

TRANSACTIONS  
OF THE  
BELFAST MEDICAL SOCIETY

1845 TO 1846

A transcription can only approximate to the original. Any errors not in the original are mine.

J I Logan  
28 November 2016

BELFAST MEDICAL SOCIETY.

Monday Evening, 3rd March, 1845.  
Mr. Officer in the Chair.

Dr. SAUNDERS opened the proceedings of the evening by drawing the attention of the meeting briefly to a case of haematocele, the cure of which was completely effected after simply removing the fluid. This case from the patient's own account, was one of ordinary hydrocele of six or seven years standing, and was tapped on three or four occasions. Some weeks prior to admission into hospital, an attempt at the *radical* cure by injection had been made, but the fluid seemed to have returned. He was now again tapped, and a quantity of bloody fluid with some purulent matter withdrawn. No inflammatory action ensued, and no fluid of any description was afterwards formed.<sup>1</sup>

In the remarks which followed the detail of this case, some of the members observed that the time was rather short for forming a true opinion with regard to the stability of the cure. The *rationale* of success in this case was generally admitted to depend mainly on the intensity of the inflammation which supervened in the operation of injection.

Dr. DILL brought before the notice of the meeting a very interesting case of Lupus, which attracted much attention. The subject of the case was a gentleman aged 80 years, and to all appearance, and from his previous history, of good constitution. On 26th September, 1844, he consulted Dr. Dill about a tumour on his right temple, the size of which was 3 inches long and nearly 2 broad. Its short diameter reached anteriorly to the external angle of the orbit, and posteriorly to the hairy scalp. It was of an oblong figure, and much more elevated on its orbital margin. Indeed, its posterior boundary so sloped towards the scalp, that its elevation here was very indistinct. Its surface was rather irregular, and seemed as if subdivided into numerous small cells by partitions of thin cellular membrane, from which a quantity of serous fluid would at all times exude, with or without pressure. Its aspect was glossy red, and an erysipelatous blush extended from the tumour over the integument of the eyelid and part of cheek. It afforded no uneasiness beyond an occasional slight itchiness, and at no time did it show any disposition to ulceration.

The patient's attention was first drawn to it about one month previously. It then appeared like a pimple, which gradually enlarged till it assumed the size of a pea, and was of a red colour. From this it gradually increased to its present state. This tubercle was not long solitary, for soon another formed. Both now went on increasing, and approximating each

other, until they formed one tumour, with a partial division. At this time there were observed at the upper margin small indurated prolongations extending across the forehead, and at the other extremity of the tumour a third tubercle gradually formed till it assumed the size of a pigeon's egg. These prominences, when pressed, sent out a quantity of fluid, and became for a time considerably flattened. In a few hours, however, they would fill up again, and present the same appearance as before. The patient's general health continued good, and all his functions were carried on naturally. The treatment up to this time consisted of the separate and successive administration of the following medicines, viz., iodine and hydr. pot., both internally and externally; Fowler's solution internally; cold evaporating lotions; Donovan's triple solution internally; and terchloride of carbon both internally and externally. Notwithstanding these remedies have been found useful in similar cases, and though to each sufficient time was given to test its influence over the disease, yet not one proved in the slightest degree satisfactory. Under these circumstances, it was agreed in consultation that the application of caustic potass., to endeavour to remove the disease completely, should be employed. This was accordingly done, (the application being made every third or fourth day,) till the tumour was nearly destroyed. The centre of the tumour, however, still resisted the influence of the caustic, and to this part a thin plaster of chloride of zinc paste was applied, which soon removed the remaining portion. The part was now poulticed for a few days; the slough separated, and all went on for a short time very favourably. The wound granulated and began to heal; but just at this time the surrounding edges began to rise, and to put on the appearance of the original tumour, and the integument towards the face became deeply inflamed and indurated.

Up till the 19th of February, 1845, his general health continued unimpaired. On this day he did not feel so well as usual. He complained for the first time of want of appetite, with slight giddiness and tinnitus aurium. On the 21st he had an attack of swooning, and after recovering from this, appeared somewhat excited, and his mind wandered a little. He was able, however, to walk up stairs steadily to bed, and got up without assistance twice during the night. Shortly after this he fell into a comatose state and died. The aspect of the diseased part was not altered in the least during this sudden change.

In remarking upon this case, Dr. Dill observed that though the diagnosis was not immediately obvious, the course of the disease soon told of its malignant nature. The appearance and history of the case, indeed, did not correspond exactly with the

established description of the disease, Lupus, as found in our best authors. Biett and Green, however, are exceptions, for they speak distinctly of a form of Lupus in almost all respects analogous to the present case, and which they designate Lupus with hypertrophy.

With regard to the issue of this case, it may be considered highly probable that, had the local applications been used earlier, the disease might have been arrested; but it was not considered judicious that such extreme measures should be resorted to, till the usual and frequently successful internal treatment had been first fully tested.

Several observations were made by some of the members present. The rarity of the variety of the disease was generally admitted. It was regretted by some that a post-mortem examination was not obtained, in order to clear up any doubts about the possible existence of previous disease of the brain, a supposition which was held plausible by some, but not for a moment entertained by those who saw the case. The fact of cicatrization having occurred in this case was adverted to as of rare occurrence in malignant ulceration. The sudden termination of the case was generally viewed as the result of cerebral effusion, which not unfrequently occurs in aged persons without any decided cause. It certainly was not altogether dependent on the local affection.

BELFAST MEDICAL SOCIETY.

*Monday Evening, April 7, 1845.*

Dr. Thomas Read in the Chair.

Dr. Malcolm brought before the notice of the meeting a very interesting case of pneumo-thorax, of which the following is a brief report: –

On the 23rd September, 1844, a little girl was brought to the dispensary rooms by her mother, who stated that she had been ill for six months. From enquiries it was found that her maternal grandmother had died at the age of 42, of what was reported to have been "consumption," as also one of her paternal uncles. Two of her brothers it was ascertained had died, one at the age of 19, and the other at 7, of phthisis pulmonalis, and a third of Bright's disease and nutmeg liver. To ordinary observation she was at the time apparently in good health; but her florid and clear complexion, plumpness, and brightness of eye, betokened serious indisposition to the eye of the physician.

Her principal complaints were debility and distressing cough. This cough had come on very gradually – almost imperceptibly, and no means had been used to remedy it. During the last three months

it had been much more frequent, and accompanied occasionally by pains in the front of chest, and dyspnoea at intervals. The cough was never of a hacking character, and generally single, as if some irritating body existed in the trachea. The expectoration was muco-purulent at this date. The appetite was latterly declining, and the tongue was pale. She complained occasionally of vomiting of food. Latterly she had been observed to be emaciating; and the nocturnal perspirations distressing.

The symptoms continued much as usual till the month of December, when diarrhoea set in, and continued with little abatement till the day of her death. Abdominal pain was only complained of for a few days before the fatal event. The appetite which was failing on the first report, is stated to have become an unnatural craving, which was frequently satiated by the very sight of food. For two months before her decease, vomiting of food was a very constant symptom; and she complained much of a burning feeling over chest. During the last three months, it is reported that she spoke frequently of pains in her right side, which, however, were neither constant, nor severe.

On the evening of the 29th ultimo, while sitting at stool, she suddenly complained to her mother of a great faintness, or feeling of sinking coming over her, and exclaimed at the same time, "Oh! mother, hold me, I am getting quite blind!" The muscles of the face became convulsed, and her colour assumed a deadly hue, and her respiration became exceedingly embarrassed. For two hours, she was suffering in this manner, before the breathing became even tolerably quiet. I should have mentioned that for some time she could only lie on her right side; and, now, the least turning, even round to the supine posture, induced the most urgent dyspnoea. Her mother observed ever since the change just mentioned, that the right side was more prominent than the other. For three days, the debility and dyspnoea became greater and greater, and she breathed her last on the second day of the present month.

On the following day, I was requested by the mother to make an examination of the body, the report of which is as follows: –

The cadaver was in a state of extreme emaciation. The right side of the chest was evidently more prominent than the left, and yielded a tympanitic sound on percussion, while the left side was comparatively slightly dull.

The left pleural cavity presented no adhesions, and only a small quantity of serous fluid of a pale yellow colour. The left lung was tuberculous, in every part several large cavities, of an irregular shape, and partially filled with grey thick matter, more observed in the upper lobe, and to these could be traced

several divisions of the bronchial tubes. Small tuberculous masses were scattered here and there throughout the lung. Around these, as also in the walls of the cavities, portions congested as in the second stage of pneumonia.

Upon opening the right pleural cavity, a quantity of odorless gas escaped. Many old adhesions and bands were observed connecting the pulmonic and costal layer, particularly at apex. About four or five ounces of purulent matter with shreds of coagulable lymph were seen in the bottom of the pleural cavity. Upon examining the lung carefully, an ulcerated opening was detected at the posterior and middle part, just close to the commencement of the extensive adhesions at the apex. This aperture, when traced on, led to a large cavity, into which, several divisions of the bronchial tubes entered. This cavity could easily contain an apple of ordinary size. The lung did not seem compressed, which was accounted for by the numerous adhesions, and the extensive tuberculization, preventing any collapse. The bronchial membrane was injected, and lined by a brown muco-puriform secretion. The pericardium contained rather a larger quantity of serous fluid than natural; but it, as likewise the heart, presented no morbid appearances. Upon opening the abdominal cavity, about one quart of serous fluid was observed; but the peritoneum exhibited no mark of disease. The liver was much enlarged, especially the left lobe, and presented the *nutmeg* appearance. The spleen was normal. The mesenteric glands were universally tuberculized. Some were much enlarged, and all, when incised, were observed filled with true tubercular matter. Even several of the lacteals could be distinctly traced, filled with this product. The whole tract of the small intestines, especially the latter part of the ileum, presented numerous ulcers. In the jejunum, they were few and small, and only as if follicular ulcerations. But in the ileum, the glands of Peyer appear to have been especially affected. In some of them, the ulceration had extended through the muscular structure, and were almost dividing the peritoneal coat. These ulcers had thick and ragged edges, and their bases were invariably covered more or less with tubercular matter. The colon, at its latter part, was slightly ulcerated; but the rectal mucous membrane was almost riddled, so thickly set were the ulcerations. The kidneys were evidently softened and congested, but not otherwise affected.

In his observations upon this case, Dr. Malcolm remarked that its comparative rarity had induced him to lay it before the society. He considered this rarity mainly owing to the frequent existence of pleuritic adhesions in tubercular lungs, which fenced and protected the cavities just as they were encroaching upon the surface of the lungs. But for this,

pneumo-thorax would be tolerably common. Few cases survive longer than two or three days after perforation has occurred. In the present case the time elapsed was 72 hours; but in one mentioned by Louis, it was 36 days. Of course much depends upon the co-existent disease, which, in our present case, was sufficient alone to have destroyed life. The want of correspondence between the symptoms and the vast amount of intestinal disease was remarked on, as showing that tubercular disease may induce the most frightful ravages, without its being indicated by the usual evidence; abdominal pain was only complained of for a very short time, before death. No treatment is mentioned in this case, as the patient was only seen once during life.

In the discussion which followed, the principal topics noticed were the nature and treatment of phthisis pulmonalis. With regard to the former, it was generally admitted, that although tuberculization cannot be considered of the same nature as the process of inflammation, still, in our present state of knowledge, our plans of treatment must rest upon the general indications observable in true inflammatory affections; and of these, one essential is, the prevention of all vascular irritation. The prophylactic effects of iron, especially in children, were also confidently spoken of. The utility of this agent, however, seemed to be confined to this application: as, when given during the existence of the disease, it has seemed in many instances to accelerate, rather than retard, the course of this fatal malady.

BELFAST MEDICAL SOCIETY.

Monday Evening, June 2, 1845.

DR. GORDON IN THE CHAIR.

Doctor Read commenced by saying, that the conflicting testimony of eminent surgeons at the trial of Baker *versus* Lowe, had suggested to him, that the consideration and discussion of the treatment of gangrena senilis, or Pott's gangrene, might not be an unprofitable use of the time of the Society.

Before narrating the cases, with their treatment, he was about to bring under the notice of the Society, he gave a concise retrospect of the various methods employed by Wiseman, the surgeons prior to and contemporary with Pott – Pott's treatment, Baron Dupuytren's, Mr. Liston's, Mr. Symes'. He then related seven cases managed by himself, or conjointly with other surgeons, concluding with the following analysis. Four were in the humble classes, three were essentially, as regards the means of subsistence, in equal and real opulence. In the poorer subjects, the disease assumed the dry form; in

the rich, it was moist, i. e., the cuticle gave way early. Out of seven, two underwent amputation; a third also, if removal at the ankle joint with a scissors could be so named. Only one case was under 63 years old: two died out of seven – both poor. One case was a female; one (the same) was in the hand; one, which he regarded as the most singular, was of symmetrical disease in opposite limbs. One, ninety years old, died, after the disease had stopped, worn out, (this was the ankle-joint amputation); five were treated with opium, in which it was found indispensable, though he did not assume that it alone subdued the disease in all that recovered, but that without it several of them could not have been cured. In one case bleeding was used; it, however, was local, and to small amount – that case was successful.

He next referred to the pathology of the disease, which he considered was not clearly established: as to the proximate cause, ossification, atheromatous and steatomatous deposits, or change of structure in the arteries of the limb were each equally untenable. Baron Dupuytren's decision of inflammation of the artery was worthy of respectful consideration from his high station, but his judgment appears arbitrary, as based on a very limited number of cases. It has been sufficiently submitted to time and experience, and may now be pronounced rejected, as unsupported in the sense and meaning of the Baron.

The phenomena of arteritis does not of necessity include gangrene. Dr. Graves has described a different class of symptoms. To the precision of his description, Dr. Read could bear his testimony, from two cases seen by himself. According to the structural seat of arterial inflammation, it is manifest, very different phenomena will be exhibited, whether it be the external, the middle, or internal coat of the vessel be engaged: "Exempli gratia," in the case lately reported at the Surgical and at the Pathological Societies of Dublin, by Mr. Carmichael and attended by him, Sir Philip Crampton, and other eminent surgeons in Dublin, the disease appears to have been inflammation of the internal coat of the artery, but gangrena senilis will occur without any such deposit of coagulum in the leading vessel. Must there not be another agency to cause the singular and true phenomena of this disease? or the existence of a concurrent disease? He believed this to be the fact.

He then referred to an opinion long entertained by himself in regard to ramollissement of the brain, but which he, perhaps, would have hesitated to introduce to the notice of the Society, unless he had recently found that this opinion had the sanction and authority of Dr. Richard Bright, of the affinity or rather identity of certain cases of ramollissement and gangrena senilis, in both cases

there being a destructive disintegration of the capillary vessels, which might either be produced by a lesion of nervous function in those delicate vessels, or even from an altered constitution of the blood itself chemically acting on them. He remembered that Andral alludes to certain poisons injected into the veins of dogs, causing mortification of the feet. Mr. Carmichael, in his observations on the case before referred to, seemed to think he had traced a possible connexion with diabetes in some of the fatal cases he had seen. In Dr. Head's seventh case this connexion had existed; yet the termination had been perfect recovery. The case is well known to Sir Philip Crampton, the advantage of whose advice the patient had frequently.

Dr. Read concluded by expressing his conviction, that Pott's treatment is by no means obsolete; that with proper modification, it still contains the essence of the most successful treatment of the disease. He also narrated instances in which the most substantial benefit was derived from the permanent elevation of the foot above the head and trunk, thereby bearing off the weakened and threatened vessels the impulse and hydraulic pressure.

He finally apologised for the obscurity that necessarily attended the exposition of his views from over condensation, being reluctant to intrude too much upon the time and patience of the Society.

The paper having been read, Dr. Bryson observed, that in his experience of the disease, he has found Pott's treatment of great value. He particularized the cases of five elderly ladies. In two of them, the disease commenced in the toe, and in the remainder, in the heel. The local applications were chiefly soothing and emollient. All did well. He thought it but right to observe, however, that one died three months afterwards of another disease.

Dr. Dill remarked, that his experience tended to show, that the disease occurred more frequently in females than males. In ten cases which he had met with, seven occurred in females: they were all above fifty years of age. While he had charge of a country dispensary, some years ago, he observed that he had thought he could trace its existence *then* to the effects of a bad harvest upon the poor population. He concluded by making a few observations upon the evidence in the case of Baker v. Lowe, recently discussed in the journals.

Mr. M'Cleery, in giving his testimony in favour of Pott's treatment, detailed a case of dry gangrene occurring after fever.

Mr. Browne suggested that the definition of what is commonly called Pott's gangrene, was not sufficiently understood. It was not at all confined to any particular period of life; but its distinctive

characters depended more upon the appearance presented in the part affected and the manner of its approach.

Mr. Mulholland related a case in which no treatment was used whatever, and yet where the case went on favourably.

Dr. Saunders observed that the disease may arise from various causes at different times. He laid considerable stress upon the elevated position of the limb as of great value in the treatment. Dr. S. suggested that Mr. Mulholland's case might not have been an ordinary case of Pott's gangrene. He related the case of a young robust woman who received a punctured wound from a pin in finger. Deep incision was made on second day, and on third, mortification of first joint set in. He then adverted to the circumstance of epidemic gangrene, first occurring in Germany from the effects of ergot of rye.

Dr. Bryce observed, that the treatment will vary a little in each individual case. He was inclined to think, that in a great proportion of cases, debility was chiefly to be regarded.

Dr. Malcolm remarked, that although Pott's treatment, in a moderate degree, appeared generally applicable, still, cases do occur when local depletion at least will be found necessary, particularly in cases analogous to those described by Dupuytren. Indeed, the general state of the constitution, and the other concomitant circumstances, would always induce the practitioner to modify his general treatment.

Mr. Lamont expressed his well-grounded doubts about the case of Mr. M'N., detailed in Dr. Read's paper, coming under the designation of Pott's gangrene. He considered it bore a closer resemblance to one of the terminations of local inflammation.

Dr. Gordon observed, that the common occurrence of ossification of the arteries was only accidentally connected with Pott's gangrene; and that this disease was not confined to any particular part of the body. He also made some observations upon the decay of branches of trees, as a slightly analogous phenomenon to some features in the disease.

Dr. Read in reply, had wished, in bringing forward his paper, to ascertain the opinion of the Society as to the effects of the different plans of treatment which had been brought forward by different authors. In speaking of Dupuytren's treatment, he observed that he had never seen a case which he would be induced to bleed. He concluded with some remarks upon the uniformity of the treatment recommended by the members present. He also said, in reply to an observation of Dr. Saunders, that under existing obstruction, or other disease of the artery, he had specially considered elevation of the limb inapplicable; and to Mr. Lamont's doubts of identity of the disease in the case of Mr. M'N., he

replied, that the symptoms Mr. L. suggested as contradictory, arose from the obstinacy of the patient using malposition of the limb, and indulging at table as he liked; all of which were corrected, and then Pott's gangrene had to be treated *per se*.

BELFAST MEDICAL SOCIETY.

Monday Evening, August 4, 1845.

DR. M'CORMAC IN THE CHAIR.

Dr. Sanders briefly related a case of injury of the elbow joint, for which excision of the joint was performed with complete success. A young man was admitted into the Belfast Hospital on the 1st May, 1843, who received a severe wound of the left elbow from a scythe, which completely separated a portion of the olecranon process, opening the joint. He had slight faintness from the shock, and but a trifling loss of blood at the time of the accident; water-dressing, and a supporting bandage were used, and a proper regimen, &c. enjoined. On the third or fourth day, however, violent inflammation set in, and involved the whole arm. Notwithstanding appropriate treatment extensive suppuration ensued; and, ultimately, the bones constituting the joint, took on diseased action. On the 18th day after the injury a consultation was held. The discharge at this time from the joint was very profuse, and it was a matter of surprise that the patient existed at all. Two views were suggested as the only resort – amputation, or excision of the joint. Although the majority were in favour of the former course, it was finally agreed upon to adopt the latter, as Dr. Sanders was sanguine as to the possibility of saving to the poor boy a valuable member. Accordingly, on the same day, Doctor S. removed the ends of the humerus, radius, and olecranon (a portion of the latter had been partially removed at the time of the accident); having made the usual H incision, the sides being made parallel to the long axis of the arm. No arterial hæmorrhage occurred; but a good deal of venous blood, proceeding from a sinus along the humerus, gave some annoyance. This cavity was, however, filled with lint dipped in a solution of alum, and the edges brought into apposition by a few points of interrupted suture. Water-dressing, and a light bandage completed the dressing. So little disturbance of the system ensued, that on the second day after operation, his pulse was only 108. On the following day the lint was removed from the cavity and some matter escaped; this created little disturbance, for soon this discharge diminished, and (which is curious) just as it decreased, abscesses formed in different parts of the body – first over sacrum, next in calf of leg, and lastly over shoulders. This condition was

attended with great debility, and required the administration of wine. In three weeks the incisions and abscesses had all healed, and passive motion of the elbow was made. In two months after the operation the patient was discharged from the Hospital, with considerable power of motion of new joint, which he was instructed to exercise gently but regularly. It is now more than two years since the receipt of the injury.

The patient was here presented for the inspection of the members, several of whom minutely examined the state of the part, and expressed their surprise and admiration at the completeness of the cure. Pronation and supination, extension and flexion seemed *perfectly* natural, and by a mere spectator scarcely any trace of deformity could be detected.

The CHAIRMAN observed that the case was very satisfactory, as showing the utility of the operation. He remarked that the formation of the abscesses throughout the body might be ascribed, with plausibility, to the inflammation of the veins of the bone. The great frequency of death from operations is now ascertained, beyond doubt, to arise from such a cause. He suggested, in similar cases, that an issue of some kind should be established in some convenient part, immediately after such operations, in order to lessen the chance of Phlebitis.

Doctor READ observed that had deposits of purulent matter occurred internally instead of externally, in all probability the case would have been fatal; as it happened a safety valve had been providentially afforded. Analogous phenomena are presented in cases of small pox.

Dr. MALCOLM next read a paper on a very interesting case, of which the following are some details: –

On 17th January, 1843, Marcella Robinson, aged 19, a worker in a flax spinning mill, first applied for advice. Her figure was slight, but her general appearance evinced no trace of ill health. She stated that she had been suffering more or less for five years, and more especially for the last two months. The chief symptoms were pyrosis and frequent attacks of vomiting after taking food, accompanied by pain, variable in degree and duration. The matters vomited were always acid, and occasionally bitter. The pain complained of occurred more frequently in the early part of the day, chiefly existed in the epigastric region, but sometimes moved to the right side, and then felt as a stitch. It was generally of a burning character, and relieved for a time by pressure, a dose of soda, and low stimulants. Of her articles of diet she found potatoes the least hurtful. Flatulence was commonly present. She was often thirsty and wished especially for cold water when pain was present. The menses had been regular for the last nine months,

and always accompanied by pain of the back. They appeared for the first time two years ago, but during the first fifteen months were very irregular. No tenderness along the spine; bowels generally confined; slept well; complained frequently of palpitation, and appeared of a nervous habit. The pulse at this date 96, and small.

An alkali with a light bitter, and some aloetic purgatives were prescribed. Under this treatment the vomiting entirely ceased, but the pain continued. Six leeches were now applied to the epigastrium, which gave great relief.

On 21st March, the report mentions, – pain, though not gone, much diminished, and only occasional; the menses absent two months, appetite pretty good, flatulence. The alkaline tonic mixture and aloetic purgatives repeated.

In April, the pain is mentioned as still recurring. Eight leeches to epigastrium, and alkaline mixture ordered.

In May, had several turns of faintness while at her work in the mill.

In August, the pains of epigastrium not so annoying, but complaining one month of the right side and lumbar region; much debility; bowels with difficulty kept regular; some partial vomiting of food, but unaccompanied by sickness; appetite impaired. Pills of iron and aloes were now ordered.

During September the same treatment was continued. Leucorrhœa now existed.

In October the menses appeared for the first time for five months; pain and pyrosis at intervals. No report now till January, 1844, when pain of right side and lumbar region much spoken of; menses had appeared three times since, and now absent six weeks; tongue clean, soft and smooth; gastric symptoms better; appetite pretty good again; feet generally feel cold; pulse 96 – same treatment during this and following month.

The report now appears<sup>1</sup> in the month of December of same year. Gripping pains in abdomen, pain in lumbar region, and some transient soreness in lower limbs complained of now; appetite not so good; sickness gone; menses absent about three months.

In January, 1845, the pains were severe, and chiefly confined to hypogastric region. Six leeches were applied to the vulva, followed by the frequent application of hot stupes and the administration of pills of opium and hippo.

The bowels during all this time were free. From these means much relief was obtained. Soon after had some cough and expectoration; the menses were still

---

<sup>1</sup> The irregularity of the report is accounted for by the person being one of the external dispensary patients, whose attendances are proverbially defective.

absent; the pains now only seemed to have remitted, as they are again reported very severe, and confining her partly to bed. They were generally diffused, but especially referred to the left side and epigastrium; and here upon examination there was great tenderness; the bowels free, and the pulse did not rise above 100.

A bleeding from the arm almost completely relieved her, and ultimately, by the administration of a hyoscyamus mixture, all the pains were gradually removed. Now when she became able to resume her usual employment, the gastric symptoms returned once more; pain in stomach now mentioned as coming on after dinner regularly, and some attacks of pyrosis are reported.

Small dose of hyoscyamus and soda were administered with relief; though the uneasiness after food still continued, and in the beginning of May is mentioned as still existing, though all other pains had ceased.

On the 17th of this month an important change occurred in the symptoms. At this date she was *suddenly* attacked with severe pain in the left hypochondriac and left lumbar regions. Twelve hours previously, she stated, had complained of pains in arms, feet, and legs, but had had no rigor. On admission into the Belfast Hospital on the 19th inst., the pain was excruciating- She could not rest in any one position for any length of time, and at the same time the slightest change produced an aggravation of her sufferings. Her pulse was very quick and small, skin hot, great anxiety of countenance and distress of manner.

Bleeding was adopted to a large extent both generally and locally. She was put under the mercurial treatment, and a large blister applied to the abdomen.

Notwithstanding the large administration of mercury, the gums could with great difficulty be affected, and indeed were only slightly touched. The bowels were, however, much disturbed at intervals during the first eight days, for which opiates were administered freely. The pulse gradually fell to 95 on 12th day from commencement of attack, then suddenly increased and again fell to this figure on 20th day; after this, gradually rising with only occasional vacillations towards the close. She complained much of pain of left shoulder throughout Erythematous patches appeared over body and remained vivid one day. Sickness and vomiting set in on the 14th day for the first time, and recurred frequently afterwards, accompanied by distressing cough on 11th of June and subsequently. The pain of the left side was more or less complained of at all times, but certainly was much abated for many days. On 15th June on examining chest at lower lobe of left lung, some bronchial and sub-crepitating rales

indistinctly heard, some dulness, but no differences on measurement. On 23rd, the report mentions dulness over region of heart rather greater than natural. Sounds not altered; pulse 140; respiration very quick; on same day was seized with general trembling over frame, of the fingers, and gnashing of the teeth, and an appearance of insensibility. Face became first livid, then red, and subsequently pale, the surface generally cold. This state lasted a few minutes, and seemed to the spectators one of dissolution. By the application of stimulants and heat she recovered from it, and shortly afterwards vomited a small quantity of what appeared to have been blood, and on 26th June vomited more of same appearance, but of a very offensive odour. The perspirations were very distressing throughout.

On 29th June she died, gradually exhausted. It is sufficient to mention, that during the last month the treatment consisted of occasional counter-irritants, tonic stimulants, stomachics, and anodynes; in short, remedies merely adapted to the general conditions and the particular phases of symptoms as they arose.

*Examination of the body thirty-five hours after death.*

The cadaver was considerably emaciated. The right side of chest normal; rather old adhesions in left pleural cavity; some induration at lower lobe of left lung, but only marginal. Stomach large and adherent to liver and diaphragm. Upon opening it, a large perforation of the size of half-crown piece, with smooth edges and without any induration, was detected at small curvature which opened into a cavity, bounded superiorly and posteriorly by diaphragm and base of left lung, inferiorly by upper surface of spleen, left lobe of liver and stomach, and anteriorly by diaphragm. The walls of this cavity appeared as if roughly dissected, and numerous shreds of cellular tissue hung from them in all parts, The greater portion of the diaphragm, where it is bound to the ribs at left side, was ulcerated. The pleura at base of left lung was partially destroyed. Two other small perforations were also observed in anterior and posterior walls of stomach leading into same cavity. In this cavity and also in the stomach was found a large quantity of dark, coagulated and grumous blood; and an offensive odour proceeded from these parts. The left lobe of the liver was much atrophied, and the spleen very soft. The pericardial sac contained about two ounces of pale serous fluid, and one part of its inner surface was covered with a thin layer of soft recent lymph, and the cardiac surface was roughened with the same deposit. The kidneys were anæmic, and their cortical portion rather hypertrophied. No peritoneal inflammation

was detected, except at parts engaged in the disease.<sup>1</sup>

Dr. Malcolm on commenting upon this highly interesting case, stated that he was induced to bring it before the society on account of its great rarity, the fulness of its details, and as exhibiting much useful matter for the study of diagnosis. An analysis of the case presents the following circumstances: – A young female had been subject for many years to symptoms chiefly gastric and of a recurrent nature, and of these especially, pain and pyrosis, accompanied with much irregularity of the menstrual function. For a time, abdominal pains, more especially referred to the left hypochondrium, now occupied the place of the gastric symptoms. After a little, suddenly appeared symptoms of local peritonitis and pleuritis in the region of the diaphragm at left side. Abatement of these symptoms only lapsed into the hectic state, and in a short time the case was rather suddenly closed by death.

From the examination of the morbid appearances, all these different phenomena became easily explained. The chronic ulceration of the stomach produced the lingering gastric symptoms which affected her during the first six years of her illness. The process of adhesion to the diaphragm, liver, and spleen, was marked by the attacks of abdominal pains. The sudden peritonitic symptoms betrayed the moment of perforations, and the apparent recovery from this state was interpreted by the manner in which the ulceration was found hemmed in, and lastly, the suddenness with which the vital powers sank was fully accounted for by the traces of extensive hæmorrhage found in the stomach. Now all this seems clear; but how difficult such interpretation during life. In many a case, indeed, has the scalpel to be our teacher. The peculiarities in the case were the localized nature of the peritonitis, the perforating ulceration of the diaphragm, the pericarditis, the hæmorrhage, the distinct remission of the symptoms several days after perforation of the stomach, the absence of hiccup, and the presence of hectic. With regard to the hiccup, however, it must be stated, that the cough was of such a spasmodic character, as always to be accompanied by vomiting, and thus approached the appearance of singultus. The pericarditis, whose traces were observed in the examination, must have occurred very shortly before death, and evidently owed its origin to the contiguity of the sac to the inflamed diaphragm. Though frequently examined for this disease during life, the heart sounds, &c, gave no evidence of its existence beyond more marked

<sup>1</sup> Owing to the difficulty of obtaining even this portion of the examination, the state of the other organs was not observed. The intestines, however, normal

dulness, which might have arisen from other causes.

In remarking upon the treatment in this case, Dr. M. observed, that opium might have been more freely given at the first, as so applicable in such cases. When the mercury began to act on the bowels, it was administered pretty largely, but not earlier, as at that time it was doubtful whether there might not have been obstruction in the colon from accumulation, more especially as it was ascertained that her bowels had been very constipated before admission, and it is well known that accumulations will sometimes induce symptoms exactly simulating peritonitis.

On the question of diagnosis of the perforating ulcer of the stomach, Dr. M. remarked, that it was still very imperfect prior to the moment of perforation.

Dr. Osborne, of Dublin, had added some important facts on this subject, which require to be more attended to. His diagnostic mark, position, did not seem available in the present case. The symptoms of perforations marked in the generality of similar cases were here not completely conclusive; and whatever idea of perforations might have been formed at the period of attack, certainly the subsequent remission did not seem to corroborate it. The symptoms were much more like those of abscess in the vicinity of the diaphragm at left side, most probably local peritoneal or sub-peritoneal, and this opinion seemed much strengthened by the supervention of hectic and the marked attack of rigor which occurred three days before the fatal event. Indeed, from the fact that perhaps only two or three detailed similar cases are on record, it is not surprising that its diagnosis was a matter of uncertainty.

The character of the perforation, the smooth edges, the regular form, the natural appearances of the surrounding portions of the stomach, its position in the small curvature, the age and sex of the patient, the nature and extended period of the symptoms, all agree with the account usually given of the simple perforating ulcer.

Different opinions have been entertained respecting the origin of this ulcer. Mr. Crisp, a writer in the *Lancet* of 1843, who has collected a large number of such cases, lays great stress upon the disorder of the menstrual function and chlorotic condition of the system as predisposing causes. Rokitanski refers to circumscribed softening and diminished vitality of part, and others to slow chronic inflammation of stomach as predisposing this form of ulcer. Though we might be inclined from some of the principal symptoms in such cases, and from the fact, that cicatrization sometimes occurs, to consider a slow inflammatory process in progress, still we must modify our ideas of inflammation very much, to permit them to include the true, simple, perforating

ulcer. In the great majority of these cases, we find none of the usual character of ulceration from inflammation. The appearances are much more those of ulcerative absorption, or at least of a disease *sui generis*.

Dr. M. then gave an analysis of a considerable number of cases of perforation of the stomach which are to be found detailed here and there in the medical periodicals and other works. He distinguished them as follows: – 1. The simple defined perforation. 2. The same, with adhesion of stomach to adjoining viscera. 3. Perforation with tubercular or other diseases of contents of stomach. Fifty-four cases out of eighty-seven were of the first class, twenty-one of the second, and nineteen of the third. Of the fifty-four, thirty had the perforations with edges thin or smooth, sixteen with edges thickened, raised, or cartilaginous, seven accompanied by one or many ulcerations besides the perforations, all, except one, of circular or oval form, two very large, and these occurred in the splenic end of stomach.

One of these cases is worthy of being particularized. E. W., female, aged 36, had been complaining many years with gastric symptoms; pain, however, only occasional in epigastric region. The bowels were generally constipated; at one time had profuse hæmatemesis. After thirty hours' illness with symptoms of sudden peritonitis, she died; and upon examination, a perforation was discovered opening into a large cavity situated between muscular and peritoneal coats. The latter had given way. The seat of the perforation was near lesser curvature, one finger's breadth from pylorus.<sup>1</sup> In the great majority of these cases, the seat of perforation was in the small curvature.

Under the second division, Dr. Malcolm enumerated three species – 1st. Cases of simple adhesion by agglutination of adjoining layers of peritoneum. 2nd. Cases of adhesion which formed a circumscribed cavity, preventing the escape of the contents, thus prolonging life. And 3rd. The same, with perforation of the diaphragm, and thus causing thoracic symptoms. This division forms a most interesting section, and it may be pardonable to state briefly the particulars of some of the cases in the order laid down, omitting the first species as common. Cases of second species here follow: –

1. \_\_A female aged 25 was attacked, without previous illness, with sudden pain in epigastrium and left hypochondrium, accompanied by vomiting, extreme anxiety, and general abdominal pain. For a time symptoms seemed relieved, but again returned, and in some parts accompanied this time by excessive palpitation and occasional syncope and great

dyspnoea. She survived 12 days after first attack. Upon examination, stomach was found perforated; aperture leading into a cavity formed by left lobe of liver, diaphragm, stomach.

2. A very similar case may be seen in the first Number of the London Medical Gazette, N. S., May, 1844, p. 13. The cavity in this case was bounded above by the diaphragm, which was very much forced upwards. Its front and sides formed by the ribs, and the lower boundaries of it were the left lobe of liver, the spleen, and superior part of stomach.

3. A man aged 45 complained three years of dyspeptic symptoms. Latterly his chief symptoms were constant sickness and vomiting. Soon an appearance of tumour was observed in the epigastrium, and suppuration became apparent. Hæmatomosis, however, set in, and death soon followed. Upon examination, an ulcer of stomach was found perforating the rectus muscle and forming an abscess in the cellular tissue anteriorly, and thus causing the epigastric tumour.

4. Rokitanski mentions another case where the perforation ulcerated its way through abdominal parietes and the matter appeared externally.

Madame G \_\_, aged 80 years, had been complaining 36 years previously. The chief symptoms were severe abdominal pains and frequent attacks of vomiting; ulceration occurred at epigastrium, and contents of stomach were observed to escape thereby. This state continued some time. Her death occurred rather suddenly, and, upon examination, a circular aperture in stomach led into a cavity formed by cellular tissue underneath abdominal integument, and which led to ulceration in the abdominal parietes.<sup>1</sup>

Third species: –

1. A female, aged 26, had been ill for several months; a pale, emaciated creature; complained much of pain of right hypocondrium and umbilical region, and afterwards suddenly attacked with violent palpitation, cough, and expectoration of a dirty purulent matter. For a time she appeared relieved, but soon after suddenly died, two weeks after symptoms of perforation. Upon examination, perforation of the stomach was discovered, leading into a cavity bounded above by diaphragm, below by liver, and at sides by union of diaphragmatic and hepatic peritoneum.<sup>2</sup>

2. Rokitanski mentions another case in which the diaphragm was perforated, and the base of the adherent lung involved in the alteration.

3. A man aged 40 had been long ill, complaining alternately of pain in head and stomach,

<sup>1</sup> Case by Mr. Crawfoot, *Lancet*, Vol. I. p. 347.

<sup>1</sup> Med. Chir. Rev. Vol. xxiv. p. 497.

<sup>2</sup> Rokitanski's Cases.

accompanied by occasional vomiting. Hæmatemesis ensued after four days of severe illness, with peritonitic symptoms; he died, and, upon examination, an ulceration was formed, whose edges adhered to the base of left lung, having perforated the diaphragm.<sup>1†</sup>

4. A case related by Dr. M'Cormac in *Lancet*, Vol. iii. 1834.

5 & 6. Two cases of females by Laisná.

The third division includes cases of cartilaginous, cancerous, gangrenous, and tubercular disease of the stomach, with perforation, and, therefore, cannot properly be considered here.

The foregoing results may be thus statistically given: –

1st Class.	
1. Cases of simple defined perforation of the stomach, with thin or natural edges,	30
2. _____, with thickened edges,	16
3. _____, irregular edges,	1
4. _____, with ulcerations besides,	7
Total,	54
2nd Class.	
5. Perforation and adhesions to adjoining viscera,	9
6. _____, forming circumscribed cavity,	6
7. _____, and perforation of diaphragm,	6
Total,	21
3rd Class.	
8. other diseases of stomach,	12
Grand Total,	87

Dr. ANDREWS, in reference to the subject of perforation of the stomach, related a case which was chiefly remarkable as shewing an unprecedented length of survivance after this accident. It was that of a young female, aged 25. She had been complaining of slight dyspepsia for some time, when she was suddenly attacked with symptoms of local peritonitis in right iliac region. She continued suffering from local pain one week, when she suddenly became much worse. The pain and tenderness became general over abdomen, and were intense: she seemed in a dying state. After the lapse of a few hours, pain ceased entirely, and a state of collapse ensued. Notwithstanding, she rallied, and seemed better for two days, when, a second time, symptoms of sinking set in; she, however, again revived, but only for a time – in three weeks she expired. Upon examination, one

circular perforation was observed in stomach, and another in small intestine; an ulceration nearly extending through the coats was also detected in the former organ. The whole surface of intestines was covered with lymph in bands and otherwise, and purulent matter, and at one spot (circumscribed) a local peritoneal abscess was seen, which, however, had no immediate connection with the perforations. In this case the bowels had acted throughout, and she took some food regularly.

Dr. GORDON observed, that from the extensive ulceration of the diaphragm there could be no question about the phrenic nerve being involved, and this case apparently affords us a corroborative instance of a motor nerve, (which all physiologists agree this nerve is,) when irritated at one of its extremities, conveying an impression along its course which would communicate to the sensitive nerve an irritation which would give rise to the sensation of pain.

Dr. DILL would only remark, that, as a matter of practical interest, practitioners should pay more attention to that treatment of a large number of cases of chronic dyspepsia which has been recommended so satisfactorily by Dr. Stokes of Dublin. He considered that such a course would prove more generally serviceable than was usually supposed.

Mr. BROWN, R. N., related briefly the case of a sailor who was shot through the stomach by a musket ball. The ball had torn away a portion of the organ, and thus produced but one aperture. Though the injury was followed by sudden collapse, he survived 48 hours, opium having been the principal remedy administered.

Dr. READ adverted to cases of recovery from similar injuries to the stomach. In connection, also, with Mr. Brown's observations, he instanced the case of Mr. Drummond. With regard to the opinion expressed by Dr Dill, he begged to state that his view of the general treatment of dyspepsia was very different. He believed that the great majority of such cases had no connection with inflammation as the pathological state.

The PRESIDENT remarked that the fact of perforation of the stomach was one of the best established in the whole range of Pathology, He considered it as the result of chronic ulceration; but at the same time making a distinction between the latter and inflammation. Cases of this description have become of late years very interesting, on account of their similarity to the effects of poisons; and to this view of the subject

Orfila has especially directed attention. Ulcerations of the stomach may exist during life, without being suspected, as in the case of Salina Beelard, the anatomist, and others. In the case before

<sup>1</sup> See L. M. J. Vol. ii. 347.

the society, the prolongation of life after perforation was evidently owing to the isolation of the cavity into which perforation had taken place. We have instances on record, in which ascarides have penetrated into the peritoneal cavity, apparently before death. Indeed cases do occur, and not unfrequently, as in tubis mesenterica, wherein perforations take place months, and even a whole year, before death. He detailed the case of a boy, with perforation of intestines through umbilicus, by which a discharge of faeces, caraway seed, and other matters, took place at intervals, for a considerable period before death. The President concluded with making some observations upon the agency of the gastric juice, so termed, and morbid secretions of the stomach. It was his opinion, that it would account for many of the so called morbid appearances, frequently described by authors as occurring at the *post mortem* examination.

Dr. MALCOLM, in reply, would observe with regard to the very interesting case adduced by Dr. Andrews, that it sometimes happens that prolongation of life arises from a fold of intestines blocking up the aperture, and thus preventing the escape of the contents of the stomach or bowels, as the case may be. Also in some instances the adhesive process may localize the extravasated contents in a comparatively small part of the abdominal cavity; and the free administration of opium may likewise assist in warding off, for a time, the fatal event. As to the treatment of dyspepsia, as adverted to by Dr. Dill, Dr. M. was inclined to believe, that in a considerable number of cases of chronic gastrodynia, &c. relief was best afforded by employing a modified antiphlogistic treatment. It would be rash, however, to introduce this course of treatment as a rule of practice. However undoubted the agency of the gastric fluid may be in macrating tissues, under particular circumstances, still he could not subscribe entirely to the observations of the President on this point. In avoiding the error of considering every *post mortem* abnormal appearance the result of disease, we must likewise take care of harbouring the other extreme.

BELFAST MEDICAL SOCIETY.

Monday Evening, September 1, 1845.

MR. MURRAY IN THE CHAIR.

DR. GORDON read the following paper on a peculiar dislocation of the femur on the pubes –

A stout and muscular male subject, about 64 years of age, was brought into the anatomical room of the Belfast Royal Academical Institution for dissection. When placed upon the table, and the lower extremities approximated, I observed that the

left was much shortened, adducted, and inverted, with the great toe resting upon the dorsum of the opposite foot, and having the patella almost three inches higher; there was also a tumour, about the size of an orange, in the situation of, and internal to, the anterior inferior iliac spine; the thigh was immovable upon the pelvis, on a plane anterior and somewhat in front of its fellow, and so adducted that the knee passed considerably beyond the median line of the body; the external iliac or gluteal region was wasted, and the trochanter major was prominent, but nearer to the anterior superior iliac spine than natural.

*Dissection.* – When the integuments and subjacent fasciae were removed, Poupart's ligament was observed projecting forwards, and lying in front of the tumour; the sartorius, near its origin, as it passed in front of this tumour was smaller than natural, and converted, at this part, into a flat tendinous band, containing much fat; the upper portion of the rectus femoris was also similarly affected, and its tendon was closely adherent to, and lodged in, a deep groove in the front of the neck of the femur. The relative and natural positions of the femoral artery, vein, and anterior crural nerve, were much disturbed; the vein occupied its natural situation, the artery lay in front of it, and the nerve before both, but more external, lying upon the internal and superior surface of the tumour. The muscular substance of the gluteus medius and minimus, obturator externus and internus, pyriformis, and gemilli, muscles was completely absorbed, and its place occupied by a large quantity of fatty matter, but they apparently retained their normal quantity of fibrous tissue, which was very tense, holding the articular surfaces of the femur and pelvis in contact like ligaments.

The iliacus internus had almost completely disappeared, and what remained of it was pushed upwards and inwards off the brim of the pelvis by the tumour. The psoas magnus was smaller than natural by one half, and mixed with a considerable quantity of fat, its tendon lay in a deep groove upon the pectineal eminence.

After removing these parts, the tumour on the brim of the pelvis came distinctly into view, it originated superiorly from the brim, but inferiorly it was continuous with the femur, and it was also evident that it consisted of two separate portions, as, by moving the femur, the lower part was observed to glide slightly upon the upper, which felt firm and stationary.

The next step in the dissection was to separate the femur from the pelvis, and, in so doing, it was necessary to cut through a strong, dense, and closely adherent fibrous tissue, which strengthened considerably the articulation; yet, when this was

done, the surfaces were still almost immoveably united, but, by forcing the blade of a strong scalpel into the joint, and using force, I was enabled to separate the articulating surfaces, but not without some difficulty: the medium of union was principally cartilaginous, resembling very much that of the sacro-iliac synchondrosis. There were no traces of either the former capular ligament, or of the ligamentum teres.

Having thus separated the femur from the pelvis, the articulating surface of the latter consisted of the old acetabulum, part of the brim of the pelvis, and a new formation extending considerably above the brim.

The original acetabulum, or the part corresponding to it, is much higher than natural, less deep, and comparatively shallow; its margin is very irregular, presenting superiorly a process which overhangs its cavity. The new formation extends from the pectineal eminence to the notch below the anterior superior iliac spine, encroaching considerably upon the internal iliac fossa: in shape it bears some resemblance to a short, thick wedge, the base looking downwards and outwards, and immediately above the original acetabulum, the apex or thinner extremity looks upwards and inwards, having the superior internal angle somewhat rounded, and superior external angle presenting a rough hook like process; the posterior surface is rounded; the anterior or articulating surface looks downwards, forwards, and inwards, is almost plane, but quadrilateral being two inches vertically and the same transversely. At the union of the internal border of this process with the base is a deep groove leading from the original acetabulum, in this the tendon of the psoas magnus was lodged; this groove corresponds to the pectineal eminence, so that the whole of the new articulating surface is external to the os pubis. Hence the dislocation was upon the ilium rather than the pubes, the neck of the femur lying upon the part of the brim included between the pectineal eminence and the anterior inferior spinous process of the ilium.

The neck of the femur is attached to the shaft on a plane somewhat below that of the lesser trochanter, it, as well as the head, is flattened, compressed, and expanded from above downwards, forming a single articular process, articulating with the new socket and brim of the acetabulum. This process, when viewed from above downwards, presents a quadrilateral surface, two inches in the antero posterior, and the same in the transverse direction; its margin is irregular, presenting anteriorly, at the part apparently where the head joins the neck, a deep groove, in which the tendon of the rectus femoris muscle was lodged. Besides this, there

is another articular surface joining it at right angles, and articulating with the altered original acetabulum, and formed by the upper and posterior part of the base of the neck of the femur gliding into this cavity, as the neck became absorbed from the pressure exercised upon it by the border of the acetabulum; its surface is convex, and its extent considerably increased, especially behind, by bony deposit around its margin.

In addition to these alterations, we find that the neck of the femur is so twisted forwards and outwards on the shaft, that, if we place the femur upon a plane surface resting on the posterior parts of the condyles and the great trochanter, and let fall a line perpendicular to the centre of the shaft, opposite the neck, this line will almost touch the outer border of the part corresponding to the head of the bone.

The principal concavity of the shaft does not correspond to the *linea aspera*, as in the healthy femur, but exists along the inner surface of this bone.

If we examine the pelvis we will find other alterations as remarkable as those described, especially in comparing the *ossa innominata*, and at the same time we may grant that the right *innominatum* bone is unaltered, (to all appearance it is so) and that it is the left which illustrates the abnormal changes resulting from this luxation. These are as follows –

Left *os innominatum* smaller than the right. Left ileac crest higher than the right, less curved, and shorter by almost half an inch, measuring from the attachments of the ileo lumbar ligaments to the anterior superior spinous processes. Left anterior superior spinous process thicker, less curved, and less everted than the right. Left anterior inferior spinous process involved in the bony mass which forms part of the new socket. Left internal ileac fossa less deep, and of smaller extent than the right; the two laminae of bone, which are generally in contact in the centre of this fossa, and sometimes even translucent, are separated from each other by a thick layer of diploe. Left posterior superior spinous process smaller and less prominent than the right.

The distance between the anterior superior and the posterior superior spinous processes is nearly half an inch shorter on the left than on the right side, measured by lines drawn transversely across the *dorsum ilei*.

Left obturator foramen is considerably smaller, especially in its vertical diameter, and of a different shape than the right. Left greater sacro-sciatic notch is regularly oval, having its greatest diameter transversely, and its larger extremity directed forwards. Left lesser sacro-sciatic notch is greater than the right.

A vertical line drawn from the eminentia

ileopectinea to the tuberosity of the ischium measures on the right  $4 \frac{5}{10}$ , and on the left  $3 \frac{8}{10}$  inches; the eminentia ileo pectinea being on the same plane on the brim of the pelvis, it follows that the left tuberosity of the ischium does not reach so low by  $\frac{7}{16}$  of an inch on the left as it does on the right side; or, in other words, the left tuberosity is on a plane  $\frac{7}{10}$  of an inch higher than the right; indeed it seems as if we had united the os pubis and ischium of a shallow pelvis on the left to the os pubis and ischium of a deeper pelvis on the right side.

The arch of the pubis resembles more that of the female than the male; this peculiarity is owing to the shortening and diverging of the ascending ramus of the ischium, and the descending ramus of the pubes.

The left sacral groove (the continuation of the vertebral groove) superiorly is little more than half the breadth of that of the right. The lumbar vertebræ are twisted, being convex towards the right, and concave towards the left. The left lumbar intervertebral foramina look outwards and forwards, the right, backwards, and outwards. The left transverse process of the fifth lumbar vertebra is nearly double the thickness of that of the opposite side, and the left ileolumbar ligament is also the larger.

*Remarks.* – This case presents an anomaly very unusual, and, I might say, never before described. In all the cases which I have consulted, the limb is described as everted; indeed, it is almost impossible that the toe can be turned inwards when the dislocation is recent, as nearly the whole of the muscles attached to the femur counteract this condition of the limb, as the following observations will clearly demonstrate. If we so place the neck of the femur upon the brim of the pelvis that the extremity would be inverted, and, if at the same time we reflect on the action of the different muscles attached to the upper extremity and shaft of the femur, we shall find that the anterior fibres of the gluteus medius and minimus will elevate the thigh, but the posterior will act in producing eversion; the same condition will be induced by the psoas, iliacus, the adductors, and the other external rotators. Poupert's ligament and the inferior border of the internal, oblique, and transversalis muscles, may, by their pressure on the front of the head and neck, tend to produce inversion, but any action which they might exert would be too near the centre of motion, and would avail very little in counteracting the action of the numerous and powerful muscles just mentioned.

The semi-membranosus, semi-tendinosus, and the tensor vagina femoris muscles, will undoubtedly tend to produce inversion, but in the recent luxation the outward rotators would still preponderate, and

would more than counterbalance any inward rotation which might be produced.<sup>1</sup>

The peculiarities of this case are, I think, easily accounted for, if we first consider the situation occupied by the head and neck of the femur, and after this, the action of the muscles upon it when so dislocated.

The situation of the femur was, as already described, as follows: – The lesser trochanter occupied the acetabulum; the root of the neck rested against the upper border of this cavity; the head projected above the brim of the pelvis, and the trochanter-major was external to the acetabulum. Place a healthy femur in this position, and we shall find that the limb will be everted; and in addition to this, the fact of the tendon of the psoas muscle being situated between the brim of the pelvis and the posterior and inner part of the neck, will also lead us to suppose that there was considerable eversion, as the tendon, so placed, would push the neck of the bone more forwards and outwards, and would consequently induce a greater degree of eversion.

The femur thus placed, was firmly retained in this position by the different muscles; in front, it was held against the brim of the pelvis by Poupert's ligament, and by the tendon of the rectus femoris, which lay imbedded in a deep groove in front of its neck, and also by the sartorius; behind it was held against the acetabulum by the tendon of the psoas muscle, which had produced a deep groove on the brim of the pelvis; from this we observe that the femur, not only from its abnormal situation, but also

---

<sup>1</sup> We find in the 20th volume of the *Medico Chirurgical Transactions*, a case recorded by Mr. Benjamin Travers, Jun., which strongly corroborates the opinion just advanced, viz., that in the recent luxation there is always rotation outwards. A sailor, aged 19, fell from the height of about twenty feet into the hold of a vessel on the left buttock, and, after a lapse of eight months, the following was the state of the parts. "The left buttock is flattened; the trochanter is left rather below and to the outer side of the anterior superior spinous process of the ilium. The neck of the bone lies apparently between the two anterior spinous processes, so that when the patient is erect, the limb appears slung or suspended from this point. The head of the bone cannot be felt, it is invested by an abundance of bony matter, which extends backwards and inwards over the brim of the pelvis and iliac vessels, occupying in front nearly the whole space between the inferior spine of the ilium, and that of the pubis respectively. There is complete eversion, slight mobility, and imperfect progression with the aid of a crutch."

If we place a femur in the situations respectively occupied in the case just read, and in that which is the subject of the present communication, we would at once observe that inversion, if such could be, was far more likely to happen in the former than in the latter instance.

from the mechanical pressure exercised upon it by some of the muscles would be almost immovable; now, as a consequence of this immobility, a great number of the muscles being unable to act would degenerate, hence, unquestionably, was induced the complete conversion into fat of the two glutei, obturator externus and interims, pyriformis and gemelli muscles.

The limb was also much adducted, projected forwards, and, I may also add, everted; (because we cannot place the healthy femur as here described, unless it be everted,) a position very favourable to the action of the semi-tendinosus and semi-membranosus, not only as extensors of the thigh, but also as rotators inwards. The attachment of the outward rotators to the great trochanter, and the pressure of the tendon of the rectus femoris muscle upon the front of the neck, would prevent the femur, during rotation, describing a part of a circle, of which the radius would be represented by the length of the neck; before this could take place it would be necessary that these muscles, should either be ruptured, or at least their tendinous substance much elongated; but the dissection shewed that there was neither rupture, nor elongation, but that the fibrous tissue, belonging to these was tense, and held the articular surfaces in contact like ligaments. Now, the force of rotation, produced by the semi-tendinosus and semi-membranosus muscles would thus be exerted upon the root of the neck of the femur, and by rotating this bone, as it were, upon its own axis, would gradually alter the natural position of the shaft to the neck, rolling it forwards and outwards.

This rolling forwards and outwards is not entirely confined to the junction of the neck with the shaft, for, if the upper extremity of the latter be attentively examined, we will also find it somewhat twisted.

If we reflect on all these circumstances, I think, the conclusion is evident; viz., that owing to the situation of the femur, and the action of the muscles upon it when so placed, it was almost immovable; that as a consequence of this immobility, the greater number of the outward rotators degenerated into a fatty mass, as muscles usually do when unable to act; that the adduction and eversion of the limb, increased the influence of the semi-membranosus and semi-tendinosus as inward rotators, they, during each act of progression, also acted as inward rotators, and having lost their antagonists, the outward rotators gradually produced the inversion observed, and the rolling forwards of the neck upon the shaft of the femur. The great shortening of the extremity was evidently much increased by the pressure from above downwards, causing absorption of the upper and posterior part of the neck, and its descent upon the

shaft when the patient used the limb in progression.

In this case we have a remarkable example of the efforts of nature in repairing an injury of so important a joint as that of the hip, by the formation of a strong and thick process for supporting the head and neck of the femur. The same reparative process is not alone confined to dislocations of the hip, we also observe a new socket formed around the head of the humerus when it is dislocated, either on the dorsum or venter of the scapula, and even when the lower extremity of this bone is luxated forwards upon those of the forearm. It seems as if the head of the bone by its pressure on the surrounding soft parts caused condensation of those, and consequent on this condensation bony matter soon becomes deposited and firmly attached to the neighbouring bone, forming a strong support to the dislocated extremity. But what appears more remarkable in this instance is, that the base of the new socket, or process, should extend so far backwards upon the ileac fossa; and, if conjecture be allowable, we might say that nature continued to add deposit after deposit until she had formed a buttress, which would not only resist any impulse communicated by the femur, but would also bear an assault which would be more than sufficient to fracture this bone itself.

I will now trespass a little longer on the time of the society by offering a few remarks on the causes, symptoms, and reduction of this dislocation.

As predisposing to this accident, I may mention, that in a few instances I have found the capsular ligament deficient on its anterior and upper part, and a free communication was, by means of this opening, established between the cavity of the hip joint, and the large bursa which lies behind the psoas and iliac muscles, as they pass over the brim of the pelvis. In the subject, whose dissection has just been related, there was an elliptical deficiency of the upper and outer part of the capsule, in the opposite joint, of fully an inch in its vertical diameter.

When speaking of the causes of this accident, Sir Astley Cooper observes, "it happens when a person, while walking, puts his foot into some unexpected hollow in the ground; and his body being at the moment bent backwards the head of the bone is thrown forwards on the pubes." I will not deny that the accident happens as frequently, if not more frequently, in this manner than in any other; and it is also probable that all the cases induced in this way will present nearly the same symptoms, and may justify us in laying down certain uniform signs as invariably belonging to this luxation; but that it is produced by other causes acting very differently is unquestionable, and hence we may have a great variety in the symptoms. In the case mentioned by Mr. Travers it was produced by a fall on the left

buttock, from the height of about 20 feet into the hold of a vessel. In a case mentioned by Mr. Brausby Cooper (Guy's Hosp. Rep. vol. 1.) it was produced by a wheel of a waggon passing over the hip. There are many more instances recorded in which the luxation was thus produced by violence acting directly upon the neighbourhood of the joint

We have thus this accident induced in two very different ways; in one, it happens when the foot is fixed at the same time that the body is thrown backwards, and the limb then acting as a lever, the head of the bone is forced through the capsule of the joint, and thrown upwards upon the pubes; in the other, the force is applied directly to the neighbourhood of the joint, lacerating its capsule, displacing the articular surfaces, and bruising the soft parts. A division of the causes, inducing the accident, such as this, will be of considerable practical importance, and will greatly assist our prognosis as to the probable issue of the case. If the luxation has been produced by a cause acting through the femur or extremity as a lever, without any other injury of the joint, we may safely say to the patient, that he will soon be well, after the reduction of the bone. But the issue of the case may be different when the luxation is caused by direct violence, as we have not only the luxation, but also considerable, if not great injury to the soft parts; and the reduction may be accomplished, yet the patient may die from the amount of injury inflicted upon the joint and the surrounding soft parts.

The position of the limb varies very much: it may be separated to nearly a right angle from its fellow, and "turned in" (up) on the pelvis; (Med. Chirurg. Rev. vol. 1, page 500): it may be slightly abducted, or it may be adducted, as described by Mr. Morgan in the first volume of Guy's Hospital Reports, who says, "the injured limb had a tendency to cross that of the opposite side, so as to throw the heel over the instep of the opposite foot; nevertheless when they were placed side by side they remained in that position." The femur may have a direction slightly backwards, or there may be flexion forwards.

The degree of shortening will also vary much; sometimes the shortening is very slight; sometimes as much as three inches. In all recent cases, the limb is everted, and so much so, as almost, in some cases, to give the toe a direction backwards.

The head of the femur may be thrown so much inwards as to compress the crural vessels and anterior crural nerve, producing a varicose state of the veins, and numbness of the extremity; it has also been observed lying behind the crural artery and nerve. It is situated more frequently external to the crural vessels, lying between these and the anterior inferior spinous process, and may even be placed

between the spinous processes. Sometimes the head is so buried in the abdomen that it can scarcely be felt. In the majority of cases it may be felt prominent behind Poupart's ligament, and sometimes it is situated below the ligament.

In the case dissected by Sir Astley Cooper, the state of the parts was as follows: – The original acetabulum is partly filled by bone, and partly occupied by the trochanter major, and both are much altered in form. The capsular ligament is extensively lacerated, and the ligamentum teres is broken. The head of the thigh bone had torn up Poupart's ligament, so as to penetrate between it and the pubes. The head and neck of the bone were thrown into a position under the iliacus internus and psoas muscles; the tendon of which, in passing to their insertions over the neck of the bone were elevated by it, and put on the stretch. The crural nerve passed on the fore part of the neck of the bone upon the iliacus interims and psoas muscles. The head and neck of the thigh bone were flattened, and much changed in their form. Upon the pubes a new acetabulum is formed for the neck of the thigh bone, the head of the bone being above the level of the pubes. The new acetabulum extends upon each side of the neck of the bone, so as to lock it laterally upon the pubes.

Poupart's ligament confines it on the fore part; on the inner side of the neck of the bone passed the artery and vein, so that the head of the bone was seated between the crural sheath, and the anterior and inferior spinous process of the ileum. (Cooper, Sir Ast. on Dislocat and Fractures, 7th ed. p. 66.)

There is, in the Museum of Guy's Hospital, a specimen of this luxation, presented by Sir Astley Cooper; and the following is the state of the parts, as shewn by the preparation, twelve years after the occurrence of the accident. (Guy's Hosp. Rep. vol. 1, p. 98.) "The old acetabulum is deprived of articular cartilage, and in part filled up by bony deposit, so as to be rendered wholly unfit for the reception of the head of the femur. The new acetabulum is placed above the old one, and formed partly by the body of the pubes, and partly by the inner side of the inferior spinous process of the ileum; its form is very similar to a natural acetabulum, but not quite of equal dimensions; it is protected above, it may be observed, by a growth of bone which overlapped the head of the femur, and must have formed the principal point d'appui for that bone. The inferior part of the circumference of this new acetabulum is the most deficient. Between the new and old acetabulum there is a smooth articular surface, of irregular form, upon which the posterior and upper part of the trochanter major rested and moved, in the newly acquired motions of the joints. Both the new acetabulum and this articular surface portray, by partial deposition of

porcelain like concretion, the precise points where the head of the femur and the trochanter moved upon them.

" The head of the femur is altered from its original figure, so as to be adapted to the new acetabulum, portions of it being diminished where it did not come in contact with the new cavity, so that its spheroidal figure is lost. The periosteum of the femur, as well as of the new acetabulum, assisted in forming the new capsular ligament. The articular cartilage of the head of the femur has been absorbed, and the same porcelain-like concretion as is seen in the acetabulum is provided at corresponding points.

" From the form of the articular surfaces, and the fixed position of the femur, both at the head and the trochanter major, it will be observed, that no other motion than flexion could be permitted; and even that motion, from the closeness of the attachment at the trochanter, but to a limited extent."

In the three dissections which I have now detailed, we observe the same changes induced, with slight modifications, viz.: the gradual alteration and filling up of the old, and the formation of new acetabula; various alterations in the head and neck of the femur; motion of the joint very limited; articular surfaces sometimes united by cartilage, at other times the surfaces are free, but rendered smooth by a deposition of a porcelain-like substance. There was no true ankylosis observed, nor is it probable that it ever occurs, if it be allowable to form such an opinion from the numerous dissections of such joints, not only observed on the pelvis, but also on the scapula, which are recorded. When the luxation has been unreduced, the limb is not useless, nor will the patient be under the necessity of using crutches during the remainder of his life. In the case of John Fox, the subject of the last dissection which I have mentioned, "in two or three days after the accident, left his bed of his own accord, and, with the assistance of a stick, he began to walk, although, from his expressions, it seemed to have occasioned him great suffering." This same patient, six years afterwards, with the assistance of his stick, (which he could never lay aside) walked a distance of 42 miles in one day, and returned the day but one following. In the subject, which I dissected, there is every reason to suppose that he, while alive, did not use crutches, as the muscles of the calf of the leg of the injured side were a great deal more developed than those of the opposite side. Indeed, they were larger than we usually find them in the bodies of those brought into anatomical rooms.

In this dislocation it would be difficult to say how long the femur may be luxated, and yet reducible; but it is probable that, as in other cases, the time will vary very much in different individuals. In

Mr. Travers' case, already alluded to, the head of the bone was invested by bony matter, eight months having elapsed from the receipt of the injury.

On the reduction of luxations in general, Sir Astley Cooper observes: – "The power and direction of the larger muscles are, in the first instance, to be duly appreciated, as these form the principal causes of resistance." This statement may be regarded as an axiom, but the question may be asked, has it been applied and carried into practice in the reduction of the dislocations forwards and upwards? The method recommended by Sir Astley, and now followed by almost all surgeons, in reducing this luxation, does not accord with the spirit of this axiom. If we minutely analyze the practice recommended, we will find that the muscles which impede most the reduction are not relaxed; their "power and direction" are not duly appreciated, and, instead of being relaxed, they are put upon the stretch, even before the extension has commenced. "The extension is to be made on a line behind the axis of the body, the thigh bone being drawn backwards." If we wish to relax the psoas and iliac muscles, we flex the thigh upon the pelvis; if we wish to put them on the stretch, we extend the thigh. These muscles form the principal impediment to the reduction, and instead of removing this impediment by relaxing them, they are put upon the stretch, and then the extension is commenced. This mode of procedure is certainly wrong in principle, although it has succeeded in practice; and if we are to be guided by sound reasoning, based on correct anatomical principles, we should first relax as much as possible the muscles opposing, before we attempt the reduction.

The following procedure, if adopted, would accord with these principles: the patient is to be placed on his side, and the pelvis fixed by means of a girth passed between the thighs and fixed to a staple, a little before the line of the body; the leg is to be flexed upon the thigh, and the thigh upon the pelvis, as much as possible: a girth is now to be passed around the upper part of thigh, at right angles to the axis of the body, and firmly fixed to another staple. This latter girth will serve as a fulcrum, and, by seizing the lower extremity of the femur and by pushing it upwards and inwards, we will cause the head of the femur to pass downwards and backwards towards the acetabulum. It may be objected to this project, that it is very good in theory, but that it may not succeed in practice. To this I would answer, that surgical science is based on correct anatomical principles and the more we study these principles, the more correct and satisfactory will be our practice.

If we take a general review of the recorded cases of this luxation, we will find that the head and neck of the femur has been observed respectively

upon all the parts of the brim of the pelvis included between the anterior superior spinous process and the spine of the pubes; that in the majority of cases, nearly the whole of them, the bone is placed external to the pubes, so that from this we may question the propriety of the name applied to this luxation, viz. dislocation upon the pubes. Nor will the appellation upwards and inwards express the position occupied by the femur, as it is in some cases luxated directly upwards. It is an abuse of anatomical nomenclature to call the part of the ileum which is internal to the anterior inferior spinous process, the body of the pubes, and it is a still greater abuse to style a case as one of dislocation upon the pubes, when the neck of the femur rests between the anterior spinous processes. We find in the 2nd volume of the Lancet, for the years 1840 – 41, the dissection of a case of luxation directly upwards, which will serve to shew how very much the names at present given to these luxations are at variance, as expressing the situation occupied by the luxated femur. In this case, "on examination after death, it was found that the bone had been dislocated directly upwards, the head lying on the anterior inferior spinous process, and a little to its outside. The trochanter major was situated posteriorly, resting on the dorsum ilei, the trochanter minor resting on the outer edge of the acetabulum." This is certainly a case of dislocation on the dorsum of the ileum, but it does not accord, either in its position or symptoms, with that described by systematic authors as belonging to this luxation.

We observe, in all the luxations of the femur upwards, that the head either looks forwards and inwards, and the trochanter backwards, or *vice versa*, with the head backwards and the trochanter forwards. If the head looks forwards, the limb will be everted; if backwards, the limb will be inverted. Now, if, instead of dislocation upon the pubes, or upwards and inwards, and dislocation upwards and backwards or on the dorsum ilei, we were to use the term, dislocation upwards with eversion, or on the anterior part of the brim of the pelvis, as characteristic of the former, and dislocation upwards and backwards with inversion, as characteristic of the latter, we would avoid the error of implying that the femur was situated on a part of the pelvis which it really did not occupy. These objections do not apply with equal force to the term, dislocation upwards and backwards, or on the dorsum ilei, as they do to that of dislocation upon the pubes, or upwards and forwards; because the dislocation upon the pubes is certainly an exception to a general rule, and a luxation which has seldom been observed, unless we take the same liberty with the pelvis as is done with the humerus, viz., describing two necks, an anatomical and a surgical, and when we say the pubes, in surgical

language we mean the space included respectively between the anterior inferior spinous process and the symphysis of the pubes; but science will scarcely admit of such liberties, by requiring that a term signifies one thing in surgical and another in anatomical language. The term, dislocation on the dorsum ilei, is not so objectionable, as the cases are few in which the symptoms differ much from those usually given in systematic works, and a contrary case may be regarded as an exception to a general rule.

Dr. MOFFAT observed, in remarking upon the case, that there seemed to be some predisposing cause of this peculiar dislocation, from the appearance described by Dr. Gordon, as found in the structure of the pelvis, favouring a particular direction of the force, at the time of the injury. The examination of the parts would also tend to show that the accident had occurred to the person when young; and that he had been enabled to use the limb (with the aid of a support) for a long time previous to his death.

Dr. PELAN related a case of dislocation of the femur, with fracture of the acetabulum, producing a very important variety. The dislocation was reduced on several occasions, as no permanent position could be maintained. In consequence, deformity always remained.

Mr. BROWNE, R. N., adduced two cases of dislocation of the femur on the pubis, which had occurred in his practice. He begged to express his favourable opinion of the manner of reducing such dislocation just recommended by Dr. Gordon, not from experience (for the plan is evidently new), but from reasoning on its capabilities.

Dr. KELSO, of Lisburn, read a paper on an epidemic of Scarlatina, which, in the spring of the present year, prevailed to a great extent under a rather severe and fatal fever, in and about that town; in which he took occasion to notice more particularly some of the more important features that characterised its history, pathology and phenomena, together with a few of its commonest sequelae. After remarking generally on the importance of the medical man recording, as occasion may seem to require, the results of his individual observation or experience in reference to some or any one of the host of diseases which swell indefinitely our nosology, as a ground of comparison with prevailing impressions or ideas regarding them in their several bearings and relations, medicine, as a science, having, in some measure, by this means progressed to its present *status*; and further noting, that many of the observations to be offered were not put forward as presenting, in themselves, much that was very peculiar, much, if any thing, that might not have been before noted by others as occurring in similar preceding epidemics,

and forming part of the literature of our science; he proceeded to say, that the observations to be then submitted to them had reference more especially to 200 and odd cases of the disease, of which memoranda, more or less perfect, had been preserved at the time of their occurrence. He regretted, however, that his notes of many of the cases were but imperfect in several respects; enumerating among the causes of this – his inability, in the fatal cases (of which there were 8 noted; but he was satisfied there must have been several more,) of obtaining an after-death inspection, and the information derivable therefrom; his want of opportunity of seeing many of the victims of the disease more than once, or perhaps twice during its progress, and the knowledge thereby to be acquired from the modifying influences of treatment, &c.; concluding, introductorily, that notwithstanding these drawbacks, something of a profitable or interesting character might still accrue from a brief review of the registered facts which might, it was hoped, prove not altogether unworthy of some share of their attention.

The author then went on to say, that the epidemic, which attacked both young and old, comparatively speaking, and individuals in more comfortable circumstances as well as those belonging to the poorer classes, continued for a period of three months, commencing in the middle of March and ending about the middle of June. The unusual time of its appearance here elicited a remark in passing; and in corroboration, a passage was quoted from Doctor Tweedie, in the article *Scarlatina*, in the *Cyclopædia of Practical Medicine*, which went to show that, of all the different periods of the year, the spring months were particularly exempted from all such epidemic visitations. The state of the weather by which it was attended was next referred to. March, it was mentioned, was found to be particularly cold and rather blowing, accompanied with intense frost almost throughout; April was much less severe; while May, towards the latter end of the month, was quite genial.

The difference of view regarding the nature of *Scarlatina* entertained by different writers on the disease, and the corresponding difference in classification of which these views were the source, were now dwelt upon by the author at some length. According to one of these views, the external phenomena which the affection usually presented shadowed forth the chief and essential links in the chain of morbid actions in which the disease consisted; and hence the usual division of it into *S. Anginosu* – *S. Maligna* – *S. Simplex* – and *S. Faucium*. According to the other, in which the pathology is exclusively regarded, the varieties of form which the affection assumes, representing as they did the

corresponding pathological states, were now generally considered as consisting for the most part, in common with the other exanthemata, of the *congestive* and *inflammatory* description; not to mention subdivisions that might be made of different combinations of these two. Among the chief advocates of the latter doctrine, which the author regarded as the more scientific of the two, the names of Drs. Hamilton, sen., and MacKintosh were particularly specified. Having stated thus much, he then intimated his intention of reviewing the facts or observations relating to the epidemic in connexion, in the first place, with the chief symptoms of the disease, and, in the next place, in relation to the pathological phenomena manifested by it.

In adverting to the first of these symptoms, namely *fever*, the author stated that while in several cases it was extremely mild and transient, in many more it was characterized by greater or less intensity of the leading phenomena, which either yielded on the full appearance of the cutaneous rash, or persisted during the whole course of disease, and occasionally even for some time after the disappearance of the superficial symptoms. Referring to the predominant character of the fever, he did not hesitate to regard it for the most part as in some degree inflammatory in the outset, but subsequently, especially when protracted, assuming more or fewer of the symptoms characteristic of the typhoid type. In some instances, again, typhoid symptoms were mixed up to some extent with those of an inflammatory nature from the first setting in of the disease; in which case, the eruption on the surface presented more or less of a livid colour, was less quickly and fully developed than usual, and presented nothing like regularity in its progress and decline.

The *cutaneous eruption* was the next of the symptoms noticed. But of the 200 cases of the disease of which the author has preserved an account, in only 105 was it to be detected, though he would not contend but that it might have existed imperfectly and fleetingly in a larger number of them. Regarding this phenomenon, as he did, in a two fold point of view – namely, as presenting more or fewer of the recognised characters of *regularity* or *irregularity* in its development, progress, and decline, of the 105 instances mentioned, 45 were referred to the former category, and the remaining 60 to the latter. Speaking generally, the early and free establishment of the efflorescence was always looked upon as a favourable occurrence.

The *inflammation of the throat*, as forming the last of the external and distinctive symptoms was then disposed of. In none of the instances was this absent in some degree, either accompanied with or without swellings of the tonsils or other organs about

the throat. In the severer cases, marked by the supervention of typhoid upon the pyretic symptoms, this topical affection never failed to become more decidedly aggravated, attended by the occurrence of ulceration and considerable swelling in the inflamed parts. Sloughing, following upon ulceration, was of very rare occurrence, inasmuch as only one was observed by the author, and that only incidentally, the person, a child of about 5 years old, being at the time in *articulo mortis*; nor, upon inquiry of his professional friends in Lisburn, could he learn of any thing similar having been experienced by any of them during the continuance of the epidemic.

The epidemic in its pathological relations then came in for a rapid survey. Of these, the condition involving congestion of some internal vital organ or part first elicited some passing and general observations; and, in application, the annexed case was related by the author: – a child, years old, was seen by him on May 19th, labouring under these symptoms; – considerable and manifest depression of the vital and bodily powers, as evinced by pallor of countenance, drooping of the upper eyelids, somewhat oppressed respiration, accompanied with occasional sighing, and rather feeble and small pulse (96); the tongue was further mentioned as being furred and presenting a slightly mottled appearance, and the bowels confined. The child's illness it was learned, commenced a few days previously with symptoms of pyrexia, but the tendency to somnolence, with the other symptoms of depression, was only observed on the foregoing evening. Two leeches were ordered to each temple, and a dose of jalap and calomel prescribed. A warm bath was also advised in the evening, with some diaphoretic medicine in the mean time. On the 30th, there was observed some improvement from the treatment, with some faint development of rash on chest. On the 21st, things were worse. There was more of oppression, seemingly, at the chest, and there was some cough, accompanied with mucous rales especially in right lung. Countenance pale, and expressionless as at first; tongue furred, feet rather cold. Arrow-root for diet to which a little wine was allowed to be added. A slightly stimulant mixture containing some carbonate of ammonia was prescribed. The patient made a slow but perfect recovery.

The other pathological condition, which the affection almost always involves, in some degree, the *inflammatory*, namely, was next generally adverted to; and, in applying the general statement to the results of observation in reference to the epidemic, the author considered 2-5ths of the cases, at least, as coming within its meaning.

Some allusion to the *sequelæ* of the disease

then followed. Anasarca, in the first place was observed upon by the essayist; next rheumatism; and lastly, bronchitis and broncho-pneumonia. With reference to the dropsy, this, which was generally of the inflammatory character as usual, was most common, but in many instances so mild and fugitive as to require little or no treatment beyond aperients. The commonness of albuminuria in connexion with a deficiency of the animal principle of urea, as ascertained from some experiments, formed the topic of a passing remark, as well as that of some other alterations more commonly exhibited by the urine.

The next of these sequela<sup>3</sup> reviewed by the author, *rheumatism* namely, and which, as far as he was aware, had been mentioned by no other author with the exception of Dr. G. Bird, was not of uncommon occurrence, though generally so mild as not to require active interference. In several instances, however, it was observed to assume a much greater degree of severity; in proof of which a case was then detailed. Reference was in the last place made to bronchitis and broncho-pneumonia which, though of unusual occurrence as a sequela of the disease, was in the epidemic under notice any thing but uncommon. The essay wound up with some general remarks relating to this point.

Mr. BROWNE, R.N., would remark that after the epidemic referred to, a muco-purulent ophthalmia prevailed to a very great extent, among the children of the poor, especially in the months of June and July: a disease which, at present, very frequently presents itself, in a similar class of patients, as a sequela of measles – which have lately been epidemic. He had, also on several occasions, noticed hydrocephalic symptoms following the affection. He agreed with Dr. Kelso that scarlatinous anasarca was rarely observed in the adult. He had, however, met with three such cases in his practice in the early part of this year.

Dr. MOFFAT also believed that anasarca, at such an age was exceedingly rare, no case having come under his observation. In all the cases of scarlatinous anasarca he had met with, he observed the urine uniformly albuminous. It would be an interesting question to ascertain the cause of such a state of the urine in this disease. There is evidently, in many cases, no affection of the kidney, and we must therefore refer the albuminuria to a peculiar state of the blood. Treatment during this epidemic was sometimes very inefficient. As an instance of this, he referred to two fatal cases, in both of which cerebral symptoms were marked. In the one no depletion was used; while in the other the application of leeches did not appear to make the slightest effect upon the fatal course of the malady.

Dr. MALCOLM expressed his gratification that a topic of such interest had been brought before the

society. He considered that it was extremely desirable that the subject of epidemics should be well understood by the profession, and that medical men placed in favourable circumstances for observing them, should not let the result of their observation remain profitless to the profession. Dr. Kelso had mentioned that gangrene of the mouth and throat was exceedingly rare in this epidemic. He had met, however, with two or three such cases, and would refer to one especially, in which the whole of the lower lip sloughed away before the mortifying process was checked. In this case he had found chlorate of potass with bark, of essential service. He would beg to draw the attention of the society to that rather new fact adduced by Dr. Kelso, viz., the occurrence of rheumatism, as a sequela of the disease; and this independent of the dropsical affection. It was a most important fact, and well worthy the attention of the society. During the epidemic, Dr. Malcolm observed that he had met with a very interesting case of an adult female, who, during convalescence from a rather severe attack, was seized with continued fever, and went through all its stages favourably, although slowly. Dr. Read asked Dr. Kelso, in how many cases he had seen rheumatism as a sequela of scarlatina. Dr. Kelso replied, about 20. Dr. Read then inquired had he tested the urine, if it was albuminous. Dr. Kelso said it was. Dr. Read then observed that it would have been a subject of interesting inquiry, if the urine in the rheumatic cases of the simultaneously prevailing epidemic, continued fever, had been tested for albumen.

Subsequently Dr. Read said he had been called one night to see a child aged 2 years, who died in about 12 hours after the visit. The case, subsequent evidence proved to have been scarlatina, without eruption – the epidemic appearing immediately in the usual form among the other children; and the father, who had previously had scarlatina, suffered the well-marked angina of scarlatina without eruption.

Dr. SANDER'S remarked that on several occasions every rational plan of treatment appeared deceptive. He had found in common with Dr. Malcolm that chlorine as recommended in Braithwaite's Journal, vol. 6, is occasionally very useful. He related a case of the congestive form in which the principal symptoms were prostration, languor of the circulation in the extremities, hot dry skin, great oppression, with some cerebral disturbance. In 12 hours after the use of these medicines, the skin became clean and brighter, and otherwise more natural, and the case proceeded from that time favourably. In the anasarca sequela he always looked upon depletion as a most valuable part of the treatment.

BELFAST MEDICAL SOCIETY.

Monday Evening, January 5, 1846.  
SAMUEL BROWNE, ESQ., R. N., IN THE CHAIR.

Dr. MATEER read the following interesting paper on the *complications of continued Fever*, which he illustrated by cases treated by himself in the Belfast Hospital: –

In fevers, complications occur with so much regularity and constancy, and influence to such an extent the progress and event of these disorders, that we are naturally led to consider them as their causes. This view, however, taking into account priority of occurrence alone, could be hardly adopted. There is no subject, however, relating to fevers, about which there has been so much discussion; and this has only tended to direct attention from the proper channel of inquiry, that, namely, into the essential nature of complications, and the real relation they bear to the many other morbid states and conditions constituting fever. Fever we may here define as resulting from a reaction of the system consequent on certain injurious influences, exciting and predisposing, and consisting in disturbances of the functions, occurring with more or less marked stages of increment and decrement during a definite period. This last is the most characteristic mark; definite duration serving better than any other for distinguishing febrile from inflammatory disorders, and even the species of fever from one another. Besides this, we may consider the nature and extent of complications as equally valuable for this purpose. They will be found to be distinctive, not only of fever generally – as, for example, of the simple and complicated kinds – but even of the species of this latter. Absence of complication, it has been supposed, is characteristic of simple inflammatory fever or synocha. Here there is never any, or but a trifling complication, and that resulting rather, as it would appear, from affection of particular tissues, than from derangement of organs and their functions, as occurs in the other instances. As to the relations, complications bear to the other states and conditions in the more serious forms of fever, the conclusions that have been come to from observations, are, 1st, that there are spurious and essential sorts of complications, and that the former may occur independently of, and without exerting much or any influence on the type of the disorder; 2ndly, that of the essential kind some are peculiar to and characteristic of synochus and others of typhus. But, first it may be premised, that the group, complicated fevers, might conveniently be made to include the two species, synochus and typhus; for in the milder forms of these, where, as often occurs, complications are not serious, there is mostly some

evidence of these existing in a marked or latent form. Our first inference is rather against the opinion, at one time generally held, that it is incompatible that two distinct diseases should co-exist. But nothing is of more frequent occurrence than to find patients admitted into hospital with diarrhoea, pneumonia, bronchitis, heart or spleen affections, or other local inflammatory complaints, where during the usual period symptoms of fever had progressed, and had been traced at their outset to contagion as their cause. The organic ailments had previously existed, and, progressing with the others, had either disappeared with them, led the fever to an unfavourable event, or had remained after the patient had convalesced. Thus, during a recent period, the month of December last, of 14 cases admitted into hospital, there were one of phthisis, one of peripneumony, one of bronchitis, one of hæmatemesis, two of pertussis, one of melœna, and one of pleuritis. In the greater number the fever was an eight-day one. In the two first, the two patients died on the critical day (about the ninth), from the lung disease; in the others, evident signs of febrile action had then ceased, convalescence being tedious from debility and exhaustion, consequent on the chronic ailments. The treatment was in these cases directed to the local affection, and the aggravation of this, or its relief by the remedies did not much affect the course of the febrile disorder. The last-mentioned of these is here given, as one about which there may be doubt, and as showing the difficulty of diagnosing between essential febrile action and that consequent on the local inflammation.

Case 1. S\_\_ C\_\_, aged 22, of robust habit, admitted on the 29th of December, on the fifth day of illness. Got a fall on side, which, with exposure to cold, brought on an illness which has increased till admission, when, along with the usual febrile symptoms, there were severe pain of side, increased on deep inspiration and cough with expectoration. V. S. ad XX xii.; a pill of calomel and opium gave relief. 30th – Friction rale distinct on right side; slightly so on left; pulse 90, hard; cough. Pulv. antimonial c. calomel and blister to side. 31st – Pain of side much relieved by the blister, but cough and muco-purulent expectoration continue; rales scarcely distinguishable. A cough mixture, with tartrate of antimony. January 2nd. – Pulse 98; skin hot, dry; tongue furred; much weakness and general soreness; no sleep; little or no pain of side, and that external; cough continues. 4th – Profuse sweats during the night; cough no better. From this date, convalescence seemed to progress in the usual way, and with the sense of soreness and debility experienced in this stage; but cough continues, as it may do for some time.

*Observation.* – This was considered to be a case where there was co-existence, but not a complication of pleuritis. In the three following cases there is fever with complication, and the species, that called synochus. The first shows a conversion of a synocha into a synochus; the second a synochus in its severer form; the third a conversion of synochus into typhus.

Case 2. A\_\_ M'K\_\_, aged 20; admitted on December 11, on the sixth day of fever, with the usual symptoms; and palpitations. 12th – Præcordial uneasiness continues; no cough or pain of chest, but abundant halitus from lungs; pulse 100; tongue furred. 13th. – Cough severe, and much expectoration; dyspnœa. To have cough mixture. 19th – Worse from pain of chest, which, however, is easier since application of a blister; pulse 120, strong; expectoration mucopurulent, with difficulty of breathing; face flushed. 20. – Incoherent; pulse 110, soft; breathing laboured; respirations 38 in the minute; no abnormal sounds on auscultation; sputa rusty 21st. – Cough easier; sputa not rusty; deafness; tongue clean. 26. – Return of cough with increased expectoration during the night. 28th Convalescent.

*Observation.* – Here there was simple fever at the outset, and till the 19th, when from predisposition a synochus form appeared, owing to complication of chest affection, which latter progressed with the fever itself.

Case 3. D\_\_ K\_\_, aged 45; mother of a family, all of whom are ill in fever; admitted on the 28th of December in the eighth day of fever. Cough; tongue furred, with a brown strip in centre. 30th. – Delirious since yesterday, requiring restraint; pulse 140, strong; skin hot, maculated; bowels regular; no tenderness of epigastrium; tongue furred; breathing hurried; halitus; cough. 30th. – Quieter since the evening; cough severe; breathing hurried; respiration 48; pulse 130, full and strong. Cough mixture. January 1st. – Blister applied for pain of chest in the evening gave relief; cough continues severe; respiration 40; pulse 120, irregular; sputa scanty; petechiæ vivid, red; bowels open from an enema. January 2nd. – Feels easier, but cough continues; incoherent; pulse 130, feeble; breathing more hurried; tongue dry; bowels confined. January 3rd. – Died this morning. *Observation.* – This case had been one of synochus throughout, the chest complaints progressing with the fever stages, but the system unable to throw off the congestion, which had determined more immediately to the lungs; these being the organs specifically deranged during this form.

Case 4. C\_\_ C., aged 43, married, admitted 21st November, on the eighth day of her illness. Cause contagion. Usual premonitory symptoms of \ fever with cough. 23rd. – Vertigo, vomitings, syncope,

palpitations. Tongue furred. 24th. – Measly eruption; præcordial uneasiness. 25th. – Cough but no vomiting. 26th. – Worse; pulse 120, weak; incoherent; much debility; bowels confined. Epigastrium tender on pressure. Tongue partly dry and brown. 27th. – Same as on yesterday, but vomitings. Pulse feeble. Tongue clean. 28th. – Delirious. Pulse 98, feeble. Tongue dry, brown, tremulous, with difficulty protruded. 29th. – Stupor. Dec. 2nd. – Convalescent. *Observation* – This case presented the aspect of synochus at its outset, but, about, the critical day, it assumed the typhus character, and, as such, progressed till the 19th day of the illness, when convalescence was established.

The complications in these, and the like cases, where synochus is more or less marked, are of a peculiar kind. They consist in a peculiar difficulty of breathing, with heaving of chest, hurried respiration, an abundant halitus from the lungs, particularly noticeable in a damp atmosphere, mucous, then afterwards purulent expectoration, often without much dulness of chest on percussion, or abnormal auscultation-sounds. Along with these, there are increased heat of surface, quick, hard pulse, uneasy feeling in epigastrium from fluttering or increased action of heart, petechial eruption; and incoherence. These symptoms occur in and are peculiar to synochus. Here, it is supposed, that the circulatory organs are more especially affected; and concurrent with such states, though not caused by their supervention, there is an increased intensity of the fever itself. As these occur at an advanced stage of the fever, they obviously arise out of its actions, and form part of them, but do not themselves cause the fever. This kind of chest affection and dynamic derangement of organs of circulation is diagnostic of synochus; as an abdominal affection, along with qualitative derangement of the secretions and fluids: the blood, in particular, is characteristic of typhus. Both forms, the latter in particular, tend to implicate the brain and spinal chord; whence in both there is nervous excitement from the outset, afterwards incoherence or delirium – of the sthenic kind in the one, and of the asthenic nature in the other. In both there is an eruption, obscure nearly, or, at most, vivid red specks in synochus; larger, more obvious or ecchymosed spots in typhus. These two last concomitant states, nervous excitement and eruption, are best seen in the extreme forms of these two species. However, there are gradations of forms, and states occur, where it is difficult from them to draw the precise line of distinction of the two species; as, for example, between the severer forms of synochus and the milder of typhus. In the mixed cases, where there is noticeable a transition of the one into the other, the same difficulty occurs, and when, as at

present, there is no epidemic prevailing, and that fevers assume no very decided type, such form often a large proportion of the cases. The best guide, then, is the nature of complications. It remains to notice what those peculiar to typhus are. These are perhaps better marked than the others. There are generally found a dry brown or yellow tongue, sordes, hiccup (in the advanced stages), tenderness of epigastrium on pressure, diarrhœa, or obstinate costiveness, distension of abdomen, yellowness of skin, high-coloured urine; signs caused by affection of the lining membrane of the intestinal canal, with hepatic derangements. The spleen (and, in the more advanced stages, the stomach too) appear to be less ordinarily complicated. These kinds of complications belong rather to fevers of an intermittent and remittent type, and so were very frequently observed during the last epidemic. The two following cases, one of typhus gravior, the other of typhus in its mildest form, will shew farther the nature of the concomitant phenomena.

Case 5. J. M'M., aged 45, labourer, and of intemperate habits, admitted December 9th, on the fourteenth day of fever; delirious and unable to state his history; maculated; pulse 180, weak; stupor; tongue raw, hacked; epigastrium tender on pressure. Fever mixture and wine. 10th. The same; pulse 112; towards evening, diarrhœa, sinking in bed, great prostration of strength. 11th. More delirious, picking off clothes; muttering; extremities cold, livid; maculae darkening; pulse 110, very feeble; "Risus sardonicus;" blister applied to head; much tenderness of epigastrium. *Augeatur vinum*; camphor; and Dover's powder; enema assafœtid. 12th. Died in the evening.

Case 6. A. M'C, aged 32, married, admitted November 16th, on 8th day of illness. Cause, infection, from removing to a house previously inhabited by a family in fever. Vomitings of dark bilious matters, head-ache, and chills, with pain of back and loins, and general debility, at outset of illness. Head-ache and chills have lately nearly disappeared; urine high-coloured. 17th. Slightly incoherent; pulse 130; sordes; bilious vomitings; halitus. 18th. Wandering continues; tenderness of epigastrium; tongue dry, brown; pulse 112. 19th. Head symptoms relieved; tongue as on yesterday; skin yellow. 20th. The same, but tongue cleaning and becoming moist. 23rd. Convalescent.

Cases of the kind here briefly detailed scarcely ever exhibit all the phenomena of their complications complete, some one or other being often absent; as in typhus, where the tongue is furred, or that diarrhœa is absent, or the opposite state, that of costiveness exists. But then it will be found that those that are present give evidence sufficient of the characteristic organic derangements. On the other hand, the

complications may be more than usually severe. This occurs when the subject is predisposed to organic ailments, has previously laboured under them, or is enfeebled from bad habits of living, innutritious diet, neglect of cleanliness, impure air, or has been exposed to intense virus. In such cases, the severer forms occurring, the complications are apt to lose their characteristic aspect; and, instead of forming a part of, and concurring with the other morbid states to a favourable crisis, they excite a new and more aggravated fever, under which the patient is likely to succumb. This happens, seemingly, when the stage of disorganization has set in; where there is reaction to remove it, and failing which, the functions cease to be performed. It is these severer forms that are usually viewed as the complications of fever; lesser ones being overlooked, or not considered as such, but unjustly so. The former, when present, are the cause of the increased intensity, and, too frequently, unfavourable event; the latter and less severe are never the cause; and the phenomena they give rise to when carefully traced out, serve to distinguish the species of fever. To complete the study of complications, it would be requisite to inquire into the nature of the part they act, and the modes in which they excite a more intense fever. For this, however, we should carefully consider the nature of morbid sympathies. It has been some such line of research, carried out to a great extent in the doctrines of fever, and applied to other diseases as well, that has formed the basis of a system appropriately called Physiological Medicine, and by many considered the only real philosophical or rational system.

In the discussion which ensued, the chief point of interest, of course, was the opinion of the author respecting the connection between the typhus type and the abdominal complications. It was observed, that, to substantiate this assertion, it would be necessary to draw up an extended series of cases of typhus, and observe whether the abdominal organs were more frequently and uniformly affected in them, than in a similarly extended series of other forms of continued fever. The subject was considered very important, and deserving of renewed investigation. The complications of continued fever are of essential moment; and however variable may be the opinions of authors upon the nature of the disease, the true and proper treatment must be based in a great measure upon their early and quick discrimination.

Some further interesting observations were made upon the different modifications assumed by continued fever during certain epidemics, as for example, during the epidemic of 1843. At this time several – nay, many, cases presented themselves, exhibiting many of the symptoms and features of the

yellow fever of the tropics; and indeed it was frequently called so. Such facts would tend to show that continued fever was primarily a disease of the whole economy, in which the complications were so many modifications produced by ever-varying etiological phenomena.

After the discussion on the paper, Dr. MALCOLM presented the following contribution (No. 1,) to the PATHOLOGICAL MUSEUM.<sup>1</sup> It was the right lung and pleura as they were found on examination in a case of *pneumo-thorax*. Two large cavities, one in the apex and the other in the middle lobe, were exposed to view. Immediately above the latter, was observed a round aperture, which led into the cavity. This opening was formed by the bursting of the walls of the cavity, and thus a communication was established between the bronchial tubes and the pleural cavity. Many old adhesions and bands were observed, connecting the pulmonic and costal layers, particularly at the apex. Tubercles in the crude state occupied the body of the lung, (For the history and other particulars of this case, see the Dub. Hosp. Gaz, Vol. I., p. 155.)

The next specimen (No. 2,) was presented by Dr. SANDERS, and exhibited recent portions of the diseased organs in a case of *gall-stones*. It contained a portion of the liver, the gall-bladder, pyloric half of stomach, first part of duodenum, and a portion of transverse colon. The general texture of the liver was friable, but in that part contiguous to the gall-bladder, a very dense almost cartilaginous structure was observed. Upon cutting through the latter, cysts, containing several gall-stones (one of the size of a hazel-nut,) were seen. The gall-bladder was much contracted, and quite separated from the cysts by the dense fibrous tissue above-mentioned. In the gall-duct, a calculus was observed, within one inch of its exit in the duodenum. The colon was much narrowed, and had contracted strong adhesions to the contiguous portions of the stomach and liver. The duodenum, pylorus, and remainder of stomach, presented a healthy appearance.

At the *post-mortem* examination, it was stated by Dr. Sanders, that, in the immediate neighbourhood of the mass of gall stories, suppuration had taken place to some extent.

The rest of the cadaver was not examined. The history of this case is as follows: Mrs. \_\_\_, aged 50, had been subject to severe dyspeptic symptoms for ten or twelve years past, which became greatly aggravated within the last two years. During the latter period, she had been repeatedly treated for the violent paroxysms of pain to which she was liable, and which she referred to the region of stomach and gall bladder.

<sup>1</sup> Established by the Medical Society in October last.

Her pulse was rarely much affected. This, together with a consideration of the seat and nature of the attacks, (which were characterized by sudden supervention and decline,) led Dr. S. to ascribe her sufferings to the passage of gall-stones. Her alvine evacuations were frequently washed, and searched by different members of the family; but they never succeeded in finding any gall stones. For the last four months, her general health became greatly impaired, and the paroxysms of pain were of such frequent occurrence, that she was constantly confined to her bed. She was reduced to a state of great debility – in a great measure from inanition, for the stomach became so irritable, that nothing would remain more than a few minutes until vomiting ensued. At one period (about two months ago), her skin became slightly jaundiced, and at this time there was more settled pain in the region of the liver, and also more excitement of pulse. Under ordinary treatment, she recovered from this but continued liable to as painful paroxysms as ever. For two or three weeks prior to death, the pain was so constant in the region of the stomach, and that organ was so very irritable, that it was considered probable that scirrhus of the pylorus was present. The most remarkable symptom, during the presence of the paroxysms, was the occurrence of large tumours in the course of the colon, evidently produced by flatus, but so hard to the touch, as readily to deceive, and lead any one to believe that there was solid matter in the intestine. Enemata, with assafœtida and turpentine, always dispelled these tumours more quickly than any other treatment, and frequently brought away scybalous fœces, after which there was some relief for two or three days.

The next contribution to the museum (No. 3) was presented by Dr. THOMAS READ. It was a specimen of *intus susception* in an infant. Dr. R. stated that he had been suddenly called to the case for consultation by a professional brother, who had been in attendance two days. The child was aged four months, and had been previously in the best of health. The chief symptom was obstruction of the bowels, not even complete, and unattended by any inflammatory or other severe symptoms. Vomiting had only recently occurred and took place only once or twice before death. The slight evacuations which did occur presented a sero-sanguinolent appearance. No indication that presented itself intimated the approach of the sudden fatal termination which ensued shortly after Dr. R. had seen the little patient. At the *post-mortem* inspection, upon opening the abdominal cavity, slight peritoneal inflammation presented its traces on the small intestines; and, upon first view, there seemed to be a large collection of fœces in the transverse colon, which, upon further inspection, was observed to be the seat of the

invagination. Upon more minute examination, it was found that the whole extent of the large intestine, from the cœcum to the sigmoid flexure of the colon, was in the state of *intus susception*, and presented strong marks of congestion and inflammation.

A specimen (No. 4,) of *pericarditis* was next exhibited by Dr. MALCOLM. The whole internal surface of the pericardium presented that peculiar velvety and punctuated appearance so characteristic of recent serous inflammation; and a band of lymph, about two inches long, was observed connecting the apex of the heart to the outer pericardial layer. The subject of the disease, Fanny C\_\_\_, aged 36, was admitted into the Belfast Fever Hospital on October 31st, 1843, having been then ill of febrile symptoms nine days. During the next 11 days, fever, obstinate vomiting, and debility, were the chief symptoms. From this till the 2nd December, she was apparently convalescing well, when she was attacked with relapse; rigors and vomitings again set in, and on this occasion were attended by much greater debility. After using various remedies, among which calomel and opium pills appeared to have most effect in quieting the stomach, death put a period to her sufferings on the 20th of December, 1843. At the *postmortem* examination, the only lesion discovered was that forming the specimen mentioned. In presenting the morbid parts in this case, Dr. M. regretted that a more particular and satisfactory account of the case could not be obtained, as it was peculiarly interesting in the circumstance of the symptoms having indicated gastritis much more than pericarditis.

Dr. MALCOLM next presented a specimen (No. 5) of *eccentric hypertrophy of the heart complicated with pericarditis*. The heart was of twice the usual size, and both ventricles were dilated; adhesions (which, however, were but slight) were universal between the two layers of the pericardium. A distinct membranous excrescence was observed at the edge of the tricuspid valve, and there was opacity of the aortal semilunars. In addition to the above morbid conditions, the bronchial membrane of both lungs was injected and thickened, and adhesive reddish mucus lined it throughout. The pulmonary tissue was generally congested: and at the apex of the left lung, a dense band of coagulable lymph was stretched between the layers of the pleura.

The history of the subject of this case was particularly interesting, and may be very briefly stated as follows: – A young man, aged 20, previously healthy, was attacked, after having accidentally fallen into the dock, with very severe inflammatory symptoms of the chest, especially, great dyspnoea and pectoral oppression, for which he was repeatedly treated by large and repeated bleedings, blistering,

and the administration of tartar emetic. Under this treatment, he received great relief, and was apparently recovering favourably, when the dyspnoea returned, accompanied with oedema of the ankles. Stethoscopic examination now indicated pleuritic effusion and bronchitis; and the very short, rough murmur heard with the first sound of the heart (as it eventually turned out) marked the existence of pericarditis. The pulse was 114, and soft and feeble, and there was great wake-fulness. In a few days after this report, he was suddenly attacked with the most urgent orthopnoea, and the most extraordinary palpitation of the heart, the pulse amounting to 185! Under the use of large doses of tartar emetic, his pulse fell in 12 hours to 140, and the dyspnoea became much relieved; subsequently the pulse fluctuated between 140 and 120. His respiration continued always about 40, and bronchial and mucous rales pervaded the whole chest, and masked every other sound. On several occasions the pulse became irregular, and it was ever excessively feeble; perspirations very profuse at times; purulent expectoration appeared several days before death, and faintings occurred on several occasions. During this distressing case, one stethoscopic phenomenon was uniformly remarked, viz., a mucous rale, with dulness on percussion, in left subclavicular region, which may now be explained by reference to the *post-mortem* examination. The duration of this case, from the first pulmonary attack till the fatal termination, was 12 weeks. The great interest attached to it lies in the very long period that the patient continued to linger of survivance under such intense pericardial inflammation; and in comparison with the account of the specimen (No. 4), presents a marked difference in every point of view.