in bed, and for three months after that a Sayer's jacket was kept on; she went on favourably in every way, and not only was the Potts' spine cured, with, of course, deformity, but the abscess became eventually absorbed. I examined her with the greatest care on June 21st last, and the following state of things was observed: Her appearance was healthy, though not entirely free from wear and tear; her pulse, temperature, and respiration were natural; a fulness, which when first seen had existed in the left iliac fossa, had entirely disappeared. No trace whatever of the abscess could be found on palpation, or otherwise. A severe pain in the spine, from which she had also on the occasion of my first seeing her suffered, had likewise disappeared. There was some little pain across the hips after sitting, and the left leg was weaker than the right; the bowels were moved every second day. The appetite, urine, and sleep were natural; there was neither perspiration nor vomiting. She could stoop, work, and get jolted in a vehicle without pain or uneasiness. A prominent spine, the slight pain and weakness I have referred to, and menses which were almost *nil* from the start of the disease, comprised the total of the obverse side of the pleasing picture. Though it is quite possible that in this case the remains of a partially absorbed abscess, which might recrudesce hereafter, might still be pent up in parts inaccessible to the sight and touch, yet all the probabilities go the other way, and the case may, I think, be fairly cited as one of those exceptional ones in which spinal abscess gets cured, and the rule of not allowing spinal abscesses to get very large comes in for inconvenient question. Some similar cases have, of course, been reported, but unhappily they are *rari nantes in gurgite vasto*. No one ought, I think, to propose to sacrifice the overwhelming majority for a few chance cases, and therefore these abscesses should be opened, if only a way could be found to obviate the terrible danger arising out of the existence of a long and tortuous line of inaccessible fistulae. I often asked myself, Was it possible that nothing could be done for those sad cases? and it was therefore with no ordinary pleasure that I read Mr. Treves's proposal for dealing with some of them.

Mr. Treves proposed to cut down direct on the bodies of carious vertebrae associated with abscess. He proposed to attain by such an operation four objects:

1. He would come into direct contact with the diseased areas.
2. He would open the suppurative collections at their points of origin, and evacuate their contents by the shortest possible route.
3. He would be enabled thereby to remove pieces of diseased bone.
4. He would be enabled to apply treatment direct to the local tissues.

Mr. Treves, however, proposed to confine it to the lumbar and last dorsal, and he does not state at what period of the abscess he would cut down on the spine. Now, it appears to me that, if the surgeon should wait until the abscess becomes apparent at one of the usual sites, the mere tapping of it at the proximal end, while furnishing an exit for detritus—which, no doubt, now helps to keep the sinus discharging—would not of itself prove sufficient to agglutinate the walls, and therefore dry up such sinuses.

We every day witness the continued patency of long fistulous tracts long after the disease at the proximal end has been cured. I do not see, therefore, how cutting down on the vertebrae, where a large abscess has been allowed to form, can, in the majority of cases, at all events, effect all the good we desire. I do not see either why this operation should be confined, as Mr. Treves proposes to confine it, to the lumbar and last dorsal. Such a restriction seems to me calculated to limit within too narrow a field its sphere of usefulness. I would extend it to the dorsal vertebrae, where it is we find the great bulk of the disease.

I am not blind to the anatomical difficulties which would beset cutting down on the vertebrae here. I do not, however, think that they are either insuperable or indeed at all comparable to those which have been successfully mastered in other regions of surgery. We might expect, for instance, that the pleura would occasionally be perforated, and that pneumothorax would ensue; but we have now a sufficient number of cases of this to prove that it is a very much less formidable affection than it was once supposed to be. It is not to be denied that it is much less formidable than interminable fistulae, whose existence affords a too certain presage of the patient's destruction.

Now for my second point. It will not, I maintain, do to cut down on vertebrae where an abscess can be seen and felt. The diagnosis of spinal caries having been once made, I would anticipate the external appearance of the abscess by cutting down upon the vertebrae at once, and maintain a direct opening with the diseased bodies. If disease should be really present, we might count on the presence of a considerable effusion around the bodies of the vertebrae; and this thicken-

ing might be counted on as a sufficient protection against the premature admission of air to the carious mass. The case of Potts' disease without abscess, if there be any such, would present a difficulty; but the thickening already referred to might here, as in the last case, afford sufficient protection against atmospheric action. On the other hand, if the diagnosis should be incorrect, and no spinal caries should be found to exist, no possible mischief could accrue to the healthy vertebrae themselves.

In conclusion I submit the above note to the Section with a profound conviction that for a disease which is but too often indeed the opprobrium of our art bold remedies offer the only resource.

Dr. ILLINGWORTH deprecated in the strongest possible terms the procedure recommended. The formation of any wound meant the incurring of new dangers. Aspiration, when the pus was fully formed, offered the safest means of prevention of septic processes. Spinal support during the process of aspiration was essential.—Mr. WALSHAM said that he considered Dr. Laffan's a very grave proposal. He understood Dr. Laffan to advocate cutting down on the dorsal vertebrae in cases of spinal caries, for the purpose of preventing the formation of an abscess as well as for the early evacuation of the pus, should such form. Such a procedure appeared to Mr. Walsham fraught with danger, as a deep wound would have to be made, probably a portion of a rib or two would have to be excised, and the pleura might easily be opened. On the other hand, if spinal caries was treated early by recumbency combined with some efficient support, the great majority of cases recovered without any suppuration. In the lumbar region cutting down on the vertebrae, as suggested by Mr. Treves, was no doubt, in suitable cases, of service, but Mr. Walsham would hesitate to attempt such an operation for caries in the upper dorsal region, even when pus had been formed.—Mr. EDWARD L. FREER (Birmingham) was in favour of aspiration where possible; when impossible, recourse should be had to free incision, with antiseptic dressings, weak iodine injections, and free drainage. Some disappeared altogether if the spondylitic vertebrae were kept at rest, so he did not advocate early operative interference of any kind.—Dr. GIBNEY (New York) advocated the directing of treatment to the bones diseased, and claimed that, when sufficient mechanical support, long continued, was provided, it was quite unimportant to give any attention to the spinal abscess. The cases thus managed, in New York city at least, gave satisfactory results. He was convinced that orthopaedic surgeons, as a rule, aimed to fix the spine and seldom treated the abscess.—Dr. LAFFAN, in replying, expressed his astonishment at the amazing number of cures which the speakers had had, and he invited them to authenticate them by publishing them. As for him, he had had no such success; and as far as he could gather, and he had inquired in several quarters since the commencement of the meeting, his experience was not unique. If the disease, therefore, was so fatal, he maintained that for it the remedy he advocated was the proper one. Some of the speakers had talked about the antiseptic treatment, but its advocates asked too much from it. He had tried it in these cases, and it had not saved them. He aimed at two objects in bringing that paper before the Section: the first one was to bring once again under public notice a line of treatment which should recommend itself, if for no other reason, because it had been suggested by so able a surgeon as Mr. Treves; and next, because he desired to extend and develop an operation which, he repeated, alone held out any rational prospects to patients.

TWO RARE GROWTHS OF THE SOFT PALATE.

By CLARENCE ELLERMAN, M.D. HEIDELBERG.

THE two cases which are described at length below present a certain amount of interest, on account of their uncommon occurrence, and this reason, I consider, justifies their publication.

CASE I.—Mr. S., aged 20, a student, came to the Heidelberg throat clinic (Professor Jurasz) to seek advice about his throat. On examination, he was found to be suffering from granular pharyngitis. Moreover, during the exploration of the pharynx, a small tumour was noticed lying somewhat to the right of the uvula, and partially concealed by the same; in length it measured about three and a half centimetres, was elongated in shape, and in colour agreed with the surrounding mucous membrane. To obtain a good view of it, it was necessary to seize it and draw it forward. The tumour was mobile, slightly narrowed at the base, of a soft consistency, and quite painless when manipulated. Its general appearance gave one at first the im-

pression of a large papillomatous growth, like those which, as is well known, are frequently observed at the base of the uvula. This view was, however, not confirmed by microscopical examination. The removal was easily performed without any loss of blood by means of a galvano-cautery snare. It was now for the first time observed that the surface of the tumour was not smooth and continuous, but partially divided into several portions by lateral fissures. It should also be mentioned, as it has its importance, that on the right side of the soft palate, the space between the anterior and posterior arches of the same was unusually large and deep; this appearance was found to be caused by the total absence of any trace whatsoever of the tonsil at its usual resting place. On the left side no such anomaly was apparent. The young man declared that he had never felt any inconvenience from the presence of the tumour, and that he had, in fact, been quite unaware up till now of its existence. The microscopical examination gave the following interesting results: The tumour failed to show any analogy to the characteristic texture of a papilloma, but presented a histological structure unmistakably like that of tonsillar tissue. A careful study soon left no doubt that such was the case. Tonsillar crypts, coated with a fine layer of stratified epithelium, were plainly discernible. The walls of the lacunae were studded with numerous compact nodules of lymphatic tissue, the so-called lymph-follicles. These follicles presented the well-known reticulated structure, containing in its meshes innumerable leucocytes. The epithelium rested on a fine, almost invisible, basal membrane, which separated it from the mass of adenoid tissue which lay below. Towards the centre the connective tissue of the stroma had taken the place of the adenoid tissue, and was concentrated into a dense fibrous structure very poor in cells. Several large, greatly dilated blood vessels (arteries and veins) traversed it, ramifying towards the periphery. It was, broadly speaking, identical with tonsillar tissue, and there remained no doubt that the removed tumour was an aberrated tonsil.

The case which I have just described may be, I think, accounted a somewhat rare occurrence. However, the fact that similar occurrences seldom are observed is no positive proof that they seldom occur; for it can be readily understood that such tumours, by reason of their unimportant size and the absence of any symptoms of incumbrance, often escape notice, and even when they are now and then removed, they seldom undergo a microscopical examination.

CASE II.—Miss L., aged 28, noticed for some time back that she had a pendulous tumour hanging from the soft palate, which caused all sorts of unpleasant sensations in the mouth, accompanied by a copious flow of saliva. On examination, a long, purplish looking growth was perceived on the right half of the soft palate, lying midway between the tonsil and uvula. It presented a smooth surface, and was of a yielding consistency. It was removed by the galvano-caustic process. On being examined microscopically the growth, which was composed of different papillae coated with epithelium, presented a peculiarity in respect to the condition of its blood vessels. The first thing that struck one on looking at a section through the microscope was the enormous size and development of the capillary vessels as compared with the size of the tumour itself. (This condition could be easily perceived with the naked eye on holding the section towards the light.) The capillaries were enormously dilated, ran in the centre of the papillae, and ended in the shape of a bulbous expansion. In some parts the vessels seemed to be unaccompanied by connective tissue. It appeared as though the pavement cells of the epithelium were intimately connected with the endothelium of the dilated capillary vessels. Careful observation, however, showed this view to be a mistaken one; there still existed between the epithelium cells and those of the capillaries a very delicate, almost invisible, partition of connective tissue, which appeared to be in a state of atrophy. At the point where the tumour had been severed, the walls of a large artery were to be seen. Further, in two places, clumps of adenoid tissue were visible, which were evidently to be considered as follicles. The connective tissue matrix was, moreover, in some places very rich as regards cells.

Now this is undoubtedly the picture that would be presented by a plexiform angioma, and this is what I consider it to be. It is, however, not impossible that it originally existed as an ordinary papilloma, and that through the action of the negative pressure, which arises in the pharynx during the motions of swallowing and suction, upon the vessels on the surface of the tumour, the vessels were in a constant state of dilatation, and *ektasia* was the result. An analogue for this is found in the distension of vessels in granulations which appear at the edges of a tracheotomy wound; in the latter case it is of course the result of the inspiratory dyspnoea.

THERAPEUTIC MEMORANDA.

THE ODOUR OF IODOFORM.

THE odour of iodoform, the *Pharmacopœia* states, is "persistent and disagreeable," and to some these characteristics are so intense that it is avoided in practice, and less efficient agents are used. Various attempts have been made to disguise the odour by oleate of zinc, eucalyptus, coffee, coumarin. The latter substance seems to effect this better than the other agents, but yet it is not perfect.

From a series of comparative trials I beg to offer the following prescription as securing the end in view.—R Iodoform, gr. 60; ol. amygdalæ, ℥ijss; ol. theobrom., ℥ijss; ol. myristicæ, ℥xx; moschi, gr. iij; coumarin., gr. vj; sp. tenuior., ʒi. The essential ingredient here is musk. To some people, however, the smell of musk is also disagreeable, and the other substances are added with the view of leaving a pleasant odour, neither of musk nor iodoform. If the iodoform is desired for dusting purposes, as in soft chancres or burns, the combination of 1 grain of musk to 10 or 15 grains of iodoform is satisfactory. These prescriptions have been made up by leading pharmacists here, and they bear willing testimony to the facts mentioned.

MATTHEW CHARTERIS, M.D., Professor of Therapeutics and Materia Medica, Glasgow University.

SMALL DOSES OF MERCURY IN SYPHILIS.

I AM anxious to bring before the profession a plan of treatment which I have tried in cases of primary syphilis for more than ten years, a treatment which has been attended with uniform success, and without any further symptoms after the primary ones have passed away. A modified plan of the same treatment has been most satisfactory in its results in more advanced cases.

The great secret of the treatment consists in the dose, which can be continued an indefinite length of time, enabling the practitioner to sweep out every trace of syphilis; and it will be found that when all the primary symptoms have disappeared no tertiary will follow. Sometimes a slight recurrence of the primary appears, which will quickly yield to a return of the treatment, and I have invariably found that time and patience complete the cure.

My plan has been in cases of hard chancre to give hyd. c. cret. gr. ʒ ter die, giving any tonic or other medicine with a view to keeping the patient in the best possible state of health, avoiding too much stimulant such as spirits, wine, or beer; this should be followed up for a month or longer at the discretion of the practitioner, when the dose can be given *bis die*, and after three months or longer, once daily for a considerable time. Should the symptoms be rebellious after the third or fourth month, I give in addition liq. hydrarg. perchlor. ℥v—℥x *bis terve*.

I intended to have brought this treatment before the profession several years ago, but was most anxious to be sure of my statements as shown by many typical cases which I have kept in view for many years.

S. C. GRIFFITH.

Finsbury Square, E.C.

STROPHANTHUS IN HEART DISEASE.

DR. SUCKLING's memorandum on his experience of strophanthus in heart disease comes as a thunderbolt: it certainly is at variance with the general opinion of the profession. I have used Hewlett and Sons' tincture for the last six months with immense advantage in heart affections, more especially in cases where digitalis seemed to be doing more harm than good. I quite agree with Dr. Suckling that digitalis will often do good after strophanthus has been given without relief, but this simply proves that the action of the two drugs is not the same. Strophanthus has, in several of my cases, produced an intermittency in the heart's action, always relieved by increasing the dose, (this symptom I have never seen mentioned by other observers). The salicylates can be given in combination with strophanthus when they cannot be borne alone on account of their depressing action on the heart. In conclusion, I may say strophanthus is of inestimable benefit in inorganic heart affections.

Plymstock.

EDWARD G. DUTTON.

THE TREATMENT OF HABITUAL CONSTIPATION.

AN hour after reading the memorandum of Dr. Althaus, p. 1379, on Dr. Oldtman's method of treating the above affection, I had an opportunity of trying it. Two days before I had performed herniotomy on an old man aged 74, and found that morning very distressing meteorismus, with a rising temperature, which opium had not prevented. The remedy was obviously to empty the colon with the least