever-living charities; its moving scenes of joy and sadness; its many sunny aspects; its benignant, ennobling, liberalising influences; which few beyond our own circle can properly appreciate, and none so well understand as ourselves."

It was moved by Dr. FERGUSON, seconded by Dr. MOORE, and resolved, "That the Address of the President be published as part of the Transactions."

The PRESIDENT then presented to the members a handsomely-framed engraving of the late Dr. Malcolm, Founder of the Society. He was sure his departed friend required no eulogium here, as he lived in the memory of them all; but he hoped that his example would excite them to emulate that zeal which was so characteristic of him.

SECOND MEETING.
November 5th, 1859.

The President in the Chair.

Mr. BROWNE introduced a patient on whose foot he had recently performed an operation. This man, S. G., aged twenty-two, some four years ago, first suffered from strumous disease. He then had a tumour over the carpal end of the radius, which, after some time, suppurated. Three years after, ten months since, he felt pain over the metatarsal bone of the great toe of right foot. This part became enlarged, and finally suppurated. On examination, the metatarsal bone and first phalanx of the great toe were found to be in a necrosed state, necessitating their removal. Seven weeks since the parts were amputated, and the wound healed up kindly. He now walks well, and with a very slight halt in his gait.

While under treatment, a portion of the radius was found to be necrosed; this was removed, since which the open sore, of several years' standing, has completely cicatrised, and the man's health, formerly very bad, has been quite restored.

CASE OF ELEPHANTIASIS.
By Dr. Babington, Surgeon, Londonderry Infirmary.
(Read by Dr. Cuming.)

H. S., the subject of accompanying drawings, was admitted into County Londonderry Infirmary, 15th August, 1855, presenting the appearances accurately delineated, and sketched soon after his admission.

He did not complain of any particular disease, but wished to have something done to his leg, the weight of which caused him much annoyance.

He was a man of weak intellect, and could give but an imperfect account of the commencement and progress of his case. The following particulars are all which could be obtained:—Aged thirty-six years. Disease

commenced in the skin of his back, over the lower part of the spine, when fourteen years of age, and gradually increased to its present size, as represented in the drawing. His leg began to enlarge about ten years since, and the tumours, scattered over the chest and trunk, appeared at intermediate periods—those on the face and neck since the leg began to enlarge. The leg measured twenty-seven inches in the centre of the swelling, which was quite loose, without any deep attachment, and rolled about from side to side over his foot, the skin of which was natural in appearance. An ulcerated opening existed in the lower part of the tumour, from which an ill-digested sanguous discharge flowed in small quantities. He complained of no pain either internally or externally; his urine presented no morbid indication; there was no evidence of any internal organic disease, with the exception of the left side of the chest, in which no respiration could be detected. He complained of weakness, and suffered from occasional attacks of diarrhoea. He remained in hospital till December 8th. He was again admitted on 10th April, 1856; and remained till 30th October. His appearance had undergone no change, the leg measured thirty inches. He spent the year 1857 wandering over the country as a mendicant, and again returned to the hospital on 10th May, 1858, and remained to 12th August. At this time he was suffering from severe and protracted diarrhoea. The leg now measured thirty-four inches; the other appearances had undergone no change. He was much weaker than formerly. He was admitted again, for the fourth and last time, in a state of extreme debility and prostration, on the 4th January, 1859. The leg measured thirty-five inches, and he was labouring under very severe diarrhoea, which baffled all treatment, and continued till 19th June, when he died exhausted. On the day of his death the leg measured twenty-seven inches.

The result of the post-mortem examination was anything but satisfactory. The drawings before the Society accurately represent the external appearance of the body, except that the integuments were of a darker colour. There was a total absence of fat and cellular tissue, and the greatly-thinned integuments were everywhere adherent to the muscles underneath, which were wasted and of a pale greenish colour. The tumour could be easily dissected off and had no subcutaneous attachments. The brain was softer than in health, but presented no other morbid appearance. The heart was softened in its muscular structure. Right lung healthy. Left atrophied, adherent to the spine, carni-fied, and about the size of a turkey's egg. Liver, kidneys, and spleen healthy. The peritoneum and mesentery presented no morbid appearance, but the internal surface of the intestines was thickly studded over with small tumours resembling those on the skin. A slice of the leg and one of the cutaneous tumours were microscopically examined by Mr. M. Collis, of Dublin, and pronounced to belong to a class of tumours denominated "dermoid," non-malignant, "and having a great tendency to multiplication in the same subject." A slice was also sent to Dr. Cuming, but was decomposed before it could be examined.

I had hoped to have exhibited the leg for the

inspection of the Society, but notwithstanding the greatest care, it became rotten and offensive, and the only portion that remained at all capable of examination was forwarded to Dr. Wales on the 28th inst., to be laid on the table.

CASE OF HYPERTROPHY OF CLITORIS AND NYMPHÆ. BY
SURGEON BROWNE, R.N.

The plaster casts upon the table illustrate the appearance of the morbid parts before removal, and the condition after. The first shews the size and position of the flap-like appendage, as it lay in front of, and concealing the vulva; the second shews the growth raised up, and displays the right nymphæ greatly enlarged; the left not so much so; while the third exhibits the appearance of the parts after the removal of the growth, and healing had taken place.

As will be seen, the hypertrophied structure measured 5½ inches in length, 3 in breadth, and was 7 inches in circumference at its largest point. The patient from whom these casts were taken, and this structure removed, had been for some years a prostitute, though she is now only in her 19th year. She states, that at the age of 13, she first had connexion, and suffered injury: from that time, however, she continued for some three or four years to earn her bread by prostitution; she then became diseased; after being cured, she went to the country for one or two years. About three years since, she observed the commencement of the growth which has since enlarged so much, and for several months she has not been able to pursue her unhappy calling, in consequence of the position the diseased structure occupied.

When she came into the hospital, I was not aware of the nature of the case; but desiring to ascertain her disease, I instituted an examination, and found the condition of things presented by No. 1 cast. Shortly after her admission, I determined to remove the impediment of which she complained. Having brought her fully under the influence of chloroform, I introduced a female catheter into the bladder, so as to mark the position of the orifice of the urethra, that I might avoid injury to that passage; I then made an incision on each side of the neck of the tumour, uniting them above, just within the *labiæ majores*, and then completely dissected off the hypertrophied mass, including the clitoris and nymphæ. There was very little haemorrhage,—two small vessels only requiring ligature. The upper part of the elevated structure, above the vestibule, for about one inch, was united by two sutures—the parts healed up satisfactorily, and left the improved face on affairs that are exhibited by cast No. 3. After the external parts had healed, I examined, with the speculum, and discovered several growths on the walls of the vagina,—some attached by small pedicles, and two by broad bases, the largest being immediately below the orifice of the urethra. These I removed by means of the strong curved scissors. Some of these growths were of hard firm structure, covered by the fine polished mucous membrane; and others were of the soft friable character often presented by condylomata.

On examining the structure removed, it was found to

consist of mucous membrane thickened, the mucous follicles being greatly enlarged, and the submucous cellular tissue filled with the so-called lactaceous deposit, similar to what is observed in cases of lipoma.

AMPUTATION OF FOOT.

Dr. MOORE exhibited a portion of foot, removed by Chopart's operation, on account of ulceration and swelling of a malignant character, at metatarsal joint of great toe, involving the next two toes and adjacent textures. There was considerable redness and tumefaction of the part, accompanied by pain. Dr. Moore was inclined, at first sight, to regard it as a specific ulceration, and it had been so looked upon and treated by the medical gentleman who consulted him in the case. The disease was progressing rapidly, and, fearing that it might extend to the ankle joint, Dr. Moore deemed its removal advisable, knowing as he did that several members of the young man's family (cousins) had suffered, and still are suffering, from malignant disease affecting different parts. One, a young gentleman on his return from abroad, consulted Sir Benjamin Brodie and other eminent members of the profession in London, for disease of the antrum, which had rapidly increased. He came to Dr. Moore with regard to operation for its removal; but from the extent to which the disease had engaged the bones of the face, and the ethmoid, and from its pressure on the eyeball, Dr. M. considered that there was not the slightest room for operative interference. From that time the destruction of the bones of the face, forehead, and lower jaw had progressed with great rapidity, laying open the cavity of the mouth, the orbit, and attacking the root of the tongue, rendering deglutition almost impossible. Another cousin suffered from malignant disease of breast, which was removed, but ultimately attacked her again with a fatal result. Another had a tumour of the neck of a large size, which was of a fibrous character, containing cysts of cheesy matter, which was removed by operation. Dr. Moore has since seen another member of the family with ulceration of the dorsum of foot, on which he looks with suspicion.

THIRD MEETING.

November 12th, 1859.

Surgeon Browne, ex-President, in the chair.

TURNING IN LABOUR WHEN THE PELVIS IS CONTRACTED.

Dr. DILL read the following paper:—The question of turning in the case of a narrow pelvis, or in one very slightly contracted or deformed, must be considered by the obstetric practitioner as one of some importance. It is my intention to advance a few statements and illustrations, which will prove the impropriety of having recourse to this operation. At the same time, I may here state, that I shall not by any means assert that we may not have exceptional cases. My position is, that, as a general rule, turning, under such circumstances, is bad practice. It is Professor Simpson who to a certain extent revived, and now advocates, the affirmative side of the question; and, although his name and his

authority stand high, yet, I believe, the weight of argument and evidence is against him. The following are, very briefly, a few of my reasons for not turning, where the vertex presents, in a slightly contracted pelvis. And, first, have we not all very frequently observed cases of lingering labour, where the impaction of the head in the pelvis was such as to force us, for a time, to entertain the opinion that nothing but artificial means could dislodge it, but which has been expelled after all, by the natural efforts of the mother, thereby proving that while there is in many cases a contracted pelvis, or a want of relative proportion between the head of the child and the pelvis of the mother, nature unaided will overcome the difficulty, by our merely exercising a due amount of patience. Second. In my opinion the vertex is a more favourable part to present to the brim and outlet of the pelvis than that portion of the head which reaches the brim first when extracted by the lower extremities. In the first instance, you have a part presenting of a cone-shape, and by means of the sutures, the bones so overlapping, accommodating, and adapting themselves to the pelvis as to enable the head to pass through, though it maybe with difficulty; while, in the second instance, you have to deal with a firm, angular, unyielding body. I would, therefore, be disposed to ask, if the head, with a vertex presentation, will not pass through a slightly-contracted pelvis by the natural efforts, or even assisted by the forceps, will the delivery not be more difficult, when the head is being extracted, after turning? Third. It will, I believe, be conceded that there is, at all times, considerable danger to both the life of mother and child in turning; and how often, even when turned, is it necessary to call in the aid of either the forceps or perforator to complete the delivery? But, even though these instruments be not required, have we not to contend with the long delay of the head all this time pressing upon the funis? Besides, is not the force which we are frequently obliged to apply to the neck in extracting the head, calculated not alone to endanger the life of the child, but seriously injure the soft parts of the mother? I was called upon to assist Surgeon S., in the case of Mrs. A. It proved to be very tedious labour, from a slightly-contracted pelvis in the conjugate diameter. The head had somewhat descended, but, from the long delay, it was thought right first to try the forceps, and, not succeeding, craniotomy was performed, and the child easily extracted by the hook. She became pregnant a second and a third time with similar results. I was sent for to attend the same woman in a fourth confinement, but on this occasion the breech presented, at which I was pleased, as it, without the risk of turning, afforded a favourable opportunity of testing Simpson's mode of dealing with such cases. The breech, trunk, and shoulders were expelled with some little assistance, but, with all my efforts, the head could not be brought away until it was perforated, reduced in size, and extracted by means of the hook; thus proving that by turning, in such cases, the practice becomes complicated, by adding a second, and it may be a third operation to the first.

Surgeon BROWNE introduced a patient from whom the eye had been extracted in consequence of melanosis, and said that he would lay before the Society an account of the case at a subsequent meeting.

Dr. BRYCE introduced a patient, aged thirty-eight, affected with what were believed to be fibro-cartilaginous tumours of the fore-head of ten years' standing.

CASE OF HORNY GROWTH REMOVED FROM LOWER LIP.
Surgeon BROWNE exhibited a horny growth which had been removed from the lip of a man 60 years of age in the Cookstown workhouse by Dr. D. Hamilton, and which had been sent to the Pathological Society by Dr. Thomas Hamilton, late of Belfast. This, when recent, was an inch and a-half in length, being fully an inch in circumference at the point of attachment to the lip. The man had been a great smoker, but it seems that he had always held the pipe in the opposite side of his mouth. The part from which the growth had been excised healed up, and no return took place. Mr. Browne remarked that the Society had had three different kinds of necrosed structure before it, wherein dame nature's supply of material was more abundant than either ornamental or useful.

FOURTH MEETING.

November 18th, 1859.

The President in the Chair.

CASE OF ANEURISM OF AORTA.

The PRESIDENT gave an account of three of the cases of aneurism, the histories of which he had brought before the Society towards the close of last session,¹ and exhibited the heart and aneurismal tumour of the second of those cases.

The first of those cases died on the 22nd May, after two or three days' suffering from increased stridor, dyspnoea, and much increase of lividity. Post-mortem examination refused.

The second patient died suddenly on the 30th June, without any suffering; a small quantity of blood being found on his pillow. On post-mortem examination the left lung was found adhering to the aneurism, with a rent in it and in the pleura, through which a large amount of blood had been effused into the cavity of the latter. The parts now exhibited have been subjected to a minute examination by Dr. Murney, who kindly furnished the following report:

Heart normal, 9 ounces in weight; the walls of usual thickness, except those of the left ventricle, which were slightly hypertrophied. The aortic and pulmonic valves were healthy and competent. The ascending aorta was of greater calibre than usual; patches of atheromatous and calcareous deposit were found along it, at the origins of the three great vessels, and also on the descending aorta, which were the only parts submitted to me. None of these patches were large. An irregular-shaped opening, which would readily have

admitted the extremities of three fingers, was found leading from the convexity of the aorta to the left side of the left subclavian trunk, opposite the ligamentous remains of the ductus arteriosus. It opened into an aneurismal sac about the size of a cocoa-nut, which rested across the spine, almost symmetrically, being somewhat more prominent to the left side; in appearance it was not unlike a small double hydrocele. In its general expansion forward and laterally, the areolar tissue had been spread out into an innumerable series of layers of fascia. On its anterior surface, rather to the left side, a jagged, irregular opening communicated with the interior of the aneurism. To this part the left pleura had been adherent, and on the giving way of the tumour, the membrane had also burst, permitting the haemorrhage which preceded death. Behind there was no such protection, as the vertebræ, &c., were in direct contact with the stratified layers of coagula. Pressure had caused the removal of nearly the entire thickness of the bodies of the second, third, fourth, fifth, and upper part of sixth dorsal vertebræ; the heads of the ribs corresponding to these bones, on both sides, were also partially eroded; that of the fifth, on left side, was entirely destroyed.

The trachea, oesophagus, and other parts which must have been more or less displaced or compressed, had been removed when the post-mortem was held; I cannot therefore speak of the effects produced by the aneurism on those structures.

A wax model was ordered to be taken.

The third case died on the 4th of May, after several days' severe suffering. Very great oedema appeared in region of right mamma (as in the fourth case), followed by oedema of right arm, and base of right side of neck. Considerable puffiness also appeared over sternum, with much lividity everywhere during last 48 hours.

The symptoms connected with the respiration and the pulse rendered a post-mortem examination most desirable, and every influence was brought to bear to obtain one, but without success.

CASE OF STAPHYLOPHARY.

Surgeon BROWNE introduced a young woman, aged 28 years, on whom he had operated for the case of cleft palate, on the 11th of last October. The part had united perfectly, the sutures having been removed on the fourth day of the operation. He referred to a case he had published in the *Dublin Quarterly Journal of Medical Science*, 25th vol., for 1852, and stated, that since that report, he had operated in four additional cases of cleft palate. In three of his cases, the operation had been completely successful; in one, partially so; and in another, failure followed two operations to which the patient had submitted.

He expressed his intention of giving his views on the subject of staphyloraphy, at some length, in an early number of the *Dublin Quarterly Journal*.

ARTIFICIAL ANUS.

Dr. MOORE introduced a patient who had consulted him with regard to the propriety of closing an artificial anus in his lumbar region. He was a soldier at the siege of Lucknow, and when in the act of holding his musket to

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* See *Transactions*, 1858-59, p. 91.

his shoulder, received a gunshot wound in his left arm, close to the elbow-joint; the ball passed through the arm from without inwards, then entered the abdomen immediately below the lowest rib, and made its exit above the ilium, close to the spine. He was confined in hospital in India for three months, and afterwards transferred to one of the depot hospitals in England, being in hospital eight months in all. There is a slight discharge from the wound of matter, occasionally flatus, and several times during the twenty-four hours feculent matter passes through the orifice. Dr. Moore did not deem it advisable under the circumstances, to interfere.

REMOVAL OF METATARSAL BONE.

Dr. MOORE exhibited the diseased metatarsal bone of the great toe, which he had removed from a lad 15 years of age. There was considerable swelling, and three fistulous openings existed which communicated with the bone. The great toe and the rest of the foot were in a healthy condition. Dr. M. was anxious to try, by the removal of this bone, whether the symmetry of the foot could be preserved, and whether the great toe could obtain any support after the removal of its natural one.

EXOSTOSIS OF FINGER.

Dr. MOORE exhibited a little finger which was a marked example of exostosis of the little finger; the finger weighing upwards of three ounces. The lad's occupation was that of a weaver, and the disease interfered with his prosecution of it. It was removed at the joint, and the head of the metacarpal bone, which was quite healthy, was snapped off merely to preserve the symmetry of the hand.

In answer to a question from Dr. Heeney, Dr. Moore stated that the little finger of the other hand was slightly affected with the same disease. He had observed in such cases that some of the other fingers, and sometimes toes, were similarly altered in structure.

CASE OF AGGRAVATED HYSTERIA.

Dr. C. D. PURDON read the following case—

A. B., aged 14, born in one of the Southern states of North America, of a nervous temperament, was attacked with intermittent neuralgia of the face, which continued for three weeks. After an interval of several days, gastric fever came on, and continued for six weeks. During the attack, the heart was feeble, and the pulsations amounted to 50 in the minute; and this slow state of the pulse continued for several weeks. During the convalescence, she complained of a slight pain in the lumbar region, which lasted for a short time, and was at first attributed to exhaustion. This uneasy sensation remained for some days, and then became more severe at a certain period of the day, and after continuing some time, subsided—recurring again daily at the same hour. She complained now of intolerance of light. After ten days or so, on the subsiding of the lumbar pain, she was seized with a severe pain in the head, and great intolerance of sound; and now, each day, at the same hour, she was attacked with a very

severe pain in the loins for about three-quarters of an hour; and on its subsiding, the head-ache came on, and lasted for an hour, when the paroxysm ceased. This attack came on day after day, increasing in violence and inducing great agony; and when at its height, she would throw herself about the bed in extreme pain, uttering frantic screams for four hours; on the attack subsiding, sleep would come on, and would last for a considerable time. As the disease progressed, delirium, and a state approaching to catalepsy, frequently came on, and lasted for some hours, also frontal neuralgia. The spine, at this time, became very tender, particularly at the lower lumbar vertebræ, the mammae developed, and the uterus tender on pressure; and it appeared that the catamenia would soon appear, which, however, did not take place. The disease continued increasing in violence, the patient became more exhausted each day, and every remedy that could be thought of was used in vain, as well as moral control. She was now unable to use any exertion, and on account of the extreme agony she suffered in her back, she could not be raised, for when forced to sit up, an attack of hysteria was produced, and often followed by a cataleptic seizure.

It now occurred to me to try the effect of ice, which was used successfully by Sir H. Marsh in a case of hysterical vomiting; so, half-an-hour before the paroxysm came on, I applied it to the lumbar region, and kept up the application for four hours with the best result, as there was no attack that day. This treatment was followed for several days, during which time the threatened attacks became less and less, and after the withdrawal there was no recurrence of the paroxysm. Salt water was now poured over the back every day, and a wet bandage applied round the loins, with the best effect. The intolerance of light and sound were greatly abated. After waiting for some weeks, she was raised in the bed, but the pain was so great that she became quite cataleptic for some time; after using strong sedative linaments to the spine for some time, it was again attempted to raise her, at the same time supporting the back, and still there was no improvement. I then made a gutta percha cast of the back, and padded it with cotton wadding, and applied it to the back as she lay on the bed, and then raised her up a little without much inconvenience or suffering. Each day she was raised more and more, till she was able to sit upright. The catamenia now appeared very scantily, with a still further improvement of the symptoms; and, although now and then she had frequent attacks of hysteria, in different forms, she still improved, and was soon able to be wheeled out in a Bath chair. After using the gutta percha cast for six months, she was able to take it off, and in a short time she could sit up in a chair without any other support than the back of it; and, after persevering for more than two years, I had the pleasure of seeing my efforts crowned with success, and the sufferer restored to health.

FIFTH MEETING.

November 26th, 1859.

The President in the Chair.

The PRESIDENT exhibited uterus and uterine appendages removed from a patient who had died in the Union Hospital. A large cyst existed, supposed to be connected with the round ligament of the uterus.

The specimen was referred to Dr. Murney for examination and report.

Surgeon BROWNE introduced a patient from whom he had removed three toes for serpiginous ulcer.

Dr. HEENEY introduced a young man, a millworker, in whom the left lung presented the physical signs of phthisis and extensive pleuritic effusion. He believed that succussion could be produced in the patient.

The patient was examined by several members, and a discussion ensued, in which there was evidenced difference of opinion with regard to the existence of the phenomenon in question.

CASE OF MELANOSIS OF THE EYE,

Surgeon BROWNE, R.N., read the following:—In *The Dublin Quarterly Journal of Medical Science*, for 1857, will be found a paper which I published on melanosis attacking the eye, and which was read before the Belfast Medical Society. In that paper, I stated, in reference to the disease under consideration, that there cannot be a question that melanosis is closely allied, in some respects, to tubercular and cancerous deposits or growths, bearing some resemblance to both; like tubercle, it has not any true organization within itself, while the cancerous growths have; but, like all of these affections, the deposit of which it consists, once commenced, goes on to invade and destroy the organization with which it is in contact, finally leaving an inorganic or foreign mass in place of the vital structure which it caused to disappear. The origin and cause of melanosis we do not know; there is no appreciable sign by which such a development can be prognosticated, nor do we really know what is the first step in a disease which always leads to a fatal deterioration of the frame; hence, in this, as in all the so-called malignant affections, we cannot adopt any means to prevent their origin and consequent growth. Whether the system be in the first instance affected in all or in any of these malignant diseases, is very uncertain; but it must be admitted that a very short time elapses until it participates in the morbid action; and then the disease, no matter under what name, is no longer a local malady and removable. The question then arises, is there any time in the existence of these malignant affections that they can be said to be certainly removable? My belief is, that many of them may be so removed, when in the very early or the inactive stage, and are situated in parts that admit of operation. I believe that some of these growths may be removed with certainty before the taint has been re-absorbed into the system, and hence we have permanent recoveries after the excision of undoubted cancerous or analogous growths. Now, I consider that

melanosis of the eye illustrates this position. Very early removal of the eye has frequently preserved the system from contamination, and consequently has saved life, while late extirpation has always been followed by an outbreak of the disease in several other localities. Hence, I feel satisfied that whenever we find an eye deprived of sight, and presenting the signs of melanosis, we should extirpate at once; and the same remarks apply to cancerous and medullary disease of the eye. Melanosis usually begins within the eye, seemingly in the choroid; it is said also to attack the conjunctiva. I have never seen the disease, in the first instance, in that tissue; but wherever situated it soon invades the surrounding structures. Like the other forms of malignant disease, it is often associated with another form of destructive growth; and the case I am now to submit to the Society illustrates this fact, as will be seen presently.

On the last day of meeting, I introduced to your notice a respectable female whose eye I had recently extirpated in consequence of the organ being affected with melanosis; and the members had an opportunity of observing that the person seemed to be in robust health, as she stated herself to be. Her history may be briefly related. She is 66 years of age, is unmarried, had enjoyed good health till within the last two years. About fifteen years since, after exposure to cold and wet, she had severe inflammation of the right eye, which resulted in destruction of sight, but without deformity of the organ. Some time after, a small black speck became visible on the upper and outer side of the sclerota: this gradually spread until the entire globe became involved in the disease. She never suffered any pain in the part until two years since. When I first saw her in July last, the globe was greatly enlarged and protruding—the camera was clear in its surface, but surrounded with a nodulated black mass, and behind it there was the same dark-coloured appearance. The eye was also quite immovable; while on its outer side, within the margin of the orbit, and in the situation of the lachrymal gland, there was a small hard mass, which could be slightly moved.

I advised immediate extirpation of the diseased structure, as the only chance for prolonging life. At this time, I should remark, the patient's health was very much impaired; she seemed weak and emaciated, she had lost her appetite, and her nights were nearly all sleepless, and she suffered constant severe pain; her colour was very dusky, and characteristic of a person labouring under malignant disease.

The first week in August I extirpated the eye—the patient being under the influence of chloroform,—the haemorrhage was not very great, and was easily suppressed; the entire contents of the orbit were removed, with the exception of some perfectly healthy adipose structure. The optic nerve was divided close to the optic foramen. With the exception of some slight sickness at stomach,—the effect of the chloroform,—the patient recovered without an unpleasant symptom, and she returned home at the end of three weeks, greatly improved in health and in capital spirits, so that she could at last sleep, and eat, and drink, and enjoy life as formerly. More than three months have now elapsed

since the operation, during which time the patient has not had a single uneasy sensation, and her health continues to be excellent; but time alone can shew whether the disease has been not only locally removed, but also completely banished. Of course the chances are rather against her, and in favour of a return of the disease, as there cannot be a question but that the taint of the disease was in the system before its local extirpation. An earlier operation would have given her a much better chance of complete immunity. This has been fully exemplified by the case to which I referred at the opening of this paper. That young lady now enjoys most perfect health, though more than two years have elapsed since I removed her eye. In her case, moreover, the system was still free from any apparent taint at the time of the operation. At all events, in the case immediately before us, the complete extirpation of the eye was the only chance to prolong the poor patient's existence.

The diseased mass removed is now before the Society, and presents the usual appearance exhibited by melanosis of the eye of some standing—namely, a complete destruction of the normal parts, and the substitution of this peculiar deposit. In its present state, after being in spirits for three months, it looks like a mass of fresh consolidated peat; the sclerotica and cornea alone remain, the former surrounded by the melanotic matter externally, and its inside completely filled with the same. When the parts were freshly removed, nothing of the original tissues, save those I have named, remained; the deposit seems to have filled up the inside of the globe of the eye, and then to have burst through the sclerotica on the upper and outer side, a line or two from the margin of the cornea. The growth seems to have been circumscribed or restrained, in a measure, by the suspensory ligament of the eye—the fibrous membrane, which Mr. O'Ferrall has described as the *tunica vaginalis oculi*—and which surrounded the growth like a capsule. This may be still observed, giving a smoothness to the surface of the growth. On the outer side of the removed mass, the hard substance to which I have already alluded was found loosely attached. This was not the lachrymal gland, but a scirrhus deposit, and which, under the microscope, exhibited the usually-observed cancer cells, thus illustrating what has often been remarked by pathologists, the coexistence of what has been considered distinct varieties of the car-cinomata.

On examining the cut optic nerve, its structure was found to be quite healthy, and it had been divided beyond or outside of the capsule-like tissue, which surrounded and enclosed the melanotic mass.

I have already referred to the adipose condition of the orbit; this was perfectly healthy, and unaltered. The lachrymal gland, which was removed, was free from any change, though it was somewhat flattened by the pressure to which it had been subjected by the diseased growth.

SIXTH MEETING.

December 3rd, 1859.

The President in the Chair.

NOTES ON SCARLATINA.

Dr. M'GEE read the following:—

Scarlatina, from its prevalence and severity of late, having become of more than usual interest to us all, to bring the question fully before the Society, I have availed myself of its occurrence in a family which I attend, and where it was ushered in, accompanied, and followed by an epidemic, if not a contagious, visitation of a throat affection, closely resembling *cynanche tonsillaris*, attacking nearly all those of the family who had in former years had scarlatina.

The family in question, residing in a large, airy mansion, in a rural district, where scarlatina of a malignant type had appeared about three weeks before, consisted of fourteen, exclusive of servants, viz., the parents, governess, and eleven children. The five youngest children alone had never had scarlatina. Of the six elder children, five of whom had, in former years, passed through the disease, the youngest, a boy, Master F—, now aged 12, had had the disease (if at all) in so mild a form that a subsequent attack was prognosed.

This boy was attacked on the 14th Nov. by sore throat and difficulty of swallowing, accompanied by high fever, hot but moist skin; tongue thickly loaded with brown fur; no fiery edges on tip; no prominent papillæ. Both tonsils, the uvula and soft palate, were swollen and of a dusky red, and the lining membrane of the posterior nares seemed to partake of the inflammatory action. Notwithstanding the local application of nitrate of silver, and the use of antiphlogistic treatment, the left tonsil and left side of the soft palate suppurred and burst on the fifth day, when the fever subsided, leaving a cool, but harsh, dry skin. The uvula now became rigid and more swollen, as if infiltrated, and its point covered by a diphtheritic patch, stood prominently forward. On the tenth day his pulse had fallen to 68, and his pupils, usually large, were still more dilated. He had no rash nor desquamation, and his tongue, on becoming clean, shewed no trace of scarlatina. On the 12th day he was convalescent, and recovered without further unpleasant symptoms.

On the 19th Nov., five days from Master F— being attacked, one of the younger children sickened—the tongue and throat indicating scarlatina, and a well-marked rash appeared on the third day. Between the 19th and 22nd, the remaining four of the younger children were attacked by scarlatina. Of the five cases, three might be termed scarlatina simplex, and two scarlatina an-ginosa. In all, the characteristic strawberry tongue was present. The tongue covered over its roots and centre by a thick, brown fur. On this coating becoming detached (about the fourth or fifth day), had the raw-beef appearance, with a glazed centre, as if seared by a hot iron. All, during the progress of the disease, had the uvula swollen, rigid, and protruded, or pointed forward, as in the case of Master F—, and in two there were a few small patches of diphtheria on the tonsils. They were all convalescent

on the tenth day. During convalescence, three shewed some slight puffiness of the face. In two, the desquamation was furfuraceous, and in three flaky.

I need not at present occupy the time of the Society with a detail of the local and general treatment. I may state, however, that so long as there was morbidly pungent heat, I used frequent tepid sponging, and gave nauseating doses of ant. tart., without any evidence of sinking. To the tonsils, uvula, and soft palate, nitrate of silver, in both its solid and fluid state, was applied freely during the first three days of the attack.

During the progress of the younger children toward convalescence, three of the elder children, with the governess, and Mrs. F ___, were attacked by sore throat, with much pyrexia and constitutional disturbances; pulse very quick; skin hot, but moist: tongue furred deeply; dark brown at the root and centre; loss of appetite; little thirst. In every one of these cases diphtheritic patches were observable on the tonsils and uvula—very trifling, indeed, in three of the cases, and well marked in two. Mild purgatives when required, stimulants to the throat externally, and nitrate of silver internally, were the remedial measures adopted in four of these last cases, and I tried a capsicum gargle, but it did not answer. I am happy to be able to say that the four here referred to are convalescent, the tongue having presented nothing of the raw, seared look present in the cases of scarlatina.

I have now to describe the remaining case, that of Miss F ___, aged 21. She was seized with symptoms closely resembling those of Master F ___, my first patient, but in a more intensified form, with some pain on pressing over the thyroid cartilage and sides of the trachea; no hoarseness, and little pain in speaking; deglutition difficult, and very painful; the left tonsil and left side of the soft palate more especially affected. The uvula on the second day became rigid, and as if infiltrated. Treatment similar to that adopted in Master F.'s case was used, with the inhalation of the vapour of hot water and vinegar, with external stimulants. On the sixth day, the left tonsil had suppurated and burst; but, although the fever abated, and the pulse fell to 86, she had little relief from pain. Swallowing still difficult and painful; both tonsils tumid; uvula yet more rigid, and turned upward and forward, shewing its posterior surface, with its rounded tip, as if adherent to the soft palate anteriorly. The uvula, both tonsils, the arches of the soft palate, were covered by a diphtheritic exudation, of which some patches were observable on the pharynx. As is observable in some cases of cynanche tonsillaris, there was difficulty and pain felt in opening the mouth. The parts affected were mopped over with a solution of chloride of calcium, of a strength varying from two to four parts of water to one of the ordinary solution. This I have found to be a valuable application in foul or sloughing throat, or mouth affections; but it requires to be applied by means of a mop made of linen, as it almost immediately destroys sponge. Under this treatment Miss F ___ is convalescing, though slowly. The diphtheritic exudation is gradually clearing off, and no fresh patches have shewn themselves, excepting some very trifling ones on the gums over the front

teeth in both upper and lower jaws.¹ As I do not remember to have seen any case recorded in which the peculiar affection of the uvula is described, I request my medical brethren will give me the result of their experience thereon.

Some questions of interest present themselves in regard to these two sets of cases. Were the cases of scarlatina and those of throat affection the same disease? Where should we seek, if we search at all, for the source? Is it probable that the poison was conveyed to his home by the father, nine days before the outbreak in his own family, having been in contact with a mild case of scarlatina at a distance of eighty or ninety miles from home? Should we refer the source of the contagion to the immediate neighbourhood where scarlatina was rife, or to some atmospheric condition? I should not omit to state, that the servants escaped an attack, though not more favourably situated, and though two of them were in close and constant communication with the sick.

In reply to Professor Gordon, Dr. M'GEE referred to the difference in the appearance of the tongue in the two sets of cases. In all the scarlatina cases the strawberry tongue was present, succeeded by a clean, seared or glazed centre, varying in intensity in the patients. In the other cases, the tongue was covered by a thick coating of brown fur. As to the exudation being aphtha, Dr. M'G. observed that neither had the patches the appearance of aphtha, nor were his patients of the class or of the bodily condition in which such a disease could be expected to occur. As to the manner in which the poison of contagious disease had been conveyed, though he had but submitted the question for the consideration of the meeting, he detailed some curious instances.

To Dr. Ferguson, he replied that he viewed the rigid condition of the uvula as analogous to oedema, as it affects the epiglottis. He could not agree with Professor F. in classing all the cases under the head of scarlatina, even while admitting that scarlatina may appear, as he had seen it, twice in the same subject, and that the primary attack modifies or diminishes the severity of a second attack. He observed that, while the scarlatina rash is sometimes absent, yet it is usually in the very severe or malignant cases that the rash is absent. Now, in the two sets of cases there was a marked distinction:—in the tongue, as already described; in the skin, which was hot, but moist; in the throat affections, hot and dry, with a sense of itching in the scarlatina; and there was consequent desquamation in the latter cases, none in the former.

Surgeon JOHNSTON, who had entered the room after the reading of Dr. M'Gee's paper, detailed some complications attendant on cases of scarlatina in his practice, and he referred especially to diphtheritic exudation, and a very interesting discussion arose as to sthenic

¹ * DEC. 31.—Miss F ___ has had a return of the inflammation and swelling in the left soft palate, which rapidly spread across to the right side. Tongue deeply furred, of a dark brown colour; much difficulty of swallowing. The swelling and pain continued unrelieved, until recourse was had to free scarification of the soft palate, when she convalesced rapidly, and is now quite well —Note by Dr. M'Gee.

and asthenic cases, and as to the particular tissues affected in scarlatina.

MALIGNANT DISEASE OF ANTRUM.

Dr. MOORE introduced a patient, a man aged 57, with disease of antrum. About nine months ago he perceived a swelling in the cheek, and afterwards experienced pain in his gum, with loosening of a tooth. He consulted Surgeon Thomson, of Ballylesson, who diagnosed disease of the antrum, and advised him to come to Hospital for operation; but for weeks after this advice he did not present himself. On admission, it was found that the roof of the mouth had lost its resistance; there was swelling of the alveolar process, with slight discharge therefrom, and prominence of the upper maxilla. In this condition he was shown to the Society, but on Dr. Moore explaining to him the nature of his case, and the operation which would be required, namely, to remove the whole of the superior maxilla, with the floor of the orbit, and the great risk of hemorrhage, he would not consent to the operation; nor did Dr. Moore, considering his time of life, urge or wish him to undergo it, but if the patient himself would urge it he would have no objection to undertake the task.¹

SEVENTH MEETING.

December 10th, 1859.

Dr. Murney, V.P., in the chair.

REMOVAL OF TUMOUR.

The SECRETARY exhibited a portion of a tumour forwarded by Dr. BABINGTON, V.P., Londonderry, and read the following communication from that gentleman:-

"I have forwarded for exhibition at meeting of Pathological Society, half of a tumour which I removed this morning at the Infirmary here. The patient was a healthy man, aged 42. The tumour was situated on the right scapula. Had been removed twice before; first time in this infirmary, eight years since; second time, five years since, by a practitioner in his own neighbourhood. The tumour again began to grow about a year since, and has attained its present size. On removal it weighed $1\frac{1}{4}$ lb. It had no deep attachments; was contained in a capsule; and was nourished by ten arteries. You will observe a patch of ulceration on the portion sent, from which he had frequent attacks of haemorrhage."

CASE OF HARE-LIP.

Surgeon BROWNE said—The little patient which I have the pleasure of exhibiting to the Pathological Society, is one I operated on for simple hare-lip on the 15th of October last, and in whose case I used a new sort of suture. Before I enter upon any description of the operation, I beg to call the attention of the Society to the splint and metallic suture I now hold in my hand. This is the splint that has been lately introduced to the

notice of the profession of this country by Dr. Battey of America, and used by him for the cure of vesico-vaginal fistulas; and who, when here, in the month of October, kindly explained to me his operation for the lesion in question. I have not had any opportunity of using his splint and metallic sutures in a case of vesico-vaginal fistula, but at the time of his describing his method of approximating the fistulous edges, it struck me that the appliance could be adapted to a case of harelip. A very short time before this, I had operated upon a fine little fellow, three years old, the son of a gentleman in town, for hare-lip, using the ordinary needles and twisted sutures. The operation was quite successful; but I had so much difficulty in removing the needles, at the end of three days, and as one of them, which I had to leave in for another day, caused deep ulceration of the part, I determined to adopt a different method the first opportunity; and having seen Dr. Battey's splint and sutures, I fixed upon his appliance.

The child before the Society presented soon after. It was then six weeks old, a remarkably fine infant, but with a single hare-lip, the upper part of the fissure exhibiting the shape of the letter V, in consequence of a central part which stood out beneath the septum of the nose. Having the splint prepared, with three sutures attached, I brought the child under the influence of chloroform, rapidly pared the edges of the fissure, and then, with a long three-edged glover's needle, I carried the metallic sutures completely through the right and left sides of the lip, embracing both skin and mucous membrane, about the 16th of an inch from the raw edge. I then drew the sutures home to the splint, saw that the wounds were in close apposition, and fastened each point by taking a turn or two of the wire around and beneath the little shot in which the opposite end was made fast. At the end of three days I removed the splint and sutures very easily by dividing the latter as they lay across the former, then by gently raising the splint upon its edge, the sutures were drawn out without causing any disturbance or pain. The part I found to have united, save at the top—the site of the V-shaped portion—where the splint had got in beneath its point. However, I applied three slips of court plaster, and did not disturb the parts for two more days. On the fifth day after the operation, and while endeavouring to fix the little V part in its place, the child screamed and struggled violently, and the consequence was, the newly united parts were torn asunder. Though not very well pleased, I was not much disconcerted by the contretemps. I prepared a new splint, pared the edges afresh, and once more brought the parts into apposition. The sutures, as before, were removed at the end of three days, and, after carefully dressing the lip for some ten days, with ordinary adhesive plaster, complete and firm union was established.

So far as I can judge, this splint and these sutures will be found very useful in the surgical treatment of hare-lip. They bring the parts into, and retain them in, close apposition; they cannot strangulate any part of the lip; they are very easily removed; and they cause exceedingly little irritation, and might be left in for many days without causing ulceration.

The splint is a thin piece of lead, half an inch in

¹ Since then the disease has increased rapidly, the patient having left the Hospital.

breadth, and as long as may be required. It is perforated by small holes, at intervals of a third of an inch; these are in two rows, a fourth of an inch apart, and a small slit is carried from each hole of one row through the edge of the splint. The sutures are No. 32 wire, iron or silver, and each is passed through a small perforated shot, these shots forming the points of attachment for both portions of the suture.

The only thing to be observed in the application of this apparatus is the accurate passing of each suture through the entire thickness of the lip, and that they are introduced at an exact distance from the cut margin.

EIGHTH MEETING.

December 17th, 1859.

The President in the Chair.

INVERSION OF THE BLADDER.

Surgeon JOHNSTON read the following—

On the evening of Sunday, August 8th, I was requested to visit Mrs. M_____, aged 20 years, and was informed that she was threatened with a miscarriage. On visiting her I found my patient apparently suffering very intensely from "pains," attended with such tenesmic efforts, as to induce her to remain almost constantly on the night-chair. I was told that there had been considerable haemorrhage with discharge of "waters" the previous day. She had been nine months married, and calculated that she was rather more than four months pregnant. For weeks past she had suffered from irritability of the bladder, but enjoyed very fair health until Friday, the 6th, when, after over-exerting herself in lifting a box, she felt great uneasiness in her back, attended with frequent and urgent desire to pass water. These symptoms became more urgent on Saturday, and were accompanied with severe attacks of vomiting. She was unable to retain the contents of the bladder; the tenesmus was most distressing; and she had no relief except when on the night-chair. It was thus I found her on my first visit; and after considerable persuasion I succeeded in getting her to retire to bed. On my attempting to make a vaginal examination, she became very impatient, and complained very much of the intense pain I gave her, far exceeding that commonly given in a vaginal examination. This did not escape my notice. On examining I found a soft fluctuating tumour, in size about that of a pear, pyriform in shape, extending as far down as the os externum of the vagina, and feeling very like a bag of membranes. My finger passed from the base of the tumour along its narrow neck-like portion, into a small narrow cavity, which I considered was the dilated os uteri, being also under the impression that the narrow neck-like portion of the tumour was the cord attached to the ovum. I followed up this cord into a cavity, which I presumed to be that of the uterus. My patient now insisted on being allowed again to remain on the night-chair, and complained of her inability to bear any further examination. Being under the impression that the uterus would expel its contents, and there being no haemorrhage, I gave some general directions and

returned home.

I visited her on Monday morning, and found her in the same state of suffering; and having slept none during the night, her pulse was now excited, and the attacks of vomiting frequent. She was unwilling that I should make any examination. I therefore administered an anodyne, and returned in the evening with my friend Dr. Bryce, to whom I communicated my impression that my patient was going to miscarry. He examined the tumour; but in making his examination, discovered that he could pass his finger up behind it, into the vaginal canal, where he felt the "os uteri" still undilated. He felt puzzled to explain matters, and at first suggested the idea that there was a malformation. On further consideration he concluded that the tumour was a vaginal vesicocele—a prolapsed bladder—and not a bag of membranes.

Dr. Bryce's discovery of the vaginal canal, and of the os uteri still undilated, was certainly new light to me. I again made an examination of the tumour; in doing so, I found that it yielded to gentle pressure, continuing which, it retired upwards, through the cavity which I had supposed to be the os, into the cavity which I had supposed to be the uterus, but from which flowed a small quantity of urine. The true nature of the case was for the first time manifest, viz., that it was one of inversion of the bladder, that the os through which I passed the tumour was the "meatus urinarius," dilated to such a capacity as to admit two of my fingers. I suggested this explanation to Dr. Bryce, and, in order to satisfy ourselves on this point, we made an ocular inspection of the state of the meatus urinarius, which confirmed the diagnosis. Immediate and decided relief followed the reposition of the inverted bladder; the vomiting ceased; the pulse fell; our patient's expression changed; the pain in the back ceased; the urgent symptoms of irritation of the bladder were almost quite relieved; and she soon fell asleep. We visited her some time afterwards, and found that there had been no return of the inversion. I drew off a quantity of bloody urine with the catheter. We enjoined her to employ no voluntary efforts in micturating, for a time; administered an anodyne; and ordered an oil draught the following morning.

The next day I found her comparatively easy. During the next month, however, she suffered from incontinence of urine, even when sleeping; and complained very much of a scalding sensation in the urethra. The urine was bloody, and there was a considerable deposit of mucus. These symptoms were treated, and gradually disappeared. I saw her last on the 3rd of December. She was then quite free from any vesical uneasiness; was able to retain her urine as usual; felt in perfect health; and was soon expecting her confinement.

Believing that medical science may be advanced by a publication of our mistakes, as well as of our successes, in practice, I have given a fair and candid account of this peculiar, and I believe I may add uncommon, case. Prior to my meeting with it, I had never heard of such an accident. I was, therefore, quite unprepared for it, and did not recognise it. It is well that it should be recorded, in order that it may enable others to exercise caution in dealing with tumours of an obscure

character, and attended with perplexing and anomalous symptoms. We should ever be prepared to meet with cases presenting symptoms and features for which we may have no precedent. It may appear strange that I was so slow in recognising the true nature of the case, and that in the first instance I made a very decided, and what might have been a very serious, error in diagnosis (as owing to the view I first took of this case I contemplated puncturing the membranes). I had been led to believe that Mrs. M— was about to miscarry. My mind was preoccupied with that idea; and after I examined, I felt so satisfied that the tumour was the ovum entering and protruding from the os, that I did not see any necessity to push my external examination, and my patient was certainly very unwilling that I should do so. To Dr. Bryce belongs the credit of throwing that light on the case which led to the recognition of its true nature. I have been unable to discern any similar case on record, viz.—inversion of the bladder occurring during pregnancy.

Dr. Meig, in his work on "Diseases of Women," details the history of a case of inversion of the bladder at the orifice of the urethra, in the person of a little girl three years of age. In her case, it was mistaken for a vascular tumour, and was about being ligatured, when its true nature was fortunately discovered. Dr. Murphy had a similar case in Dublin, an account of which I have been unable to find. Jones and Sieveking, in their "Pathological Anatomy," mention the possibility of introversion of the bladder, and even, in females, of its projecting from the meatus urinarius externally. We find, therefore, that inversion of the bladder is an accident with which we should be prepared to meet in females—that we may meet it in children, or in pregnant females. In the former we should be careful to distinguish it from a vascular tumour, and avoid ligaturing it; in the latter from a bag of membranes, and avoid puncturing it, as in either case fatal results would be almost certain to follow. I would only suggest whether we might not mistake inversion of bladder for polypus?

Surgeon JOHNSTON also introduced a patient, the subject of extraordinary contraction of the thoracic parieties, the result of empyema.

NINTH MEETING.
January 7th, 1860.
The President in the Chair.

Dr. HEENEY introduced a patient over the greater part of whose chest a loud blowing sound could be heard, the cause of which was the subject of considerable difference of opinion among the members present.

PERICARDITIS AND HYPERTROPHY OF HEART.

Dr. PIRRIE exhibited a greatly-enlarged heart, weighing 34½ oz. There were vegetations on the mitral and aortic valves. The pericardium was covered with highly-organized lymph. The patient had had an attack of rheumatism two years since, which had left him subject to palpitation, in consequence of the increasing hypertrophy. A recent attack of rheumatism caused his

admission to Hospital, during the progress of which pericarditis had supervened.

TENTH MEETING.
January 14th, 1860.
The President in the Chair.

SOME CASES OF EXCISION OF THE EYE.
Mr. BROWNE read the following:—

In the Transactions of the Pathological Society for last session will be found the record of a case in which I excised the globe of the eye, to relieve the patient from the constant pain which he suffered, and to save the other eye from the destructive effects of irritative or sympathetic inflammation with which it was threatened, and which is a most intractable form of disease, and very frequently destructive of vision.

I have now to bring before the Society two other cases in which I excised an eye, and for similar reasons, and under similar circumstances, to the one already related.

The first is that of A. M'G., aged 54 years, from Islandmagee. About eleven years ago, a chip of metal was driven forcibly into his right eye; the immediate consequence was intense inflammation of the organ, with great swelling: when this subsided, he was without any vision in the eye. From that time, he suffered at intervals excruciating pain in the part, and which, during the time, incapacitated him for any work; latterly, the left eye began to be affected with cloudiness of vision, and he was advised to have the injured eye removed. In August last I excised the globe; he recovered without a single setback, and returned home at the end of a fortnight. Since then he has been quite free from his former severe suffering; he is in perfect health, and the left eye has quite recovered its impaired vision.

As in the former case, a minute particle of metal was found imbedded in the choroid, near the bottom of the eye; and the lens, vitreous humours, and retina, had completely disappeared.

The second case is that of B. M'G., aged 46 years, of Belfast. Some seven years since, this man was struck upon the eye by a chip of metal, which stuck in the margin of the right cornea, but did not penetrate. Severe inflammation followed—this I was enabled to subdue by active treatment. For some time the sight did not seem to have suffered; but, at the end of several months, vision began gradually to be lost, without any severe pain. About that time, he received another blow in the eye from a chip of metal—this rekindled active inflammation, and vision became permanently extinguished. I was not certain whether this latter chip of metal had penetrated the chambers of the eye; but as he suffered very severe paroxysms of neuralgic pain in the globe and eyebrow occasionally, it was considered probable that a foreign body lay in the interior of the organ. About a year ago, the left eye became sympathetically affected, vision becoming cloudy and indistinct; this, with the frequent attacks of pain in the right eye, prevented him from following his trade, that of a "fitter," and he finally consented to have the injured

organ excised. This operation I performed early in September last, and with very good results, as the patient has been free from pain ever since, and the clouded state of vision in left eye is gradually clearing off.

I carefully examined the excised eye, but could not find any foreign body, properly so called; but the structure of the part was entirely changed. The choroid was thickened and strongly adherent to the sclerotic, while it surrounded and was firmly attached to bone-like lamina of considerable density, which represented the hyaloid membrane. There was not any vestige of the retina left, and the lens was shrunk to the size of a mustard seed. This, the nucleus, apparently, of the lens, was attached loosely to the hollow bony plate which had replaced the anterior part of the hyaloid membrane. The iris and ciliary body were thickened—the former adherent to the cornea. The long ciliary nerves were seen penetrating the sclerotic and passing along the surface of the choroid to their destination. On separating the choroid from around the optic nerve, the mouth of the central artery of the retina was visible, and the remains of its direct branch which runs in the vitreous humour to the back of the lens, could be seen entering a foramen in the posterior bony plate which represented the hyaloid membrane.

This conversion of some of the inner structures of the eye into bony or calcareous matter I have frequently seen. I had a beautiful specimen of a crystalline lens I extracted, which had been converted into a solid, polished bony ring, the centre consisting of a very fine cribriform plate. But I have never before seen the vitreous humour, or rather the hyaloid membrane, thus changed into bone-like structure. The cases I have now submitted to the Society beautifully illustrate the several results which may follow inflammation in the same organ in separate individuals. In one, scarcely a vestige of normal structure remains; in another, a part of these structures are converted into a new organization; and in a third, an inorganic material has not only replaced the original structure, but has invaded the surrounding parts also; and beyond that, even the system has become contaminated from this source.

With respect to the operations of extirpation and excision of the eye, I need scarcely trouble the Society with any remarks, beyond stating that the one is very simple as compared with the other, as may be imagined, as in the one case the entire contents of the orbit are, or should be, cut out, while in the other, the globe is merely removed.

ELEVENTH MEETING.

January 21st, 1860.

The President in the Chair.

RETAINED PLACENTA.

Dr. HALLIDAY read the following case:—

On Saturday, the 16th inst., I was called upon, at 12 o'clock, noon, to visit Mrs. S_____, aged 38, a dispensary patient, who, I was informed, had been delivered prematurely of her twelfth child, at 6 A.M.; and the

placenta not having been thrown off, the parties became uneasy. I found her in bed, free from pain, but evidently under the influence of drink; there was little or no loss. On making an examination, and exerting gentle traction on the cord, it broke off; the midwife having previously tried to remove it by pulling. I was barely permitted to pass my finger inside the vagina, up to the os uteri, which was considerably closed, but through which I could feel the edge of the placenta. Upon endeavouring to pass my hand a little further, so as to lay hold upon it (having previously firmly pressed over the fundus), she became exceedingly impatient, and would permit no farther interference. I endeavoured to reason with her, but all in vain. I then prescribed ergot, and left. On calling again I found she had not taken the medicine, but said she would not mind anything, as she was well enough, and would be all right. For two or three days she remained free from pains, and had little or no discharge, when she got up and attended to her household duties. On the fifth day after delivery she began to have occasional loss, with pains, which increased up to Tuesday week, the eleventh day, when the mass was expelled, accompanied with violent haemorrhage, occurring to such an extent as to endanger life. She recovered, however, although slowly; and months elapsed ere she regained her usual looks or health.

I should have stated, that during all the time there was little or no pain on pressure; the pulse was but slightly quickened; and the child, though it lived for a short time, could not be quite seven months.

PENETRATION OF BRAIN BY A NAIL.

Surgeon JOHNSTON read the following case:—

A lad aged 15 was, with other boys, amusing himself and them by firing off a pistol, to ram down the coifing of which they used an ordinary cut nail of about four inches in length, as a ramrod. The nail was slightly bent. Accidentally the pistol went off in the hands of one of them, while the nail acting as the ramrod had not been removed. In consequence of the discharge the nail passed through the hand of one of the lads, and entered the brow of the patient, above the internal angular process of the frontal bone, passing horizontally into the brain. He was seen by Surgeon Johnston and Dr. Bryce, who, on examination, found a hard body embedded underneath. The nail was then withdrawn by Mr. Johnston and the boy sent to Hospital.

Dr. MOORE stated, that when the boy was admitted to Hospital there was slight ptosis, with swelling of eyes. He ordered him to be put under a mercurial treatment combined with antimony. This course was pursued, due attention being paid to the state of his bowels, till ptyalism was produced, cold lotions being applied to the scalp, the hair having been shaved off. Under this treatment his pulse, which had risen to 120, gradually became slower. In a few days the exudation from the wound was of a clear amber-like colour, in considerable quantity, and which became gradually less as the wound cicatrized. Dr. Moore remarked that he had seen many injuries of the brain from the wounds of which the same class of fluid exuded when the substance of the brain had been penetrated. Dr. Moore

did not wish to bring him down from his ward, as his pulse rose on the slightest exertion or excitement, but hoped, on that day week, that he might be able to do so.

Dr. HALLIDAY introduced a boy the subject of very frequent micturition, each evacuation of the bladder being followed by a discharge of blood.

TWELFTH MEETING.

January 28th, 1860.

The President in the Chair.

Dr. WALES introduced a patient with an intractable eczema.

INJURY OF THE BRAIN.

Dr. MOORE introduced the boy whose brain had been penetrated by a nail, and whose case had been described by Surgeon Johnston and himself at previous meeting. The lad was doing very well.

TUMOUR OF CRANIUM.

Dr. MOORE introduced a patient with extensive atheromatous deposit, forming a continuous tumour of the forehead and side of the head, who had come to the Hospital expecting its removal by operation. From the nature of the tumour, and its extent, he did not think operative interference advisable, but merely introduced the patient as an example of an interesting affection.

SCIRRUS OF THE PYLORUS.

The PRESIDENT exhibited the liver, kidneys, heart, and stomach of a woman who had died in the Union Workhouse of scirrus of the pylorus. He said—I exhibit to-day some morbid parts removed from the body of a married female aged 56, who died a few days ago in the Union hospital.

She complained on admission chiefly of cough, and some dyspnoea, and that she had suffered occasionally from vomiting. The chest symptoms were soon relieved by the ordinary treatment, when vomiting became a more prominent symptom, and led to an examination of the region of the stomach, where a knotty tumour was found rather to the left of the medial line of the epigastrium, and could be traced to be connected with a larger, but much smoother tumour in the right hypochondrium. There was, however, so distinct a sulcus to be felt between the two, that I considered there was evidence of scirrous pylorus, as well as of enlarged liver. The vomiting was immediately checked by bismuth, lime water in milk, and a diet of broad and milk—a course of treatment which I have often found markedly beneficial in similar cases, only requiring small quantities to be administered at a time. The vomited matters had never been discoloured, or of "coffee-grounds" character, consisted chiefly of food, and an acid, glairy fluid.

The vomiting did not return for fourteen days, when it became for the first time of "coffee-grounds" character, and continued so until her death, accom-

panied by tarry evacuations from the bowels. These, no doubt, led to a fatal termination sooner than I anticipated, for she was neither so emaciated, nor had her abdomen the retracted appearance which almost invariably precedes death in such cases. This latter might, perhaps, be partly owing to the fact that she had never given birth to a child, and, consequently, the abdominal walls had not lost their natural tension, whilst the absence of extreme emaciation, was, no doubt, owing to the fact revealed by the post-mortem examination, that the pyloric orifice was patent enough to permit the digestive process to be generally completed. Like many childless women, she had a considerable beard upon the chin.

The post-mortem examination revealed a moderately dilated stomach, with a dark patch on the mucous membrane of the greater curvature, and a similar, but smaller, discolouration near the pyloric orifice; from these the blood had probably been effused, but there was no ulceration in either. The pyloric orifice was surrounded by a hard, but not very thick, ring of scirrous matter, with nodulated parts on both the mucous and peritonæal surfaces. It admitted readily the passage of the little finger through it; and there was no ulceration. A firm adhesion existed between the pyloric end and the liver; and the sulcus observed during life was still quite evident.

The liver was greatly enlarged, and was studded with a large number of whitish-coloured tumours; some distinct, and having a well marked central depression, whilst in other parts they appeared to run into each other. Where some of these tumours were in contact with the peritoneum of the abdominal parieties, an elevated deposit had taken place on the latter, but without any direct vascular continuity. Similar tumours also existed in the omentum, which was attached to the uterus by a firm adhesion.

A section of the liver found some of the tumours distinct, but the majority coalesced, and left little of the natural structure of the liver to be seen. A few of the tumours had a vascular ring about one-eighth of an inch from their circumference. Their density was not so great as the deposit at the pyloric orifice; but near the latter there was one that was so soft as to bear a great resemblance to broken down reddish cerebral matter.

The microscopic examination by Dr. CUMING confirmed the opinion that the deposit in the liver was that of encephaloid cancer. The spleen was free from disease.

ENLARGEMENT OF TESTICLE.

Dr. MOORE introduced a patient who had been admitted to hospital with a chronic enlargement of testicle to the size of an ordinary clenched fist. He did not look upon it as a malignant disease, but as that class of enlargements of the testes which is remediable by the introduction into the bladder, twice or so weekly, of a full-sized metallic bougie. This course was persevered in for two or three months, and now the testis was reduced to almost its natural size, and the patient stated that its wonted action was renewed.

FLUID FROM RANULA.

Dr. MOORE exhibited a quantity of glairy amber-coloured fluid, about 3 ounces, which he had removed from the mouth of a middle-aged man in the hospital on the previous day. The patient presented himself with a tumour near the ramus of the jaw, as large as a turkey's egg, which fluctuated; but opening the mouth, the tongue was seen to be pressed aside by a well-formed ranula.

A portion of the tumour was lifted up by the forceps, and about an inch in length of the covering below the tongue was snipped away with scissors. The glairy fluid exhibited flowed out with slight pressure upon the tumour. The sac was then thoroughly emptied, and its lining membrane was swabbed with a strong solution of caustic. Dr. Moore found by the introduction of his finger that no concretion was present. The operation has been followed by complete recovery.

THIRTEENTH MEETING.

February 4th, 1860.

The President in the Chair.

CASE OF HYSTERIA.

Surgeon JOHNSTON introduced a girl affected with what he supposed to be hysteria. She was in a debilitated state, and had menstruated scantily, though regularly. The most marked characters of the case were the frequent recurrence of incomplete syncope, without loss of consciousness, apparent respiratory distress, and a slight cataleptic tendency, as exhibited in the momentary preservation of any altered position of the extremities. Considering debility to be the chief cause of the malady, he had prescribed suitable sanatory measures, together with chalybeate and other haemetic remedies, but so far without any apparent effect.

Concurrent opinions as to cause, nature, and treatment of this case were expressed.

PUERPERAL OBSERVATIONS.

Dr. W. AICKIN exhibited a placental cord 4 feet 3 inches long, which had encircled the child's neck five times. The case did not present any remarkable features; the only point worthy of note being the fact that ergot had failed to excite uterine action, while opium had succeeded. In the course of his remarks, Dr. A. condemned the side as a lying position in advanced labour, and recommended the back, which led to the following observations on the merits of different parturient postures.

Dr. PATTERSON—"The back is the best position during labour."

Surgeon JOHNSTON—"Nothing is gained by separating the knees during the expulsion of the child."

Dr. WALES—"The practice of abducting the knees during expulsion of the child endangers the perineum by advancing and tightening it anteriorly"

Dr. HALLIDAY, in reference to the cord encircling the neck: "It is elongated in proportion to its requirements in this respect."

The PRESIDENT—"Observed the funis so much shortened by entwining the neck as to retard labour."

Surgeon BROWNE—"No advantage generally in any particular position in labour, save convenience; uterine action being sufficient to effect expulsion of the child without other muscular aid, as evidenced under the administration of chloroform."

Dr. M'GEE—"Will not agree with Surgeon Browne in ignoring the powerful aid afforded by the respiratory and abdominal muscles."

Dr. DILL—"Most women seek fixed points for muscular action during the throes of labour. If this has a purpose, auxiliary muscular action has its advantages. The left side is the most convenient; and in the obese, separation of the knees during expulsion of the child diminishes resistance. The occasional success of opium in exciting the uterus to action is due entirely to its first or stimulating effects."

EXHIBITION OF RECENT PARTS.

The PRESIDENT exhibited some morbid parts removed from the body of a female, aged 25, who died of phthisis.

A large amount of tubercular deposit existed in both lungs; and the disease appeared in a more advanced stage in the right than in the left, which had also been indicated by auscultation during life. The liver was very pale, greatly enlarged, and much thickened at its base; its surface was smooth, pitted, and broke down easily on pressure, and was deeply indented by the pressure of the ribs. When a slice of it was placed in the centre of a bright fire, it shrivelled up like a piece of leather, without emitting any sparks or flame; nor was any mark left on paper when a piece of it was laid on it on the heated bar of the grate. As it did not therefore furnish the indications usually relied on as indicative of a deposit of fat, a piece of it was boiled in a weak solution of nitric acid, when it became white—in so far tallying with Dr. Budd and Dr. Beale of what takes place with one test when the deposit is chiefly of an albuminous nature.

Dr. Cuming then examined a portion with the microscope, and found a considerable amount of oil globules; but as some oil might be present when the deposit was chiefly albuminous, Professor Hodges, M.D. kindly undertook to ascertain the per-cent of fat, and found it to be nearly 9½, the healthy proportion being about 4, which has been found by Dr. Beale to be reduced to near one, or even so low as one-half per cent., when the enlargement of the liver was due to an albuminous deposit. This chemical analysis proving that the enlargement of the liver was owing to a deposit of fat and not of albumen, the fire and the paper tests were applied again at the end of ten days, when it was found that owing to the evaporation of fluid, and consequent drying of the liver, it now both stained paper and emitted sparks and flame in the fire, thus indicating that before a liver can be pronounced not to be enlarged by fat, care must be taken that it is sufficiently dried when applying the rough and ready tests that were relied on till the introduction of the microscope, &c.

Great dulness, on percussion, existed at the base of the chest, but the enlargement of the liver was so evident on percussion and to touch, that no difficulty

existed in accounting for the dulness. There was neither jaundice nor ascites, and not more œdema of the limbs than is usually present in phthisis. This patient denied that she had ever expectorated blood, nor was any observed during her two visits to hospital.

FOURTEENTH MEETING.

February 11th, 1860.

The President in the Chair.

CONGENITAL MALFORMATION OF THE PUPILS.

Mr. BROWNE introduced a little girl, aged 10 years, in whom there exists a peculiar malformation of the iris in each eye. In the right, the pupil is transverse, and has a double aperture; in the left, the pupil is single, but is also transverse, the slit extending to the ciliary attachment on the outer side, while on the inner side, the iris presents the appearance as if the transverse slit had become united for about half a line in breadth. Both pupils, upon being dilated with atropia, became nearly circular; both apertures, in the right, dilating so as to leave a merely thread-like division of the iris between them. Vision in the left eye is good, but in the right, is very imperfect, in consequence of the anterior chamber having become greatly enlarged from hydrocephalus. The cornea, and about a line in breadth of the upper portion of the sclerotic, being very much thinned, Mr. Browne expressed it as his opinion, that nothing could be done to remedy these changes of structure in the right eye; but that tonic treatment, rest, and care, might prevent the left eye from becoming dropsical also.

IMPACTION OF A PIN IN THE THROAT FOR FOUR MONTHS.

The SECRETARY read the following case from Surgeon M'DONNEL, of Randalstown:-

Catherine M'Gee, aged 61, a country servant, had been in town in September last; on her way home, she put a pin in her mouth, and forgot about it. On getting to her master's, she ate some bread, in swallowing which, she found something prick her at the lower part of her breast. She endeavoured to bring it up by retching, and succeeded so far as to get it to the upper part of the oesophagus. She now found it impossible to swallow anything, either food or drink, and she remained in this state for eight days, when she applied to me. I examined her throat carefully, but could find nothing; however, I passed a probang into the stomach, and this enabled her to swallow, but she complained of pain in doing so. I heard no more about her till the 1st of January, when she came to me, saying she was sure the foreign body still remained, and pointed to a swelling over the thyroid cartilage. On examining this swelling, I thought I could find fluctuation, and made an incision in the median line,—a little unhealthy pus came away, but I could detect no foreign body. I desired her to poultice for a few days, and return again. She did so on the 3rd inst., but I was unsuccessful this time also. She became much alarmed, and requested me to do anything that I considered safe to relieve her. I was cautious in cutting in so intricate a situation. I made my first incision in a V shape, extending the

lateral cut along the corner of the thyroid body, and raised the angular flap, and after a long and careful search, I found the head of a pin protruding through the hyo thyroid ligament, about half-an-inch from the surface. The greatest difficulty I experienced was from the cough produced on touching the deep parts. I would infer from the way it came out, and its appearance—the head and great length of the pin, being oxydized carbon, and the point clear—that it passed across the trachea and pierced the oesophagus; but how it got into this position, and how she tolerated it so long in so important a part, is what I cannot account for; and also the head of the pin appearing first, seems to me strange. I may add, the old woman got immediate relief, and she is now quite well.

DISEASE OF THE HEART.

The PRESIDENT exhibited the heart, kidneys, and liver of a female, aged 57, who had died of dropsy.

When first seen, she was found lying flat in her bed, with intense circumscribed lividity of her cheeks and nose, general anasarca and ascites, with lividity of forearms and legs, and pulsation in both jugular veins. She suffered much from cough and dyspnoea, and large crepitation was heard over both lungs. The rales in her chest prevented any correct conclusions being formed as to the state of the heart. When the lung symptoms had been considerably relieved by treatment, a systolic murmur was heard below the nipple, which could be traced with increasing distinctness towards the cuniform cartilage, but not in the direction of the side:—at the right side of the upper portion of the sternum, three sounds were audible, having a striking resemblance to the cantering sound heard often in pericarditis. She continued to assume a perfectly prone position to the last, and died sooner than was expected.

Post-mortem examination found a hypertrophied and dilated right ventricle and auricle, which had permitted regurgitation, and consequent pulsation in the jugular veins. The left ventricle had been laid open, without testing the sufficiency of the aortic valves—a deposit had taken place between the folds of membrane forming these valves, and there was a small vegetation on the aortic surface of two of them; a similar deposit, but to less extent, was found also in the pulmonary valves, but no vegetation. No murmur had been heard at the base of the heart during any of these examinations. The kidneys were enlarged and deeply congested, but their structures healthy. On the surface of the left, there was found a cyst containing more than an ounce of fluid. The urine was not albuminous. The liver was enlarged and thickened at its base, where it had several fissures of near an inch in depth. Dr. Murney stated, that he had only met with these in females, and that he ascribed them to the habit of wearing stays—but as these fissures were vertical, it is difficult to account for their production by pressure of this kind.

OBSERVATIONS ON MUSHROOMS.

Professor DICKIE, M.D., made some observations on mushrooms. He said that many varieties of these fungi,

which were considered unsafe as food in this country, were used on the continent. Pickled mushrooms and black bread constituted a meal in some parts of Russia. To the *Amanita Muscaria* he called particular attention. After describing its beautiful appearance, he said it was met with in Autumn throughout Europe, and flourished in Colin Glen, in our own neighbourhood. The Kamtschatkans, and other inhabitants of the north-eastern parts of Asia, used it in a dried condition, as a means of producing intoxication; and he adverted to the long-known fact of its inebriating principle being eliminated by the kidneys almost unimpaired. In illustration of this peculiarity, he said it was common for an individual, his edible stock being exhausted, to prolong his debauch for several days by the more disgusting debauch of drinking his own urine; and also, that the urine of one who had feasted on the *Amanita* was esteemed by his more degraded companions for its inebriating qualities, who in turn, and through several successive persons, could reproduce the original effects. He next called attention to the physiology of the action on the body of this class of fungi as a field for investigation almost untrodden. So far as known, the poisonous mushrooms might be considered narcotic, the first effect being stimulation, and the second, sleep. In conclusion, he expressed himself willing to aid in a more extended inquiry into their actions on the system. He also said that the mushroom fungus could be developed by exposing ergot of rye in a warm and moist situation.

FIFTEENTH MEETING.

February 18th, 1860.

The President in the Chair.

Dr MURNEY exhibited several specimens of the shortening of the neck of the femur from injury without fracture, which were interesting from the liability to error in diagnosis. His remarks will be given in detail in Appendix.

SIXTEENTH MEETING.

February 25th, 1860.

The President in the Chair.

Cases brought forward at this meeting by Professor Gordon, Dr. Moore, and Dr. W. Aickin, on chimney-sweeper's cancer, medullary disease of testis, destructive ulceration of fore-arm, and carcinoma in sub-maxillary region, have not yet been furnished to the Secretaries, but will be given in Appendix.

SEVENTEENTH MEETING.

March 3rd, 1860.

The President in the Chair.

Dr. WALES introduced a child suffering under chronic hydrocephalus. The head was greatly enlarged and increasing, and yet the little patient was improving in general health. Dr. W. observed, that the child's mother

was lying under well-developed small-pox when he delivered her, and he considered the absence of the disease in the child an interesting fact.

Dr. IIARKIN exhibited a girl having a small encysted tumour above clavicle, which, from pulsation derived from the carotid, simulated aneurism.

CASE OF COMPOUND COMMUNICATED FRACTURE OF TIBIA AND FIBULA.

Surgeon BROWNE stated that the specimen before the Society was taken from the leg of a patient at present in hospital, and which had been amputated after an attempt to save the limb had been persevered in for nearly four weeks. He stated, also, that the specimen which he exhibited was a beautiful illustration of the lesion sustained by the bones of a limb from direct violence—the result, in fact, of a heavy body having passed over the leg while it was extended, on its outer side, on the ground. It would be observed, that about an inch below its centre the tibia is fractured obliquely, with a small detached portion; opposite this point there is an oblique fracture of the fibula also. About three inches lower down the tibia is again fractured transversely, the posterior part of the bone being comminuted; the part of the bone between the oblique and transverse fractures is detached and displaced outwards above, its upper point pressing against the oblique fracture of the fibula. It was, he might remark, at these points—at either end of the separated portion of the tibia—that the injury had become compound, as a wound extended through the soft parts to the bone. Then a little above the inner malleolus there is a split into the structure of the bone, perpendicularly for an inch and a half, extending towards, but not into, the ankle joint. The fibula is likewise again broken a little above the outer malleolus. It would be further observed, that the detached portions of the tibia and fibula are stripped of their periostum, and are becoming necrosed.

The immediate cause of amputation, was the amount of suppuration which had taken place, and which was daily increasing—and it would be seen from the specimen before the meeting, that there was no other resource to give the patient a chance for life. Indeed, it is now clear, that from the first there could not have been any reasonable prospect of saving the limb, and it is to be regretted, that primary amputation had not been resorted to. However, in these days of conservative surgery, and as he had not the consent of his colleagues, he did not urge what all along he believed to have been the safest step for the patient.

The question of primary amputation is one of vast importance, and is one, also, frequently of very difficult solution; still, in cases like the one under consideration, the difficulty is, in some measure, removed—as every hospital surgeon must be aware, that in injuries arising from very heavy bodies passing over a limb, there is often, very generally, a much greater amount of lesion, both to the bones and soft parts, than what is indicated by the eye; and that, in these cases, the attempt to save the limb is not only a hopeless proceeding, but exposes the patient to greatly increased risk. In corroboration

of these remarks, his hospital experience had afforded him many examples, and he had, on more than one occasion, to regret some attempts at preserving limbs, which after circumstances had proved to have been wrong in the first instance.

The patient now under notice is doing pretty well, and he hoped would eventually recover.

Dr. ROSS read the following paper
ON TYPHOID FEVER.

Of late years it has been much insisted upon, by many able clinical observers, that typhus and typhoid are different forms of fever, and my own experience leads me to believe that the distinction is well founded and has important practical bearing. The few following remarks will apply to the *Aetiology, Pathology, Semiology, and the Therapeutics* of typhoid fever.

Etiology.—It has been a matter of much controversy whether typhoid fever is infectious or not infectious, which I believe it to be not at all so much so as typhus—Cases have occurred to me in which it appeared to be undoubtedly propagated in this way. I consider the alvine evacuations more than any of the other excretions, a fertile source of its communication from person to person, and that it is prudent to act on this opinion, and to pour some solution of chloride of lime into the bed-pan before using it, and to have the defecations removed from the patient's bed-room at once, and so disposed of as to have as few individuals as possible exposed to their poisonous influence. Defective action of the excreting organs seems to have some influence in the causation of typhoid fever, and in this way I account for its being occasionally a sequel of long-continued delicate health. To neglect of the laws of hygiene, as unhealthy residence and bad sewerage, its origin is most of all attributable. This has been well exemplified in the Windsor Epidemic.

Pathology.—In this disease there is a peculiar fever poison in the blood, and, as in other constitutional affections, so in this, nature tends to throw off the poison by elimination. To Peyer's glands the *materies morbi* is remarkably directed, causing their enlargement, congestion, and too often their ulceration. Thus I view the morbid changes of these bodies, which are so pathognomonic of typhoid fever, as an invariable complication, and not, as some would have us believe, the *fons et origo* of the mischief. Allowing for the difference between an acute and a chronic disease, we may see some analogy between the destruction of Peyer's glands by the fever poison, and the injury to the kidney by the gouty poison. In each case the organ does nature's work, excretes a poison from the system, but in doing so may suffer more or less disorganization.

Semiology.—No symptom is so diagnostic of typhoid fever as diarrhoea, coming on during its course without any assignable cause, or after a mild aperient, and obstinately resisting treatment; with the looseness, gurgling over the ileo caecal valve, and tympanites, are generally combined. Gastro-enteric derangement, foul tongue, and foetid breath, generally precede the diarrhoea. Chest affections are frequent complications, particularly latent bronchitis, indeed I don't recollect meeting with a case in which the pulmonary mucus

membrane was not engaged in a greater or lesser degree. In the early stage only a few rales may be heard, but these often extend, pass through the dry and moist characters, and implicate both lungs. The cerebral functions are often disturbed, and I have been often struck with the alternation between the delirium, bronchitis, and diarrhoea. A rose-coloured rash over the chest and abdomen is another most important sign of typhoid fever. The constitutional affection is indicated by the febrile symptoms, as quick pulse, hot skin, loaded urine, general depression of the vital powers, and pains over the body and limbs.

The difference in the countenance of one in typhus and one in typhoid fever is marked. In the former, from an early period, the face is confused, oppressed, and congested. In the latter, there is an absence, at least in the early stages, of these signs, and the patient is more intelligent when addressed.

It is now well established that typhoid fever is chiefly confined to the ages from 15 to 30—not so typhus.

The duration of typhoid fever is much longer than that of typhus. While in the latter a crisis generally comes on about the 14th or 15th day, typhoid is not unfrequently of several weeks' duration, exhausting the patient, and also his physician and relatives.

Treatment.—The important rule of supporting the system until nature effects a crisis is as necessary in this form of fever as in the other varieties.

The entire affection indicates a bland and farinaceous diet; but there are few cases in which, as the disease advances, wine or brandy and animal broths, with arrow-root, do not become necessary. Much discretion, however, is required in the use both of food and stimulants.

Whilst using these general means, we must keep a strict look out for the complications. If there be head affection, the hair must be cut off, and cold lotion or affusion used at intervals. Leeches and henbane will be useful if there be sleeplessness.

If there be much chest affection, we must be sparing in the use of full opiates, and we will find sinapisms and blisters, hippo, camphor, and ammonia most useful aids, if employed with discrimination.

But of all the complications, the diarrhoea requires the most careful management, preventing it, as much as possible, by regulation of diet, and by abstaining from purging. When it does become troublesome, the opiate enema, chalk mixture and catechu, lead and opium, and counter-irritation of abdomen, are the remedies which I have used with the most benefit.

Attention to the bladder, the prevention of bedsores, general cleanliness, and pure air, are, I need scarcely say, indispensable to the safety of the patient.

EIGHTEENTH MEETING.

March 10, 1860.

The President in the Chair.

CASE OF ELEPHANTIASIS OF PENIS.

Dr. CORRY introduced a young man, aged 22, by occupation a labourer, affected with elephantiasis of the penis. The history of his case was rather peculiar.

He stated that about six years ago he had one day fallen asleep in a field, exposed to the glare of a scorching sun, from which he was awakened by an acute pain in his genital organs; this continued for several days, and prevented him following his usual avocations. From that date his penis has gradually increased in size, and he has had a periodical return of the pain about four times each year. On examination, the penis was found greatly hypertrophied, presenting a fine specimen of the true Elephantiasis Arabum; it measured seven inches in length, and in circumference, five inches at root, seven inches at body, and six inches at glans. The organ had a hard, horny appearance, being intersected by several deep fissures, and studded over with a number of small tubercles; the prepuce was much thickened, and had completely lost its distinctive character. The disease, which had evidently commenced in the penis, was gradually extending, the scrotum and inner parts of the thighs having become implicated.

This case created considerable interest among the members on account of its extreme rarity in this country.

Dr. PURDON said the disease was endemic in Kilkenny.

Dr. C. D. PURDON read the following observations on
THE USE OF THE HYPO-PHOSPHATES.

The hypo-phosphates were first brought under the notice of the profession by Dr. Francis Churchill, of New York, who then stated that he had found the use of them to be very successful in phthisis, but the results in this country not being so very favourable, the preparations had fallen into disuse; but having tried these remedies frequently in gastric afflictions of children with great benefit, I again bring them under your notice as most useful remedies in these diseases. The first case in which I used these remedies, was one of chronic remittent fever, which had persisted for one year and a-half in spite of all remedies, and the little patient was rapidly sinking, and from the state in which she was in, there appeared no release from suffering but death. I may mention the symptoms, viz.—loss of hair; dark coloured rays under the eyes; point of nose red; aphthæ at either commissure of the mouth, as well as in the mouth; gums spongy; tongue covered with a creamy exudation, which frequently exfoliated; abdomen tympanitic, with enlarged inguinal glands; constant diarrhoea, with clayish-coloured stools frequently, at other times rather dark coloured and mucous, always offensive; frequent prolapsus of the rectum, which was dry and glazed and aphthous; vulva covered with aphthæ; limbs wasted, and body covered with small boils; skin dry and rough. As a last resource, I tried the hypo-phosphates, and after persevering in their use, the child rapidly improved, and is now a fine healthy one.

The next case in which I used them was a child that had been under treatment for several months for remittent fever, and was wasting away as children usually do in that affection, no remedy having any permanent effect; and on having recourse to them, the child gradually improved, and the hectic fever, as well as the other symptoms, abated, and the child became

quite convalescent.

I have used these remedies in cases where there was gastric irritation with good results, and from the great improvement that I have witnessed from their use, I can confidently recommend them as a most valuable remedy in gastric and mesenteric affections.

As to the manner in which I use it—I always, in gastric fever, try to improve the character of the bilious secretion; and, should the disease continue after the natural-coloured stools are obtained, then I have recourse to it. In the case of gastric irritation, I give them at once, in syrup, three times a day on an empty stomach.

"RESPIRATORY DISTRESS" NO LONGER A PATHOLOGIC SYMPTOM OF FATTY DEGENERATION OF THE HEART.

The PRESIDENT made the following communication:—

A remarkably well-formed man sought Hospital relief in consequence of his suffering from cough and dyspnœa, and latterly from anasarca. During the night after admission, he had a severe paroxysm of dyspnœa, which caused him to rush into the lobby for air, and made the night-nurse raise the Resident Surgeon to see him. At my visit next morning, I was struck with the peculiarity of his breathing, and his position in bed, and elicited from him the following history:—

He stated that he was by trade a cooper, and that his age was 56, although he looked at least ten years older. During the last two years he had been subject to cough and dyspnœa, and was compelled to lie almost constantly on his left side; but he had never expectorated any blood. For six months past he had suffered much from pain in his shoulder, neck, and head, on the right side, but never on the left, nor had he at any time an attack of acute rheumatism. His legs had been oedematous during the last half year. Some months ago he had a "catch in his breathing" similar to that of last night, which compelled him to run into the street for air; and he pointed out the seat of his suffering to be between the Pomum Adami and upper edge of the sternum; and was certain he had never had any dysphagia.

Increased pulsation was seen in the carotid and subclavian arteries, and was more manifest at the right sterno-clavicular articulation than on the left. A feeble, undulating pulsation was also seen between the third and fourth intercostal spaces on the right side near the sternum, but none on the left.

Strong pulsation was felt at the right side of the sternal notch, and in behind the insertions of the sterno-cleido mastoid muscle, unaccompanied with thrill; and both subclavian arteries expanded much, just where they escaped from under the clavicle.

A single murmur was heard in the carotid and subclavian arteries, which became double under the top of the sternum and sternal end of right clavicle, and continued so as low down as a line on a level with the left nipple. A single murmur could be heard about two inches lower, and to the left, in the region of the apex of the heart.

The impulse of the heart is entered in my case-book as "fair," so that it was neither unusually feeble, nor in excess; nor was any heaving expansion of the chest to

be seen or felt when it was examined in profile.

Both pupils were natural.

On watching the peculiarity of his breathing, it was found to be an example of the "Respiratory Distress of Stokes"¹ on that day, unaccompanied with moaning, and much less intense than it became subsequently, but still presenting its peculiar ascending and descending scale.

When a paroxysm of the distress had terminated, and that the breathing had become quiet or had ceased for a time; he would then be attacked with a fit of coughing, which afforded no relief, as he was unable to obtain any expectoration. During the fit of coughing both external jugulars, and a large vein crossing just above the sternal notch, were distended to a size not less than that of the fore-finger, without any pulsation being observed in them. The pulse, if counted during a minute, would be described as irregular; but presented that regularity in its irregularity, which several members of this Society had an opportunity of witnessing last year, in two of the aneurismal patients whose histories I brought before you, and in whom the symptom of Respiratory Distress was also present.² This patient was therefore the third, during the last twelve months, in whom I had observed, that during the paroxysm of "distress," the pulse became invariably slow when the distress was greatest, and as invariably quick when it was subsiding, or whilst the patient had ceased to breathe. I am therefore disposed to believe, that this is not "a mere coincidence," but that it and the distress stand towards each other in the relation of cause and effect; and as I find no mention of this peculiarity in the pulse by any writer on cardiac pathology, I believe I may claim to be the first who has noticed its association with the Respiratory Distress. Neither it nor the distress, is to be found equally marked or intense on every day, for, as in other cases of suffering, the patient has his "good days" and his "bad days," his hours of comparative ease as well as of severe suffering. Innumerable opportunities, however, were afforded me of pointing out the peculiarities of both to my Clinical Class and some medical friends; and I had also, the gratification of being able to show them in full intensity to Surgeon-Major Pilleau, M.D., and to Staff-Assistant Surgeon O'Brien, M.D., when I had the

¹ It may not be out of place if I quote a description of a paroxysm of the Respiratory Distress. I shall presume that one has just terminated:-

"After a period of apparently perfect cessation of breathing, the faintest possible inspiration takes place, succeeded by one a little stronger and longer; the respirations then gradually increase in strength and depth, till the respiratory act is carried to the highest pitch it seems capable of; when the head is thrown back, the shoulders raised, and every muscle of inspiration thrown into the most violent action, accompanied often by a loud moan from the patient. When the respirations have reached this maximum, they pursue a descending scale, and commence to regularly diminish in strength and fulness, until they apparently cease;" when, as some members present saw in one of my patients last year, the sufferer may say—"Now, I am quite well;" or the respiration may cease for so long as to impress a looker on, as it did my nurse in this case—"Sir, his breath stopped for so long that we thought he was dead."

² * Transactions of the Belfast Clinical and Pathological Society, p. 97, 1858-59.

pleasure of a visit from them at the Hospital. The pulse at the wrist varied in strength and fulness, but in the brachial arteries it presented the well-marked character of the "jerking pulse," and occasionally also in the radial artery.

During the ten weeks this patient was under observation, I never found him lying on his right side but once; his usual position was leaning on his left elbow, with his head about a foot off the pillow; occasionally resting it on his hand, which was, no doubt, the cause of a varying oedematous state of his left arm and forearm. He had most ease sitting up with his feet hanging over the side of the bed, and although at the very side of the fire, and that he had abundance of clothes, he was always complaining of cold. His sufferings were generally increased in the evening, and he insisted at night on being allowed to sit before the fire with his bedclothes wrapped round him. This necessarily led to considerable dropsical swelling in his legs, which, indeed, vesicated and burst, and were with difficulty healed. At no period of his illness was there any ascites, or œdema of the face—nor was the urine albuminous.

In the two other patients with Respiratory Distress there was a constant craving for stimulants, but such was not the case with him; for although he was aware that several hours of severe suffering would be relieved in a few minutes by a couple of ounces of whiskey, he had generally to be solicited to take it.

With respect to the diagnosis in this case. The double murmur at the base of the heart, and the single murmur at the apex, warranted the conclusion that both the aortic and mitral valves were incompetent to close their respective orifices. In support of this view we had also the "visible pulsation" of Dr. Corrigan in the carotid sub-clavian and brachial arteries; but not to be seen so distinctly in the radial. We had, however, in addition, some of the symptoms that I had observed in the female who suffered from the fusiform aneurismal dilatation of the aorta and innominata (but without any imperfection of the aortic valves) the diseased structures of which I exhibited here last session [Transactions of the Belfast Clinical and Pathological Society, p. 99, 1858-59]. I therefore concluded, that a similar lesion existed in this patient, for he had also suffered from pain in his shoulder, neck, and head, confined exclusively to the right side; accompanied by a pulsation to be felt and seen at the right of the sternal notch, and in behind the insertion of the sternocleido mastoid muscle.

In the female referred to, and also in the third aneurismal case, in which there was every reason to believe that the aorta and innominata were also dilated (though a post mortem examination was refused), there appeared some time before death, œdema of the right mamma, and upper part of the right side of the chest.

This did not take place in this patient, which was probably owing to the incompetency of the aortic valves, preventing the possibility of continuous pressure by the dilated arteries on the right vena innominata.

But the chief diagnostic interest in this case is connected with the symptom of Respiratory Distress,

to which Dr. Stokes was the first to assign a diagnostic interpretation; making its presence pathognomonic of fatty degeneration of the heart, as he states¹ "that he had never seen it except in examples of that disease." I had only been able to obtain a post mortem examination in one of the other patients, in whom this symptom was present; and as fatty degeneration of the muscular fibre of the heart existed in her, I continued to look upon it as a symptom that might be relied on as indicative of the presence of that particular morbid state. I therefore added to the diagnosis of fusiform aneurism of the innominata and aorta, with incompetency of the aortic and mitral valves, the further lesion of fatty degeneration of the heart.

I am unable to offer anything but a speculative explanation of the undulatory pulsation that could be seen, but barely felt, between the third and fourth intercostal spaces on the right. If we admit that the regurgitation through the mitral orifice would so impede the circulation through the lungs, as to prevent the right side of the heart having free action; then a distended state of the right auricle might be the cause of a feeble pulsation in this locality. This is the second occasion in which I have observed this symptom. The first was in a patient of Dr. M'Gee's, with enormous hypertrophy of the heart. It is a symptom of some interest, as its locality would suggest the idea of a sacculated aneurism, though it is deficient in the expansile force of an arterial pulsation.

Having the good fortune to obtain a post mortem examination, I again availed myself of Dr. Murney's well known microscopic and anatomical knowledge, to obtain for the Society an accurate examination of the state of the morbid parts that had been removed, which was granted with his characteristic readiness to oblige, and he reports as follows:-

"The heart, when divested of extraneous matter weighed 27 oz. There were several 'lymph spots,' apparently between the serous membrane and the muscular structure; one, of several inches in extent, on the right ventricle. The hydrostatic test showed the pulmonic valves to be perfectly competent, but the aortic semi-lunars were quite incompetent—on each of its three divisions a hard calcareous-like deposit was found. On the back of two of these, little wart-like growths projected from the surface. There are a few soft wart-like vegetations on the mitral valves. The left ventricle is considerably dilated; its walls very much thickened, measuring at its middle 1 1/8 inch; the muscular structure firm, and without any trace of fatty degeneration, when carefully examined by the microscope. The right cavities and valves are normal, and without any dilatation of the venæ cavae. The lining membrane of the aorta was thickly studded for several inches with atheromatous deposit. The aorta and innominata were dilated, and, in order to note the extent, they were compared with a healthy specimen. When both were slit open and spread out, it was found that the aorta in the healthy specimen measured, transversely, 2½ inches immediately above the semilunar valves, and the innominata, before its bifur-

cation, 1 1/8 inch; whilst in the diseased specimen they measured at the same parts respectively 4 inches and 1 3/8 inches. There was calcareous and atheromatous deposit in both coronary arteries, which were also dilated."

I need not say how disappointed I was to find that Dr. Murney's microscopic examination of the structure of the heart had proved it to be free from fat, and that the symptoms of Respiratory Distress must henceforth cease to be looked upon as pathognomonic of fatty degeneration of that organ.

Before communicating this result to the members of this Society I felt bound, in justice to Dr. Stokes, as well as for the interests of science, to have Dr. Murney's opinion either confirmed or disproved; and I, therefore, wrote to my friend Dr. S. Gordon, of Dublin, requesting him to have the slices from base to apex of both ventricles, which I forwarded, thoroughly examined with the microscope, which he was kind enough to do, and says, in reply—"The result of my enquiries as to the condition of the heart-fibre which you sent me for microscopical examination, is that it is quite healthy. One gentleman writes to me, 'it is quite healthy, even up to the fat under the "white spot" there is no degeneration; under the said spot, there is some common yellow fat. As in all negative cases, this result has only been arrived at, after a careful examination of several parts of the specimens. The glass used was Smith and Beck's one-fifth.'"

A similar opinion as to the absence of fat was given by several others, who examined it for Dr. Gordon.

No practical physician likes to part with a symptom that has been held to be pathognomonic, and, therefore, further observation must determine, whether Respiratory Distress may be found associated with any other lesions of the heart than fatty degeneration, and those present in this patient. I would be disposed to think that it would not, because a little reflection will suggest to any one how similar the state of the circulation must be in the minute capillary vessels of the brain, upon which the integrity of the nervous system depends, produced by fatty degeneration of the heart, and by regurgitation from the arteries into the aorta, then into the ventricle, and again into the auricle; and how difficult it would be to find a lesion that would produce a similar effect on the brain, which I believe to be the cause of this Respiratory Distress. And should further observations prove this limitation, it is evident, that, as the stethoscopic and other symptoms would generally ascertain the existence of regurgitation, when it was proved absent, Respiratory Distress would still remain a most valuable diagnostic symptom of the presence of fatty degeneration, though this case removes it from the higher position of being pathognomonic.

I shall not, however, enter on any speculations on this point, feeling that I have only been justified in occupying so much of your time, in consequence of the points of diagnostic interest that were connected with this case, and that the exhibition of morbid structures here, are chiefly of value in confirming or rendering more accurate our means of diagnosis.

I have now only to mention the state in which the

¹ Stokes on Diseases of the Heart, &c, p. 324.

post mortem examination found some other structures. There was no effusion into the pericardium or peritoneum, but there was a considerable amount into both pleuræ; the left lung was quite healthy, but there were very firm adhesions of the base of the right lung to the diaphragm; and bands of several inches in length between the sides of the chest and the surface of the lower lobes. The liver was healthy. On the spleen there was a depressed spot, with calcareous deposit in it. The left kidney was very small and lobulated, but its structure healthy; whilst the right was very large, and had a considerable amount of fatty deposit in its cortical structure.

NINETEENTH MEETING.

March 17th, 1860.

The President in the Chair.

NECROSIS OF FEMUR.

Surgeon BROWNE exhibited a portion of the left femur, which he had amputated on the preceding Monday for necrosis. The history of the patient, a lad of 15 years, was, that about six years since he had injured the limb in leaping, that suppuration immediately above the inner condyle had taken place, and that some portions of bone had been cast off. For the last four years, up till six weeks ago, the limb had been pretty well. Within the past two months he had begun to feel pain above the knee, and to walk with a halt; there was some swelling and tenderness of the soft parts. Two weeks since he applied for admission to the General Hospital, and could still bear his weight on the leg, and walk. On admission it was found that a strumous abscess had formed on the outer side of the thigh, a few inches above the knee; this was opened, and discharged some unhealthy grumous matter. About a week after, in attempting to get into bed, he heard a crack, felt something give way, and immediately observed deformity of the part. At first it was imagined that the epiphyses had separated from the shaft of femur; but further examination showed a spontaneous fracture had taken place four inches above the knee. Extensive suppuration followed, with marked symptoms of hectic, and, on consultation, amputation was decided on. This operation was performed, under the influence of chloroform, by the long anterior flap, made from without inwards, and a short posterior flap made by transfixing the limb. The bone was sawed above the middle third, and was found healthy.

On cleaning and examining the amputated bone, traces of the old inflammation and exfoliation were visible, and a rugged portion through a necrosed shaft some five inches above the condyles. This point was very much thinned and discoloured, without the smallest sign of any attempt to repair.

The point of interest is, that the patient could have used such a limb up to within a fortnight of its having given way under slight exertion.

Since the operation the little fellow has progressed most satisfactorily, the hectic has entirely ceased, and there is every prospect of his being quite well in the course of a month.

Dr. GRAVES, of Cookstown, read the following
CASE OF GASTRIC PARASITES.

Some months since a patient came under my notice in the Cookstown dispensary. A young woman about 24, in phthisis, in the second, and verging on the third stage. In the physical signs there was nothing unusual, nor in the symptoms, save that she complained of frequent severe deep gnawing pain at the epigastrium, very irregular and intermittent, but generally worse when the stomach was empty. I saw her one evening suffering severely and prescribed a draught with morphia and hyd. acid. On the following morning her mother brought me the specimens contained in this bottle and told me the girl had slept well and comfortably during the night, that while dressing she was suddenly seized with pain and vomiting, and that these parasites were ejected on the floor. Instant relief followed. This is the only history of the case I can give. But let it be remembered, from this date the gastric symptoms entirely ceased. She lingered for some weeks, and was carried off as we had foreseen, by pulmonary consumption.

I must confess these worms puzzled me not a little. I have never seen any similar, nor can I in the limited references at my command, find any description of them. When brought to me, some two or three hours after their ejection, they were exceedingly active, of a deep straw colour (the spirit has darkened them), and rather elastic to the touch—reminding me much of a grub I have seen in turnip fields. One I sent to my friend Dr. Hay in Dublin, who submitted it for observation to Professor Bache. I much regret having mislaid the Professor's most courteous letter. He pronounces them to be the "meal worm," and suggests that the girl might have eaten some unsound meal in which the ova might have been conveyed to the stomach. It is not unusual for farm servants to help themselves to the raw material while preparing "porridge," but on this point I could obtain no information. I find a curious case in the last vol. of Rankin's Hosp. Prac. Assist. recorded by Mr. David Dickman, extracted from the Lancet, October 1st, 1859, in which a girl of 12 vomited seven or eight garden slugs, the smallest two inches long, and all alive. Some others—supposed from the patient's sensations who "felt something crawling up her throat," and "frequently introduced her fingers to seize what she felt"—were killed by repeated doses of ammonia and camphor.

After stating that the girl had an unusual craving for fresh vegetables during her illness, the author goes on to say [I quote from Rankin]:—

"The three slugs that came up first were not preserved; but the five others have been kept alive and fed on vegetables, which they preferred being cooked, having at first refused to eat them raw.

They are now fed on raw vegetables." I regret I did not know this before, otherwise you might have had those curious specimens of "our fellow-lodgers" alive and active before you, with a small stock of oatmeal as their entire subsistence.

Dr. CORRY read the following
CASE OF EPILEPTIC PUERPERAL CONVULSIONS.

Feb. 25th, 1860.—At 8 A.M. was called to see Mrs. G., aged 21, who was suffering from severe epileptic convulsions. On enquiry I ascertained she was eight and a-half months pregnant of her first child, and had, for several weeks past, been affected with giddiness, headache, digestive derangement, and anasarca of face, upper and lower extremities. The primary attack occurred at 9 A.M. the previous day; but as her friends attributed it to a fright she had received, little alarm was at first created, however, during the day, the paroxysms increased in frequency and violence, though she was conscious during the intervals. About 9 P.M. the symptoms became greatly aggravated, and from that period she had remained in a state of insensibility. On my arrival I found her skin hot, face flushed, eyes injected, breathing laboured, pulse, 140 firm; on examination, the os uteri was discovered low in the pelvis, but firmly contracted. Ordered two drops of croton oil, and six leeches to the temples, head to be shaved and ice applied, also a blister to nape of neck, and an enema of castor oil and turpentine.

12, noon.—Paroxysms more frequent and severe, face greatly swollen, livid, and distorted, bloody froth exuding from the mouth during each attack, breathing stertorous, pulse 155, very firm, involuntary discharge of urine and faeces, os uteri dilated about the size of a shilling, bled from the right arm to the extent of thirty ounces.

1.30, p.m.—Skin cooler, pulse softer, but still very rapid, paroxysms greatly diminished in intensity. On examination, found os uteri fully dilated, and child's head low in pelvis; introduced the short forceps, and in a few minutes delivered the patient of a stillborn male. Shortly afterwards, during a fit of convulsions, the placenta was expelled, the uterus contracted well, and there was no tendency to haemorrhage.

4, p.m.—Symptoms much improved, though patient still continues unconscious, has had only two attacks since delivery, countenance pale, pulse 120, soft, introduced a male elastic catheter, and obtained about one ounce of urine, free from blood or mucus, for chemical examination.

9, p.m.—Has had only one attack since last visit, remains in a comatose state, bowels have acted freely, and blister has risen well.

26th, 9, a.m.—Has had only one fit during the night, slept well, and is now conscious; but does not incline to speak much, skin cool, pulse 115.

9, p.m.—No change since last visit.

27th, 12, noon.—Continues to improve, pulse 112, no abdominal tenderness.

28th.—Still improving, skin cool, pulse soft, 110, no evacuation from bowels since 26th instant, ordered six drachms castor oil.

Since the last date she has progressed favourably, and is now convalescent.

Remarks.—As with some members of the medical profession there has of late been a feeling adverse to blood-letting in the treatment of puerperal convulsions, I have been induced to bring forward the foregoing case, as I believe it was one in which the free use of the lancet was required. I had previously availed myself of the various remedies recommended by the

most recent writers on the subject, but without success, and it was not until after thirty ounces of blood was abstracted that relief was afforded. It may be suggested that this was not a case of albumaria, however, such was not the fact, as upon subsequent examination of the urine, I found albumen present in large quantities. There are several strong reasons in favour of venesection in puerperal convulsions, accompanied by vascular plethora; it acts as a powerful sedative, and tends to preserve the brain from injury during the convulsion, assists in dilating the os uteri, and greatly diminishes the tendency to abdominal inflammation.

Dr. CORRY, in reply to the observations of several members of the Society, was strongly of opinion that the line of treatment followed in the foregoing case, was in accordance with the views of the most recent writers on obstetrics. He was by no means an advocate for the indiscriminate use of the lancet; but in this instance, the free abstraction of blood was followed by such favourable results, that he considered it his duty to report the case to the Society.

Dr. MOORE introduced a person from whose foot he had found it necessary to remove the metatarsal bone of the great toe. No retraction of the toe had taken place, and the perfect use of the foot was preserved.

TWENTIETH MEETING.

March 24th, 1860.

The President in the Chair.

Dr. CORRY introduced a young woman who had suffered from

LACERATION OF THE CORNEA.

He gave the following details of the case:—

"May 1st, 1858.—I was sent for to see Agnes Smyth, aged 20, who had received severe injury to one of her eyes from the shuttle of a steam-loom, which had penetrated the sclerotic, producing a lacerated wound extending across the cornea, and dividing that texture. From the formidable nature of the accident there appeared little chance of preserving vision; however, I as soon as possible brought her under the influence of mercury, at the same time applying anodyne lotions to the injured organ, and producing dilatation of the pupil by belladonna. This course was pursued for three weeks, by which time the wound had completely healed, leaving a white line or cicatrix which has now partially become absorbed; and there is little deformity."

Dr. W. MAC CORMAC read the following

OBSERVATIONS ON THE SYPHILITIC POISON.

In laying the following observations on syphilis before the Society, I cannot claim its attention on the score of saying anything new, or perhaps, anything which is not known to most of its members; but the subject is interesting in itself, and from the fact of the large proportion of the human race it affects, our best skill and attention will be demanded in furthering the better knowledge of its nature. Mr. Solly of London propounds a doctrine, which, if carried out to its fullest

extent, would prevent the administration of a dose of medicine for the treatment of syphilis. I think his tenets are hardly consistent with true philanthropy, nor would I rank Phillippe Ricord among the least of the many benefactors which medicine has conferred on our kind. He it was who, in conjunction with Cullerier, first developed the rational treatment of the disease. It was Cullerier who rescued the unfortunate sufferers from the dungeons of the Bicetre, where they were confined, often enduring the utmost hardship, till released by death from their tortures.

Having attentively followed the clinique of Ricord for nearly a year, I have become more or less imbued with his doctrines. He acknowledges two forms of the so-called primary disease, viz., the soft and the hard chancre. The first, known by its peculiar worm-eaten appearance, its tendency to be multiple, its extreme contagiousness, and usually the presence of a suppurating bubo in the groin, from the pus of which the chancre may be reproduced by inoculation, and lastly, by the absence of all constitutional affection. The second variety, known by its peculiar hardness, the multiple induration of the glands in the groin, subsequently those of the neck and elsewhere, without suppuration, by its being single usually, and non-inoculable, and lastly, by the inevitable occurrence of secondary symptoms in a space of a month or six weeks, sore throat, roseola, falling out of the hair, &c. In the first case, local treatment alone is required; in the second, constitutional measures are imperative. That these well-marked distinctions exist, I have ascertained, scores of times, in the wards of Midi, and have been able to trace their progress for myself. In my own mind, I am convinced of their truth. The soft chancre exists in far greater proportion than the hard. M. Puche in 10,000 cases, collected in from 1840 to 1852, found the ratio 4 to 1. The soft chancre may attack the same subject several times, while, except in the rarest instances, the victim of a hard chancre is not again liable to the disease. The soft chancre reproduces the soft chancre, whether on the same or another individual, and whether these individuals have suffered from syphilis or not, except in certain exceptional cases which I shall afterwards endeavour to explain, while the hard chancre only once affects the same individual, and is not transmissible to a person who has had constitutional syphilis. Thus it is that the doctrine of syphi-lisation falls to the ground. It is but the reproduction *ad infinitum* of the soft chancre in the same individual. Lindmann, who inoculated himself upwards of 2,200 times, did not attain the desired saturation; and some of the more celebrated expounders of the doctrine, Hebra and Sigmund, of Vienna, will not assert that the most thoroughly syphilised persons possess an entire immunity. The contrary has been established, in fact, by Ricord, who has more than once exposed the fallacy of this pretended protection with the point of his lancet. Before the time of Hunter, and since it, down to our own time, the different forms of the malady were ascribed, not to any modification of the virus, but to such causes as a different constitution, temperament, &c.—in fact, the unity of the virus was universally admitted. Several modern writers have sought to

explain the different manifestations of the syphilitic poison by adopting a plurality of causes. Carmichael was among the first who mooted this idea. He proposed to recognize four distinct forms of virus, each the antecedent of a peculiar variety of the disease. This theory, however, could not stand the test of a more extended experience. It has yielded in later times to the doctrine formalised by Ricord and his followers, viz., that there are but two distinct primary manifestations of syphilitic poison,—one the hard or infecting chancre, the other the soft or non-infecting chancre. Bassereau further believes that each of these varieties transmits itself as a pathological species, and cannot engender the other. Bassereau attempts to establish his position by historical evidence. Up to the end of the 15th century, gonorrhœa, chancre, buboes, were described by writers on these subjects, as diseases merely requiring local medication, and in no instance were any sequelæ to these diseases mentioned. The end of the 15th century, however, is stated by contemporary writers to have been marked by the appearance of a new disease, the symptoms of which were similar to those now described under the titles secondary and tertiary syphilis, and for the treatment of which constitutional measures were necessary. When Bassereau asserts that the one form of sore is not convertible into the other, he is mistaken, as, under peculiar conditions, as I shall afterwards strive to explain, a hard chancre may be transmitted to another individual under the form of a soft non-infecting sore, while authentic instances are also recorded when the soft chancre will produce the hard infecting sore with all its sequelæ in the economy. Bassereau and Clerc, as well as Diday and Rollet, of Lyons, from their personal experience, state that the hard chancre transmits itself in its own form. Ricord cites fifty-nine examples in which the origin of the disease was traced, and in each case, without a single exception, the relation was found to hold good. In all these cases, however, the subject to whom the chancre was transmitted by contagion, was free from all syphilitic antecedents. In the case of persons who have previously had syphilis, the question becomes changed. Let us now inquire if the hard chancre always owes its origin to a chancre of a similar nature, or can give rise to any other form of primitive sore. It has been established by the syphi-lisators, though the result had been an undesired one, that the ordinary soft chancre in a person free from constitutional syphilis, can only recognise for origin chancre of the same nature. There is, however, another variety of soft chancre, undistinguishable, save by its origin, from the usual kind. It is the chancre produced in a person who has had syphilis, by the contagion of a hard or infecting sore. This, in virtue of the unity of the syphilitic virus, does not indurate, it presents the usual characters of a soft chancre; and, according to M. Clerc, who has given it the title of chancroid, should perpetuate itself in that form, totally irrespective of its origin. But the question now arises, whether this so-called chancroid, if transmitted to a third person, free from all syphilitic antecedents, would retain the non-infecting character, or take on the infectious nature of its origin. This is a

point which cannot be very readily cleared up, from the number of elements concerned in its solution. There is a less complex problem, however, which has been satisfactorily answered, viz.: can a person having had constitutional syphilis, the subject of a new chancre, which must, of necessity, be a soft one, transmit to another individual hitherto free from syphilis, a hard chancre, followed by the symptoms of secondary syphilis? Cullerier has furnished us with an example in the affirmative. Robert of Marseilles, one of the most ardent champions of the unity of the virus, has given us several conclusive examples to the same effect. But it is by no means a necessary consequence, and Ricord arrives at the following conclusion on the matter, viz.:—that the chancre with soft base occurring in syphilitic subjects, may transmit itself either as a hard chancre, or as a soft chancre, and that it is probable that the form under which this chancre reproduces itself, depends on the nature of its origin, that is to say, whether it was derived in the first instance from a hard or a soft sore.

It is these points of connection which lead one to believe that the two forms of primary sore are not manifestations of two different forms of virus, however different they may be as to their primary aspect, and as to the after progress of the disease. That they are sufficiently distinct as pathological conditions is admitted, I believe, by most persons. And it is surely a matter of vital importance, as to whether we have to deal with a local disease, merely requiring topical medication, or a constitutional malady, which some of the greatest authorities consider can never be entirely eradicated from the system. Nevertheless, in spite of well-marked distinctions, I think the weight of evidence goes to establish that the two varieties of chancre are manifestations of one and the same virus; that in some instances they are convertible, although in the great majority of cases they follow distinct courses. There is another circumstance also, which, I consider, establishes a close relation between the two chancres—one which fortunately cannot be put to the test of experience in this country—namely, that as yet no example of soft chancre has ever been found on the face or scalp. It would seem as if any syphilitic sore, whatever be its origin, were, of necessity, of the infecting kind when situated in that region. M. Puche gives 28, and M. Ricord 26 examples, in which chancres situated on the cephalic region, whether externally, or on the tongue, lips, nostrils, always evinced an infectious nature, and were of the indurated variety. In the course of last year, M. Founder published a pamphlet on the subject of cephalic chancre, in which he records 120 cases collected at the hospitals of Midi and St. Lazare, in which he states, that in only two or three instances were the sores in this region unfollowed by the usual sequelæ of the hard infecting chancre, and that in these two or three instances there was a considerable amount of doubt as to the true nature of the affection. This is a very important fact in the history of syphilis, and is an additional circumstance in favour of the unity of the syphilitic virus. Moreover, if the two forms of chancre were proved to belong to two distinct pathological species, it would establish nothing

contrary to the unity of the true syphilitic poison. It would merely prove that in addition to the syphilitic poison, there was another affection commencing in a similar manner, with a sore, secreting virulent pus, but unlike syphilis, exercising no after effect on the economy.

I do not consider myself justified to judge on this matter, but I have ventured to lay the subject before the notice of the Society, in order that the individual experience of the members might be brought to bear pro and con on the subject.

TWENTY-FIRST MEETING.

March 31st, 1860.

The President in the Chair.

Dr. HARKIN introduced a child six days old, in whom the cerebrum was very imperfectly developed. The cranial bones were fully formed, the scalp loose, and the pupils contracted to the finest points. The child in other respects seemed healthy.

CASE OF NEUROMA.

Surgeon BROWNE exhibited a neuroma which he had dissected out of a stump of the arm a few days previously.

The man from whose arm the growth was taken had, in Nov. last, his hand crushed by machinery, necessitating amputation of the forearm; this was done by Dr. Murney; disease of the bones, however, ensued, and the arm was again amputated about the middle. The case had been brought under the notice of the Society early in the Session, by Dr. Murney. When the stump had healed up, acute irritation and periosteal inflammation set up, leading to the fear that it would be necessary to remove the limb at the shoulder joint. After some active treatment, however, the inflammation was subdued, and the part healed up entirely, save at one point, where a ligature was firmly held, and touching which gave intense suffering. At length, after repeated efforts, the ligature came away, the wound healed up, and the man was discharged for change of air, as his general health had declined considerably. He remained out of hospital for four or five weeks, but did not improve, as he latterly suffered constant irritation of the stump, and neuralgia of almost the entire system. On readmission, it was found that a neuroma had formed, and from which all his suffering proceeded. This growth was firmly attached to the inner portion of the cicatrix, in connexion with the bone.

"This," Mr. BROWNE then said, "I dissected carefully out, dividing all the nerves I could discern in connexion with it, and divided the nerves some inch and half above the neuroma; in this dissection the brachial artery and a smaller vessel were divided and ligatured. My friend and colleague, Dr. Murney, examined the removed structure, and found the growth contained the extremities of the median, ulnar, and internal cutaneous nerves. The ulnar exhibited principally the congested and inflamed condition usually observed in this painful affection. Of course there is not any

certainty that the disease will not return. At present, however, while there is pain and inflammation in the part, the general neuralgia has almost subsided. The patient I shall now treat by the exhibition of the preparations of iron, quina, and valerian, with a view of improving the health, and acting specially on the nervous system. Of course change of air will be advised."

Dr. CORRY presented the Society with a drawing copied from one which accompanied the history of a case of Molluscum, furnished by Dr. Babington, of Derry, on the 5th Nov. last. The thanks of the meeting were conveyed to Dr. Corry for his contribution to the Museum.

TWENTY-SECOND MEETING.

April 7th, 1860.

The President in the Chair.

Dr. PIRRIE exhibited a foetus, with extra-cranial development of cerebrum.

CASE OF SENILE GANGRENE.

Surgeon BROWNE exhibited the morbid parts in, and read a case of, Senile Gangrene.

The patient, J. M'C, aged 67, a native of Whitehouse, was admitted into the Belfast General Hospital on the 12th of March, labouring under an attack of *gangrene senilis* of the leg and foot. The history of the patient may be briefly stated. He had been an agricultural labourer all his life; had worked very hard; had been frequently exposed to great hardship and vicissitudes of weather; he had always lived temperately, and had reared a family of several children. Up till six weeks before admission to hospital, he had enjoyed excellent health, and had followed his calling every day. At the time specified, he began to have an uneasy burning sensation about the toes and heel of the left foot, with a pain and stiffness in walking. For three weeks he continued to work in the fields, the pain, however, increasing. About that period, he first saw discolouration of the toes, and he observed a coldness and numbness in the part. He was then compelled to take to his bed, the discolouration and coldness gradually creeping up the leg.

On the day of his admission to hospital, he presented the following signs and symptoms. From the left knee to the toes the part was quite cold and insensible; the upper part a deep olive colour, and flaccid to the touch; the lower portion and the foot quite black, and harder than natural. Above the knee there was an irregular line of demarcation, the part being dusky red and exceedingly painful; along the thigh, and upon the abdomen, the superficial veins were of a deep chocolate colour, and highly congested; the skin was covered with a free perspiration, and was all over of a dusky hue; the tongue was thickly coated with sordes; he had great thirst and oppression in breathing, and was very restless; the pulse was very irregular, weak, and about 110 beats in the minute. On examining the heart with the stethoscope, it was found to be weak and laboured

in its action, an intermission, or rather a flutter, taking place about every four or five beats; no bruit could be detected; sugar in quantity was found in the urine. The femoral and external iliac arteries of the left limb were quite obliterated; the vessels of right limb pulsated throughout. This state of matters continued increasing, the thigh became greatly swollen and discolored, and the superficial veins all over the body became congested, and a most offensive odour escaped from the gangrened limb. For a few days before his death, the pulsation ceased in both radial arteries, and in the brachial artery of the right side; but on the 5th of April, the day before he died, pulsation, warmth, and colour were restored to both arms.

The post-mortem examination showed the heart to be hypertrophied in its left ventricle, with some fatty degeneration. The mitral valve was quite healthy, but the aortic semi-lunars were incompetent. The ascending aorta was considerably dilated, and covered with patches of atheroma, while the entire of that vessel, as well as the iliac arteries, were greatly inflamed. In the left common iliac there was a firmly-organised fibrinous clot; the vessels also arising from the arch of the aorta partook of the arteritis which prevailed in the main trunk. The iliac veins and ascending *vena cava* were also inflamed, while in the latter, for several inches there was a fibrinous deposit or clot, firmly adherent to the lining membrane of the vein.

Surgeon BROWNE directed attention to the similarity of the case before the Society to one he had related in the November number of the *Dublin Journal of Medical Science*, and to be found among the *Transactions of the Belfast Medical Society*, for 1859, and which he had given in full detail. Both cases illustrate the pathology of senile gangrene, as demonstrated by the Baron Dupuytren, namely, inflammation of the arterial system in some of its parts, and also of the veins; this inflammation, no matter how provoked, causing occlusion of the vessels, and consequent gangrene in the parts which they should supply with blood.

Dr. DRENNAN exhibited the larynx and lungs of a man whose symptoms previous to death were aphonia, cough, and great debility. The condition of the parts did not explain the cause of the aphonia, and though the lungs exhibited numerous isolated diseased spots, their condition was deemed insufficient to account for death.

TWENTY-THIRD MEETING.

April 14th, 1860.

The President in the Chair.

Dr. MOORE introduced a coloured woman, the greater part of whose right upper maxilla he had removed some time since. The absence of much apparent deformity, and the partial reproduction of the lost parts, were the points of interest in the case. He also exhibited a cast of the parts removed, which contrasted surprisingly with the slight deformity now discoverable.

TYPHOID FEVER.

The PRESIDENT made the following communication:-

I exhibit to-day two morbid specimens, of much interest in connection with the pathological changes occurring during "typhoid fever." It is only occasionally that such cases occur under circumstances that render them instructive and available for the elucidation of disputed points in the etiology or symptomatology of that disease. I shall, however, at present only allude to such of these points as my cases appear capable of illustrating.

I may premise my observations on the patients to whom these specimens belonged, by stating, that in this town and neighbourhood there has prevailed, for some time past, and in greater frequency than our usual "maculated typhus," a fever bearing the characteristics of the species to which the name of "typhoid" has been given.

Since the publication, in 1829, of Louis' treatise on the typhoid fever of France, much discussion has taken place in this country as to whether typhoid fever existed also here as a separate species, capable of being recognised and distinguished from our own "maculated typhus." Unfortunately, the discussions on the affirmative and negative sides of this question were, until very recently, couched in general terms by both parties, without any attempt at investigating the subject by the method adopted by Louis. Whilst, therefore, we are not unmindful of Dr. Stewart and other physicians, who had ascertained and asserted that typhoid and maculated typhus were different species, we must accord to Dr. Jenner, of London, the merit of having been the first who adopted fully the method of Louis in his investigations, and of having succeeded in convincing many, that both species may be found prevailing at the same time in this country, and with varying frequency in the same hospital;—that infection from one kind will not produce the other, and that they are capable of being recognised and distinguished at the bedside of the sick.

In my report of the epidemic fever that prevailed in this neighbourhood in the years 1847 and 1848, which appeared in the *Dublin Quarterly Journal of Medicine* in 1849, I had advanced similar views respecting there being a plurality of fever poisons in that epidemic. Two years afterwards, I had evidence to satisfy me that typhoid fever existed also here as a distinct species, with all the characteristics described by Louis; that it might be found in the same hospital with cases of maculated typhus, and I am now certain that I had previously classified many cases of it as "synochus."

In opposition to those who assert, that the different fevers which they acknowledge they meet with are merely the result of the influence of age, peculiarity of constitution, season of the year, or epidemic constitution of the year, the holders of the doctrine of a plurality of fever poisons adduce, as one of their arguments, that infection from one kind will not produce fever of another kind, and that it is possible to be able to trace in innumerable instances, that the cases of one species have been infected by persons suffering under the same kind of fever.

Now this is one point upon which I believe that the

histories of my patients may be said to be instructive.

For some months past typhoid fever has prevailed in a village in this neighbourhood, and, through the kindness of a medical friend, I have been able to ascertain that both patients were, from periods varying from one to five days, in the house of his patients there who were ill with typhoid fever; whilst from another medical friend, who visited them when they took ill on their return to town, and whose official position keeps him cognisant of the diseases prevailing where they resided, I have ascertained that there were no other cases of fever in their house, or in the neighbourhood of their residence.

Having thus traced them to have been within the sphere of typhoid infection, I next proceed to state the histories of their illness, and I shall commence with that of the girl who died first, premising that they were both aged about 18. This girl could give no history of her illness, being unable to speak when first seen, and, therefore, the account of it had to be obtained from her sister and others, who, however, agreed in all important particulars.

She visited the infected house on the 26th February, slept there at night, and returned to town the next day; continuing to work till mid-day of the 29th. Between these dates, it has been ascertained that she had frequent rigors, with intense headache, and alternate pallor and flushing of face. Diarrhoea also existed, as the floor of her room was in many parts covered with intestinal discharges. Her sister (whose intelligence was perfect) stated that the bowels had been very loose from the commencement, and that she had a rigor on the 27th. The existence of vomiting could not be ascertained. From the 1st of March her sister could not understand what she said, and in this state she was seen by her town attendant at his first visit, on the 4th, who directed her removal to hospital, which she did not reach till the evening of the 5th. She was then very cold and trembling, with a feeble pulse; her right eye much injected, the right pupil contracted, the other dilated, and still unable to speak. The appropriate treatment for the relief of the head symptoms was adopted, and she was reported, at my visit in the morning, to have improved in appearance during the night. I could not, however, count her pulse with accuracy, owing to the great subsultus, nor could she speak or protrude her tongue, although she appeared to understand what was said to her. The pupils were then both dilated, and the eyes injected. The bowels had become quiet. No improvement took place during the day, and she died before midnight of the 6th.

On post-mortem examination, the membranes of the brain appeared to be minutely injected with blood, entirely free from opacity in any part, and without any serous effusion. The substance of the brain, on being sliced, presented numerous dotted points, but there was no effusion into the ventricles. The lungs were both healthy.

No evidence of disease was found in the small intestine, until within a foot of the caecum, when the mucous membrane became intensely injected. Peyer's patches were now found swollen, red, and elevated above the surface, and this became more manifest as

the cæcum was approached; six of them were found, (as may be seen in the specimen,) in a state of ulceration. There were no ulcers in the cæcum or colon, but about four inches from the commencement of the latter a brightly-injected patch of some inches was found. The mesenteric glands were enlarged to the size of filberts, and of a bright red colour.

This preparation, having been kept in spirits for some weeks, has become shrunken and much paler, and the non-ulcerated patches less raised than they were at first. Even the ulcerated patches have contracted fully one-half, so that the specimen has now less the appearance of acute disease than it had on removal.

Such was the state of the morbid parts on the ninth day, after she had spent a portion of a day and night in a house in which typhoid fever prevailed; and on the eighth day after she had experienced the initiatory rigor and other symptoms of her own illness.

And here I have to mention one of those disturbing elements that so often interferes with the accuracy of our conclusions in the investigation of disease. Had there been no possibility of her receiving infection, except during her visit on the 26th, we could have said, that the period of incubation in typhoid fever might be only 24 hours; but, it unfortunately happened, that the sister, whose history I have next to notice, had spent a portion of the day of the 19th February in the infected house, and as we admit that the infection of maculated typhus may be carried by the clothing of a healthy person going from an infected to a healthy house, if we extend the same law to typhoid fever, we must admit the possibility of her having imbibed the infection off her sister's clothing during the night of the 19th, which she spent with her in town, this sister having returned to the country the next morning. This would extend the period of incubation to eight days. I am not, however, disposed to adopt this latter view.

In addition to our being able to trace this case to have originated in infection from a typhoid patient, there are several other interesting circumstances connected with it.

1. Her death, within eight days after the initiatory rigor had taken place, and the existence already of ulceration in the ilium. Louis records only three cases of death so early as this, and it is somewhat remarkable, that the cerebral symptoms, such as the intense headache, the state of the pupils, the indistinct articulation, and latterly the taciturnity, and also the state in which the post mortem examination found the brain and the ilium, were, with a few trivial variations, precisely similar in his cases to what were present during life, and now exhibited as found after death in this case.

2. I believe that I am justified in ascribing the early death in this case to a destruction of nervous power from the circulation of the fever poison through the brain. We know that in small-pox, scarlatina, and maculated typhus, cases occur occasionally, in which the nervous system is destroyed at once by the poisons of these diseases, and that the patient dies before their usual symptoms have had time to develop themselves.

3. The case is also instructive, as showing how early in the illness ulceration may take place, and that the

disease is always farther advanced in the vicinity of the cæcum than in the direction of the duodenum. It also shows that the mesenteric glands are involved from the commencement of the fever, and not, as has been said by some, from irritation produced by extensive ulceration in the intestines.

I have next to notice the history of the second girl.

She, as I have already stated, visited the infected house on the 19th Feb., coming into town in the evening, and returned to attend the sick the next day, remaining with them till the 25th. Her intelligence, when seen, was unimpaired, and she stated that she was in perfect health on the 29th, that she had rigor and headache on the 1st March, and, although unwell, struggled on at her work till midday on the 3rd, when she was obliged to give up, and, as there was no one to look after her or her sister, they were sent into hospital on the 5th.

On the morning of the 6th her pulse was 114, her tongue red at the tip, furred, and moist in the centre; her bowels had been loose from the commencement, but the evacuations were free from blood. Her abdomen was full, and there was pain in the region of ilium. She had slight vertigo, but the headache had ceased; there was no noise in her ears, and the eyes were bright. A few red papulæ were found on the back of the chest, removable by pressure. There was no cough, but there was present a symptom which I have observed to be of serious import, namely, a jerking or rather sobbing kind of inspiration.

I shall not occupy your time with a detail of the symptoms as they were daily entered in the case book, but shall only mention the gradually increasing intensity of them all till her death on the 25th of March, the 25th day after she had suffered from rigor and headache; and, it will be observed, that the day of the month answers also for the day of her disease, as her illness began with rigor on the 1st. On the day after her admission the pulse had risen to 132, and was found only once again so low as 120, having on two occasions reached 140. On the 6th of March the tongue was dry at the tip, and this state soon became general over it. On the 12th it was protruded with difficulty, and the voice became tremulous on the 18th, with indistinct articulation on the 20th. On the 19th there was tremor and subsultus; and on the 21st these involved almost every muscle of the body. Only once did she complain of headache; and her eye remained clear and bright till within a few days of her death. From about the 20th she was much disposed to sleep, and there was occasional quiet delirium. The bowels acted two, four, six, or sometimes eight times daily, through all her illness; the abdomen was tympanitic, and remained full, whilst it was never free from tenderness on pressure over all the lower part of it. The evacuations from the bowels were generally very fluid and yellow, and never contained any blood. There appeared some cough on the 21st, with frothy expectoration, occasionally streaked with blood; it did not, however, increase in intensity. There was never any epistaxis.

On post-mortem examination, the lungs were found quite healthy.

Over several feet of the ilium, the elliptical or Peyer's

patches were found red, raised, and ulcerated, as also a few of the solitary glands. These patches are evidently larger, and the disease in a more advanced stage, in the immediate vicinity of the cæcum. Two ulcers were found in the cæcum, and two on the commencement of the ascending colon. The mesenteric glands were found enlarged and much injected with blood, but not so swollen as in the other case. It is not without interest to observe how closely the morbid appearances found in this patient tally with several of Louis' cases who died about the twenty-fifth day of their illness. The brain was not examined. The immersion in spirits of the morbid parts since the 26th, has rendered them paler and contracted, and thus diminished the appearance of active and acute disease which they presented on their removal. I was constrained to do this, by feeling that I could not present their cases so instructively before you, until I had ascertained the nature of the disease from which they appeared to have imbibed infection; and for the trouble taken by my medical friends in obtaining information for me on this point, I feel very grateful.

Surgeon JOHNSTON read the following

CASE OF EMPYEMA.

During the summer of 1856, the subject of these remarks went to Newcastle for a holiday; when there he caught cold, and was seen and treated by Dr. Rea, who was also there at that time. He returned to Belfast in the beginning of September, when he first came under my notice. At this time, he looked very ill, had fever of the hectic type, suffered from dyspnoea and cough. On examination, I found evidence of disease in the upper portion of the left lung. There was crepitation, the expiratory murmur was unusually loud, and there was slight comparative dulness. The heart was in its normal position, and there was a bruit heard over its apex. Connecting the local and constitutional signs and symptoms, I was led to fear that his disease was of a tubercular character. Dr. Seaton Reid also saw him, and after repeated examinations, was of opinion that there were evidences of diseased action in the upper portion of left lung. He remained in town during the winter of 1856, and until the summer of 1857. During this period, he continued in delicate health, suffered from exhausting night perspirations, had an attack of diarrhoea, and was quite unable to continue his duties as a clergyman. About July he went to the country, and whilst there he was laid up with what his friends considered an attack of fever, but which attack was ushered in with a severe shiver, and acute pain in his left side. Finding that he only partially recovered, and that his health continued to decline, he went to Dublin in October, 1857, and placed himself under Dr. Stokes's care. Dr. S. now discovered that he had extensive pleuritic effusion into the left side, the heart being completely displaced to the right. Dr. S. prescribed a prolonged course of iodine taken internally, and applied externally. He also administered the infusion of digitalis for a few days, but with great caution and constant watching.

Dr. Stokes took a great interest in his case: and here I cannot help gratefully acknowledging his uniform

kindness and generosity to him,—I believe, only in keeping with his usual benevolence. Finding that the effusion continued, and that its amount was uninfluenced by the remedies administered, that the side was distended, and that the fluid was rather increasing than diminishing, he entertained the idea of tapping the chest. With this view Dr. S. called in Mr. Adams; on consulting, however, and hearing somewhat more of his previous history, and of his illness here in 1856, they determined not to interfere. He passed the winter of 1857 and spring of 1858 in Rostrevor. Writing from Rostrevor in December 1857, he thus describes his own feelings, position, and appearance, "It has pleased God to lay me aside as a useless vessel, a broken trumpet, a bruised reed. I have long felt as one carrying his coffin under his arm, unseen by any but himself."

He returned to Belfast in the summer of 1858, and I now for the first time had an opportunity of examining him since he left Belfast in 1857, and of course since the effusion had taken place in the left pleural cavity.

He presented an emaciated anaemic appearance. His pulse was seldom above 84. He had no hectic. The digestive functions were but slightly impaired. He slept comfortably, lying diagonally on the diseased side. He had a dry cough, and except when hurried, complained very little of any respiratory distress. I should say that the ratio of the respiration to the pulse was but slightly, if at all disturbed. His voice was weak; he complained very little of any local pain. The left side was visibly enlarged, and its movements restricted as compared with the right. The intercostal spaces were dilated and bulging.

The mediastinum was displaced; the left hypochondriac region was filled up; there was complete dulness all over the left side, absence of the respiratory murmur, except at the vertebral column behind, where respiration of a bronchial, blowing character could be heard. Vocal vibration was abolished. The heart was felt beating to the right of the sternum, beyond the cartilage of the fifth rib. And here I must advert to a symptom, in the observation of which Dr. Stokes took a considerable interest, viz., a distinct pulsating movement conveyed to the empyema from the heart, and manifest in the left cardiac region, so as at first to lead you to believe that there was two centres of pulsation.

This curious phenomenon may exist in various degrees, and is adverted to by Dr. Stokes p. 607 in his work on Diseases of the Heart. Walsh also, in his treatise on chest diseases, has described a pulsating variety of empyema, and narrated cases in illustration. The right lung was healthy, the respiration loud and puerile. From this period up till his death he continued under my observation. In the spring of the year 1859 he had a sharp attack of bronchitis in the right lung, which confined him for some weeks to the house, and caused him considerable uneasiness. If I except this illness, I might say that, up to within ten days of his death, he was able, with care, to follow to a very great extent his ordinary pursuits. He visited his friends, and enjoyed their cordial hospitality—administered to the poor and the sick. He presided at public meetings, and frequently preached and conducted the religious

exercises of his charge. All this will appear the more wonderful if we contemplate "the coffin he was carrying about under his arm."

Ten days prior to his death he presided at an evening meeting in one of the churches in town. The following day he felt ill, and was seen by Dr. Rea, who, with Dr. S. Reid and myself, attended him until his death. He had a shiver, and complained of acute pain in his right side, near the base of lung, where, on examination, we found evidence of localised pleuritis. There was also considerable diffused bronchitis. His pulse quickened; his breathing became somewhat distressed; he complained of a feeling of distension and uneasiness in the left side. He lost his appetite; stomach refused to retain food; he gradually sank, and without much pain or distress, died on the evening of Tuesday, March 14th, aged 36 years. His death was rather from asthenia than dyspnoea.

Dr. Murney kindly conducted the post mortem 30 hours after death, in presence of Dr. S. Reid, Surgeon Rea, and myself. The left hypochondriac region was completely filled up by a prominent fluctuating tumour. On opening the abdominal cavity, we found the left pleura covered by the left leaf of the diaphragm, projecting into and completely filling up the left hypochondriac region, even extending into left iliac, displacing the left lobe of the liver downwards, and to the right, and pushing the stomach completely into the umbilical region. The liver was not larger than usual. It presented a mottled or speckled appearance. There were no evidences of any tubercular deposits in the abdominal cavity. On opening the left pleural cavity, we found it completely filled with pus, which, on careful measurement with a graduated measure, was found to amount to above the almost incredible quantity of two gallons. A small elongated, flattened mass, about four inches in length, and two in breadth, was found at the upper and back part of the cavity. This was all that remained of the lung, its surface covered with a false membrane fully one-sixth of an inch in thickness, and completely tied down by firm bands of adhesions. On making a section, we discovered purulent deposits in its substance.

The small bronchial tubes were very manifest, and on careful examination of the compressed mass, we found traces of an old-standing cavity, viz., a defined space, lined with a thin membrane, with the extremities of small bronchial tubes opening on its surface, but no evidence of its having been a tubercular cavity, nor could tubercle be discovered elsewhere in the compressed lung. The right lung was considerably encroached on by the fluid contents of left pleura, as well as by the heart. It was rather hypertrophied, somewhat emphysematous, but perfectly free from any tubercular deposit. The pleural covering of the base was coated with recent lymph, and there was about 10 or 12 ounces of serous effusion into the right pleural cavity. The heart was small and flabby; its apex was opposite the right rib one inch beyond its junction with its cartilage.

The retrospect of this case suggests two or three points of interest. First, the amount of purulent effusion found, is, I believe, almost unparalleled. Dr.

Watson mentions a case in which Sir P. Crampton drew off the "almost incredible" quantity of fourteen pints—here we had over seventeen. No doubt the fluid had increased during the patient's final illness, but even making some allowance for such increase, does it not strike one with surprise, that for the last two years and a-half he was capable of such physical and mental efforts. Not more than two months since, I was myself present at a large public meeting at which he presided, and made a very happy and pleasing speech in honour of a much esteemed friend, who had been acting for some time as his assistant. We have certainly here manifest proof of great strength and composure of mind, as well as of the adapting and sustaining power of nature. But another point of interest suggests itself—was the effused fluid from the first of a purulent character; or was it sero-albuminous?—the sac afterwards taking on a pyogenic character, and the watery constituents of the primary effusion undergoing absorption. I am rather inclined to think, that the chronic supervened on the acute attack—and that the products of the diseased action changed. The absence of any well-marked hectic, for a period of above two years, is worthy of notice, and was calculated to mislead one in regard to the nature of the contents of pleural sac. He had no night perspirations of any moment after the spring of 1857, and his pulse was seldom or ever above 84. But the most important inquiry in connection with this case is, how far it would have been suitable for the operation of paracentesis, and whether such operation would have proved effectual, in restoring or prolonging the life of our patient?

In Ireland we are much behind our French and English brethren in adopting this operation. "A procedure," says Walsh, "which, no matter how divided opinion may be respecting its general feasibility, has assuredly been sufficiently often either completely successful, or productive of marked improvement, to justify its being numbered among the valuable gifts of surgery." Dr. Watson lays it down as a rule, that whenever (no matter how we ascertain the fact) the effused liquid consists of pus, it should be let out. And Laennec advocates the performance of the operation in tuberculous patients, because even in them it may be the means of somewhat prolonging life. Out of sixteen cases of empyema, in which paracentesis was performed, Dr. T. Davis reports twelve recoveries.

The necessity of operating in the case I have detailed was for a time a subject of serious consideration with Dr. Stokes; and now, in reviewing the case, with the light thrown upon it by the postmortem, I am inclined to conclude that, failing the remedies administered to promote the absorption of the fluid, it would, (when the adhesions were recent,) have been a fair case for the operation. No doubt, we are now in possession of knowledge which at that time it was impossible to arrive at, and in regard to which the weight of evidence leads one to arrive at a different conclusion from that to which the results of the post-mortem conduct. I refer, of course, to the prior existence of tubercular disease of the left lung.

Whether it is possible that the pressure of the fluid may have expelled any tubercular matter from the

cavity, the remains of which we have shown you, may admit of some doubt; but I believe that the weight of evidence is in favour of the view, that the attack at the apex of his left lung, for which I attended him eight months prior to the effusion, was of an asthenic inflammatory character, terminating in abscess, but not tubercular.

The absence of all trace of tubercle, either in the healthy lung, or in the abdominal cavity, and of any cretaceous particles in the remnant of the left lung, lead one to conclude that we had not a tubercular patient to deal with. And if we add to this the power which his constitution showed in bearing up so long and so well under such an amount of disease, we will feel more impressed with the opinion that, at an early period, paracentesis might have possibly been attended with success. No doubt any interference of late would have been very injudicious, the lung being so firmly compressed and bound down by such thick adhesions, as to forbid any hope of its expansion—a very material condition to a successful issue.

In support of the view I have here taken, I cannot help adverting to the case of M'Donnell, the news-boy, whom I presented to the notice of the Society some time ago. In this case, nature performed the operation under very unpromising circumstances, and yet, notwithstanding that he has been constantly exposed during the past inclement winter, his health continues to improve, the discharge from the fistulous openings has almost ceased, and I believe that there is now every prospect of a permanent recovery. On the other hand, however, weighty reasons may be adduced for not interfering in the case now reported:—The absence of hectic, or any urgent symptoms of respiratory oppression, and the fear that the entrance of air might have caused putrefactive decomposition, with accompanying constitutional disturbance, under which our patient might have succumbed at a much earlier date.

TWENTY-FOURTH MEETING.

April 21st, 1860.

The President in the Chair.

ANEURISM OF AORTA, OPPOSITE THE COELIAC AXIS.
The PRESIDENT said:—

I exhibit to-day some morbid structures, removed from the body of a patient who died from the bursting of an aneurism.

His age was 40. He stated that his employment had required him for years past to lift heavy weights; but that he had never felt any sudden pain, or received any injury till about one year and a half ago, when, on stooping to roll a barrel, he felt a severe pain across "the small of his back."

Having a considerate employer, he was changed by him to a less laborious kind of work, which enabled him to continue constantly on duty till one month ago.

Since he first felt pain, he has always had difficulty in stooping, and required help to put on his shoes in the morning. The pain was always increased in the evening, and during the early part of the night, till he became warm in bed. It was renewed by cold, and became less

severe when he was engaged at work. It was so much relieved by the hot weather during two months of last summer, that he thought he had got rid of it entirely.

The pain was of a constant boring kind across the spine, and in both haunch bones, "as if his loins were in a vice," but this feeling did not extend to the front of the abdomen.

He had never had any shooting pains or cramps in the abdomen or legs. He is unable to flex the right leg up towards the trunk as perfectly as the left, and when he stands it is advanced forward in much the same position as in a person with hip-joint disease. There is no oedema of the limbs, but when he stands up the veins in both legs become suddenly and unusually prominent.

He has never had any difficulty in swallowing, or any hiccup or vomiting. His bowels only require medicine occasionally; they act without pain, and the evacuations have never contained blood. He has no difficulty in passing urine, which has never been bloody; its specific gravity is 1,635, neither saccharine nor albuminous. He has never had any pain in the testicles.

He lies best on his right side, less easily on his back, and worst on his left side.

His countenance is pale and sallow, and he has been emaciating rapidly during the last four or five weeks.

He has never had any cough or dyspnoea, or expectorated blood.

About two weeks ago, he observed "a beating pain" in his back, and some numbness in right loin, extending about four inches forward.

A pulsating, slightly elevated tumour is to be felt and seen between the 11th, 10th, and perhaps 9th intercostal spaces, on the right side, about one or two inches from the vertebræ, but none on the left. Pulsation is also seen extending forwards round the right loin, just below the margin of the ribs. The slightest pressure over this locality gives acute pain, but there is no pain on left of the spine.

A slight pulsation is to be seen and felt in the mesial line between the ensiform cartilage and to within an inch or two of the umbilicus.

A double sound, almost identical with that of the heart, is heard quite distinctly over the tumour and the spine, and to the left of the latter; but there is no murmur. This sound only continued for about four days after he was first seen by me.

A single murmur is heard about half an inch below the ensiform cartilage, and over a triangular space, bounded by the margins of the ribs and a line crossing about an inch above the umbilicus. This murmur is best heard on light pressure with the stethoscope, and disappears entirely as we approach the region of the heart. It is but doubtfully heard when he stands erect, and is not equally distinct on every day.

No murmur is heard in the aorta, at, or below the umbilicus.

The right pupil is markedly smaller than the left, but capable of being dilated by belladonna to the same size as the left; again resuming its contracted state as soon as the effects of the belladonna passed off.

There is a distinctly increased pulsation in the right side of the neck, and in behind the sterno-clavicular

articulation, which is very marked when compared with the left side.

A double sound is heard continuously from the top of the sternum, and its margin on both sides, till the heart is reached. No murmur is heard at any portion of the chest or cardiac region, till the stethoscope again reaches the epigastrium. No heaving pulsation is to be seen or felt over the front of the chest or cardiac region in any position.

Such is a statement of the positive and negative symptoms, presented by this patient when I first saw him.

The only change in them for several days, was his feeling more pain in the left hip, and some pain for the first time in his left shoulder, and in attempting to raise the arm of that side; A "smarting pain" was also felt in the right loin, where the sensation of numbness existed; this continued till the morning of the day on which he died. At two o'clock in the morning of that day, he awoke with a "tickling in his throat," coughed once or twice, and brought up two mouthfuls of blood, he was certain he coughed it up, and did not vomit it. Shortly afterwards, he experienced a very severe pain below the right nipple, which compelled him to turn on his left side, being quite unable to lie on his back.

At my visit in the morning, I found he had passed urine; he had no cramps in his legs, or hiccup, or vomiting; he had felt very faintish when up to get his bed made.

The pulsation was less in the right side of the neck, he had no noise in his ears, and there was no change in the tumour in the back. His pulse was 114, with little strength, and his skin was hot and dry. At 7, P. M., the pain in the right side of his chest became so severe that he could lie no longer on the left side, and he was gently turned over on the right; he immediately coughed up two or three ounces of frothy blood, became pale, with profuse perspiration all over the body, and gradually cold.

The breathing never became hurried; and some rale that appeared after he had brought up the blood, soon ceased.

He became gradually weaker, and died quietly, and without any convulsion, at half-past nine, within three weeks after he had first observed the "beating pain," and in about six after he had been obliged to give up working.

I had no difficulty in arriving at the conclusion, when I first saw this patient, that he was the subject of aneurism; and I considered that the locality of it was the very lowest portion of the thoracic aorta.

I was led to this conclusion respecting its seat by the distinct pulsation that was felt and seen between the two, if not three, lowest intercostal spaces on the right side, but more especially by the fact that he asserted that there was but one kind of pain, and an entire absence of the shooting or lancinating pain first noticed by Dr. Beatty, of Dublin, to be one of the most certain diagnostic symptoms of abdominal aneurism, when conjoined with the constant gnawing pain so very frequently present in all internal aneurisms. Nor was there any vomiting, or peculiar pain when the bowels acted, or indeed any symptom of disordered

function of any organ below the diaphragm. In support of the opinion that there was no disease in the upper portion of the aorta, we had neither cough, nor dyspnœa, nor stridor, nor pain in or between the shoulders, nor diminished expansion of one lung, nor heaving pulsation of the upper portion of the chest; in fact there was not a single chest symptom except the pain and pulsation at its very base; and although Stokes, Bellingham, Walsh, and Sibson all mention that aneurism of the descending portion of the thoracic aorta almost invariably makes its way between the intercostal spaces on the left of the spine, still, from from the absence of the symptoms discovered by Dr. Beatty to be peculiar to abdominal aneurism, as well as of those of the upper portions of the aorta, I felt justified in assigning to the aneurism the locality I have named.

Having been fortunate in obtaining a post mortem examination, the following is the state in which the various organs implicated were found.

On laying open the chest, nothing unnatural was found in the left side except a band several inches in length between the costal and pulmonary pleuræ. A considerable amount of serum flowed out from the right pleura; and at its back part were found several pounds of firm clots of blood, which had compressed and indented the upper portion of the right lung. The lower lobe of this lung was found adhering at one part to the aneurismal sac, and through the walls of the latter lower down a rent had taken place into the pleural cavity, through which the blood had escaped.

The heart was healthy in structure and size—no disease of any kind was found at either of the orifices, or in the structures of the valves. The arch of the aorta was not dilated; there were a few soft atheromatous patches in it. The innominate artery, when slit open and spread out, measured transversely 1½ inch, and the right carotid appeared also a little dilated. This dilatation of the innominate and carotid would explain satisfactorily the increased pulsation that existed during life in the right side of the neck. With the exception of some atheromatous deposits, the calibre and coats of the aorta appeared normal until within an inch and half of the origin of the coeliac axis, where it became dilated to near double its natural size, and continued so for about an inch below it. From the back, or vertebral surface of this dilatation, two sacs, or perhaps a bilocular aneurism, were given off; that on the left side of the vertebræ was about half the size of a cricket ball, whilst that on the right was the size of a large cocoa nut, and had dissected its way between the diaphragm and the pleura, extending into the cavity of the chest fully six inches, and perpendicularly to almost the same extent, firmly attached to the sides of the bodies of the four last dorsal and two upper lumbar vertebræ, and in close contact with the ribs for several inches.

Over the anterior portion of this large sac, the upper or great splanchnic nerve can be seen stretched. The bodies of two or three of the vertebræ can be felt to be eroded.

The origin of the right psoas magnus muscle was stretched by the lower portion of the aneurismal sac,

which was no doubt the cause of the imperfect flexion of the thigh upon the trunk.

In addition to the rent into the cavity of the pleura, another had taken place into the lower lobe of the right lung, and had dissected the pleura from the lung for several inches in extent. To this rent we are no doubt justified in ascribing the occurrence of the hæmoptysis on the two occasions shortly before his death. This would appear to be a very rare symptom in aneurism of the aorta opposite the cœliac axis, as in 131 cases tabulated by Dr. Sibson, in his "Medical Anatomy," hæmoptysis did not occur once.

I apprehend that the locality in which this aneurism extended is a very unusual one. I find no record in any of the books I have access to, of an aneurism separating the pleura from the diaphragm; and whilst the original opening was in that portion of the abdominal aorta that is behind the origin of the cœliac axis, still the aneurismal sac extended in a direction and produced symptoms that were exclusively thoracic in their seat, and unassociated with a single symptom that is considered to be characteristic of aneurism of the abdominal aorta.

There is just one other point of interest in connection with this case, to which I feel called on to refer. I allude to the undoubtedly contracted state of the right pupil. A contracted state of one pupil has been found to be of frequent occurrence in thoracic aneurism, since the attention of the profession was directed towards it by Dr. W. T. Gairdner of Edinburgh, in 1856. So far as I am aware, the patients in whom it was observed had all suffered from aneurism or dilatation about the arch of the aorta, or a non-aneurismal tumour in the neck, in which cases it was considered to have been produced by pressure on the sympathetic, or on the anterior roots of the spinal nerves in the lower cervical or upper dorsal region, which are supposed to confer a motor power on the filaments of the sympathetic which join the 5th pair that supplies the dilating fibres of the iris.

It is clear, from the slight amount of dilatation of the innomina and healthy state of the aorta in this patient, that there was no possibility of any pressure being made at the cervical region in him; and we are therefore forced to inquire if the contracted state of the right pupil might not have been owing to the unavoidable pressure that must have been made on that portion of the sympathetic that forms the great splanchnic nerve, by its being stretched to such an extent over this large aneurism on the right of the vertebræ.

It is not without interest to notice how this man was able to continue in an occupation that required frequent changes in the position of the trunk of the body till within five or six weeks of his death, and that his disease, up till within a few weeks of its termination, had originated (so far as he had observed) but a single symptom, or at most two, namely, pain and an inability to stoop to put on his shoes.

MALFORMATION OF STERNUM.

The PRESIDENT next introduced Herr Johann Heinrich Woyniz, a young man, who is the subject of a

remarkable congenital depression of the lower third of the sternum and adjoining cartilages. By measurement, it was found that the sternum, at its greatest depression, approached to within about an inch and a-half of the vertebral column. Whether depending on this condition of the chest, or otherwise, the subject of this formation exhibited extreme mobility of the shoulder articulation. He was thus enabled to rotate and advance his humeri to such a degree as readily to bring their external condyles together. The Society deemed this malformation of sufficient anatomical interest, in relation to the existing healthy condition of the thoracic viscera, to authorize a cast of the thorax, which was accordingly secured, and has been added to the Pathological museum.

TWENTY-FIFTH MEETING.

April 28th, 1860.

The President in the Chair.

ARTICULAR INJURY.

Dr. MOORE introduced a person who had sustained an injury some time since, by which the ankle joint was laid open. By suitable treatment, Dr. M. was enabled to bring about the recovery of his patient, with the function of the articulation unimpaired. He considered the case a good example of conservative surgery in a most serious class of injuries.

ARTIFICIAL ANUS.

Surgeon JOHNSTON introduced an aged woman who had escaped the consequence of strangulated hernia by the spontaneous formation of an artificial anus in the left inguinal region. She experienced little inconvenience beyond that produced by a prolapsus of the gut at the artificial opening; to prevent which, she was obliged to resort to mechanical support.

TWENTY-SIXTH, OR ANNUAL MEETING.

May 7th, 1860.

The President in the Chair.

The business of this, the final meeting of the session, was entirely engrossed by the details of the Society's management and progress, comprising reports from the Council and Auditors, and the appointment of the Executive for the ensuing year.

REPORT OF COUNCIL.

In bringing forward the report on the Session which is now closing, the Council has much satisfaction in congratulating the members of the Clinical and Pathological Society on its position and prospects.

The Society now includes within its ranks 100 members, of whom 45 are town members, 52 are country members, and 3 are honorary members, showing an increase of 6 upon the number of members in last Session, and of 4 upon Session 1857-58.

This augmentation of the Society's numbers, in itself highly satisfactory, becomes especially gratifying when viewed in connexion with the fact, that the annual payment for the Abstract of the Society's proceedings, which in former years was paid only by a limited number of members, has, during the present Session, been made compulsory on all. This change, recommended by the Council, was adopted at a special meeting of the Society, held on the 24th of September, 1859, and the Council refer with pleasure to the fact, that an addition to the amount of subscription has been accompanied by an increase of the number of members as a significant evidence of the existing appreciation of the utility of the Society, and as an auspicious omen of its permanence and progress in the future. During the Session 26 ordinary meetings have been held, at which a large number of communications of value and interest have been brought forward.

The Museum has been increased by specimens, casts, models, and drawings, and considerable progress has been made towards the completion of a catalogue of this valuable collection.

In conclusion, the Council has great satisfaction in being able to bear testimony to the undiminished interest which the members have exhibited in the progress and welfare of the Society, and to the unbroken harmony which has continued to characterize the meetings, as well as to the able and dignified manner in which the presidential duties have been discharged by Dr. Seaton Reid.

Drs. Cuming and Wales, the Honorary Secretaries, having resigned, and their successors appointed, the proceedings were brought to a close by the thanks of the Society being conveyed severally to the retiring President, the retiring Secretaries, and the Treasurer.

OFFICERS FOR 1860-61.

PRESIDENT.—Professor Gordon, M.D.

EX-PRESIDENT.—Professor Reid, M.D.

VICE-PRESIDENTS.—(Town)—Dr. Patterson, Dr. Pirrie, Dr. Bryce. (Country)—Dr. Babington, Londonderry; Dr. Dunlop, Holywood; Dr. Graves, Cookstown.

COUNCIL—Surgeon Johnston, Surgeon Browne, R.N, Dr. Dill, Dr. Drennen, Dr. Corry, Dr. Mulholland.

TREASURER.—Dr. Halliday.

HON. SECRETARIES.—Dr. W. MacCormac, Dr. W. Aickin.

LAWS OF THE BELFAST CLINICAL & PATHOLOGICAL SOCIETY.

I. NAME AND OBJECTS.—The Society shall be called "The Belfast Clinical and Pathological Society," whose objects shall be the cultivation of Practical Pathology, Diagnosis and Therapeutics, by means of the accumulation and analysis of appropriate Cases and Pathological Reports, and public discussion thereon; the establishment of a Pathological Museum; and the keeping of records, to indicate the progress of discovery in Medical Science.

II. MEMBERS.—The Society shall consist of Ordinary Resident and Non-Resident, and Honorary Members—number unlimited.

III. QUALIFICATION.—The Candidates for Membership shall be regularly qualified Physicians or Surgeons.

IV. ANNUAL SUBSCRIPTIONS.—The Annual Subscription shall be *Twelve Shillings and Sixpence* to Residents, and *Seven Shillings and Sixpence* to Non-Resident Members, payable on the first day of Session, or, if a new Member, on the day of his election.

V. ELECTION.—The Candidate for Membership shall be proposed by two members at one meeting, and balloted for at the next; one black bean in five to exclude, and prior to ballot, the legality of his qualification shall be duly certified, and his subscription paid.

VI. HONORARY MEMBERS.—Honorary Members shall be elected only at the stated annual meeting; the names of candidates to be entered on the Minutes at least one month previously, and proposed by four members. When elected, they shall be free to all the privileges of membership, except share in the property, without subscription; and in the ballot for honorary members, one black bean shall exclude.

VII. OFFICERS.—The officers of the Society shall consist of a President, to be elected annually by a majority of votes, not re-eligible for three successive years after expiration of office, but entitled, as Ex-President, to be placed on the Vice-President list for one year after expiration of office, six Vice-Presidents (three of whom shall be chosen from the Non-Resident Members), exclusive of the Ex-President, two General Secretaries and a Treasurer, all to be elected annually by a majority of votes, and after expiration of office, eligible for re-election.

VIII. THE COUNCIL.—ITS FORMATION AND DUTIES.—The Council shall consist of the Office-Bearers, and six other members, who shall be also elected annually by a majority of votes.

The duties of the Council shall be to make all the necessary preparations for the ordinary weekly meetings, to examine the contributions of members, and select for reading such as may be eligible; to report, by the aid of sub-committees, upon any morbid specimen which may be forwarded by members, or examination of which may be specially requested by a vote of the Society; to conduct the financial and ordinary business of the Society; to make bye-laws and other regulations not provided for in the stated laws of the Society; to report at the annual meeting upon all the proceedings of the session, and draw up the annual

transactions.

IX. DUTIES OF THE GENERAL SECRETARIES.—The General Secretaries shall keep a record of minutes, enter the cases and notices received, or remarks furnished, in their respective books, and summon and attend all meetings of the Council and Society.

X. DUTIES OF THE TREASURER.—The Treasurer shall keep an account of all receipts and disbursements, and furnish his financial statement twice during the session, also at the close, and whenever required by a vote of the Society.

XI. CASE PAPERS.—Each member can be supplied with forms of "Case Papers," having the annexed heading to guide him in drawing up the contributions which he may furnish. "The reporter is requested to note particularly the following points, in the reading of his case, viz.:—If from any author, the particular volume and page; if original, the place and date; in any case, his age, history, management, impressions regarding same at different periods, the termination, and P. M. examination if any."

XI. MEMBERS' CONTRIBUTIONS.—The contributions shall be of the following description:—

1. Cases showing unusual sequence or co-existence of diseases.
2. Do. showing any practical lesson, point, or caution, useful in practice.
3. Do. exhibiting any rare form, complication, exception to the laws of Diagnosis, Pathology, or Therapeutics; or unusual interpretation.
4. Summaries of Medical Statistics to prove frequency of type, average of age and mortality, and effects of remedies in any disease, or other point susceptible of proof by statistics.
5. Reports on *novel modes of practice* in any disease.
6. Morbid Specimens of Pathological or general interest, with or without case, or for Microscopic or Chemical examination.
7. Replies to *Medical Queries* proposed by members.
8. Brief *Clinical facts* of practical interest.

All contributions to be original, or original translations from authentic foreign records, not generally accessible to members.

XIII. THE SESSION.—The Session shall commence on the last Saturday in October, and terminate the first in May; and the ordinary meetings shall be held every Saturday, at three o'clock, afternoon; and the *annual meeting* the first Saturday in May.

XIV. BUSINESS OF THE ANNUAL MEETING.—The business of the annual meeting shall embrace the following subjects, viz.:—1. The Report of the Council. 2. The Report of the Auditors. 3. The announcement of the New Office-bearers. 4. The Election of the New Council. 5. The Closing Address of the retiring President. 6. Installation of the President-elect.

XV. BUSINESS OF THE ORDINARY WEEKLY MEETINGS.—The ordinary sittings shall be limited to *one hour*; but, at the discretion of the President, may be extended to *one hour and a-half*: five Members to form a quorum. On the first Saturday of November, January, and March, any business may be introduced without notice having been previously given. The following shall be the order of proceeding:—

1. The chair to be taken by the President: if he be absent, by one of the Vice-Presidents present, if possible in rotation.
2. The Minutes of the previous meeting read and signed.
3. Announcements from the Council.
4. The proposal of Candidates and Election of New Members.
5. The following in such order as the Council may direct:—
 - a. The Exhibition of Morbid Specimens.
 - b. The result of Microscopical and Chemical Examination.
 - c. The Reading of Cases.
 - d. Brief notices of Clinical Facts and Summaries of Medical Statistics.
 - e. The Exhibition of New Instruments and Medicines.
 - f. Papers on New Modes of Treatment.
 - g. Debates on doubtful points in Medical Practice.

XVI. VISITORS.—Medical Students shall be admitted as visitors by official orders of Members only. Any Medical practitioner, not being a member, may be admitted as a visitor once only during a session, on being introduced by a member.

Surgeons and Assistant-Surgeons of the Garrison, also of the Militia and Navy on active service, may be admitted to any meeting on Members' orders.

XVII. RESERVE FUND.—One-fourth of the subscription money shall be set aside as a reserve fund, and deposited in bank in the names of the President and Treasurer for the time being, to the credit of the Society, and shall not be drawn thence except by a vote of the Society at the annual meeting.

XVIII. BOOKS OF THE SOCIETY.—The books of the Society shall consist of the following:—General Minute Book; Council's do.; General Proposal Book; Treasurer's Account Book; Treasurer's Receipt Book; General Case Book; General Note Book for Record of Discoveries, Inventions, and interesting Medical Notes; Pathological Museum Record; Microscopical Reports; Document Book.

XIX. PROPERTY OF THE SOCIETY.—The property of the Society shall not be disposed of except by the unanimous vote of a special meeting. Due notice of intention to take such a vote shall be given in a special circular to all members, one month previously.

XX. DEFAULTERS.—No fines whatsoever shall be imposed on members; but in case of Subscriptions more than two months due, and after two successive notices from the Treasurer, the names of the defaulters shall be struck off the Roll of Members, and they shall be ineligible for re-election during the remainder of the current session. The last day allowed for payment of subscriptions for old members shall be NEW YEAR'S DAY each Session.

XXI. EXPULSION or MEMBERS.—Members may be expelled for unprofessional conduct, by a vote of the Society, provided that such vote be carried by three-fourths of a meeting of at least twelve resident members, and that due notice of the intention to take such a vote, with grounds of the charge, be given to each member eight clear days before meeting.

XXII. PRIVILEGES.—It shall be a privilege exclusively granted to Members, to receive reports upon any morbid specimens which they may furnish for examination.

Members shall be also entitled to receive the "Transactions," being a Record of the Proceedings of each meeting during the session.

XXIII. ELECTION OF THE OFFICE-BEARERS AND COUNCIL.—Ballot papers, initialed by one of the Secretaries, together with a list of members and their attendance during the session, shall be issued to the Members on or before the third Tuesday in April. Each Member shall send forward to the Secretary his ballot paper properly filled with the names he shall select, on or before the fourth Tuesday in April. If a candidate for any office be unsuccessful, the votes recorded in his favour shall be available for the next lower office.

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

EIGHTH SESSION – 1860-61.

Pulmonary Phthisis—CASE OF DR. M'MINN, M.D.

Professor Reid said—The proceedings of our Society, Mr. President, become unusually interesting, when they refer, as on the present occasion, to the illness and death of a member, who a few months previously had attended our meetings; and who, when dying, gave an unequivocal proof of his zeal for the advancement of medical science, by directing a post-mortem examination of his body to be made, and the result communicated to the society.

The preliminary history of the case was detailed by Dr. Patterson, who said—When I first became acquainted with the late Dr. M'Minn, in the year 1835, he was then in the 35th year of his age, a remarkably fine-looking, handsome man, six feet high, about fourteen stone weight. Some years previously he had completed his studies for a Presbyterian minister, but never took out license. After this he made a trip to Canada, and travelled over the greater parts of British America. During his residence there he had a severe attack of cholera; and from this time, during the remainder of his life, he was liable to periodical attacks of bilious diarrhoea, and boils occurring on all parts of his body. He was subject all his life to great mental depression, which increased greatly during the last few years.

In 1837 he married, and went over to Edinburgh to complete his education for the medical profession. Two sisters and a brother died, in successive years, from consumption. In 1838 he graduated, and took a diploma in surgery in Edinburgh. On his return he had frequent attacks of diarrhoea, which he regarded as salutary, and also almost constant cough and expectoration, which, he said, arose from the stomach, and that when either was checked by medicine, he was invariably worse. He also suffered from haemorrhoids, which frequently bled—he also regarded this as beneficial. About eight years ago, when his cough was unusually troublesome, he was persuaded to give Locock's wafers a trial. On doing so, his cough and expectoration was checked; also the diarrhoea and bleeding from the haemorrhoids—a high feverish state set in. This was the first time I professionally saw him. I ordered leeches to the anus, which was the first thing gave him relief. After some time, the cough and expectoration retarded, and he was gradually restored to his usual state. This was, I think, the last time he would take any remedy for his cough—though he consulted many medical friends their prescriptions were not taken. All this time he resided in the country, but in November, 1847, he disposed of his farm, and came to reside in Belfast. During the winter, his cough, on the whole, was better, though his spirits were greatly depressed, and he regretted giving up his farm, which

had been a source of occupation. In the latter end of 1858 he lost his wife, after a protracted and severe illness. After this time he never recovered his spirits. His cough and diarrhoea became very severe, and he was urged, or rather "driven out," as he said, to try Harrogate. He remained there six weeks, using the waters. Although he said the diarrhoea was very severe while there, he gained flesh, and the cough also improved, which continued up to Christmas, when the diarrhoea and cough again increased violently. Early in February I visited him, at the request of his sister. I found him in bed in a most desponding state. The cough was severe, with copious mucous expectoration; there were no perspirations; he never had an attack of haemoptysis; he was suffering from one of his usual attacks of diarrhoea; the evacuations were highly offensive, as they always were when he was labouring under such attacks. He was recommended change of air, either Queenstown or some other milder climate than Belfast. For some time he positively refused, but on the 1st of March he left home, and on the following day stopped at the Hydropathic establishment at Blarney, where he remained for nearly four months, under active hydropathic treatment. On his arrival there, he was able to walk into Cork and back on the same day, which he did on several occasions during the first month. For the first three or four weeks he wrote that he was gaining flesh; that his appetite was remarkably good. From the end of the first month he wrote in the most melancholy strain—his strength, he said, giving way, and losing flesh. Still he continued the hydro-pathic treatment, though he complained the baths were not agreeing with him. When he returned, in the latter end of June, it was quite evident that he had lost flesh, and was much weaker than when he left home—he was low and nervous.

Early in August he went over to Edinburgh, Dr. Simpson paid him the greatest attention, and had many medical friends to examine him, and a variety of prescriptions were given him, none of which were taken more than once or twice, except the infusion of Virginian prune, which he thought was useful, but, after using it a week or so, it checked the expectoration and diarrhoea, he then gave it up. On his return to Belfast, his depression of spirits was so great, that his friends persuaded him to go to Ballynahinch Spa, where he drank the waters, and took a great deal of outdoor exercise, both on foot and car; his spirits became more cheerful, the character of the excretions from the bowels, he wrote, were much improved, and, on the whole, he considered himself better than he had been for some time. When he had been there for some weeks a sudden change took place—the pulse, which had hitherto been quite regular, suddenly became quick and weak; urine scanty; oedema of feet and legs; diarrhoea increased; and, for the first time, he wrote asking me to send him some astringent for the bowels. I sent him chalk mixture and catechu, a few doses of which checked the diarrhoea, and it did not annoy him again during his lifetime. I advised him to give up the use of the Spa waters; on doing so, the urine returned to its usual quantity. I may here remark, it was frequently tested and was always normal; the oedema in

feet and legs greatly subsided, but the prostration increased. He bore the journey home well in a carriage; it was quite evident his decease was near at hand. From the time he arrived home he gradually became weaker; he suffered from dyspnoea at intervals, which was relieved by chlorodyne. He sank on the evening of the 30th October, having been perfectly composed and tranquil up to the moment of his death.

The only pain he ever complained of was in the rectum, after having a motion; for the last six weeks, he said, he was liable to it.

Dr. Reid detailed the particulars of his physical examination of the chest, and confirmed Dr. Paterson's account in his review of the history and general symptoms. He said the disease was senile phthisis, brought to a premature termination by failure of the heart's action from atrophy of its muscular tissue.

The following is an account of the post-mortem and microscopic examinations, by Dr. Murney, and also the results of an analysis of a portion of the calcareous deposit in the right lung, by Dr. Cuming:—

"Post-mortem examination on the body of Dr. M'Minn, at a quarter-past ten o'clock, A.M., on Thursday, the 1st November, thirty-eight hours after death, in the presence of Drs. Patterson, H. Ferguson, Moore, Reid, Cuming, and Mr. Aickin:—

"Some slight rigidity of the limbs, as the rigor mortis had not passed off completely. On cutting through the soft parts to open the chest, the greater pectoral muscles were found atrophied; in fact, but a mere trace of the muscular structure remained. In the bag of the pericardium about two or two and a half ounces of clear serum was found.

"The Heart.—On the surface were three 'lymph spots.' The organ was rather larger than natural; its structure soft and flabby. I had not the means of weighing it, but consider it was about ten ounces; had its tissue been dense and normal, I would have calculated the weight at twelve or thirteen ounces. The thickness of the walls, and capacity of the cavities were natural; the mitral valves healthy; The aortic semilunars presented on the outer or arterial aspect of each at its base a hard calcareous-like nodule; there was no deposit or growth on the ventricular surface. A piece of the wall of the left ventricle was removed for examination, and submitted by Dr. Cuming to the microscope. He states he observed absence of the striæ in the muscular structure, but noticed no very large globules, but a large number of granules and oil matters. Subsequently the specimen was given to me. I also was unable to find the transverse striations; but on the addition of acetic acid, I think I witnessed a greater number of oil globules than were seen by my friend; at the same time, the number was very inconsiderable. I conclude, therefore—and in this statement I am joined by Dr. Cuming—although not a well marked example of fatty heart, the softened texture and microscopic appearances indicate the early stage of that degeneration. A few small patches of atheromatous deposit were found at the commencement of the aorta.

"The Pleura and Lungs.—Several old adhesions of the right pleura were found, more especially at the upper part; similar connections existed on the left side, but

much stronger; in fact, in breaking them down to remove the lung, the apex was torn in two places. The lobes of the right lung presented to the touch the nodulated sensation customary to phthisis; on being cut into, tubercle was scattered in all parts, even to the base—of different degrees of consistence, the soft or semifluid, cheesy-like, and the hard chalky concretions. The latter were only found in the apex; no cavities were found here. In the left lung similar diseased conditions were found, but much more extensive; the masses of tubercle were, in many places, larger; and some vomicæ were opened in the apex, from the size of a pea to that of a small walnut. I may add, the tissue of the upper lobes, on both sides, readily broke down under manipulation.

"The liver was of normal size and consistence. It presented on the upper surface of the right lobe three broad sulci, as if indentations produced by the ribs. They could not, however, have been produced by this cause, as they passed vertically. Section presented the appearance of some fat; the lobules were in the condition of the first stage of venous congestion; under the microscope, a considerable amount of fat was observable; otherwise the tissue was natural. A small piece of the pyloric end of the stomach and upper part of the duodenum was laid open, and was found perfectly healthy.

"The physicians who had visited Dr. M'Minn declared it was unnecessary to prosecute the examination farther. I did not, therefore, remove the other abdominal viscera, nor was the head opened."

Dr. Cuming stated that the cretaceous mass which he had examined consisted mainly of phosphate of lime, with some phosphate of magnesia and carbonate of lime. There was about eleven per cent. of organic matter in it. He said that he had been surprised to observe a statement in the work of Messrs. Sieveking and Jones, on Pathological Anatomy, to which his attention had been drawn by Professor Reid, that these concretions consisted of sulphate of soda and chloride of sodium. Such was certainly not the fact; and he was at a loss to conceive how salts of such marked solubility could possibly exist as concretions in the lungs.

Dr. Reid then resumed his remarks:—

The post-mortem examination having discovered cavities at the apex of the left lung, and the microscope atrophy of the muscular substance of the heart, confirms the opinion I had given, as to the nature and localities of his disease. The examination revealed another fact, viz., that disease was rapidly disorganizing the entire substance of both lungs. In addition to calcareous deposit (of course, of old standing) at the apex of the right, tubercular deposit had recently invaded the middle and lower portions of both lungs; and though the liver was found of natural size, yet a considerable amount of fat was deposited in it; a change which, when unaccompanied by enlargement, we have no means of detecting during life.

The different conditions in which the deposit was found at the apices and bases of the lungs, warrant, I think, the conclusion, that two deposits of tubercle had taken place, and at considerable intervals of time; the

first at the apex, and the second lower down; that at the right apex was changed into calcareous matter, the qualitative and quantitative composition of which has been so fully ascertained by Dr. Cuming; whilst that on the left, if also changed into earthy matter, had been expectorated, and originated the cavities that have been mentioned. It is, therefore, not improbable that our friend was saved from dying of phthisis in early life (like some other members of his family) by the tubercular matter becoming changed into calcareous.

The opinion that there were two deposits is also supported by the firm adhesions that existed at the tops of both lungs; that on the left being so firm, that the substance of the lung was torn in separating it; indicating clearly that a cause of irritation had long ago existed there, and had produced a localised plastic pleuritis.

The second deposit had taken place in the middle and lower portions of both lungs, and was evidently of a more recent date, as no portion of it had yet taken on the process of softening.

The case is instructive to us all, by showing how necessary it is to have healthy lungs as a standard for comparison when practising percussion. In this case, the existence of very great dulness below the left clavicle, masked whatever was produced by the calcareous deposit below the right one; and as tubercular deposit existed at the back base of both lungs, the percussion sound was the same in each, and the existence of deposit there was, in consequence, not detected.

So convinced was our friend that his disease was seated in the digestive organs, that he had been studying Dr. Johnson's work on Indigestion, and had found a case recorded, in which the same severe pain had existed in the rectum, whilst the only cause found after death for it was an aneurism in some portion of the arch of the aorta. I could detect no pulsating tumor along the abdominal aorta; and it entirely escaped my memory to have the lower portion of the intestines and the cavity of the abdomen examined carefully after death, in the hope of discovering its cause. I am under the impression that this peculiar pain in the rectum had been noticed by the late Dr. Marshall Hall, in some of his writings; but I have not been able to find the passage in either of his volumes on "Observations on Medicine," though I have a distinct recollection of his mentioning it as an ailment that could be relieved by some kind of manipulation about the sphincter ani muscles.

I cannot close this communication without expressing a feeling of deep respect for the mental constitution of our late friend; for whilst we can all be eloquent on the propriety and advantages of post-mortem examination, it requires a high caste of intellectual endowment to direct examinations to be made of our own bodies, with the sole object of advancing science and benefiting mankind.

Fifth Meeting.

Dr. Patterson, V.P., in the chair.

Dr. Halliday presented a patient with a fluctuating tumor around the first finger. He stated there was no pain, and considered it non-malignant.

Dr. Murney exhibited a case of epispadias in which the anterior wall of the bladder was absent. The testicles were contained in folds similar to the labia majora, ascending and descending according to the variations of the temperature. The urethra was imperforate. The penis was capable of erection.

Dr. Dill exhibited a child with spina bifida. At first the lesion appeared like a simple ulcer, and the character of the disease was not manifest.

Sixth Meeting.

Dr. Patterson, V.P., in the chair.

Dr. Browne introduced a patient who had recovered from a fracture of the ulna and radius together with a fracture of the humerus. The arm was at first completely distorted, and doubts were entertained as to the possibility of saving the limb. It was, however, put up in a gutta percha splint, and now, at the end of six weeks, complete recovery had ensued.

AMPUTATION OF FOOT.

Doctor Murney showed a portion of foot, which he had amputated by Chopart's operation.

The patient, a young gentleman, has, for the last twelve months, labored under brown fibrogelatinous degeneration of the synovial membranes of the small articulations of the tarsus and metatarsus. The operation had been deferred, at the request of the sufferer, until the loss of appetite and sleep, with other symptoms of irritation, indicated immediate removal. After the lapse of three weeks, the stump is almost completely united. He has not had a single bad symptom. From the day of operation his appetite was restored. He now rests without the use of anodynes, and is beginning to get fat.

CASE OF FEMORAL HERNIA.

Dr. Murney also shewed a specimen which he had removed from the body of a patient on whom he had operated for strangulated hernia, and who died thirty-six hours subsequently. The following report was given:-

A woman, aged 50, labored under reducible hernia for twelve months. On the 20th November, when crossing the street, the tumor became irreducible. She was admitted into hospital on the 21st; and thirty hours after the increase of the protrusion, having constant vomiting of the contents of the duodenum, and other symptoms of strangulation, chloroform was administered, and the taxis being tried without success, the usual operation was performed. Cutting down to and opening the sac was effected with great facility. It contained omentum only, somewhat, but not

greatly congested. A stricture at the usual situation was relieved, and the protruded parts returned. In doing so my nail twice caught upon a firm band of lymph, situated anterior and external to the ring. This was cut, the parts dressed, and the patient taken to bed. At the time, the prognosis was more favorable than in a similar case of femoral rupture, on which I operated a week before; yet the more unpromising case recovered, and she, with brighter prospects for a few hours only, seemed to be relieved by the operation, and sank with symptoms of strangulation on the morning of the 23rd, sixty-six hours from the commencement, and thirty-six from the time of operation. For eighteen hours after section of the stricture, pain at the umbilicus and vomiting became much less frequent, but then returned, and continued almost constantly until death. The friends would not permit a proper examination post mortem, so I merely examined the parts adjacent to the wound, ten hours after the termination of life. The opening through which the hernia had passed was quite free. A piece of small intestine projected into it, but was not subject to the least compression. On enlarging the wound, fresh lymph was poured out freely on the visceral and parietal layers of peritoneum of the inguinal region. For about one foot in length, the vessels of the small intestine were congested, apparently the extension of irritation from the region of the femoral ring. Nearly every portion of the small and large intestines was examined through the wound, but, with the exception of the parts referred to, nothing was noticed. Close in front of the femoral vein, near the band of fibrine which was divided during the operation, lay a little pouch of serous membrane, about $1\frac{1}{4}$ inch in depth, sufficiently wide at the bottom to hold a shilling, with an orifice only large enough to admit a No. 4 catheter, puckered and appearing to have been as dilated as its cavity, but contraction of the lymph had caused it to assume its present appearance; it bearing a good resemblance to a purse or bag provided with a "string-case" drawn tightly.

Now, although the abdominal cavity was not freely laid open, so as to permit an examination of the different viscera, I have no doubt all the parts in any degree implicated in causing the strangulation were exposed. The feeling of the constriction before its division, and the appearance of the protrusion, shewed distinctly it was not what would be designated a tight stricture; no doubt quite sufficient to cause the symptoms, which, however, yielded upon its relief. I therefore think we cannot attribute the condition of the patient for the last eighteen hours directly to injury done by the stricture to bowel or omentum but ascribe it to the formation of this bag of peritoneum, which, I believe, did not exist until after the hernia became irreducible, was, in fact, created by the lymph poured out during the inflammation, and as this underwent organization, the orifice become more and more contracted. Why a condition of parts, such as I have described, not involving any vital organ, and certainly not interfering directly with the peristaltic movements of the intestine, should produce fatal results, I am unable to say; but we have all had ample experience that such terminations are not unfrequent.

Dr. Browne remembered having operated on a case where the peritoneum formed a band tying down the bowel, outside the position of the internal ring.

Seventh Meeting.
The President in the chair.

CASES OF EXCISION OF EYE.

Dr. Browne read the following:—During last session, I brought under the notice of the Society three cases in which I had found it necessary to remove the globe of the eye. Two of these were removed by excision, in consequence of the irritative inflammation induced and kept up in the uninjured eye, by a foreign body which had been in the opposite eye for some time. The other was extirpated for melanosis of the organ. In this case the disease has returned.

I have now to bring before the Society the brief notes of two additional cases of excision of diseased eyes.

The first is that of a young lady from the country, aged eight years, who was first brought to me in September, 1859, in consequence of her parents having observed something unnatural in the appearance of the left eye, and loss of sight in it. Upon dilating the pupil and examining the organ, the bottom of the eye presented a dull white appearance, and the ophthalmoscope revealed a prominence on the right side of the centre of the retina, with enlarged vessels passing on it. The retina seemed totally insensible to light, though the pupil, before the use of the atropia, contracted under its stimulus, evidently through sympathy with the healthy eye. At that time I advised the parents to bring the little girl to me at the end of three months, and, as she was not suffering any pain, and was in excellent health, I prescribed nothing for her. She did not return till July, 1860, when I found the aspect of the eye considerably altered; the growth seemed to have advanced toward the front; the vessels radiating on the growth were visible to the unaided sight; the conjunctiva was injected, and there was constant lacrymation; besides which objective symptoms, she had constant severe pain in the eye, brow, and head, and her general health had become affected.

Under these circumstances, though I could not pronounce the disease malignant, I thought it right to advise extirpation of the diseased organ. The operation was accordingly performed on the 8th of July. She made a rapid recovery, and remained quite well till the end of September, when her health began to fail, and constant severe pain in the head to be felt. Although the orbit has not yet exhibited any disease, I fear very much that the optic nerve within the skull is diseased, and that the case will prove to be one of fungus haematodes.

The diseased eye was examined after extirpation by Professor Gordon, who looked upon the case as non-malignant, as he could not discover any cancer cells, only exuded lymph and granular deposit at the bottom of the eye.

The next case is that of J. B. Dunlop, aged thirty-five, who applied to me early in August last. He stated that

in the month of May, or early in June, he had observed his right eye to become bloodshot and painful every evening, with some dimness of sight; for this he was treated by a careful and experienced practitioner in the country. The disease, however, increased, the cornea gave way, the globe became greatly enlarged and exceedingly painful.

When he applied to me, the eye presented a very suspicious appearance, being very much enlarged, projecting from the orbit, and of a dusky red color, the blood-vessels being large and tortuous. There was constant pain in the part, and a considerable amount of sympathetic irritation in the left eye. The only remedy was excision, and that operation I performed early in September. He made an excellent recovery, and has remained quite well ever since.

The diseased eye was exhibited, and shewed a lobulated appearance within the sclerotic, the entire structure being filled up with organized lymph, presenting much the appearance of the vitreous humor, as figured by M. Bannon in his paper on the structure of that body. The case was regarded as non-malignant.

CYANOSIS.

Dr. Warwick exhibited a case of cyanosis in a child eighteen months of age. He said—According to her mother's report, this child enjoyed good health for about two months after her birth. I saw her for the first time about six months ago, when I found her laboring under a succession of violent paroxysms and remissions, accompanied with venous congestion, great difficulty of breathing, coldness of body increasing towards the extremities, as well as lividity of face, hands, and feet. There is distinct pulsation of the jugular veins at all times, which are very much dilated during the attack, especially the left, which is much larger, caused by regurgitation of blood from the venous side of heart. I think I have been able to detect a distinct murmur, not only over the apex, but also over the base of the heart. She has become greatly emaciated and very peevish, sleeps badly, and takes very little food. She has a great desire for cold liquids, such as water and milk, which she consumes in large quantities, while the father of the child has told me that hot tea will produce a fit.

Dr. Browne asked if the symptoms might not be ascribed to mere anaemia.

Professor Ferguson found, on auscultation, a very intense murmur, which he found difficult to localise. He did not consider anaemia as a sufficient cause for the child's present condition.

Dr. Drennan stated his opinion; that to be a case of open foramen ovale it was by no means necessary that the child should manifest lividity immediately after birth.

The President considered the case one of imperfect septum.

Dr. Johnson read notes of, and exhibited a case in which there were extensive osseous deposits in a number of the muscles.

Eighth Meeting.

Dr. Patterson, V.P., in the chair.

Dr. W. MacCormac introduced a patient with aneurism, probably of the ascending aorta. It formed a swelling of the magnitude of half an orange, in front, and to the left side of the sternum. The patient enjoyed capital health, and positively asserted that, until two months previously, there had been no appearance of the swelling.

Surgeon Johnston introduced a child with a vascular tumor situate in the cheek, and alveolus of the left side. When the child cried oozing from the gums in the vicinity took place.

CASE OF INTUSSUSCEPTION.

Dr. Pirrie reported the details of a case of intussusception in a healthy infant four months old.

Dr. Pirrie had arrived at a correct diagnosis of the case during life chiefly from the suddenness and severity of the abdominal symptoms, and the long-continued efforts at straining without the evacuation of anything but a little bloody serum.

The post-mortem examination showed that the cœcum had entered and passed along the ascending colon, and through the sigmoid flexure, till it had almost reached the top of the rectum, where two ulcers had formed on the sheath of the volvulus, opening into the peritoneal cavity.

Models in wax of this interesting specimen, shewing the relative position of the parts of the intestine involved, are preserved in the Museum of the Society.

Ninth Meeting.

Surgeon Browne in the chair.

On a report from Dr. Murney on the case of tumor of cheek, exhibited by Surgeon Johnston at last meeting, a discussion arose in which Dr. Murney, the chairman, Dr. Johnston, and Dr. Moore took part.

Tenth Meeting.

Dr. Patterson, V.P., in the chair.

Dr. Drennan introduced a child with extensive gangrene in the region of the mouth and nose, and with the same lesion manifesting itself in different parts of the body.

Dr. Moore exhibited an example of cancer of superior maxilla. The disease commenced in the base of the tongue, attended with difficult deglutition. It rapidly extended, until it involved the larger portion of the superior maxilla, and ran its fatal course in about three months.

A large pebble was exhibited by Dr. Moore, which had been swallowed by a patient in the Lunatic Asylum. It was lodged in the œsophagus, and was there felt by Dr. Purdon, who was, however, unable to seize it. The

patient drank a large quantity of water, both before and after he had swallowed the stone, and by this means emesis was induced, and thus the stone was forcibly ejected.

Twelfth Meeting.

Dr. Patterson in the chair.

Dr. Corry introduced a man subject for many years to an immense scrotal hernia. The tumor varied somewhat in bulk, but was about the size of the man's head. It was irreducible, and Dr. Corry had constructed a large bag by which adequate support was afforded.

Dr. Moore exhibited four fingers removed from a boy's hand, in consequence of injury received from a circular saw.

He also exhibited a hand which he had amputated just above the wrist, in a man of sixty years of age. The injury had been sustained by the hand passing diagonally between two cog-wheels belonging to a threshing-machine. Complete laceration had taken place in consequence, necessitating removal of the entire member. The operation was performed four hours after the accident, without chloroform, at the wish of the patient. Compression was maintained so perfectly throughout, that no blood was lost during the operation, and, on the third day after, union by the first intention had taken place.

Thirteenth Meeting.

The President in the chair.

DISEASE OF THE PANCREAS.

Professor Reid stated—I exhibit to-day some morbid parts removed from the body of a patient who died early last summer.

His age was forty-four; and he stated at my first interview with him that he had been subject to frequent attacks of vomiting during the previous three years; that the matters ejected were very acid, and often contained "sooty-looking" matter, or what we would have described as "coffee grounds."

The case possessed two points of diagnostic interest. First, with reference to a tumor that was felt in the region of the pyloric orifice of the stomach; and secondly, with respect to the frequency of vomiting.

At first a very hard, knotty tumor was felt in the region of the pylorus, and could be traced extending in a semicircle to near the margin of the right ilium. After a few days had elapsed, this tumor became much less distinct, and might have escaped detection on a cursory examination. In this way it would be on some occasions quite perceptible, whilst again it would be much less so. It was always, however, felt to be of the semi-circular form I have described. There was no enlargement of the veins of the abdomen, or of the limbs, nor did the latter ever become edematous.

He stated that at first vomiting generally occurred about three quarters of an hour after taking food. In a few days, however, the period and frequency of its

occurrence changed; and during a period of five weeks it took place regularly on every second day, and at varying intervals after taking food. These changes were so well marked as to attract his own attention.

During the succeeding two weeks, the vomiting did not occur oftener than every fifth day. This was followed by a remission of remarkable duration, for no vomiting took place for a period of three weeks, which excited in him much hope of recovery, as he had not enjoyed so long a respite at any time during the previous three years. After this it appeared at very regular intervals, and which became shorter as his life drew to a close.

The colour of the matters vomited varied much, being sometimes yellow, then changing to green, and during the last few days chiefly of a "coffee-ground character."

The evacuations from the bowels presented nothing peculiar in their appearance, and although minutely examined, no fatty matter was ever observed in them.

The emaciation of the body increased steadily, notwithstanding the long intervals between his attacks of vomiting. He suffered much from mental depression, and seldom spoke to any one.

On post mortem examination no fluid was found in the peritoneal cavity, although the vena cava was encircled by the tumour. The stomach was found much dilated; its mucous membrane free from any ulceration, though stained from ecchymosis in several parts. The posterior portion of the pyloric orifice was found intimately adhering to a tumor, but the anterior was not, and the forefinger could be passed freely through it, the elasticity of this portion being quite unimpaired.

A hard knotty tumor was found crossing the spine, involving the pancreas, surrounding the vena cava, adhering, as already stated, to the back of the pylorus, implicating the omentum, and with it forming the semi-circular hard tumour that was so often felt to the right of the mesian line during life.

Dr. Moore exhibited a *cancerous tumor of mamma* which he had excised. He also introduced a patient labouring under general icthyosis.

Dr. Pirrie exhibited a *diseased uterus*. The cervix and body were very much elongated, and the fundus was occupied by a large fibrous growth. For upwards of three months this patient had been in hospital. She had been admitted for rheumatic pains of a trifling description. About a fortnight subsequently she complained of intense pain in the right knee, and soon afterwards the thigh and lower limb of that side swelled very considerably. This condition gradually became worse and worse, until the entire member was double the size of the other limb. No local tenderness was discovered along the course of the veins, but the general aspect indicated phlebitis. The woman was about fifty years of age, and had had children, but no uterine symptoms were complained of. On one or two occasions she suffered from temporary retention of urine. On examination after death, the uterus was found, as described above, lying over the right common iliac vein. The vessels on that side were, with

surrounding cellular tissue, matted together as the result of long standing inflammation, and a tuberculous matter was found in considerable quantity in the neighbourhood. The right femoral vein was found to be plugged up with a mass of lymph. The iliac veins, and all the veins of the left side, were free. The veins on the affected side were not traced further, owing to the great obesity of the subject, nearly two inches of fat being found in the sub-cutaneous cellular tissue.

Professor Ferguson asked if the presence of such a tumor of the uterus could be accounted an adequate cause for such an extensive lesion of the veins.

Dr. Murney, who performed the post-mortem, believed that, as the site of venous obstruction was the femoral, the uterine tumor which lay over the iliac vein could not be considered the primary cause.

Dr. Pirrie thought it probable that the uterine tumor was the starting point of the disease.

The President thought it probable that the venous system of the entire limb was diseased, although the lesion only extended upwards as far as the profunda femoris.

Fourteenth Meeting.
The President in the chair.

Dr. Drennan exhibited the heart and lungs of a woman aged between thirty-five and forty, who had for twenty years suffered from bronchitis and dyspnoea; her cough had latterly subsided, but her asthmatic symptoms had become much aggravated, and were accompanied, on her admission to hospital, eleven days before death, by anasarca swelling of feet and legs. The chest was of rounded form and limited motion, with a clear sound and feeble respiratory murmur throughout; a loud bruit was heard with the first sound at the apex of the heart, and the jugular veins were tortuous, distended, and pulsating.

The post-mortem examination revealed strong and extensive pleuritic adhesions on both sides, and distended lungs, presenting round their edges especially, numerous projecting sacculi, from which the air could be with difficulty expressed. The right heart was much dilated, and slightly hypertrophied; both mitral and tricuspid orifices were abnormally patulous. Dr. Drennan considered the case as a typical one, both as to symptoms and morbid anatomy.

Dr. S. Reid referred to the difference of opinion entertained by Drs. Stokes and Walsh, with reference to friction sounds as diagnosing the particular form of disease.

The President considered that the intensity of friction sounds depended very much on the state of the rubbing surfaces, whether they were moist or dry.

Dr. Ferguson said that the dry crepitus described by Laennec was not to be confounded with the rough sounds produced by effused lymph.

ANASARCA.

Dr. Dill exhibited the brain and kidneys of a patient who died in hospital last night, at eleven o'clock, in convulsions. He was sent for about two o'clock to see a

patient just admitted, suffering from acute anasarca, with convulsions. On his arrival he found the breathing stertorous, with great labour and distress, and congestion of face. Pulse was quick and flagging. The pupils were dilated and fixed, especially the left. The convulsions were often repeated until the time of death, which took place during one.

The patient was a man of twenty-nine years of age. He was large, stout, and fat, and of generally healthy appearance. There was not much appearance of anasarca during life, but some was apparent after death.

Dr. Johnston said that the patient came, on Thursday last, to the dispensary, complaining of a cold; had puffy eyes and cheeks; never before had fits; told him to encourage the action of the skin; and gave him a purgative powder; saw him at his home on Friday morning; he was then heavy, restless, and somewhat stupid, not inclining to rise. He had three convulsions before being sent to hospital. He was conscious after the first two but not after the third. The habits of the patient had been intemperate.

Dr. Murney had made a post-mortem examination. The brain surface was covered with blood. The veins and structure were very much congested. The substance and ventricles contained no effused blood. The brain seemed very healthy. The kidneys were both much larger than normal, especially the right, which was very much congested. They each weighed about six ounces, being two ounces more than normal. The structure of the left kidney was completely altered, being paler than in health. No urine could be procured during life, but after death two ounces was procured from the bladder, which appeared more like thin porridge.

It was found to be completely albuminous.

Dr. Pirrie said that of course the congestion of the brain was secondary, depending on the previous state of the kidneys, very similar to cases of puerperal convulsions.

Dr. Ferguson observed that this form of disease was like another form of apoplexy, that the two diseases are too often amalgamated, and that a very large proportion of deaths, apoplectic so called, are examples of this, the true form of Bright's disease.

Dr. Drennan detailed the case of a sailor who died with similar symptoms. The form, however, was rather coma; the case appeared to result from disease of kidneys, but, after death, there was no appearance of unhealthy structure in either brain or kidneys; there was, besides, no albumen discoverable in the urine.

Dr. Pirrie referred to the case of a servant of this hospital who has had several attacks of convulsions with coma, one of which attacks lasted five days. He is the subject of albuminuria.

Fifteenth Meeting.
The President in the chair.

AMPUTATION OF HAND.

Dr. Brown exhibited a hand removed by operation after a mill accident. The skin had been torn down off it like

a glove, and the hand itself greatly mutilated. He remarked that in all such accidents it seems necessary to remove the injured parts at a point higher than the apparent injury, as the stretching of the soft parts render them liable to extensive sloughing.

The President exhibited one very similar, but not so much mutilated. Had two former cases of more extensive tearing, from the elbow down, followed by tedious inflammatory action, rendering the limbs almost useless. The cases referred to were not healed after eight months, so that experience would show the necessity of operation immediately, or within a few days after accident.

An interesting discussion ensued between Dr. Ferguson and Drs. Browne and Gordon with reference, (1) to allowing the integument to be replaced over the denuded bone and soft parts, in such cases as might be given a chance of healing without operation; (2) the comparative merits of reapplying the raised integument, or application, such, as cotton wool, lint, and unctuous dressings; (3) the comparative vitality of integument torn up or down off the arm, and compared with vitality in the scalp; (4) the nature of the anatomical formation of that covering which replaces lost integument.

Sixteenth Meeting.
The President in the chair.

RHEUMATISM.

Dr. Graves brought under the notice of the society the therapeutic action of the tincture of actea racemosa in cases of acute rheumatism. He had tried it in several cases successfully, and had failed in only one case, when he had recourse to the opiate treatment. The disease generally yielded in about four days, and in no instance was the treatment prolonged beyond seven days. In none of the cases was there any cardiac affection. The dose was thirty drops thrice daily. It seemed to cause the subsidence of pain and uneasiness. It likewise produced a certain amount of diaphoresis and diuresis. He brought the remedy before the notice of the society, not as a specific, but as having succeeded with him in several cases. Dr. Simpson of Edinburgh had used it with great benefit in hypochondriasis and debility after parturition.

Dr. Browne asked if it had been employed in chronic as well as acute rheumatism.

Dr. Johnston inquired if it was equally applicable in cases where complication ensued.

Dr. Ferguson entertained great doubts as to the efficacy of specifics generally, and thought that this would probably run the course of such remedies. At the same time, he could not doubt the evidence of the facts laid before the society by Dr. Graves.

BELFAST CLINICAL
AND PATHOLOGICAL SOCIETY

NINTH SESSION
1861 – 1862

President HENRY MURNEY, M.D., Surgeon to Belfast General Hospital; formerly Demonstrator of Anatomy Queen's College, &c., &c.

FIRST MEETING
October 26th, 1861.

Case of Cataract.

Dr. BROWNE introduced a young girl, aged 14, from the country, labouring under cataract in both eyes.

He observed, that the case before the Society presented the usual appearance of congenital cataract, though the patient, up till two years ago, had enjoyed good sight; since that time the powers of vision had gradually declined, until now she could merely distinguish the outline of large objects, even when the pupils were fully dilated. No cause whatever could be assigned for the occurrence of the disease, as there had not been any injury or previous affection of the eyes. In his opinion it was the result of slow inflammation, and the consequent arrest of nutrition, just as, he believed, occurred in congenital cataract, either in utero or very soon after birth. Certainly it was very rare, he said, to see cataract occurring, as this had done, in a perfectly healthy young person, and where there had not been injury.

The operation he designed was that for breaking up and absorption—improperly called the operation for solution. He observed, that the needle—a very fine one—should be introduced through the cornea, and the capsule of the lens should be only slightly torn in the first operation, lest inflammation should be set up. In the future operation or operations the needle could be more freely used with comparative safety. Some weeks should intervene between the operations; indeed the needle should be only used afresh when absorption or the disintegration and disappearance of the cataract seemed at a stand still.

SECOND MEETING
November 2nd, 1861.

Dr. BROWNE exhibited a patient labouring under *traumatic cataract*. The capsule had been wounded by a blow from a hackle-pin; and spontaneous cure was now going on by absorption.

THIRD MEETING
November 9th, 1861

Case of Enchondroma of Hand.

Dr. BROWNE presented the model of a hand, taken in plaster, and also the morbid specimen which he had recently amputated for *enchondroma*.

The patient was a woman, aged 64 years, from the

country, near Belfast. She stated, that some 16 years since she had observed a small swelling close to the head of the metacarpal bone of great finger. This, she says, was entirely dispersed by treatment. Within the last two years, however, it had returned, and the swelling extended rapidly from that point to the rest of the hand, involving the metacarpal bones and the phalanges, with the exception of the distal phalanges of the thumb and little finger. The principal enlargement was on the back of the hand, where the tumour presented a somewhat unequal, glistening surface, the veins at some parts being tortuous, full, and enlarged. This tumour was elastic; and, at one or two places, there was a sensation of fluid beneath the touch. She came into hospital on the 4th; and on the 10th. of September the hand was amputated three inches above the wrist joint, by the double flap of the integument and circular of the muscular structure. The stump, an excellent one, healed up kindly. Six weeks after the operation he saw the patient in excellent health. Indeed her health had not suffered much before, as she had not had very much pain—only neuralgic uneasiness arising from pressure upon the nerves.

On making a section of the tumour, and dissecting back the integuments, there was a very thin shell of soft bony structure, then cartilaginous structure containing gelatinous matter in cells. This portion very closely resembled boiled sago mixed with red wine. The entire normal structures of the entire hand had been destroyed. The metacarpal bones of the thumb and little finger were flattened, and changing into cartilage, the osseous structure having nearly disappeared.

Though the age of the patient, the rapidity of the growth, and resemblance of some parts of the mass to colloid cancer, might raise a doubt as to the true nature of the growth, he still thought the case one of *enchondroma*, rapidly degenerating—doubtless a rare affection, and not one of malignant disease.

FIFTH MEETING
November 23rd, 1861.

Fracture of Clavicle.

Professor GORDON exhibited a patient who had sustained a fracture of the clavicle at the junction of the outer with the two inner thirds. The outer fragment had undergone the usual displacement, inwards and downwards. He has maintained, for some time past, that in fracture of the clavicle the shoulder is elevated, instead of being depressed. In the treatment of this accident he does not push the shoulder upwards and backwards, as usually recommended, but depresses it. He places a very large pad over the lower part of the side of the thorax; along the arm and forearm an angular splint, well padded above, where it rests against the biceps muscle, and extending from the anterior border of the axilla to the hand. The lower part of arm and inner surface of elbow is then firmly bandaged to the large pad. The elbow joint being thus fixed, and rendered incapable of flexion by the splint, he next elevates the forearm at the wrist, by a sling, which passed round the neck; and by so doing the

shoulder is depressed and pushed outwards. In the present case this apparatus has succeeded admirably in maintaining accurate apposition of the fragments. It is simple in construction, easily applied, and not liable to become disarranged.

Professor GORDON introduced a patient whom he was treating for *comminuted fracture of the clavicle*.

The PRESIDENT then read his opening address which had been deferred until this date owing to his unavoidable absence: —

*On the Statistics of the Mortality of Fractures of the
Skull; Effects of Operation, &c., &c.*

I HAVE frequently noticed there is a tendency to class all fractures of the skull together, and to look upon the patient's prospect as little short of hopeless. Serious as the mortality is, I did not think an examination of statistics would show so many sufferers rescued from death.

I would here observe that, as a rule, I look with great caution on statistical tables, knowing how frequently cases are classed together because of some trifling point of resemblance, although they may differ in most important particulars; and also, that it is much more likely a man would publish a successful than a fatal case, not that any desire to mislead or give a false idea of the mortality of a disease might exist; but when, from the serious character of the affection, it was expected the tendency would be to death, a sense of satisfaction, perhaps a lurking one of pride, that, contrary to all anticipations, recovery ensued, might tempt him to place on record that which probably he would not have done if the prognosis had been verified. Grave objections, no doubt; but, on the other hand, I may say, for some time past, our Medical Journals have contained records of all the most serious cases, with operations performed, in the London and principal Provincial Hospitals in England, we are thus likely to obtain an account of all unsuccessful as well as successful cases, and will be enabled to approximate the mortality of many injuries not yet precisely defined. I would add my belief that, from the fatal character of fractures of the skull, surgeons hesitate less about the publication of the cases than in many other affections requiring interference. These reasons I consider are sufficient to warrant a greater degree of confidence than is usually reposed in statistical tables, and I make use of them as giving by figures an approach to the mortality, effects of operation, &c., &c., and some other particulars in this class of affection.

I have records of several cases of fractures of the head which have come under my notice, I shall take the liberty of referring to a few of them where I find they illustrate portions of the subject. My information is not so accurate on some points as I could wish: for instance, in fracture of the base, the reporter frequently mentions that fact without specifying the part of the skull involved; and in injury of the superior region of the head, the calvaria is named without specifying the bone or bones injured.

I have taken a period of 10 years, from 1851 to 1860, inclusive, and have tabulated the cases of fractures of

the skull to the number of 253, which appear in the following Journals:—*Times and Gazette; Lancet; Dublin Medical Press; Dublin Hospital Gazette; Edinburgh Monthly Journal; Dublin Quarterly; Guy's Hospital Reports; and the Trans. Belfast Clin. & Path. Soc.* I have also examined Braithwaite's Retrospect, and the *British and Foreign Medico Chirurgical Review*. I had not access to other Journals. Twenty five cases were treated by practitioners not attached to public institutions; all the others were contributed by the attendants on the large metropolitan and provincial institutions, or by medical officers in the public service.

Of course I shall follow the usual division of the subject, viz.:—Fractures involving the calvaria or lateral parts of the head, and fractures of the base; and first of the former:—In addition to cases I have treated myself, I have the particulars of 187. In 84 of these the fracture was situated in one of the parietal bones; in 57 the frontal; in 9 the occipital; and in 37, two bones of the calvaria or lateral regions of the head were implicated, or the precise part of the skull-cap was not specified.

The mortality in these several localities was as follows:—most serious of the last mentioned—out of 37 cases, 22 died; then in fractures of the occiput—of 9 cases, 5 died; next we have injury to the frontal bone—of 57, 25 died, and one remained under treatment. Fractures of the parietal bones were most numerous and least fatal, as of 84 cases, 34 died, and one remained under treatment. As a summary we have 86 deaths; 99 recoveries; and two undisposed of, in a total of 187 cases, being 46 per cent. of deaths. A question has occasionally arisen, which are the most fatal fractures of the superior region of the head? The above shows that injuries to the posterior region are most, and to the superior least dangerous; and that fractures of the frontal occupy the middle place in danger as in frequency.

Of the 187 cases the bone was depressed in 149. Should the bone be elevated in every such case? should elevation be performed on the occurrence of reaction, whether symptoms of compression are present or not? or would the prospect be more satisfactory by delaying till well marked signs of pressure are exhibited? does the age of the patient modify in any way our opinion?

On reference to some of the older writers, as Pott and O'Halloran, we find that every case of fracture, with depression, was considered fit for the trepan. In the introductory observations to his work on injuries of the head, published in 1793, the latter writer lets us know, in his quaint style, how frequently he was called on to perform this operation, he writes:—"I have had no less than four fractured skulls to trepan on a May morning, and frequently one or two. In the course of above thirty-five years practice, I may safely affirm, because truly, that on an average, one month with another, from three to four cases have fallen to my share, of either fractures, concussions of the brain, or extravasations."¹ Again he says, "Every fracture with depression necessarily demands the operation; and though some particular cases may be adduced, when nature has somehow or other brought about the

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Introduction, p. 5.

business of healing, yet it is by no means to be trusted to; and the surgeon is inexcusable who fails to attempt, at least to propose and press it. Simple fractures of the cranium, with depression, when relieved on the spot, or in the space of two or three days, almost always terminate happily. In the course of more than 200 accidents of this simple kind, I cannot recollect a failure in a single instance."

"Fractures without depression do not demand operation."¹ Pott considers all depressed fractures require operation; and nearly all undepressed, also require the interference of the surgeon. He says, "perforation is absolutely necessary in seven cases out of ten, of simple undepressed fractures of the skull. Let us for a moment inquire why it is so. The reasons for trepanning in these cases are, first, the immediate relief of present symptoms arising from pressure of extravasated fluid; or second, the discharge of matter formed between the skull and dura mater, in consequence of inflammation; or third, the prevention of such mischief as experience has shown, may, most probably, be expected from such kind of violence offered to the last mentioned membrane. These are the only reasons that can be given for perforating the skull in the case of an undepressed fracture; and very good and very justifiable reasons they are, but not drawn from the fracture."²

In another place he says, "I have no doubt that although by establishing it as a general rule, to perforate in all cases, some few would now and then be subject to the operation, who might have done very well without it; yet, by the same practice, many a valuable life would be preserved, which must inevitably be lost without it, there being no degree of comparison between the good to be derived from it when used early as a preventative, and what may be expected if it be deferred till an inflammation of the dura mater, and a symptomatic fever make it necessary."³

I find elevation of depressed bone was practised in 124 of the cases I have tabulated, of these 60 died; 62 recovered; and 2 remained under treatment; as nearly as possible the deaths were 50 per cent.

In 25 cases of fracture with depression, no operation was performed. On analysis of the symptoms of those who recovered—one had profound insensibility; another was insensible and convulsed; another had partial paralysis; the remainder were partially insensible, or had threatened inflammation in the head. Of those who died the symptoms recorded are:—insensibility in one; paralysis in another; epileptic fits in a third; (I use the expressions of the reporters,) 7 died; 18 recovered: being a mortality of 28 per cent.

Some interesting Cases of Fracture of the Calvaria with Depression, have come under my observation in hospital: –

A lad 16 years of age, while engaged at work in one of the ship yards, received a blow on the side of the head from a heavy piece of timber which had fallen a height of 10 or 12 feet; when brought to hospital we were

informed he had vomited a large quantity of blood; he laboured under collapse first, then concussion; on careful examination of the head (there was no scalp wound,) a fissure extended from the left parietal protuberance forwards for about one and a half inch, bifurcated, producing the shape of the letter Y ; the piece of bone between the limbs of the letter, and also, one margin of the fissure, in its posterior part, were depressed, I would say rather more than the thickness of a half-crown. The symptoms of concussion yielded after a time, and were followed by cerebral irritation, and inflammation of a not very intense form. When convalescent I felt dissatisfied with his stolid stupid manner, but learned from his friends he was of a sulky disposition, and that his mind and character were as before the accident. The treatment adopted was cold applied to the head, mercury in small doses, until the constitutional effect was produced, and when necessary purgatives.

In this case, from the vomiting of blood, I feared more serious mischief than the fissure of a small portion of bone. The possibilities of fractured base, or of injury to the liver, or some important abdominal organ, suggested themselves; but when hours passed by and full reaction was established without its recurrence, my attention was fully turned to the concussion; as it subsided from the depression of bone, I looked for the appearance of symptoms of compression—had such manifested themselves, I would have cut down and raised the bone.

A few days after the admission of the last, a boy, aged 13 years, came under treatment. Two evenings previously, while seeking for a ball, he had fallen from a man's shoulders and alighted on his head; he is reported to have been insensible for a short time, and on recovery to have vomited repeatedly, and complained of pain in the part injured, with general headache and sickness of stomach. On admission the head was shaved, no wound or abrasion was visible, but a fissure of the skull, as in the other case, was felt, extending from the left parietal protuberance forwards almost to the anterior border of the bone; the upper margin of this was depressed to about the same extent as in the other case.

I placed him on low diet, gave him some alterative doses of mercury, and kept him in hospital for a time.

Here we have one of those most infrequent cases—a grave injury followed by most trifling constitutional disturbance; in fact, from the time he came under my care he was well—all headache, &c., &c., had passed off. My treatment was merely precautionary.

Again, about a week later, a fine boy, about eight years old, was brought to hospital—a log of timber had fallen on him, fracturing the right forearm very severely, and causing a wound which commenced at the right frontal protuberance and stretched upwards and backwards about four and a-half inches in length; the scalp was separated to a considerable extent, and a fracture, parallel to the wound, occupied fully three inches of the frontal and a small portion of the parietal bones; there was depression to fully the thickness of the skull. In the unavoidable absence of my colleague on duty, I saw him about an hour after admission.

¹ Introduction, p. 31.

² Vol. I., p. 104.

³ Page 111.

Bodily warmth was then restored, his pulse and respiration were slow; pupils dilated, uninfluenced by light; he lay quietly, head resting on the right (the injured) side; when turned on the left side he gave a fretful cry and endeavoured to replace it; by sharp speaking or pinching he could be partially aroused—give a monosyllabic answer, and then sink back into insensibility. The house surgeon informed me, half an hour before my visit he could be roused with much greater facility, when he gave his name, residence, &c., &c. That I might have an opportunity of noting the increase of the coma, I deferred operative interference for an hour, when I returned and examined him, and was satisfied the insensibility was greater than before.

I then had him removed to the theatre for the purpose of operation; immediately before commencing, I again essayed to arouse him, when suddenly he opened his eyes and answered quite collectedly, although slowly and rather stupidly. Under these circumstances I did not deem it necessary to raise the depressed bone.

The boy passed to the care of my colleague; he laboured under concussion for a time, and gradually recovered. He was discharged in seven weeks.

This was to me a most interesting case; had the profound insensibility, which was twice so marked, continued, my treatment would have been elevation of the bone with Hey's saw, if possible, if not, by the trephine first, then the saw. The occurrence of insensibility, followed by a state from which he could be aroused, I believe, was due to cerebral congestion, for, after severe injury the circulation is embarrassed and imperfectly performed; and, I have several times noticed, although not so well marked as in this case, the insensibility sometimes more, sometimes less profound, without any apparent cause.

Ten months ago, a boy, 16 years of age, fell a height of 12 feet in the hold of a ship on Queen's Island, he alighted on the posterior part of his vertex. I was in the hospital on his admission, and was informed that he was insensible for a period of about 10 minutes after the accident, but from the time he was placed in the ferry boat until his arrival here, he was perfectly collected. There was a wound one and a-half inch long, situated over the upper part of the occipital bone; almost at the summit of that bone a V shaped fracture was seen, the point directed upwards; the limbs were each about one inch long; the bone was depressed fully the thickness of two half-crowns; he merely laboured under collapse, and was quite astonished when I ordered him to bed. The wound healed up, and he was discharged in a month.

I saw him six months afterwards, he had not experienced the slightest bad effects from the fracture.

This is another example of a most serious injury without the appearance of a single bad effect—in fact, so well did he feel, I had considerable difficulty in keeping him in hospital for a reasonable time.

Is the danger to the patient increased by cutting down to make an examination merely of the site of fracture—by, in fact, rendering the fracture which was simple, compound? Most surgeons are opposed to this treatment, Sir Astley Cooper, in his forcible language,

says, "the man who would do so should be cut for the simples." Mr. Guthrie and others do not consider the patient's danger is in any way increased by it.

I believe the principal advantage to be attained by it is, that we can ascertain more accurately the extent to which the cranium may be fissured, and the amount of depression of the outer table; also, if death of a piece of bone is about to take place we are made cognizant of the fact at an early period by its altered appearance. Although I would not practice it heedlessly, or without due consideration, I should have no hesitation in cutting down, provided I was uncertain as to the extent or amount of the depression of bone.

Of fractures without depression we have reports of 38 cases, of which number 25 were subjected to operation and 13 were not; of the former 13 died, 12 recovered; of the latter 5 died, 8 recovered. Among those subjected to operation, we have 3 cases of paralysis; 5 more or less convulsed or with epileptiform fits; 4 insensible; 3 of compression; 3 of encephalic inflammation; and, what I consider strange, 5 are marked as labouring under very slight symptoms or none at all. Those not submitted to operation suffered from slight concussion, collapse, effects of shock, &c., &c. One, a recovery, had epileptic fits.

In December, 1858, I brought before the notice of the Belfast Clinical and Pathological Society, some cases of fracture of the skull. One was a patient with fissure of the frontal bone. In giving a brief account of his case, I stated, he laboured under paralysis which gradually became general. Under treatment this slowly passed off, and he was discharged from hospital quite restored. Twelve months after, this man came under the care of one of my colleagues, he had fallen into a vat of boiling ley in a bleaching establishment. He told me he had enjoyed excellent health since his dismissal; he had not suffered from headache, loss of power, or any effect of his injury. In a few days after his second admission he was attacked with tetanus, and died. I made an examination of the head and removed the portion of the calvaria which had been fractured, and which was completely united. The dura mater was most intimately adherent to the bone in the vicinity of the fractured part. The brain, &c., &c., were perfectly normal.

A man, aged 22, had the upper part of his occipital bone fractured by a heavy piece of iron falling on him, from a height of 12 or 14 feet. When admitted he laboured under the ordinary symptoms of collapse; then well marked concussion. The fissure of the bone could be readily detected at the bottom of an extensive wound. There was no depression. In a month he was discharged from hospital perfectly well. The case was an average one, without the appearance of a single peculiar or anomalous symptom.

Thirty-four cases with depressed bone, although not labouring under symptoms of compression, were operated on; of these, 22 recovered, 12 died. As many of the contributors do not mention the symptoms (if any) which existed before operation, I have no doubt, this series should be much greater. I have, however, merely tabulated those in which the writer distinctly records the absence of compression.

I must confess my inability to understand the indication for the use of the trephine or saw, where the report states the patient was "sensible" or had no symptoms of compression. And, although I find this practice has been followed by some surgeons, I would not pursue it, therefore, cannot commend it. I consider, at all times, even in the hands of the most skilful, the use of the trephine must expose the patient to considerable risk of encephalic inflammation, and, that we are not justified in operating as a mere precautionary measure, but only in those cases, in which, from symptoms of compression, we have reason to believe there is pressure on the brain which may be relieved by interference.

There may be an exception to this rule, as occurs frequently in military practice, a bullet producing what might be styled an indented or stellate fracture; or in civil practice, a blow from the sharp angle of a brick or slate, driving in the outer table and breaking the inner to a greater extent. Here we might expect pressure on the brain or more extensive laceration of the membranes than the slightly depressed condition of the outer table would indicate; in such a case the appearance of less urgent symptoms, as convulsive twitchings, epileptiform seizures, would be a sufficient warranty for the use of the trephine.

I may here appropriately refer to the question of the frangibility of the tables of the skull. For many years my anatomical experience made me look with considerable doubt on the generally received opinion, that the inner table is so much more easily fractured than the outer. I often observed, if great violence be applied to a skull-cap, the tables would be fractured to about the same extent. In 1858, in a most valuable series of lectures, delivered in the College of Surgeons, England, Mr. Prescott Hewett, not only noticed this, but carried his observations further, he found where violence is applied from within outwards, the outer table is usually injured more extensively than the inner—if from without inwards, the reverse; where great force is used, both will be broken to about the same extent. On reading his remarks I tried these experiments repeatedly, and believe his statements are correct. If, then, an individual has fallen from a great height, alighting on his head, or has received a fracture in some other way, from great violence, I would anticipate the tables of his skull would be broken to the same, or nearly the same extent, but, if a less force were applied to a small surface, I would dread splintering of the inner table.

Another question of interest is that of injury to the brain. We all know the prospect is much brighter where bone is merely depressed without lacerating the dura mater; and injury to that membrane is less fatal than where some of the cerebral texture is torn, and possibly protruding from the wound. Some of the most experienced surgical writers look upon this latter form of injury as almost necessarily fatal—the mortality is very large—and yet many recover. I have made a distinction between protrusion of the brain and hernia cerebri, as it is at times called, on the one hand, and simple wound or laceration on the other. Where wound of brain has terminated in hernia, I have placed the case under the former head.

Of cases styled protrusion or hernia, there were 35 reported—17 died, 18 recovered. Of wound or laceration, 27 cases—18 died, 9 recovered; total, 62 cases, with 35 deaths. Of these, 9 had more or less of paralysis or convulsive twitchings; 7 symptoms of inflammation of varying degrees of intensity; 9 compression, the majority well marked, although some were not very profound. Then we have concussion, collapse, and shock; several described as not labouring under any symptoms; and some, in which the reporter mentions many of the leading features, but does not state this particular.

On looking at the mortality as it occurred at the different periods of life, we find up to the age of 10 years, inclusive, there were 24 cases with 9 deaths; between 10 and 20, 49 fractures, with 16 of a mortality; from 30 to 40, 86 cases, 48 fatal; and from 40 to 60, 24 with 10 deaths; two had not terminated when their reports appeared.

I do not consider it necessary to give an analysis of the plans of treatment pursued. In a considerable proportion indeed, the writers seem to have considered the indications so obvious, as not to have recorded it at length. I would merely observe, venesection was practised in 24 cases only. A marked contrast to the custom of the older writers, and also to the injunctions of many within a very recent period. Tartrate of antimony also seemed to be at a discount, for I find it was used in three instances only. The preparations of mercury were most generally employed, in some, merely as purgatives, in a considerable number until the constitutional effect was produced.

I would briefly sum up my views of fractures of the calvaria. The most dangerous are those of the occipital; the frontal next in order; the parietal least so.

The mortality in fissure of the calvaria and depressed fracture is nearly equal, considering all the cases. But take all the cases, whether depressed or not, in which operation was performed, the death rate was 50 per cent. All the cases where no operation was performed, the per-cent-age was about 34; or if we contrast those cases in which there was depression but no operation, the mortality was 28 per cent.; with those also depressed and operated on without any symptoms, the deaths were 36 per cent. These facts must, I consider, point to the conclusion, that operative measures should only be used as a *dernier ressort*.

The cases of fracture without depression subject to operation, showed a mortality of 52 per cent. Similar cases not operated on, presented 33 per cent. of deaths. In cases of injury to the brain, the mortality was about 43 per cent. Operation is fully warranted when the injury is of the indented class already referred to.

In simple fracture, where there exists a doubt as to the extent of the depression, I consider the surgeon adds extremely little, if anything, to the risk of his patient by cutting down. Fractures are borne with greatest immunity in the first and second decennial periods. The danger to life is greatly increased in the third and fourth, and again diminished in the fifth and sixth periods. I have given a brief report of six cases of fracture of the calvaria with recovery in each. In two of

these the occipital—in two the parietal—and in one the frontal were broken—and in one case the frontal and parietal were both involved.

I have examined the reports of 66 cases of fracture of the base of the skull. Of this number, 46 died, 20 were restored; about 69 per cent., an enormous death rate.

When we consider the great injury inflicted on parts so nigh to the most essential portions of the nervous system, generally themselves sufferers from laceration or extravasation, and the uncertainty which surrounds the recognition of these fractures during life, we need not feel surprise at the short list of authenticated recoveries.

In those injuries hitherto considered we had, generally, *tangible* and frequently *visual* evidence of their existence. In the present class, during life, in many cases we are dependent for our prognosis on symptoms which bear no proportion to the amount of fracture sustained.

As an illustration, I would mention the following:—Within half an hour of the admission of the boy with compound fracture of the frontal and parietal bones, whose case I have related just now, a man, aged 60, was also admitted to hospital. While engaged white-washing a house, on a ladder about 20 feet high, a sudden gust of wind precipitated him to the ground. When I saw him about half an hour after admission, the surface was cool, not cold; he was perfectly collected; described how he had been engaged before his fall; said he was insensible until shortly before his admission; complained of pain across the temples. I noticed he was somewhat (a little) deaf; I asked was this the result of his injury, he stated he had been deaf for many years—he had bled from the right ear; but when I visited him within an hour of the accident the hemorrhage had ceased, and there was a little dried encrusted blood in the meatus externus.

Immediately after leaving the bed, the house surgeon, in conversation, suggested the existence of fracture of the base. My reply was, it may be present, but if we have not an opportunity of examination we are not warranted in placing the case on record as one of this injury.

This, with the other patient, passed to the care of my colleague on his return to town. Frequently, when in the ward, I spoke to the man; his mind was quite clear; he many times complained of being deprived of his snuff box. The only circumstance which attracted my attention was, he always lay on his back, and complained of pain in his head if the nurse turned him on his side. Until three days before his death, when he had symptoms of encephalic inflammation, his mind was perfectly clear. Death occurred ten days after admission.

I was not present at the *post-mortem*, but was informed the brain showed evidence of inflammation, and a fracture passed through the right petrous bone, without involving the tympanum.

Now, I consider the absence of all head symptoms fully warranted the opinion I expressed. The small quantity of blood which flowed from the ear was of no value as a diagnostic, and the trifling complaints of the patient might readily be caused by contusion.

I consider these two cases are worthy of being placed on record. First, a sailor, 20 years of age, was admitted on 16th. June, 1859. While intoxicated he had fallen into the hold of his vessel, a height of 12 or 14 feet, alighting on his head, and receiving a fracture on the left side of his forehead from the sharp angle of a brick. The fissured condition of the bone was visible at the bottom of an extensive scalp wound, it stretched down to the supra orbital foramen, and was of a † shape. The amount of insensibility was only partial, as he could tell his name and age. His breathing was natural; pulse 60; skin cool; on being let alone he turned off to sleep immediately. There were two small contused wounds on the left side of the face, one beneath the outer, the other beneath the inner canthus; for some hours continuous bleeding poured from these wounds, followed, for 24 hours, by copious weeping of serum. There was considerable extravasation of blood behind the left ocular conjunctiva, and the eye-lids were very much ecchymosed. From this I diagnosed that the fracture, which was traced to the supra orbital foramen, extensively involved the roof of the orbit. I also considered the serum was arachnoidean which had passed behind the ball, and made its way out by these wounds. On the 18th, he had well marked symptoms of inflammation of the encephalon; on the 21st, he had paralysis of the right side; he died on the 25th.—nine days from the injury. Insensibility was almost complete after the first day.

I made a *post-mortem* 12½ hours after death. A large collection of pus occupied the cavity of the arachnoid anterior to the left hemisphere; the arachnoid, especially in the neighbourhood of the superior longitudinal sinus, was thickened and opaque; general vascularity of the pia mater. On removing the brain, two clots, each about the size of a shilling, were found, one on the roof of the left orbit, the other in the middle fossa of the left side; the brain substance was normal in consistence, but highly vascular in all parts, both cortical and medullary. The fracture in the calvaria was more extensive on the inner than the outer table, without depression, extending from below the left frontal eminence to the margin of the orbit at the supra orbital foramen, in length, say one and three-quarters inch; a similar fissure extended across the top of this, at right angles, producing a T shape. In the base the fracture stretched backwards, from the supra orbital foramen through the roof of the orbit, completely breaking away a piece of bone, nearly circular in shape, of the size of a shilling, rather internal to the centre of the orbital roof; this could be readily removed by the forceps; the continuation of the fracture extended from the left towards the right side, through the olfactory process and body of the sphenoid bone, into the right side of the basilar portion of the occipital, terminating half-inch anterior to the foramen magnum. None of the other cavities were examined.

The extravasation beneath the conjunctiva enabled me to express the opinion that the fracture extensively involved the roof of the orbit. The weeping of serum also pointed to fracture of the base. I had never witnessed it from this situation, nor do I recollect having seen it recorded—I think it must be infrequent.

The second case was somewhat similar:—On 11th May, last year, a man, 19 years of age, fell from a scaffold 20 feet high, alighting on his head. On admission he had bleeding from the left ear and nose; he had also extravasation of blood beneath the left ocular conjunctiva; he had symptoms of collapse first; then concussion; during the day he several times vomited blood. As the effects of the concussion passed off in the evening and early part of the night, he was not only able to answer questions, but manifested curiosity as to where he was; how the accident occurred, &c., &c. This continued till within an hour of his death, which took place 13½ hours after the accident. On examination, two fractures extended from the left frontal eminence downwards; one in front of the external angular process, the other behind it; the brain was considerably congested, but was not lacerated or injured in any part; a small extravasated spot was on the most prominent portion of the middle lobe of the left side; another over the superior vermiciform process of the cerebellum; and a third on the upper surface of the tentorium, near the right perpendicular semi-circular canal; the brain substance was healthy.

There were two fractures in the roof of the orbit—one at its fore, the other at its back part; both were connected with the fissure which stretched down the forehead; two also ran in the middle fossa and terminated at the foramen ovale. Here the bleeding from the ear and nose, with the vomiting of blood, pointed to the existence of fracture of the base; the extravasation behind the conjunctiva, to injury of the orbital roof.

In the former case, the fracture stretched into each of the three fossæ, in this the anterior and middle were involved.

Two other instances of extensive fracture of the base came under my notice. One, an elderly man, was knocked down in the street by a blow from the shaft of a car, he lived five days. On post-mortem at least one ounce of blood lay between the dura mater and the skull-cap; there were three clots on the surface of the brain, and there was laceration of the grey matter on that portion of the middle lobe which occupies the middle fossa; the calvaria was most extensively broken, and the anterior and middle fossæ fractured. The other, also an elderly man, had fallen down the cabin stairs of a steam boat, a height of about 12 feet; he lived 24 hours. On post-mortem the condition of the brain and membranes was much the same as just described; there was no fracture of the calvaria; in the base the middle fossa was extensively broken, and the lesser wing of the sphenoid chipped off. I do not give the details—as neither of these cases presented features of much interest, but place them on record for future statistical inquirers.

From the accounts of the post-mortem examinations, the following were the situations of the fractures:—Of the middle fossa alone there were 11 cases; of the anterior 10; of the posterior 2; of the anterior and middle 4; of the posterior and middle 9; one of these had separation of the coronal suture. There were 5 cases of fracture running into each of the three fossæ;

three of these had, in addition, separation of the coronal suture. There were 5 cases in which the precise locality is not described. On analysis of the fatal cases, we may fairly exclude the following, when considering the per centage of mortality. First, a case of fracture of middle and posterior fossæ, with fracture of some of the lumbar vertebrae; second, fracture of the anterior fossa, and of the seventh cervical vertebra; third, fracture of middle and posterior fossæ, with fracture of several ribs and other injuries.

In such instances the serious injuries mentioned would of themselves suffice to cause fatal issue.

Again we have unusual, and I may say, necessarily fatal cases, such as a piece of nail-rod penetrating the roof of the orbit, lacerating the brain, and causing copious hemorrhage by rupture of the anterior cerebral artery.

The extremity of a walking-cane passing through the nostril, perforating the ethmoid and sphenoid bones, and impacted in the lower part of the brain.

Brass ferrule of an umbrella perforating the roof of the orbit and impacted in the brain—and a piece of tobacco pipe lodged in the same locality. The last three were only discovered on post-mortem. In all, 7 to be deducted from the number of 46 deaths, which would leave 39. Add to these the 5 cases I have now recorded. This would leave the mortality as already stated. I have brought forward some of, to me, the most interesting matters connected with 193 fractures of the calvaria, and 71 fractures of the base of the skull. In all, 264 cases. Many of the matters I have only touched upon would, I know, supply ample material for valuable papers.

SIXTH MEETING November 30th, 1861.

Compound Comminuted Fracture of the Tibia and Fibula of the Right Leg.

Dr. BROWNE read the following case: —

George Mayers, aged 18 years, a strong healthy young man, was admitted to the General Hospital on the 18th. of October; three hours before, the wheel of a baker's heavy cart had passed over the right leg, about four inches above the ankle. Both bones were broken. At the posterior part of the leg a wound existed about an inch in length; but the bones did not protrude from this, though the bruised tissues did. The limb was put, upon the outside, in a padded splint, and flexed at the knee, and the wound covered by water dressing. Erysipelatous inflammation, with considerable serous infiltration, soon set in, and extended to the knee; and in a week after admission the integuments on the front part, over which the cart-wheel had passed, as well as the posterior wound, had sloughed, exposing the broken ends of the tibia, denuded of periosteum for about three-fourths of an inch. Various contrivances were adopted to keep, or rather to bring, the fractured ends in apposition; but this could not be accomplished. At this time the constitutional disturbance became great, and the suppuration copious; still it was determined to give him a chance of saving the limb.

Stimulants and tonics were freely exhibited; and, for some days, considerable improvement took place. However, the sores soon after assumed a very sloughy, in fact phagedenic appearance, the constitutional irritation increased, and there was great infiltration of the entire limb up to the groin, with pain along the course of the saphena and femoral veins, upon pressure. At that time the fractured parts of tibia were exposed for an inch above and below, and a large slough had taken place in the back part of the limb, behind the seat of fracture. Under these circumstances, though the issue seemed very doubtful, it was evident that amputation must be resorted to, to save life, if possible. The operation was accordingly performed by me, on the 14th. instant, by the double flap of the integuments and circular incision through the soft parts, the bones being cut through three inches below the tubercle of the tibia. Three vessels were tied, and the stump was put up four hours after, with straps of wet lint. Besides the great serous infiltration of the limb, to which reference has been made, the veins were found to be greatly inflamed and blocked up by a clot. He had had, moreover, on two occasions, severe rigors—one a week, and another three days, before the operation.

The opium and quinine, with six ounces of wine, beef tea, &c., which he had been taking, were ordered to be continued. On the 18th. the wound was opened for the first time. The stump did not show the smallest sign of any healing by the first intention; but, otherwise, did not look unhealthy. The infiltration of the limb had greatly subsided; and the pain, on pressure along the veins, was not so great as before. Opiated mercurial ointment was directed to be rubbed along the course of the inflamed veins, and the stimulants, opium, &c., to be continued. On the sixth day after the operation, he had a sharp rigor, which caused some apprehension. On the eighth, pretty free suppuration of the stump had taken place, and there had not been any return of the rigor. On the tenth, the last ligature came way, and the patient seemed improving. On the twelfth day after the operation, however, he had, in the course of nine hours, three severe rigors, followed by profuse sweating. On the thirteenth day, an increased discharge of pus occurred; and there was not any recurrence of the alarming symptoms which caused the dread of pyemia; and he was discharged, four weeks after the operation, with a good stump, and with completely restored health, which had been so much shaken by the results of his unfortunate accident. On the whole the case is interesting, as showing that young persons will survive operations frequently, even when performed under the most unpromising conditions.

The bones of the parts at the seat of fracture were found to have been greatly comminuted, stripped of periosteum, and, in fact, in such a state as to have afforded no chance of repair.

Case of Disease of Hand, requiring Amputation.

Dr. BROWNE showed the morbid parts, and gave the following statement of the case: —

Peter M'Caffrey, aged 54, previously of excellent

health, and of temperate habits, was admitted into the hospital—first, in September, 1857, having had the middle finger of his left hand crushed between rollers, so much so that amputation of the part was performed by Dr. Browne, through the first phalanx. In five weeks he was then discharged, with the part quite healed up; and he remained well till the month of August of the present year, when he sustained a kick from a horse on the old cicatrix, which broke up the remaining portion of the first phalanx, and drove the splinters into the palm of the hand. He was admitted into hospital, when Dr. Murney removed the fractured portions of the bone, and took away the former stump at the metacarpo-phalangeal articulation; the parts healed up, and he went out quite well at the end of a month. On the 12th of October he returned with the cicatrix completely opened, and presenting a most unhealthy phagedenic character, with disease of the metacarpal bone. Extensive sloughs, burrowing beneath the palmar fascia, took place, with great enlargement of the wound; in fact the gangrenous state progressed, despite all treatment, till hemorrhage took place which could not be controlled, and rapidly reduced the strength of the patient; this, combined with the excessive pain of the part, was quickly wearing the patient out, so that it seemed amputation was the only resource left, and for which the patient was most solicitous. Dr. Browne, therefore, amputated, a little above the wrist, on the 16th. of November. The stump healed up quickly, and the patient regained his health and strength—the only retarding circumstance to his rapid convalescence having been suppuration of the glands in the axilla.

Compound Comminuted Fracture; Amputation.

Dr. BROWNE exhibited a limb which he had to amputate the preceding week, in consequence of being completely smashed by a railway waggon which had passed over it. The operation was performed through the lower third of femur, by the double flap of integument, and circular incision of muscles—care being taken to make the anterior flap long. The stump promises to be an excellent one.

Professor GORDON introduced a patient who had sustained an *impacted fracture of the surgical neck of the humerus*, together with fracture of the radius of the same limb.

Professor GORDON then showed an arm which he had found necessary to amputate for compound fracture at the elbow joint.

Epulis.

Professor GORDON exhibited a specimen of fibrous epulis, and gave the following details: —

Ann Dyer, admitted into hospital November 9, 1861, aged 18, complexion florid, and her general health very good. About five years ago a small tumour appeared in the gum, opposite the second incisor tooth of the right side. At first this tumour grew very slowly, being at the end of three years scarcely half its present size. On admission into hospital the right side of lower jaw

presents a firm oblong tumour, extending from the first incisor to the second molar tooth; it is almost an inch in length, and fully three-fourths of an inch in depth, rising upwards almost to the level of the upper margin of the crown of the canine tooth; it is not painful on pressure; in colour a little whiter than the gum; firm, and slightly elastic; its surface perceptibly irregular from numerous small protuberances. Around its margin it overlaps closely the neighbouring gum and teeth; the first molar tooth is directed more inwards than that of the opposite; but this seems due rather to crowding of the teeth than to displacement by the tumour, as none of them are in the slightest degree loose. There is increased vascularity beneath the mucous membrane, at its reflection upon the lip, immediately below the tumour.

On attempting to remove the tumour with the scalpel osseous substance was encountered. The scalpel was, therefore, laid aside, and the cutting forceps applied, one blade above and the other below the tumour. The mass was thus easily and perfectly detached; and were I called upon to perform again a similar operation I would use the cutting forceps. The fang of the canine tooth was denuded almost to its point, and an osseous spicula, about one-eighth of an inch in diameter, divided. This spicula projected fully one-fourth of an inch into the tumour.

Although the alveolus between the canine and second incisor tooth seemed sound, yet, from the recognised tendency of such tumours to repullulate, the incisor and canine teeth were extracted, the intervening alveolus removed, and the surface touched, lightly, with potassa fusa. On examination of the tumour, after removal, we find it firm, slightly elastic, colour white; its surface perceptibly uneven, with a fibrous section, presenting a groove corresponding to the fang of the canine tooth; and that its point of attachment was much less than would have been supposed from the external examination. When cut into, a small cavity was exposed, filled with sebaceous-like matter, which, when examined by the microscope, is found to consist of plates of cholesterine, oil globules, granular matter, and a few epithelial scales. The tumour itself seems, on section, to be decidedly fibrous, yet the microscope shows it to belong rather to the fibroid than fibrous tumours. The several cavities containing sebaceous-like matter are, I think, the follicles of the gum distended by a secretion which has undergone degeneration. If we give to this fact its due weight I think it will lead us to infer that the tumour involves, and has its origin, simultaneously in the gum, periosteum, and alveolus.

SEVENTH MEETING December 7th, 1861.

Disease of Femur.

Dr. BROWNE exhibited a patient labouring under disease of the left femur, and made the following statements regarding the case: –

The lad, now eight years of age, had, till four months since, excellent health, and is descended from healthy

parents, not related by blood. At the time referred to he had a fall upon the hip, but which neither caused fracture nor luxation; indeed he continued to walk for a week after the fall without suffering pain, and without lameness. He then began to keep his bed, and suffered, for several weeks, great pain, with much swelling around the hip, and of the thigh also. The medical practitioner who saw the case in the country, supposed that suppuration was about to take place. By degrees the pain subsided, and the swelling diminished; but then, for the first time, some five weeks' since, great shortening of the limb was observed to have ensued. When the boy was brought to the hospital, on the 4th. instant, he (Dr. Browne) diagnosed spontaneous luxation at hip joint, with disease of the shaft of the femur. He said he was led to believe, from the history of the case, that acute hip-joint disease had resulted from the fall; that dislocation ensued, after some weeks of destructive inflammation; and that the disease of the shaft of femur had occurred about the same time.

The present condition of the patient, he said, is obvious. The femur is displaced upwards; the head and neck partially absorbed, are resting on, and nearly fixed to the dorsum of the ilium; the shortening amounting to fully three inches; the shaft of femur and soft parts are greatly enlarged, and the integuments have large veins ramifying extensively through them. The patient's health is good; and there is not the smallest pain on pressure, or on attempting motion of the hip. Still, even with these negative signs, he could only arrive at the conclusion that cerebriform disease of the femur is present, and that it would eventually prove fatal. The progress of the morbid growth had not lately been rapid; but the members of the society were well aware that in many of these cases the disease, for some time, seemed almost stationary, when all at once it advanced with great speed; and finally, having burst through the integuments, it soon destroyed the life of the patient, either by the constitutional irritation set up, or, in some instances, by the exhaustive drain of repeated hemorrhages. He concluded by stating he would keep the patient in hospital for some time, would watch the progress of the disease narrowly, and would report the issue to the Society.

Extroversion of Bladder, &c.

Dr. BROWNE introduced a lad of 14 years of age, who had congenital absence of the anterior walls of the lower part of abdomen and bladder; the back part of the bladder projected forward, and exhibited the mucous surface to the extent of about an inch and half square, with the ureters opening at the lower portion. Beneath this the rudiment of a penis appeared, the corpora cavernosa separated above, with a small opening in the sulcus, between the bladder and back of penis, seemingly the mouth of the common seminal ducts. The testicles were fully developed and enclosed in the scrotum, which approached to the normal condition beneath, but separated above, passing to each ascending ramus of the pubis, the two portions being united by a thin integument and membranous band. The pubes were separated at the symphysis, the interval being filled by strong ligamentous structure.

There was no trace of a urethra, except what has been referred to as the openings of the ejaculatory ducts.

Excision of the Tonsils.

Dr. BROWNE introduced a young female, 18 years of age, from whom he had excised greatly enlarged tonsils, and exhibited the hypertrophied parts.

This young girl was of small growth, and not at all developed according to her age. She had suffered, for several years, from repeated attacks of inflammatory sore throat; and latterly the enlargement of the tonsils had become so great as to interfere materially with deglutition, speech, and breathing; and her general health had suffered also. The catamenia had never been properly established, and the mammae were undeveloped. Dr. Browne regarded the operation of removal as established in such cases; and his experience of many cases was, that within one year after the excision of the hypertrophied tonsils, in young females, the system became fully developed, and the health quite re-established. He considered the operation quite safe, provided the surgeon took care not to cut too deep, or outwards; but having drawn the tonsils towards the mesial line, he carried the knife—probe-pointed—with its edge directed forwards, and its flat pressing against the arches of palate, completely through the enlarged mass. Very little hemorrhage had occurred in his practice, and he had never witnessed any unpleasant results.

With regard to the notion entertained by some authors that removal of the tonsils would interfere with the sexual reproductive powers, he said, in the first place, the tonsils never were, and could not be excised; it was only the *morbid growth or hypertrophied portion* that was removed; and in the second place, he contended that the removal of these morbid growths, instead of interfering with sexual development, actually had the very opposite effect. He concluded by saying that he strongly recommended the operation in all suitable cases—such, in fact, as the one he had introduced to the notice of the society.

ORDINARY MEETING
January 4th, 1862

Dr. James CUMING read a case of:

Case of Tetanic Spasm, chiefly affecting the Extremities.

On the evening of the 7th. December, I was asked by a benevolent gentleman to see a youth, of between 16 and 17 years of age, who, he said, was dying. On reaching the house, I found the patient—a thin, nervous-looking lad—suffering from very violent pain in the region of the heart and in the limbs. On applying my hand over the precordial region, I felt the heart acting with a violent heaving impulse, shaking the patient with every pulsation, indeed I do not remember having ever felt a more forcible impulse. There was, however, no irregularity, and the pulse did not give any indication of the disturbance at the centre of the circulation, being 84, full, and not remarkably strong. The breathing was hurried. On examining the extremities, I found that the muscles of the forearm were rigid,

the wrists slightly flexed, and the thumb drawn into the palm of the hand. The fingers, without being clenched, were so strongly flexed, that a moderate force was not sufficient to open them. The feet were turned inwards and the soles arched. There was no swelling of the joints, nor any tenderness on pressure. The patient told me that paroxysms occurred about every 10 minutes, and I remained in the house so as to have an opportunity of seeing one. When it occurred, the trunk and limbs became quite rigid and extended, the abdominal muscles were strongly contracted, and the patient screamed loudly.

Observing that the affection presented a distinctly tetanic character, I looked carefully for the affection of the facial muscles, which is so generally present in that disease, but I could detect no trace of it. The countenance was certainly for a moment convulsed with pain, but there was no corrugation of the brow, no risus sardonicus.

I inquired minutely and carefully as to the existence of any difficulty in mastication or deglutition, or of any painful spasm of the jaw, but the patient assured me that he had not suffered anything of the kind, and his relatives were confident that there had been no change whatever in his features or expression. He stated, however, that his tongue had been stiff, and the tip turned up, and that there had been some pains and rigidity in the sides of the neck.

The history of the case was as follows:—He was apprentice to a carpenter, and about a fortnight before, while working out of doors, had been one day exposed to much cold and rain. The day after, he had taken the cramps through his body and limbs. For eight days he had suffered from them, at first about every hour, but subsequently much less frequently, and three days before my visit, feeling much better, he had returned to his work. But the spasms recurred so violently, that he was obliged to return home, and from that day had become progressively worse. During the entire time, the pain about the ensiform cartilage was the most severe symptom under which he laboured; and his father, with whom he slept, said that he had been kept awake by the beating of his son's heart. The bowels had been pretty regular, and he had been besides two or three times smartly purged with salts and senna; no worms had been passed, and he had always had some appetite.

I ordered small doses of laudanum and tinct. hyoscyami, to be given during the night. In the morning I was agreeably surprised to find that he had slept a good deal, and that the spasms were much less frequent. During the intervals the heart's action was tranquil and quiet, and, even during a paroxysm, the impulse had a much less violent character than on the preceding night. There was no sign of organic disease. From that period the spasms diminished in frequency and in severity, the excited condition of the heart only occurring when the spasmodic attacks supervened, and soon subsiding after their cessation; and on the 13th I allowed him to rise, as no paroxysm had occurred for 24 hours.

The chief points of interest in this case are, I think, the absence of any affection of the muscles of masti-

cation and deglutition, and the symmetrical affection of all the muscles supplied by the spinal nerves, and of that one of the so-called cerebral nerves, which presents, perhaps, the closest analogy to a spinal nerve, the hypoglossal.

It is also a question of some interest to remark how closely the symptoms resembled those of a case of poisoning by strychnia, especially when we consider that in all probability the exciting cause of the disease must be looked for in the repression of some excretory matter giving rise to an impure condition of the blood.

Bright's Disease of the Kidney; Fever.

Professor FERGUSON brought before the society some particulars of a case which, at first, presented the aspect of simple fever. The case, however, did not follow the usual course of the disease. There was constant cough, great epigastric tenderness, and subsequently bloody stools. About 36 hours before death the patient became rapidly worse, and sank without any apparently sufficient cause. At the post-mortem examination, all the mucous membranes were found congested, and in both kidneys the usual appearances of *morbus Brightii* were presented. The congestion of the bronchial mucous membrane accounted for the incessant cough. No history which could elucidate the case could be obtained.

ORDINARY MEETING

January 11th, 1862.

Popliteal Aneurism.

Professor GORDON introduced a patient who had been successfully treated for popliteal aneurism by compression. There only remained a small tumour in the ham of the size of a pigeon's egg.

Fracture of Femur; Amputation.

Professor GORDON also exhibited the amputated limb, after mill injury, which had caused separation of the lower epiphysis of the femur, and extensive separation of the periosteum.

Epithelial Cancer.

Dr. BROWNE exhibited two specimens of epithelial cancer which he had removed from the scrotum. He considered them excellent examples of the disease.

Rectal Tumour.

Dr. BROWNE showed a remarkable tumour, removed from the rectum of a boy. It had been attached by a long fibrous pedicle which gave way under slight traction. Its appearance and size was that of a small strawberry. On section, and examination under the microscope, it indicated a striking glandular structure, containing numerous secreting cells, similar to the follicles of Liberkühn of the large intestine, and lined with columnar epithelium of a very perfect kind.

Compound Fracture of Ulna; Secondary Amputation.

Dr. BROWNE exhibited a forearm which it had been necessary to amputate after severe mill injury. There

was extensive laceration of the soft parts, and fracture with denudation of the ulna. In the first instance, after consultation, it was deemed advisable to attempt to save the limb, while it was requisite to remove the lower half of the ulna, the wrist joint being necessarily laid open. The case did not progress favourably, and secondary amputation was had recourse to with a good result. Dr. Browne considered that even had the limb been saved, its usefulness would have been seriously impaired owing to the loss of so large a portion of the ulna, and the destruction of the soft parts.

Caries of the Metacarpal Bones; Amputation.

Dr. BROWNE exhibited the fourth and fifth fingers, with portions of the corresponding metacarpal bones which he had removed from a patient admitted to hospital for what was at first a simple phlegmon. This had been treated in the usual way, and the patient left the hospital almost well. In a few days he returned, unhealthy action having set in; and, on examination, the metacarpal bone of the third finger was found distinctly carious. It was surmised, but could not be clearly ascertained, that the fifth metacarpal was also diseased. Under the circumstances it was decided to amputate the diseased portions of the hand, and to be guided in the steps of the operation by the condition in which the fifth metacarpal might be found.

ORDINARY MEETING

January 18th, 1862.

Melanotic Tumour of Orbit.

Dr. BROWNE introduced a woman of 30 years of age, labouring under melanotic tumour of the orbit. In this case excision of the eye-ball, for melanosis, had been performed by him two and a half years ago. At that time the tissues external to the eye-ball were not affected. For 18 months after, the patient enjoyed good health, when a small tumour began to be observable at the inner canthus, growing slowly at first, but latterly with rapidity, extending down the cheek, and probably into the nasal cavity, as there is at present a sanguous discharge from the nose. It is now of a year's duration, in length two and a half inches from the margin of the orbit to its extremity, and rotund in shape. Sensations of acute pain are occasionally experienced in the part, followed by a discharge of blood from the nares which relieves the pain for the time. None of her relatives suffer from any form of cancer, nor can any history of it be traced in her family. Dr. Browne stated that, under all circumstances, melanotic and cerebriform tumours of the eye-ball are most liable to recur. In six cases of this form of disease in which he had extirpated the eye-ball, there was only one in which the affection did not return. Operative interference with this case would be useless now, the disease having implicated the wall of the antrum, and extended into the nasal cavity.

Congenital Cataract.

Dr. BROWNE introduced a case of double congenital cataract in a boy of thirteen years of age.

Both eyes had undergone the "needle operation," and

were progressing satisfactorily. Dr. Browne remarked, with respect to the period of life in which the operation should in such cases be performed, Mr. Saunders considered that it should be done early; whilst others held that there was a risk of too active absorption after needle operations in infancy. Dr. Browne agreed with Mr. Saunders, as when an early operation was had recourse to the children were enabled to be educated at a proper age, and the eyes had not acquired the habit of rolling about in search of light, which is extremely difficult to counteract when the muscles have once acquired it.

Since the operation the boy stated that all surfaces, whether prominent or not, appeared flat to him, and he evidently imagined all objects to be much nearer him than they really were, arising, no doubt, from the want of a proper idea of perspective.

Cataract.¹

Dr. BROWNE also introduced a case of double cataract in a girl of fourteen years of age, in whom one eye had been operated on. The needle operation had been performed on the right eye on the 29th. October. Smart inflammation ensued, persistent, requiring the repeated application of leeches. A small bit of the capsule of the lens still remained unabsorbed. Dr. Browne remarked that, when the lens is in a semi-fluid condition, there is much risk of inflammation if the needle be too freely used. In this case, although its use had been slight, yet smart inflammation had set in. This girl did not suffer from any inaccurate appreciation of distances, like the boy previously introduced, as her sight had been pretty good until two years ago.

Strangulated Incarcerated Femoral Hernia.

Dr. BROWNE read notes of a case of strangulated incarcerated hernia in a female of 40 years of age, in whom death had occurred from peritonitis, two days after the operation for the relief of the constriction.

The patient had laboured under incarcerated femoral hernia for the past two years, for which she had never worn a truss. On the 14th. of the present month she first complained of pain in the site of the tumour. On the 15th. vomiting set in, and on the 16th. she was admitted to hospital.

On admission she experienced general and diffuse pain over the whole surface of the abdomen—most marked in the vicinity of the tumour. Her face was pale, shrunken and anxious. Pulse 130, and scarcely perceptible.

On consultation with Dr. Murney it was considered advisable to operate, although sub-acute peritonitis had evidently set in.

Chloroform having been administered, the tumour, $3\frac{1}{2}$ inches in length by $2\frac{1}{2}$ in breadth, and in depth two inches, was cut down upon, the sac opened, and found full of apparently healthy omentum, on raising which, a knuckle of the ilium, three inches in length, of a very dark chocolate colour, but still retaining its glossy appearance, was found.

The stricture having been divided, the intestine was

gently drawn downwards, when the part above the site of constriction being found healthy in appearance, the gut was carefully returned—due care being taken that no part of it was constricted by omentum.

After the operation the vomiting ceased, but the pain and tenderness of the abdomen still continued, and the pulse, which had risen under the influence of the chloroform administered, became almost as rapid and feeble as before. It was evident that the operation had afforded little or no relief to the shock inflicted by the strangulation of the bowel.

Next day, on finding considerable fulness of the great intestine, an enema of oil and turpentine was exhibited without effect.

The patient gradually sank, and died on 18th, 51 hours after the operation.

On post-mortem examination, the great omentum was found much congested in its upper and middle portions; its lower border being inflamed, in a soft and ragged condition, and coffee coloured in appearance. It was adherent by lymph to the inner aspect of the opening through which the protrusion had occurred.

The small intestine, generally, was congested, and for the distance of several feet, on either side of the constricted portion, presented marks of inflammation, with spots of lymphy exudation, of the size of a shilling, or larger, scattered over its surface. The part which had been engaged in the protrusion was highly inflamed, of a dark chocolate colour (which scarcely seemed, however, so dark as at the time of the operation), its surface being studded with lymphy exudation.

Parietal peritonitis existed over the lower three-fourths of the abdominal cavity, which contained a pint and a-half of effused serous fluid. The ascending and transverse colon were full of feces.

Dr. Browne remarked, that although the presence of peritoneal inflammation, in cases of strangulated hernia, renders the prognosis very unfavourable, still it should not deter the operator, as the inflammation frequently begins to subside on the relief of the stricture. He had lately operated for the relief of a strangulated femoral hernia, of four days, duration, where subacute peritonitis also existed, and where, on opening the sac, upwards of 40 ounces of highly coagulable serum flowed away; yet, on the relief of the constriction, the unfavourable symptoms gradually abated, and the patient did well.

¹

This case is referred to in Transactions of October 26.

Lists of Members

LIST OF MEMBERS 1853/54

ARRANGED ACCORDING TO DATE OF ADMISSION.

ORIGINAL:-	Aickin, John, M.R.C.S., (Eng.) Belfast	
"	Armstrong, J. S., M.R.C.S., (Eng.) Belfast	
"	Beck, J. W., C.M., and M.D., (Glas.) Belfast	
"	Bradford, W. J., Surgeon, Dundalk	
"	Browne, John, M.D., and L.R.C.S., (Edin.) Dundalk	
"	Browne, Samuel, R.N., M.R.C.S., (Eng.) Belfast	
"	Brunker, E. J., L.R.C.S., (I.) M.D., (Edin.) Dundalk	
"	Bryce, Robert, M.D., Belfast	
"	Bryson, J. W., M.D., and L.R.C.S., (Edin.) Belfast	
"	Burden, W., M.D., & C.M., (Glas.) Professor Queen's College, Belfast	
"	Callan, Jos. M., M.D., (Glas.) L.R.C.S., (I.) Dundalk	
"	Carlile, Hugh, A.M., M.D., and (T.C.D.) Prof. Queen's College, Belfast	
"	Clark, Thomas, L.R.C.S., (I.) Belfast	
"	Daly, Edward, L.R.C.S., (Edin.) Belfast, (Resigned March 18th.)	
"	Dickson, J. S., L.F., Ph., and S., (Glas.) Belfast	
"	Ferguson, J. C., A.M., and M.B., (T.C.D.) Professor Queen's College, Belfast	
"	Ferres, Charles, L.R.C.S., (Edin.) Larne	
"	Frame, James, L.F., Ph., and S., (Glas.) Comber	
"	Gelston, James, L.F., Ph., and S., (Glas.) Comber	
"	Graves, Henry, A.B., and M.B., (T.C.D.) F.R.C.S., (I.) Cookstown	
"	Halliday, J. H., M.D., (Glas.) L.R.C.S., (I.) Belfast	
"	Hamilton, T. W., M.D., (Glas.) F.R.C.S., (I.) Belfast	
"	Hanna, H. H., M.R.C.S., (Eng.) Belfast	
"	Hunter, Samuel, M.D., (Edin.) F.R.C.S., (I.) Belfast	
"	Jamison, David, M.D., and L.R.C.S., (Edin.) Newtownards	
"	Johnston, H. M., L.R.C.S., (I.) Belfast	
"	Lynch, P., M.D., (Glas.) M.R.C.S., (Eng.) Belfast	
"	MacLaughlin, W. R., M.D., (Edin.) L.R.C.S., (I.) M.R.C.S., (Eng.) Lurgan	
"	Malcolm, A. G., M.D., and L.R.C.S., (Edin.) Belfast	
"	Marshall, A., M.D., (Glas.) L.R.C.S., (Edin.) Belfast	
"	Mawhinney, James, M.R.C.S., (Eng.) Belfast	
"	Moore, James, M.D., (Edin.) M.R.C.S., (Eng.) Belfast	
"	Moreland, Hugh, M.D., and L.F., Ph., and S., (Glas.) Belfast	
"	Murney, H., M.D., (Edin.) M.R.C.S. (Eng.), Dem. Queen's College, Belfast	
"	M'Gee, W., M.D., (Edin.) Surg. R.N., Belfast	
"	Patterson, James, M.D., and L.R.C.S., (Edin.) Belfast	
"	Pirrie, J. M., A.B., and M.D., (T.C.D.) L.R.C.S., (I.) Belfast	
"	Pollock, W., M.R.C.S., (Eng.) Dundalk	
		Purdon, T. H., A.M., and M.B., (T.C.D.) L.R.C.S., (I.) Belfast
"		Ross, Richard, M.D., (St. And.) L.R.C.S., (I.) Belfast
"		Scott, W., M.D., and F.R.C.P., (Edin.) M.R.C.S., (Eng) Aughnacloy
"		Smith, James W. T., M.D., (Q.U.I.) and L.R.C.S., (I.) Belfast
"		Smyth, John, L.R.C.S., (I.) Belfast
"		Stewart, Horatio A., M.D., (Glas.) L.R.C.S., (I.) Prof Queen's College, Belfast
"		Stronge, J. W., A.B., & M.B., (T.C.D.) L.R.C.S., (I.) Belfast
"		Thetford, Wm. W., M.R.C.S., (Eng.) Strangford
"		Thompson, Thomas, M.D., (Glas.) Belfast
"		Thomson, Henry, M.R.C.S., (Eng.) Ballylesson
"		Young, G. H., M.D., (Glas.) L.R.C.S., (I.) Holywood
Oct.	29, Breakey, John, M.D., (Q.U.I.) M.R.C.S., (Eng.) R.N. Belfast	
"	" Kidd, Abraham, M.D., (Aberd.) M.R.C.S., (Eng) Ballymena	
"	" Moore, Wm., A.B., and M.B., (T.C.D.) L.R.C.S., (I.) Ballymoney	
Nov.	19, Boyd, Samuel, L.R.C.S., (Edin.) Portaferry	
"	" Russell, Philip, M.B., (T.C.D.) L.R.C.S., (I.) Bangor	
	26, Macaw, James, M.D., and L.R.C.S., (Edin) Bushmills	
"	" M'Kibben, Robert, M.R.C.S., (Eng) Belfast	
Dec.	3, Kellett, Edward Y., L.R.C.S., (I.) Ballinderry	
"	10, Campbell, John, M.D., (St. Andrews.) M.R.C.S., (Eng) Lisburn	
"	" Kelso, J. J., M.D., and C.M., (Glas.) Lisburn	
"	" M'Cartney, John, L.R.C.S., (I.) Lisburn	
"	17, Croker, George, F.R.C.S., (I.) Hillsborough	
"	" Musgrave, Samuel, L.R.C.S., (Edin.) Lisburn	
"	" M'Cleery, James, L.R.C.S., (I.) Belfast	
"	24, Burton, Bindon, M.R.C.S., (Eng.) Ballinderry	
"	" Knox, Alex., M.D., (Edin.) Strangford	
"	" Playne, Thomas, M.D., (Q.U.I.) M.R.C.S., (Eng.) Dunmurry	
"	" Thomson, John, M.R.C.S., (Eng.) Belfast	
1854.		
Jan.	7, Black, C. S., M.D., (Glas.) L.R.C.S., (I.) Belfast	
"	" Forsythe, J., M.D., (Glas.) L.R.C.S., (Edin.) Cullmore	
"	14, Deverell, W. P., M.D., (Glas.) L.R.C.S., (I.) Dromore	
"	" Johnston, Robert, M.D., (Glas.) Newry	
"	" Madden, T., L.F., Ph., and S., (Glas.) Portglenone	
"	" Rogan, W. F., A.B., M.B., (T.C.D.) L.R.C.S., (Edin.) and (I.) Londonderry	
"	" Ross, Arthur, M.D., and L.R.C.S., (Edin.) Ballymena	
"	21, Brabazon, Philip E., A.B., (T.C.D.) F.R.C.S., (I.) Downpatrick	
"	" Forde, Robert, M.D., (Glas.) L.R.C.S., (I.) Downpatrick	
"	" M'Bride, Henry, C.M., (Glas.) Gilford	
"	" White, W. M., M.D., (Glas.) M.R.C.S., (Eng.) L.R.C.S., (I.) Downpatrick	

- " 28, Catherwood, W. H., M.D., (Edin.) Donaghadee
" " Hay, Joseph, L.R.C.S., (I.) Rathfriland
" " Shaw, William, L.R.C.S., (I.) Ballynahinch
" " Smith, John, A.M., M.D., (Glas.) Newcastle
Feb. 4, Murray, Robert, L.R.C.S., (I.) Rockcorry (Died
7th February.)
" 11, MGowan, John, M.D., (Edin.) Carrickfergus
" 18, Dickson, James, M.D., (Q.U.I.) M.R.C.S., (Eng)
Ballynahinch
" 25, Evans, Wm., M.D., (Q.U.I.) M.R.C.S., (Eng.)
Downpatrick
Mar. 4, Nixon, George, M.D., (Gott.) L.R.C.S., (I.)
Antrim
" 11, Graham, John, M.D., and L.R.C.S., (Edin.)
Belfast
" " Harrison, J. W., M.R.C.S., (Eng.) Ardglass
" " Stewart, Robert, M.D., (Glas.) Belfast
" 18, Blakely, Samuel, L.F., Ph., and S., (Glas.)
Aughnacloy
" " Fleming, Hans, M.D., (St. Andrews.) L.R.C.S.,
(I.) Carrickmacross
" " Savage, John, M.R.C.S., (Eng.) Newry
Apr. 8, Greenfield, Wm., M.D., (Q.U.I.) Holywood
May 13, Rea, Samuel, L.F, Ph., and S., (Glas.) Belfast
" 20, Read, Thomas, A.B., and M.B., (T.C.D.) L.R.C.S.,
(I.) Belfast

Lists of Members

LIST OF MEMBERS 1854/55

ARRANGED ACCORDING TO DATE OF ADMISSION.

ORIGINAL:-

"	Aickin, John, M.R.C.S., (Eng.) Belfast	Ross, Richard, M.D., (St. And.) L.R.C.S., (I.) Belfast
"	Armstrong, J. S., M.R.C.S., (Eng.) Royal North Down Rifles, Belfast	Scott, W., M.D., and F.R.C.P., (Edin.) M.R.C.S., (Eng.) Aughnacloy
"	Beck, J. W., C.M., and M.D., (Glas.) Belfast	Smith, James, W. T., M.D., (Q.U.I.) and L.R.C.S., (I.) Belfast
"	Browne, John, M.D., and L.R.C.S., (Edin.) Dundalk	Smyth, John, L.R.C.S., (I.) Belfast
"	Browne, Samuel, R.N., M.R.C.S., (Eng.) Belfast	Stewart, Horatio A., M.D., (Glas.) L.R.C.S., (I.) Prof. Queen's College, Belfast
"	Brunker, E. J., L.R.C.S., (I.) M.D., (Edin.) Dundalk	Stronge, J. W., A.B., and M.B., (T.C.D.) L.R.C.S., (I.) Belfast
"	Bryce, Robert, M.D., (Glas.) Belfast	Thetford, Wm. W., M.R.C.S., (Eng.) Strangford
"	Bryson, J. W.. M.D., and L.R.C.S., (Edin.) Belfast, (died 8th March 1855.)	Thompson, Thomas, M.D., (Glas.) Belfast
"	Burden, W., M.D., and C.M., (Glas.) Professor Queen's College, Belfast	Thomson, Henry, M.R.C.S., (Eng.) Ballylesson
"	Callan, Jos., M., M.D., (Glas.) L.R.C.S., (I.) Dundalk	Young, G.H., M.D., (Glas.) L.R.C.S., (I.) Holywood
"	Carlisle, Hugh. A.M., and M.D., (T.CD.), Prof. Queen's College, Belfast	Oct. 29, Kidd, Abraham, M.D., (Aberd.) M.R.C.S., (Eng.) Ballymena
"	Dickson, J. S., L.F., Ph., and S., (Glas.) Belfast.	" " Moore, Wm, A.B., and M.B., (T.C.D.) L.R.C.S., (I.) Ballymoney
"	Ferguson, J. C, A.M., and M.B., (T.CD.) Professor Queen's College, Belfast	Nov. 19, Boyd, Samuel, L.R.C.S., (Edin.) Portaferry
"	Ferres, Charles, L.R.C.S. (Edin.) Larne	" " Russell, Philip, M.B., (T.C.D.) L.R.C.S., (I.) Bangor
"	Frame, James, L.F., Ph., and S., (Glas.) Comber	" 26, Macaw, James, M.D., and L.R.C.S., (Edin.) Bushmills
"	Gelston, James, L.F., Ph., and S., (Glas.) Comber	Dec. 10, Campbell, John, M.D., (St. And.) M.R.C.S., (Eng.) Lisburn
"	Graves, Henry, A.B., and M.B., (T.CD.) F.R.C.S., (I.) Cookstown	" 17, Croker, George, F.R.C.S., (I.) Hillsborough
"	Halliday, J. H., M.D., (Glas.) L.R.C.S., (I.) Belfast	" " Musgrave, Samuel, L.R.C.S., (Edin.) Lisburn
"	Hamilton, T. W., M.D., (Glas.) F.R.C.S., (I.) Belfast	" " McCleery, James, L.R.C.S., (I.) Belfast
"	Hanna, H.H., M.R.C.S., (Eng.) Belfast.	" 24, Burton, Bindon, M.R.C.S., (Eng.) Ballinderry
"	Jamison, David, M.D., L.R.C.S., (Edin.) Newtownards	" " Knox, Alexander, M.D., (Edin.) Strangford
"	Johnston, H. M., L.R.C.S., (T.) Belfast	" " Playne, Thomas, M.D., (Q.U.I.) M.R.C.S., (Eng.) Dunmurry
"	Lynch, P., M.D., (Glas.) M.R.C.S., (Eng.) Belfast	Dec. 24, Thomson, John, M.R.C.S., (Eng.) Belfast
"	MacLaughlin, W. R., M.D., and L.R.C.S., (I.) M.R.C.S. (Eng.) Lurgan	1854.
"	Malcolm, A. G., M.D., and L.R.C.S., (Edin.) Belfast	Jan. 7, Black, C. S., M.D., (Glas.) L.R.C.S., (I.) Belfast
"	Marshall, A., M.D., (Glas.) L.R.C.S., (Edin.) Belfast	" " Forsythe, J., M.D., (Glas.) L.R.C.S., (Edin.) Cullmore
"	Mawhinney, James, M.R.C.S., (Eng.) Belfast	" " Deverell, W. P., M.D., (Glas.) L.R.C.S., (I.) Dromore
"	Moore, James, M.D., (Edin.) M.R.C.S., (Eng.) Belfast	" " Johnston, Robert, M.D., (Glas.) Newry
"	Moreland, Hugh, M.D., and L.F., Ph., and S., (Glas.) Belfast	" " Madden, T., L.F., Ph., and S., (Glas.) Portglenone
"	Murney, H., M.D., (Edin.) M.R.C.S., (Eng.) Dem. Queen's College Belfast	" " Rogan, W. F., A.B., and M.B., (T.C.D.) L.R.C.S., (Edin.) and (I.) Londonderry
"	M'Gee, W., M.D., (Edin.) Surg., R.N., Belfast	" " Ross, Arthur, M.D., and L.R.C.S., (Edin.) Ballymena
"	Patterson, James, M.D., and L.R.C.S., (Edin.) Belfast	" " Brabazon, Philip E., A.B., (T.C.D.) F.R.C.S., (I.) Downpatrick
"	Pirrie, J. M., A.B., and M.D., (T.C.D.) L.R.C.S., (I.) Belfast	" " Forde, Robert, M.D., (Glas.) L.R.C.S., (I.) Downpatrick
"	Pollock, W., M.R.C.S., (Eng.) Dundalk	" " M'Bride, Henry, C.M., (Glas.) Gilford
"	Purdon, T. H., A.M., and M.B., (T.C.D.) L.R.C.S., (I.) Belfast	" 29, Catherwood, W. H., M.D., (Edin.) Donaghadee
Mar.	4, Nixon, George, M.D., (Gott.) L.R.C.S., (I.) Antrim	" " Smith, John, A.M., and M.D., (Glas.) Newcastle
"	11, Graham, John, M.D., and L.R.C.S., (Edin.) Belfast	Feb. 11, M'Gowan, John, M.D., (Edin.) Carrickfergus
"	" " Stewart, Robert, M.D., (Glas.) Belfast	" 16, Dickson, James, M.D., (Q.U.I.) M.R.C.S., (Eng.) Ballynahinch

- " 18, Blakely, Samuel, L.F., Ph., and S., (Glas.)
 Aughnacloy
" " Savage, John, M.R.C.S., (Eng.) Newry
Apr. 8, Greenfield, Wm., M.D., (Q.U.I.) Holywood
May 20, Read, Thomas, A.B., and M.B., (T.C.D.) L.R.C.S.,
 (I.)
Nov. 4, Gordon, Alex., M.D., and L.R.C.S., (Edin.)
 Professor Queen's College, Belfast
" " Clarke, J. H., A.M., and M.B., L.R.C.S., (I.)
 Newcastle
" " Holmes G. S., M.D., (Glas.) M.R.C.S., (Eng.)
 Glenarm
" " M'Gowan, R., L.F., Ph., and S., (Glas.)
 Warrenpoint
" 11, Dill, R. F., M.D., (Edin.) M.R.C.S., (Eng.) Belfast
" " M'Donnell, R., M.B., and F.R.C.S., (I.) Dublin
" " Wheeler, T. K., M.D., (Q.U.I.) L.R.C.S., (Eng.)
 Belfast
" " Davidson, J., M.D., (Glas.) Belfast
" " Andrews, T., M.D., (Edin.) M.R.I.A.,
 Vice-President Queen's College, Belfast
Nov. 11, M'Mechan, J., M.D., and L.R.C.S., (Edin.)
 Whitehouse
" " Hannay, R. S., M.D., (Edin.) M.R.C.S., (Eng.)
 Lurgan
" 18, Lynn, Jos. M., M.D., (Glas.) L.R.C.S., (Eng. and
 I.) Markethill
" " Hume, G. A., M.D., (Glas.) L.R.C.S., (Eng.)
 Crumlin
" " Warwick, W., M.R.C.S., (Eng.) Belfast
" 25, M'Cormac, H., M.D., (Edin.) Belfast
Dec. 2, Johnston, Aug., M.B., and M.R.C.S., (Eng.)
 Hawkshead, Windermere
" " Johnston, Ben., M.B., and F.R.C.S., (I.)
 Ramelton
" 9, Patton, Alex., L.R.C.S., (I.) Tandragee
" " Lamont, Æ., F.R.C.S., (T.) Belfast
" " Clarke, J., M.R.C.S., (Eng.) Belfast
" " MacMullan, C. C., M.R.C.S., (Eng.) Belfast
" " Heeney, F., M.D., (Glas.) Belfast
1855.
Jan. 20, Taylor, W., L.F., Ph., and S., (Glas.) Ballymoney
" 27, Gibson, J., L.F., Ph., and S., (Glas.), Killileagh
Feb. 24, Barnett, J., M.R.C.S., (Eng.) Moneymore
Mar. 10, Anderson, J., L.R.C.S., (I.) Kilkeel
" 24, Black, W., C.M., (Glas.) Ballymena.
Apr. 14, Maxwell, J., M.D., (Glas.) L.R.C.S., (Edin.)
 Waterford
" " Clugston, W., M.D., and L.R.C.S., (Edin.)
 Ballyclare
" 28, Lochrane, Edward, L.R.C.S., (Edin.)
 Middletown

Lists of Members

LIST OF MEMBERS 1854/55

ARRANGED ACCORDING TO RESIDENCE.

45 RESIDENT:-

Doctors J. Aickin
 Andrews (Prof.)
 Beck
 Black
 Browne
 Bryce
 Bryson
 Carlile (Prof.)
 Clarke
 Davidson
 Dickson
 Dill
 Ferguson (Prof. and President)
 Gordon (Prof.)
 Graham
 Hainey
 Halliday (Treasurer)
 Hamilton
 Hanna
 H. M. Johnston (Joint Secretary)
 Lamont
 Lynch
 M'Mullan
 Malcolm (Joint Secretary)
 Mawhinney
 Moore (Vice-President)
 Moreland
 Murney
 M'Cleery
 M'Gee
 M'Cormac
 Patterson
 Pirrie (Vice-President)
 T. H. Purdon (Vice-President)
 Read
 Ross
 Smyth
 R. Stewart (Vice-President)
 H. A. Stewart (Prof.)
 Stronge
 T. Thompson
 J. Thomson
 Wales
 Warwick
 Wheeler

59 NON-RESIDENT:-

Co. ANTRIM 16
 Doctors Nixon, Antrim
 Burton, Ballinderry
 Clugston, Ballyclare
 Ross, Ballymena
 Kidd, "
 Black, "
 Moore, Ballymoney
 Taylor, "
 Mccaw, Bushmills
 M'Gowan, Carrickfergus

Hume, Crumlin
 Playne, Dunmurry
 Holmes, Glenarm
 Marshall, Greenisland
 Ferris, Larne
 M'Mechan, Whitehouse
 Co. ARMAGH 5
 Doctors M'Laughlin (Vice-President), Lurgan
 Hannay,
 Lynn, Markethill
 Lochrane, Middleton
 Patton, Tandragee
 Co. DONEGAL 1
 Doctor B. Johnston, Ramelton
 Co. DOWN 26
 Doctors Thompson, Ballylesson
 Dickson, Ballynahinch
 Russell, Bangor
 Frame, Comber
 Gelston, "
 Catherwood, Donaghadee
 Brabazon, Downpatrick
 Forde, "
 Deverell, Dromore
 M'Bride, Gilford
 Croker, Hillsborough
 Young (Vice-President), Holywood
 Greenfield,
 Anderson, Kilkeel
 Campbell, Lisburn
 Clarke, Newcastle
 Smith, "
 Jamison, Newtownards
 Armstrong, "
 Gibson, "
 Johnston, Newry
 Savage, "
 Boyd, Portaferry
 Knox, Strangford
 Thetford, "
 M'Gowan, Warrenpoint
 Co. DUBLIN 1
 Doctor R M'Donnell, Dublin
 Co. LONDONDERRY 4
 Doctors Forsythe, Culmore
 Rogan, Derry
 Barnett, Moneymore
 Madden, Portglenone
 Co. LOUTH 2
 Doctors Browne, Dundalk
 Pollock, "
 Co. TYRONE 3
 Doctors W. Scott, Aughnacloy
 Blakely, "
 Graves, Cookstown
 ENGLAND 1
 Doctor A. Johnston, Windermere.

Analysis of Changes in the Roll of Members

Total Members remaining on Roll at October, 1854, 95. Admitted during Session, 30 (this in Nov., 15; in

Dec., 7; in Jan., 2; in Feb., 1; in March, 2; in April, 3).
Tendered resignation, 6; Resigned by default, 8; Went
abroad, 6; Died, 1; Remaining as Nett Number on Roll,
at end of Session, 104.

Lists of Members

LIST OF MEMBERS 1855/56

I. HONORARY

William Stokes, M.D., Reg. Prof. of
Physic, T.C.Dublin
Robert W. Smith, F.R.C.S.I., M.D., Prof.
of Surgery, T.C.Dublin
J. Moore Neligan, Hon. M.D., T.C.D.,
Fell. King's & Queen's Coll. of
Phys. Dublin

II. CORRESPONDING

Antrim	G.M. O'Connor, M.D.
Armagh	Thos. Cuming, M.D.
Cavan	Chas. Halpin, M.D.
Donegal	R. Little, M.D.
Down	A. Erskine, M.D.
Fermanagh	W. Ovenden, M.D.
Londonderry	T.H. Babington, M.D. J.C.L. Carson
Louth	J. Browne, M.D.
Monaghan	A.K. Young, M.D.
Tyrone	H. Thompson, M.D.
Foreign	Fr. Berthold, Teplitz, Bohemia

III. RESIDENT ORDINARY

Mr. Aickin	
Dr. W. Aickin	
Professor Andrews, Q.C.B.	
Dr. Beck	
Mr. Browne, R.N., V.P.	
Dr. Bryce	
Professor Carlisle, Q.C.B.	
Dr. Corry	
Dr. Cuming, Anal. Com.	
Professor Dickie, Q.C.B.	
Dr. Dill, Council	
Dr. Drennan	
Professor Ferguson, Q.C.B., V.P.	
Professor Gordon, Q.C.B.	
Mr. Hanna	
Mr. Harkin	
Dr. Halliday, Treas.	
Mr. Heard	
Dr. Heeney	
M.R. H. M. Johnston, Sec.	
Dr. Malcolm, V.P., Anal. Com.	
Dr. Moore, Council	
Dr. Moreland	
Mr. Muholand	
Dr. Murray	
Dr. Daniel Murray	
Dr. Murney, Council, Anal. Com.	
Mr. McCleery	
Dr. McCormac	
Dr. McGee, Pres. elect	
Dr. Patterson, Council	
Dr. Pirrie, Council	
Dr. T. H. Purdon, V.P., Anal. Com.	
Dr. Seaton Reid	
Dr. Thomas Reade	

Dr. Ross, Secretary	
Dr. Smith	
Mr. John Smith	
Dr. R. Stewart, V.P.	
Professor Stewart, Q.C.B., V.P.	
Dr. Stronge	
Dr. Thomas Thompson	
Mr. Wales	
Mr. Warwick	
Dr. Wheeler	

IV. NON-RESIDENT ORDINARY

County Antrim	
Aghalee	Mr. Burton
Ahoghill	
Antrim	Dr. Nixon
do	Dr. Taggart
Ballinderry	
Ballycastle	see corr. members
Ballyclare	Dr. Clugston,
Ballymena	Dr. Ross,
do	Dr. Kidd
do	Dr. Black
Ballymoney	Dr. Latham
do	Dr. Taylor
Bushmills	Dr. Mccaw
Carnmoney	
Carrickfergus	Dr. M'Gowan
do	Dr. Forsythe
Crumlin	Dr. Hume
Cushendall	Dr.
Dunmurry	Dr. Playne
Glenarm	Dr. Holmes
Larne	Mr. Ferris
Randalstown	
Rasharkin	Mr. Diamond
T'patrick	Dr. Graham
Toomebridge	
County Armagh	Dr. T. Cuming
Armagh	
B'watertown	
Crossmaglen	
Keady	
Loughgall	
Lurgan	Dr. M'Laughlin, V.P.
do	Dr. Hannay
Markethill	
Middleton	
N'hamilton	
Portadown	
Poynitzpass	
Richill	Dr. Davidson
Tandragee	Dr. Patton
do	Dr. McGowan
Tynan	
County Cavan	see corr. members
Cavan	
County Donegal	see corr. members
Lifford	

LIST OF MEMBERS
OF THE
BELFAST CLINICAL & PATHOLOGICAL SOCIETY.

(Taken from the Transactions 1859/60.)

Aickin, W., M.D.	M'Bride, H., Surgeon, (Gilford).
Andrews, Professor, M.D.	M'Caldin, J. J., M.D. (Coleraine).
Anderson, J. C., Surgeon (Kilkeel).	M'Cleery, J. C., Surgeon.
Arnold, Wilberforce, Surgeon.	M'Clement, R. C., Surgeon, R.N.
Babington, T. H., M.B. (Londonderry)	M'Cllelland, R., M.B. (Banbridge).
Blakely, S., Surgeon (Aughanacloy).	M'Cormac, W., M.D.
Browne, Samuel, Surgeon, R.N.	M'Gee, W., M.D.
Brown, W., M.D. (Derry).	M'Gee, M., M.D.
Brunker, E. G., M.D. (Dundalk).	M'Keag, D., M.D. (Coleraine).
Bryce, R., M.D.	M'Laughlin, W. R., M.D. (Lurgan).
Buckingham, J., Surgeon.	M'Mechan, J., M.D. (Whitehouse).
Carson, J. C. L., M.D. (Coleraine).	M'Minn, F., M.D.
Cavin, W., M.D., (Coleraine).	Macaw, J., M.D. (Bushmills).
Clugston, W. A., M.D. (Ballyclare).	Madden, F., Surgeon (Portglenone).
Connor, ___, Surgeon (Newry).	Mahood, G., M.D. (Enniskillen).
Corry, T. C. S., M.D.	Mawhinney, J., Surgeon.
Crothers, R., M.D. (Moy).	Moore, James, M.D.
Cuming, James, M.D.	Moore, W., Surgeon (Dungiven).
Diamond, C., Surgeon (Rasharkin).	Moreland, H., M.D.
Dickie, Professor, M.D.	Motherell, J., M.D. (Castlederg).
Dickson, J., M.D. (Ballynahinch).	Mulholland, C., M.D.
Dill, R. F., M.D.	Murney, H., M.D.
Drennan, J. S., M.D.	Murray, D., M.D.
Dundee, J., M.D. (Carmoney).	Musgrave, S., Surgeon (Lisburn).
Dunlop, A., M.D. (Holywood).	Neligan, J. M., M.D. (Dublin), Hon. Mem.
Ferguson, Professor, M.B.	Nixon, G., M.D., R.A.A.
Ferris, C., Surgeon (Lame).	O'Hare, Owen, M.D.
Forsyth, J. M., (Culmore).	Patrick, W., Surgeon (Carrickfergus).
Frame, J., Surgeon (Comber).	Patterson, J., M.D.
Gordon, Professor, M.D.	Patton, A., M.D. (Tandragee).
Graham, J., M.D. (Templepatrick).	Pirrie, J. M., M.B.
Graves, H., M.B. (Cookstown).	Purdon, C. D., M.B.
Greenfield, ___, M.D. (Holywood),	Rea, H. P., Surgeon.
Halliday, J. H., M.D.	Reade, Thomas, M.B,
Hanna, H., Surgeon.	Reid, Professor, M.D.
Harkin, A., M.D.	Ross, R., M.D.
Hawthorne, J., Surgeon (Banbridge).	Rutherford, W., Surgeon (Anahilt).
Heeney, F., M.D.	Scott, W., M.D. (Aughnacloy).
Hodges, Professor, M.D.	Sharpe, R., M.D (Coleraine).
Hume, G. A., M.D. (Crumlin).	Smith, R. W., M.D. (Dublin), Hon. Mem.
Hunter, S., M.D.	Smith, J. W. T., M.D.
Jamieson, D., M.D. (Newtownards).	Smyth, J., Surgeon.
Jeffres, ----, Surgeon (Clough).	Stewart, R., M.D.
Johnston, H. M., Surgeon.	Stokes, W., M.D. (Dublin), Hon. Mem.
Johnston, Aug., Surgeon (Lancashire)	Taggart, J., M.D. (Antrim).
Kelso, J. J., M.D. (Lisburn).	Taylor, W., M.D. (Articlave, Coleraine)
Kennedy, Surgeon (Comber).	Thompson, H., Surgeon (Ballylesson).
Knox, A., M.D. (Strangford).	Thompson, T., M.D.
	Wales, G. F., M.B.
	Warwick, W., Surgeon.
	Weir, M., Surgeon (Dromore).
	Wheeler, T. K., M.D.
	White, Barnwell, M.D. (Derry).

Lists of Members

LIST OF MEMBERS 1859/60

ARRANGED ALPHABETICALLY WITH REGISTER OF
THEIR ATTENDENCE
AT THE FIRST TWENTY-THREE MEETINGS.

Aickin, W., M.D.	6	M'Bride, H., Surgeon, (Gilford).
Andrews, Professor, M.D.		M'Caldin, J. J., M.D., (Coleraine).
Anderson, J. C., Surgeon, (Kilkeel).		M'Cleery, J. C., Surgeon.
Arnold, Wilberforce, L.K.Q.C.P.I.	5	M'Clelland, R., M.B., (Banbridge).
Babington, T. H., M.B., (Londonderry).		M'Cormac, W., M.D.
Blakely, S., Surgeon, (Aughnacloy).		M'Gee, W., M.D.
Browne, Samuel,* Surgeon, R.N., Ex-P.	16	M'Keag, D., M.D., (Coleraine).
Brown, W., M.D., (Derry).		M'Laughlin, W. R.,* M.D., (Lurgan).
Bunker, E?/F?. C., M.D., (Dundalk).		M'Mechan, J.,* M.D., (Whitehouse).
Bryce, R., M.D.	13	M'Minn, F., M.D.
Buckingham, J., Surgeon.		Macaw, J., M.D., (Bushmills).
Carson, J. C. L., M.D., (Coleraine).		Madden, F., Surgeon, (Portglenone).
Cavin, W., M.D., (Coleraine).		Mahood, G., M.D., (Enniskillen).
Clugston, W. A., M.D., (Ballyclare).		Mawhinney, J., Surgeon.
Conner, __ Surgeon, (Newry).	3	Moore, James,* M.D.
Corry, T. C. S., M.D.	5	Moore, W., Surgeon, (Dungiven).
Crothers, D?/R?, M.D., (Moy).		Moreland, H., M.D.
Cuming, James, M.D., Hon. Sec.	17	Motherell, J., M.D., (Castlederg).
Diamond, C., Surgeon, (Rasharkin).		Mulholland, C., M.D.
Dickie, Professor, M.D.	1	Murney, H., M.D., Vice-Pres.
Dickson, J., M.D., (Ballynahinch).		Murray, D., M.D.
Dill, R. F., M.D., Mem. Council.	15	Musgrave, S., Surgeon, (Lisburn).
Drennan, J. S., M.D., Mem. Council.	3	Neligan, J. M., M.D., (Dublin), Hon. Mem.
Dundee, J., M.D., (Carnmoney).		Nixon, G., M.D., (Antrim).
Dunlop, A., M.D., (Holywood).	4	O'Hare, Owen, M.D.
Ferguson,* Professor, M.B.	14	Patrick, W., Surgeon, (Carrickfergus).
Ferris, C.,* Surgeon, (Larne), V. Pres.	1	Patterson, J., M.D., Mem. Council.
Forsyth, J., M.D., (Culmore).		Patton, A., M.D., (Tandragee).
Frame, J., L.F.P.S., (Comber).		Pirrie, J. M.,* M.B., Mem. Council.
Gordon,* Professor, M.D., V. Pres.	4	Purdon, C. D., M.B.
Graham, J., M.D., (Templepatrick).		Rea, H. P., Surgeon.
Graves, H.,* M.B., (Cookstown).	1	Reade, Thomas,* M.B., Vice-Pres.
Greenfield, __ M.D., (Holywood).		Reid,* Professor, M.D., President.
Halliday, J. H., M.D., Treasurer.	11	Ross, R., M.D.
Hanna, H., Surgeon.	3	Rutherford, W., Surgeon, (Anahilt).
Harkin, A., M.D.	5	Scott, W., M.D., (Aughnacloy).
Hawthorne, J., Surgeon, (Banbridge).		Sharpe, R., M.D., (Coleraine).
Heeney, F., M.D., Mem. Council.	9	Smith, R. W., M.D., (Dublin), Hon. Mem.
Hodges, Professor, M.D.		Smith, J. W. T., M.D.
Hume, G. A., M.D., (Crumlin).	1	Smyth, J., Surgeon.
Hunter, S., M.D.		Stewart, R.,* M.D.
Jamieson, D., M.D., (Newtownards).		Stokes, W., M.D., (Dublin), Hon. Mem.
Jeffres, __ Surgeon, (Clough).		Taggart, J., M.D., (Antrim).
Johnston, H. M., Surgeon, Mem. Council.	17	Taylor, W., M.D., (Articlam, Coleraine).
Johnston, Aug., Surgeon, (Lancashire).		Thompson, H., Surgeon, (Ballylesson).
Kelso, J. J., M.D., (Lisburn).		Thompson, T., M.D.
Kennedy, __ (Comber).		Wales, G. F., M.B., Hon. Sec.
Knox, A., M.D., (Strangford).		Warwick, W., Surgeon.
		Weir, M., Surgeon, (Dromore).
		Wheeler, T. K., M.D.
		White, Barnwell, M.D., (Derry).

Those marked (*) thus, are, or have been,
Vice-Presidents.

LIST OF MEMBERS 1860/61

ARRANGED ALPHABETICALLY WITH REGISTER OF
THEIR ATTENDENCE
AT THE TWENTY-FOUR MEETINGS.

Aickin, W., M.D., Hon. Sec.	16	M'Bride, H., Surgeon, (<i>Gilford</i>). M'Caldin, J. J., M.D., (<i>Coleraine</i>). M'Cleery, J. C., Surgeon.
Andrews, Professor, M.D.		2
Anderson, J. C., Surgeon, (<i>Kilkeel</i>).		M'Clelland, R., M.B., (<i>Banbridge</i>). M'Cormac, W., M.D., Hon. Sec.
Arnold, Wilberforce, Surgeon, L.K.Q.C.P.I.		21
Babington, T. H.,* M.B., (<i>Londonderry</i>).		M'Gee, W.,* M.D. M'Keag, D., M.D., (<i>Coleraine</i>). M'Laughlin, W. R.,* M.D., (<i>Lurgan</i>).
Blakely, S., Surgeon, (<i>Aughnacloy</i>).		4
Browne, Saml,* Surgeon, R.N., L.K.Q.C.P.I., M. Cncl.	14	M'Mechan, J.,* M.D., (<i>Whitehouse</i>). Macaw, J., M.D., (<i>Bushmills</i>). Mahood, G., M.D., (<i>Enniskillen</i>). Mawhinney, J., Surgeon.
Brown, W., M.D., (<i>Derry</i>).		2
Bryce, R.,* M.D., V.P.	13	Moore, D., M.D. Moore, James,* M.D.
Buckingham, J., Surgeon.		17
Burden, H., M.D.	1	Moore, W., Surgeon, (<i>Dungiven</i>). Moreland, H., M.D. Mulholland, C., M.D.
Carson, J. C. L., M.D., (<i>Coleraine</i>).		15
Cavin, W., M.D., (<i>Coleraine</i>).		Murney, H.,* M.D.
Clugston, W. A., M.D., (<i>Ballyclare</i>).		14
Conner, __ Surgeon.		Murray, D., M.D.
Corry, T. C. S., M.D., Mem. Council.	2	12
Cuming, James, M.D.	12	Musgrave, S., Surgeon, (<i>Lisburn</i>). Neligan, J. M., M.D., (<i>Dublin</i>), Hon. Mem.
Diamond, C., Surgeon, (<i>Rasharkin</i>).		O'Hare, Owen, M.D.
Dickie, Professor, M.D.		Patrick, W., Surgeon, (<i>Carrickfergus</i>). Patterson, J.,* M.D., Vice-Pres.
Dickson, J., M.D., (<i>Ballynahinch</i>).		23
Dill, R. F., M.D., Mem. Council.	22	Pirrie, J. M.,* M.B., Vice-Pres.
Drennan, J. S., M.D., Mem. Council.	4	7
Dundee, J., M.D., (<i>Carmoney</i>).	1	Purdon, C. D.,* M.B.
Dunlop, A.,* M.D., V.P., (<i>Holywood</i>).	4	Purdon, H., M.D., Jun.
Ferguson,* Professor, M.B.	19	6
Ferris, C.,* Surgeon, (<i>Larne</i>).		Rea, H. P., Surgeon.
Forsyth, J., M.D., (<i>Culmore</i>).		12
Frame, J., L.F.P.S., (<i>Comber</i>).		Reade, Thomas,* M.B.
Gordon,* Professor, M.D., Pres.	12	9
Graham, J., M.D., (<i>Templepatrick</i>).		Reid,* Professor, M.D., Ex-Pres.
Graves, H.,* M.B., V.P., (<i>Cookstown</i>).	1	19
Greenfield, __ M.D., (<i>Holywood</i>).		Ross, R., M.D.
Halliday, J. H., M.D., Treasurer.	10	1
Hanna, H., Surgeon.		Rutherford, W., Surgeon, (<i>Anahilt</i>). Scott, W., M.D., (<i>Aughnacloy</i>).
Harkin, A., M.D.		1
Hawthorne, J., Surgeon, (<i>Banbridge</i>).		Sharpe, R., M.D., (<i>Coleraine</i>). Smith, R. W., M.D., (<i>Dublin</i>), Hon. Mem.
Heeney, F., M.D.		Smith, J. W. T., M.D.
Hodges, Professor, M.D.		Smyth, J., Surgeon.
Hume, G. A., M.D., (<i>Crumlin</i>).		Stewart, R.,* M.D.
Hunter, S., M.D.		9
Jamieson, D., M.D., (<i>Newtownards</i>).		Stokes, W., M.D., (<i>Dublin</i>), Hon. Mem.
Jeffres, __ Surgeon, (<i>Clough</i>).		10
Johnston, H. M., Surgeon, Mem. Council.	22	Taggart, J., M.D., (<i>Antrim</i>). Taylor, W., M.D., (<i>Articlave, Coleraine</i>). Thompson, H., Surgeon, (<i>Ballylesson</i>). Thompson, T., M.D.
Johnston, Aug., Surgeon, (<i>Lancashire</i>).		2
Kelso, J. J., M.D., (<i>Lisburn</i>).		Wales, G. F., M.B.
Kennedy, __ (<i>Comber</i>).		7
Knox, A., M.D., (<i>Strangford</i>).		Warwick, W., Surgeon.
		15
		Weir, M., Surgeon, (<i>Dromore</i>). Wheeler, T. K., M.D.
		1
		White, Barnwell, M.D., (<i>Derry</i>).
		Those marked (*) thus, are, or have been, Vice-Presidents.

